

PRIORITIES in ADVANCING HIGH QUALITY VALUE-BASED HEALTH & HEALTH CARE

CMMI catalyzing innovative health system transformation

A Discussion Series convened by the National Academy of Medicine

EXPERT PANEL OVERVIEW ASSESSMENT

May 2021

OVERVIEW SYNOPSIS

Establishment of the Center for Medicare & Medicaid Innovation (CMMI) was a key provision of the Affordable Care Act. Creation of CMMI reflected from the outset that bold change and rapid learning would be required for the magnitude of improved effectiveness and efficiency needed in US health system performance. For the past 10 years, CMMI has sought to identify and assess how alternative payment strategies perform in improving outcomes without increasing costs. To date, nearly five dozen models have been implemented. Although a number have provided delivery improvements and cost saving insights, for example through shifting care to lower cost sites and strategies, most have not yet demonstrated the level of savings theoretically possible. There are several likely explanations for this: for example, the voluntary nature of participation leading to market distortions; system fragmentation and poorly aligned incentives blunting targeted impact; scope of health care services being too limited to address primary illness (and cost) drivers; ease of opting out when revenue prospects narrow. These issues speak not to the potential for better care at lower cost, nor to the prospects of using real-world experiments to identify better delivery strategies. Rather, they speak to the need for a bold and strategic pivot in the roles and activities of CMMI as a leader and change agent, internally and externally, in the context of broader CMS and Administration strategies for health system transformation.

It is very clear that the “fee for service” chassis on which the US health system is constructed cannot deliver effective, efficient, and equitable results in today’s, and certainly not tomorrow’s environment. On this, there is virtual consensus. As understanding and services grow in medicine and health, the multiple sources of illness, nature of the services, and sites required for those services simply must be more integrated in planning, delivery, payment, and accountability to the needs of individuals and families. By starting with the basic assumption that health and health care services must be more integrated and aligned, with each other and with beneficiary needs, CMMI can sharpen its focus to activities aimed at achieving four fundamental goals: 1) clearly positioning the beneficiary as the north star for all activities; 2) assuring the primacy of equity in every decision; 3) fully linking with services aimed to engage the community and social drivers of health; and 4) aligning payers and integration of payments, prospectively designed around incentives for services most important to the health needs of individuals and families.. To expedite the transformations required, CMMI should enhance its innovation role, adding to its current role of principal model builder, a role as principal facilitator—facilitator of system-wide alignment in aims and strategies, facilitator of the use of Medicare and CMS-wide levers for changes needed, facilitator of synergistic and supportive policies of other agencies within HHS and throughout the Administration.

Immediate actions toward this vision include: clear statement of broad role and commitments as a strategic change agent; priority to expanded primary care and prevention, with accelerated introduction of mandatory all-payer population-health focused primary care models with two-sided risk; accompanying mandatory specialty care bundles and episode models; expressed intent to use the purchasing power of Medicare to catalyze counterpart all-payer changes, including for Medicaid; annual beneficiary assessment to develop trackable metrics on care match with patient goals; immediate requirement that all models and demonstrations require collection and reporting core data on race, ethnicity, and related key social drivers of health; develop a support model for mental health, behavioral health, and social services, including screening and navigation strategies, community-based risk adjustment instrument, and business-community partnerships; program to work with states on the use of new resources to build infrastructure for advanced models; and a commitment to work with stakeholder groups in the development of a roadmap to whole person and population health-oriented health financing, including a small number of visible and measurable goals, benchmarks, and timetables.

CONTEXT

The health system in the United States requires transformation dependent on Medicare and Medicaid program changes for which initiatives of the Center for Medicare & Medicaid Innovation (CMMI) will be catalytic. Shortfalls in US health system preparedness and performance have been long standing with respect to effectiveness, efficiency, equity, and patient experience. During the COVID-19 pandemic, those failures were undeniably prominent and harshly accentuated. From January 2020 when the first reported death occurred in the US due to COVID-19, the nation has been gripped by three simultaneous catastrophes—a deadly pandemic, a health system unprepared with entrenched incentives wrongly targeted, and the constant and visible presence of the tragic consequences of inequities and structural racism. Among the nearly 600,000 deaths from COVID-19 that have now occurred nationally, the likelihood of fatal illness was more than three times higher for those of lower socio-economic status. Overall, blacks have experienced death rates twice that of whites, and Latinx groups have had 2.4 times the death rates. However, victims are not confined to those who often suffer disproportionately from illness or injury. People from all walks of life fell ill and found themselves confronted with a health, social, and political system that was unable to provide them or their families with needed protection, warning, guidance, or treatment, and many struggled to access the basic transportation, food, and shelter needed to maintain health.

Clearest among the painful COVID-19 lessons is that the fragmentation representing the most prominent feature of the US health system—in design, access, delivery, follow-up, and financing—constitutes a pervasive disruptive force to expected health and health care outcomes and equity. Whether from the perspectives of individuals—patients and families—or from those of taxpayers and insurance purchasers who collectively bear the financial burden, the change needed is neither singular nor marginal in nature. First and foremost, orientation of the levers of policies, programs, and services should be engaged through the lens of the beneficiary to ensure that those levers are deployed to shape strategies that optimize the seamless access and integrated delivery of health and health care services. The lessons of the first ten years of CMMI’s program—both successes and failures—provide insights necessary to identify, encourage, and require payment and delivery that is tailored to patient needs and circumstances, facilitates services from multiple domains, and designs structure and accountability for overall performance in meeting the holistic needs of people and populations, rather than around individual service encounters.

This represents a substantial departure from the *status quo*. They are not changes that will find success in the slow and incremental. Whether from the perspective of patients, clinicians, employers, or taxpayers, the level of dysfunction resident in the current system cannot be repaired without a substantial overhaul. Strong primary care is essential, and the purchasing power of Medicare is central to driving payer alignment, facilitating Medicaid improvement, and fostering system-wide transformation. We feel that CMS/CMMI should be clear that it, and the Administration, is firmly committed to bold actions and measurable results for each of four broad priorities: 1) establishing the individual **beneficiary** as the central reference point in orienting program design; 2) ensuring that **equity** is a primary goal of program design and implementation; 3) facilitating, enabling, and investing in

seamless and sustainable avenues between and among medical and **social** services where required and feasible; and 4) aligning payers and **integration** of payments for the coordinated momentum needed to promote whole person perspectives, continuity, and individual and population results in services delivery and financing.

With respect to CMMI's current activities, this will require reducing and focusing models now in play, actively coordinating them, introducing mandatory elements, robustly using waiver authorities, specifying program goals, and linking evaluation to goals. But it also requires a strategic reorientation in CMMI's role and activities. In the observations presented below, our aim is not to review lessons learned from the CMMI initiatives to date—that has been nicely done elsewhere—but to underscore the importance of a bold and vigorous agenda targeting the priorities most important for our nation. They suggest the importance of CMMI altering its role, shifting from its principal role as a model builder, and toward its role as a principal facilitator of system alignment, use of Medicare and CMS-wide levers for change, and facilitator of synergistic and supportive policies of other agencies within HHS and throughout the Administration.

ANCHOR COMMITMENTS

Beneficiary as the North Star

It is all about people. In a health system oriented to those served, the care component is riveted on the needs of people and their families, the public health and social service components are robust, and the interfaces are seamless. Medical care is accessible, affordable, effective, integrative over the life course, and tailored to individual health goals; functional linkages and support are available for social services when needed; and public health effectively interacts with medical care through interoperable data and communication systems. Accountability measures are focused on organization- and system-wide performance, reflect the most important health factors, are few in number, standardized system-wide, and are easily understood by beneficiaries, clinicians, and policy leaders alike.

These are not characteristics of the US health system, which is dominantly distinct in its level of fragmentation, not its integration. A siloed financing system has incentivized a care delivery system that to date has not focused sufficiently on the goals and needs of its patients and communities. With the increased complexity of diseases, prominence of behavioral and mental health challenges, and changes in social circumstances, the need has become more acute for a navigating agent for care processes. Yet primary care, a putative source of navigation, has provided only weak supports. Because training, incentives, economic pressures, and practice constraints have provided barriers, rather than encouragement of the necessary skills and capacity, CMMI models and initiatives going forward will need to incorporate standardized social determinants of health elements. Beneficiaries—and clinicians—should be part of the development and piloting process. Especially important in this respect, is development and deployment by CMS/CMMI of an evaluation lens that is explicitly reflective of beneficiary input and, mindful of the CMMI mandate to reduce total cost of care, accounts not only for net savings but aggregate value returned. Economic analyses should focus on the full range factors engaged and enhanced in the value equation—e.g. racial equity, match of services with patient goals, workforce benefits, and related returns to families and communities.

Equity in every policy

The most shameful blemish on the nation is the 400-year history of racial oppression and the glaring health inequities experienced by blacks. And other population groups—e.g. Latinx, Indigenous, transgendered—also experience harmful health inequities. The National Academy of Medicine publication, *Vital Directions*, released earlier this year headlined “Health Equity: The Most Vital Direction in 2021.” The numbers are stark. Black Americans have life expectancies half a dozen years lower than whites, infant death rates that are more than twice as high, chronic disease deaths that are higher by 19% for cancers, 30% for heart disease, and 23% for diabetes. Since 2019—well before the pandemic—life expectancy has actually been declining for blacks. It is very clear that beyond the challenging health risks confronting people in different circumstances, people of color have the additional burden of confronting the forces of structural racism.

CMMI has the opportunity to develop the strategies and levers for corrective actions by ensuring that every policy, program, and demonstration explicitly assess and promote equity. Testament to the challenge is the fact that to accomplish this, step one still needs to be taken: ensuring that core data on race/ethnicity, SES, disability status and social drivers of health are collected as foundational elements of every model. In doing this, CMMI can collaborate with CMS’s Center for Clinical Standards and Quality (CCSQ) and Center for Medicaid and CHIP Services (CMCS), in addition to advancing mechanisms to capture higher quality data. In the meanwhile, data available from other sources can help guide immediate actions sharpening the focus on equity.

CMMI models should be constructed to require each to assess outcomes related to equity and derive learnings, successes, and lessons to consider improvements in subpopulations that might decrease the disparities currently experienced among people of color, those with low income, those with disabilities and chronic conditions, children with special health care needs, among others. Payments can be linked to closing disparity gaps, with particular attention to disparities among children that may have lifelong consequences. To advance the equity in payments across markets and within markets, consideration by CMS of approaches to the conduct of equity audits on all CMS programs could help advance system-wide equity profiles.

Community and social drivers of health fully engaged

Health is said to often be the product of where we live, work, play, and pray. For many Americans the strongest set of health drivers resides in their social circumstances—their incomes, education, housing, food choices, transportation, social networks. These factors are important not only as causes of poor health outcomes, but also as means of intervening to improve related conditions and outcomes and reduce costs. Their assessment, and facilitation of their engagement, should be a routine element of care quality, including the use of data indices that facilitate attention and targeting, including by driving investment in progress against social drivers.

Appreciation of the importance of social determinants of health status led CMMI to explore a strategic focus on both individual and community factors in program and model design. Building on the experience, CMMI should consider engagement of non-medical home and community-based care where applicable in all payment models, and expand successful models of regional support in population, community health, and medical care-public health coordination. Experience from the work to date with

Accountable Health Communities, offers insights that can shape further exploration of approaches testing universal screening for beneficiaries for social drivers of health, navigation to community services, standard social services fee schedules, and community risk-adjustment quotients. Supportive initiatives can engage partnerships across medical and non-medical sectors—e.g. housing, food, transportation agencies—at federal, state and local levels in the design of these approaches, in the development and application of assessment measures, and in Administration-wide work on blending resources for sustainable financing of a whole person and population health-oriented health and health care system.

Payments integrated and aligned

Form follows function, and as long as payment profiles function primarily to reward service volume and delivery settings disconnected from each other, and from the principal health drivers for certain individuals, the US health care delivery system will continue to vastly underperform on effectiveness, efficiency, equity, and the experience of patients and clinicians. This is not news. CMMI was created to find a better way. With 10 years of experience in hand, some of the limited results relate to the lack of alignment in models within and across payers, pulling providers in multiple directions and distracting from the core need to change care delivery. It is now time for CMMI to reduce the number of models in play and focus its investment portfolio on a more targeted strategy, with longer term perspectives. Priority should be given to models that are mandatory and prospective, models that work with each other to move payments away from fee-for-service to those focused on ongoing commitment to value and accountability for total cost and quality, and mandatory multi-payer alignment on both dimensions. The introduction of a mandatory component will add a measure of standardization necessary for reliable learning, as will multi-payer alignment.

Moreover, it is now time to develop the roadmap and action agenda to move forward with a population health perspective, including advancing related models for the Medicaid population. The approach could take on a hybrid flavor, including introduction of mandatory all-payer primary care models with two-sided risk, along with specialty care bundles, mandatory episode models of proven productivity, and schedule for testing others. The development of “playbook” assistance will be required to facilitate the transition to shared-risk and savings, and should be coupled with streamlined assessment strategies on simple outcomes derived from previous work on core metrics, including that of the CCSQ and the NAM. To accelerate expansion of lessons from CMMI’s experience with Accountable Health Communities, additional support should be given to promotion and evaluation of comprehensive population-based payments, building on CMS Health Care Payment Learning and Action Network (LAN).

IMMEDIATE STEPS

Public announcement of directions & priorities

Signaling is important. Although most of the activities we have described are within the purview of the CMMI Director, they reflect bold strategies and priorities important for Administration-wide emphasis. A very bold signal would be an Administration-wide public announcement of the commitment to the integrated primary care and population health strategy envisioned in the four goals described, involving the White House, HHS Secretary, CMS Administrator, and CMMI Director, as well as other Cabinet Secretaries central to programs important to a coordinated multi-sector health and equity strategy.

Given the complexity and scope of the issues actions to be defined, a more realistic approach may be to obtain the general strategic agreement from the Secretary and the Administration, then taking the preparatory steps required, while announcing a CMS-centric set of activities in the near term, including those that follow.

Immediate actions

Certain immediate actions can be taken to give momentum to achieving the anchor priorities—e.g.

1. *Beneficiary as the North Star*

- Articulate tangible benefits to people and their families, in terms easily relatable.
- Announce (piloting) annual beneficiary query to yield basic information on care match with patient goals, with over sampling of dual eligibles.
- Announce public conversations engaging beneficiaries (and their advocates), payers, employers, and other stakeholders on the broad priorities, anchor commitments, and the strategies for partnerships with beneficiaries to identify value.

2. *Equity in every policy*

- Announce that all models and demonstrations will require collection and reporting of core data on race/ethnicity, SES, disability status and social drivers of health, enabling stratifying and reporting outcomes accordingly.
- Announce approaches to the conduct of equity audits on all CMMI models, along with CMS exploration of related opportunities throughout its programs.

3. *Community and social drivers of health fully engaged*

- Establish capacity for working with states in applying COVID relief funds to support development of infrastructure for state-based models to bring broad non-medical stakeholders to the table to best utilize their skills, experience, and resources as part of new mandatory elements of path to population health-oriented, advanced primary care thrust.
- Commit to robust exploration of support model for social services—e.g. screening and navigation strategies, social services fee schedule, behavioral health strategies, community-based risk-adjustment instrument, business-community partnerships.

4. *Payments integrated and aligned*

- Announce reduction in number of models, stronger alignment across models, and increased focus on advanced population health models including expanded all-payer primary care models (e.g. team-based, integrating behavioral health and social service connections) with two-sided risk, along with mandatory specialty care bundles, and episode models.
- Assess all models for performance on total cost of care accountability, multi-payer alignment, beneficiary lens, equity, engaging social drivers.
- Express intention to focus on broad results, using Medicare leverage and all-payer strategies to advance innovation system-wide.

- Convene chief executives of payer organizations, along with employers, providers, patient groups and other stakeholders, for discussion of strategies, priorities, and opportunities for collaboration. CMS' HCP-LAN is a logical locus for ramping up the focus on alignment.

5. *Targets and measures*

- Timetable for developing targets (e.g. on % patients in models with: two-sided risk; mandatory elements; capitation; multi-payer requirements; equity metrics reporting; total costs of care).
- Timetable for piloting results from small set of core measures expected for every beneficiary.
- Incorporate into broad roadmap for change, the adoption system-wide of a core set of assessment measures.

As CMMI has tested approaches for the US health system to achieve the level of results warranted from the size of its investment, its first 10 years has generated important insights from numerous creative, often complex, and highly variable models and demonstrations. Because several thorough assessments have been undertaken to reflect on the activities and results of the past decade, our intent has not been to re-evaluate those activities, but to juxtapose the overall insights gleaned with the realities and urgency of capturing the opportunities of today. We conclude that now is the time for bold departures from approaches overly beholden to prevailing practices, incentives, and the distortions of incremental manipulations. We therefore urge CMMI to devote its full authority and creativity in forging a clear path to a health system that is visibly anchored on the beneficiary, elevates the primacy of equity, fosters seamless medical-social-public health interfaces, and is following a clear roadmap for the course to the integrated payment approaches necessary.

NOTE: This document was developed to provide contextual background to a Discussion Series convened by the National Academy of Medicine on priorities in advancing high-quality value-based health and health care. **The perspectives in the document reflect the views of the experts convened, and not necessarily those of their respective organizations or the National Academy of Medicine.**



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