Roundtable on Safety Net Provider Participation in CMS Innovation Center Models
March 16, 2022

>>Adam Obest, CMS: Good afternoon. My name is Adam Obest with the Center for Medicare and Medicaid Innovation, part of the Centers for Medicare & Medicaid Services.

Welcome to today's event, "Roundtable on Safety Net Provider Participation in CMS Innovation Center Models."

Before we start today's roundtable, I'd like to go through a few housekeeping items. As you heard a minute ago, the roundtable today is being recorded. Closed-captioning is available by clicking the CC button on the bottom of the Zoom platform or by going directly to the closed-captioning website found at the link posted in the chat. A transcript for today's event will be made available at a later time. All attendees will be muted throughout this event. You can, however, provide a written comment using the Q-and-A window on the bottom right of the screen.

Again, thank you for joining us today.

And I am now pleased to turn it over to Tequila Terry, Director of the Prevention and Population Health Group and the State Innovations Group, to provide an overview of the session. Tequila, the floor is yours.

>>Tequila Terry, CMS: Thanks, Adam, and good afternoon, everyone. We're so excited to have you a part of today's session.

Again, my name is Tequila Terry, and I serve as the Director of the State Innovations and Prevention and Population Health Group at the CMS Innovation Center, and I'm honored to be cofacilitating this roundtable with Dr. Dora Hughes, who serves as the Chief Medical Officer at the CMS Innovation Center and leads the implementation of our health equity strategy in collaboration with our dedicated colleagues across the CMS Innovation Center.

As you can see from the agenda, we will hear brief opening remarks from the Director of the CMS Innovation Center, Dr. Liz Fowler, and then Dr. Hughes will give a brief overview of the Innovation Center's health equity strategy areas of focus. After that, I will turn it over to our illustrious roundtable participants, and we'll have three panels of thought leaders who will share their perspectives and recommendations for the CMS Innovation Center really on the idea of how do we increase and encourage participation of safety net providers in CMMI models?

I'm now pleased to introduce Dr. Liz Fowler, the CMS Deputy Administrator and Director of the CMS Innovation Center. Dr. Fowler, please go ahead.

>>Liz Fowler, CMS: Thanks so much, Tequila, and good afternoon or good morning depending on where you're sitting. We're really grateful to all of you for making time to engage with us on what the CMS Innovation Center is doing to advance health equity.

Today's roundtable stems from the Innovation Center's white paper that we released in October and details our vision for attaining a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. As part of our strategy to improve quality and outcomes, we're committed to embedding equity into all aspects of our models and increasing our focus on underserved populations. Advancing health equity has become one of the most important areas of focus for the Innovation Center, for CMS and HHS more broadly, and for the Biden-Harris administration. The strategy we've adopted is tied closely to Administrator Brooks-LaSure's strategy for CMS as a whole with key elements of our strategy linking back to the agency's broader agenda to make sure we're all working together in harmony to achieve a larger vision for our beneficiaries and enrollees.

The roundtable is part of a series of listening sessions to operationalize the Innovation Center's strategy. As Dora Hughes, Dr. Hughes, will be sharing in more detail, the Innovation Center's equity strategy has a focus on addressing barriers to participation for providers that serve a high proportion of underserved and rural beneficiaries. While we're looking to increase safety net provider participation in our models, I'd like to highlight some of our current work in this area, first, the primary care program under the Maryland Total Cost of Care Model, which has committed to Medicaid alignment by 2023 and will further support participation of federally qualified health centers in the model to reach vulnerable populations in the state. The Pennsylvania Rural Health Model and Community Health Access and Rural Health -- Rural Transformation Model, or CHART, both include rural acute care hospitals as well as critical access hospitals to support health transformation in rural areas. And then, finally, we just announced ACO REACH, which includes a health equity benchmark adjustment to address payments for ACOs serving higher proportions of underserved beneficiaries in order to mitigate disincentives for ACOs to serve in those communities.

The CMS Innovation Center certainly has more work to do, and I feel strongly that we can learn from all of you as we move our work forward. Achieving our vision will require a partnership with patient advocates and beneficiaries, community-based organizations as well as providers, payers, purchasers, and states, so we really appreciate your time and thoughts so we can all be working together in shaping a health system that best serves our communities, especially underserved populations. From here, I'll turn it back over to Dr. Hughes, and she'll provide an update on the CMS Innovation Center's health equity strategy. Thanks very much. Dora?

>>Dr. Dora Hughes, CMS: Thank you. Thank you, Dr. Fowler.

As Dr. Fowler mentioned, the CMS Innovation Center is increasingly focused on health equity. We have been holding listening sessions and roundtables following our October launch of the strategy refresh, and we are excited to dive deeper into implementation with today's focus on safety net providers.

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As many of you know, Congress provided CMS the authority through the CMS Innovation Center to test innovative models as part of the Affordable Care Act. The goal of the models is to preserve or enhance the quality of care for beneficiaries in Medicare, Medicaid, and the Children's Health Insurance Program

while spending the same or less. On a tactical level, this means that the CMS Innovation Center can, for example, change the way we pay for services and then evaluate whether that change improves quality or reduces costs. As described in much greater detail in the white paper "Driving Health Systems Transformation: A Strategy for the CMS Innovation Center's Second Decade" that was released in October, the CMS Innovation Center will be focused on building a health care system that achieves equitable outcomes through high-quality, affordable, person-centered care.

To achieve this vision, the CMS Innovation Center is committed to the five strategic objectives pictured here in this graphic. Today we are focused on the advancing health equity strategic objective. You can move to the next slide.

Advancing health equity is one of the six critical components of health care quality as defined by the landmark report "Crossing the Quality Chasm: A Health System for the 21st Century" from the Institute of Medicine.

The Innovation Center will focus on equity in four domains. First, CMMI will develop new models and modify existing models as feasible to address health equity and SDOH. Second, we will increase the number of beneficiaries from underserved communities in our models, in part, by increasing the providers that serve them, including safety net providers, Medicaid providers, those in FQHCs and others. Third, we will monitor and evaluate our models with health equity analyses. And last but certainly not least, we will strengthen data collection and intersectional analyses for populations defined by race, ethnicity, language, geography, disability, and sexual orientation/gender identity.

We believe these efforts individually and collectively will help to ensure that all of our beneficiary populations derive maximal benefit from the transformational work of our models and initiatives. For more information about our health equity strategy, please check out our recently released blog in *Health Affairs*.

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In our strategy refresh white paper, the CMS Innovation Center articulated its commitment to increase the number of patients from historically underserved populations and safety net providers in its models. Examples of these providers in addition to the ones I named previously included other community health centers, rural health clinics, community-based providers, and public and critical access hospitals. This roundtable will help inform our efforts to increase and support safety net provider participation in our models. Our objectives are to define safety net providers for purposes of our models, to discuss the financial incentives, structures, and supports needed to recruit safety net providers, and learn what other nonfinancial supports and infrastructure are needed to sustain their participation. Each panel will focus on one of these questions, and our panelists will have the opportunity to weigh in on follow-up questions as time permits. I am so excited to hear from our panelists, and we're going to go ahead and get started.

I am turning the mic over to Tequila Terry.

>>Tequila Terry, CMS: Excellent. Thank you, Dr. Hughes.

So, if we could go ahead and advance the slide, for our panelists, we are really excited to have you with us today. We're going to ask you to unmute and come on video when you provide your remarks, so that we can hear from you throughout the duration of the panel that you're speaking on. And for other attendees who are joining us today, you are welcome to share your comments in the Q-and-A box. I now really want to get to the meat of our discussion and turn it over to our speakers who will be focusing their remarks on our first question, which is, "Given the range of providers that care for underserved populations, how should the CMS Innovation Center define safety net providers for purposes of our model design and recruiting those providers into our models?"

For the sake of time, I'm going to provide short introductions, but the speaker bios can be found online.

Our first speaker is Mr. Benjamin Money, and he is the Senior Vice President at the National Association of Community Health Centers. Prior to joining NACHC last June, Ben led the North Carolina Community Health Center Association and also served as Deputy Secretary for Health Services. Mr. Money, the virtual floor is yours.

>>Benjamin Money, National Association of Community Health Centers: Thank you, Ms. Terry, and good afternoon. I am pleased to offer remarks to the roundtable today. I've worked for over 20 years to support federally qualified health centers and help other safety net organizations become FQHCs. In many capacities, I've partnered with and led coalitions of safety net organizations and coordinated access planning in state-level advocacy. While I represent health centers, I also admire my other colleagues in safety net who strive each day to deliver care with very limited resources.

Community-based safety net organizations, such as FQHCs, also known as community health centers or CHCs, rural health centers and clinics, Ryan White clinics, Title X family-planning programs, Title V Maternal Child Health Block Grant Programs, certified community behavioral health clinics, tribal clinics, and volunteer-based free and charitable clinics, are the backbone of the nation's care for our most marginalized and vulnerable people. The high-water standards for safety net organizations are codified in Section 330 in the US Public Health Act. While various Section 330 criteria are voluntary or even aspirational, for other primary-care safety net providers, they are mandatory for FQHCs. The regulating body for CHCs, the HRSA Bureau of Primary Health Care, conducts rigorous reviews of health center Section 330 compliance with annual reporting and a competitive application and reapplication process. Failure to adhere in any aspect of Section 330 leaves the CHC subject to dismissal from the program and loss of federal grants. CHCs must either be private nonprofits or public agencies with an independent board whose majority are active patients of the health center. This board must have full and autonomous governance, including hiring and terminating the CEO and member nomination and selection. Health-center patient board members must as a group represent the race, ethnicity, gender, and other demographics of the patients served. The health center must have a defined service area and medically underserved population. Their services and staffing must be appropriate to address unmet needs, including physical, behavioral, oral health, throughout the life span. They must also meet the cultural and linguistic needs of their patients and have ongoing referral relationships with hospitals, specialists, and other providers as well as coverage for after-hours emergencies. Health center charges

must also be consistent with locally prevailing rates and offer sliding-fee discounts for patients below 200 percent of the federal poverty level. No one is denied service due to their inability to pay. They must also have agreements with other providers for services not available through the health center. CHCs must also have an ongoing quality improvement program and publicly report the demographics of patients served, services delivered, clinical, quality, and cost data on an annual basis. To achieve economies of scale and enter value-based payment arrangements, CHCs inform health center control networks, many of which are clinically integrated. These networks should also be considered part of the safety net. CHCs and other safety net providers are located in areas of greatest need. They have a common mission to ensure that no one lacks health care regardless of their ability to pay and thereby assume inherent downside risk.

In the 12 states that have not expanded Medicaid, there are over 2.2 million people in the coverage gap. CMMI should craft alternative payment models specific to safety net providers that focus on health outcomes and not downside risk. State Medicaid agencies rely heavily on the safety net as crucial partners to address health equity, serving communities of color and other marginalized populations. Medicaid is the greatest source of payment for safety net providers, the majority of whom have slim operating margins, limited cash reserves and struggle to remain viable, particularly during the pandemic-fueled Great Resignation and inflation. Safety net providers often lack access to all the sources of patient data, sophisticated analytics, and care-coordination approaches necessary to succeed in value-based care models. They will need additional time, support, and funding to transition.

The ACO application period and launch for safety net providers must ensure that they have sufficient time and resources to build and test their ACO infrastructure well in advance of the performance period. The total model test period should run longer to acknowledge the starting point and steeper learning curves for safety net providers. Multi-payer alignment and investments will be vital for substantial change. In conclusion, we appreciate this opportunity and look forward to our continued engagement with CMMI. We'll submit comments in writing to the other two questions posed for today's roundtable. Thank you.

>> Tequila Terry, CMS: Excellent, Ben. That was tremendously helpful. I want to dig into one comment that you made about multi-payer alignment. Can you talk about why that's important and how we might think about that in the context of designing our models?

>>Benjamin Money, National Association of Community Health Centers: Great question, and the issue with multi-payer alignment is you've got to be able to develop systems within your health center. You got to be able to have consistent approaches to delivering value-based care. If you've got inconsistent measures, if you've got inconsistent program requirements, then what that means is you've got a disjointed system.

To change from fee-for-service and move towards value-based care, we need to create the opportunity for efficiencies, and by having multi-payer alignment within programs, so with Medicaid managed care organizations, for example, having consistent measures across those entities within the state as well as multi-payer alignment between Medicaid, Medicare, and ideally commercial insurance.

>>Tequila Terry, CMS: Excellent. Excellent. Really great insight. Thank you so much, Ben.

We're now going to move to our second panelist. I would like Erin O'Malley to activate her camera and unmute. Erin is the Senior Director of Policy at America's Essential Hospitals. She oversees all of the federal public policy initiatives to protect the central hospitals' interests and support their mission to provide equitable care to all. She has almost 2 decades of experience in health policy and focuses on policy development and analysis, regulatory advocacy, and safety net financing. Ms. O'Malley, you have the floor.

>>Erin O'Malley, America's Essential Hospitals: Sure. Thank you and thank you to CMS Innovation Center leadership for including us in this very important dialogue today. America's Essential Hospitals is the leading association and champion of safety net hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. We greatly appreciate the Innovation Center and the fact that you're thinking about ways to ensure that safety net providers are not left behind in the development of innovative care as well as payment model. Essential hospitals are key partners in advancing health equity and ensuring that all people have the ability to lead healthy and productive lives.

As we think of defining safety net providers, we believe it helps to look at the services that they provide as well as the patients and communities that they serve. Essential hospitals serve all patients regardless of their health or insurance status, and they share a mission that expands to a number of vital services for their communities, including providing specialized and life-saving care through trauma and neonatal burn clinics as an example. They're training the next generation of health care professionals. They deliver comprehensive, coordinated care across extensive ambulatory networks, providing care to patients exactly where they need it. And finally, they're meeting public health needs by addressing population health as well as preparing for and responding to emergencies as they arrive. Further, patients served by essential hospitals live in some of the nation's most historically under-resourced communities. This includes serving communities in which 22.3 million individuals live below the poverty level, and 9.9 million struggles with food insecurity.

And while many essential hospitals lead the way in innovative programs informed by their on-the-ground experience to address inequities, resource limitations limit their ability to maintain and to expand this work, and for others, they're unable to make an initial investment to establish such programs. Essential hospitals shoulder a disproportionate burden of the nation's uncompensated care with three-quarters of our patients being either uninsured or covered by Medicaid or Medicare. From design to evaluation, we believe that new models must keep the needs of under-resourced communities and the safety net providers who care for them front and center.

So, as we think about recruitment into as well as participation in such models, we encourage the Innovation Center to infuse the following five core elements into your work moving forward. First, we believe it's imperative that new models identify and then disseminate evidence-based interventions to reduce disparities and address social determinants of health. Second, data. Data should be leveraged to improve outcomes as well as to mitigate health inequities. Third, the unique needs of safety net providers in their communities should be accounted for by at least in part acknowledging that a one-

size-fits-all approach often disadvantages the safety net. Fourth, upfront funding should be provided for safety net providers to invest in the infrastructure, staffing, as well as care redesign that's necessary to both execute and to thrive in new models. And then finally, fifth, we encourage the Innovation Center to adjust the outcome measures to evaluate performance to account for the factors outside of a safety net provider's control. Otherwise, new models could inadvertently exacerbate health disparities, creating a vicious cycle that reduces even further the resources that are needed to address these disparities.

Today, essential hospitals vary in their engagement in both current and past models, and we do know that organizations with prior risk-bearing experience are more likely to achieve savings. That is why new models should consider a full range of experience that safety net providers have with value-based care, those with past successes as well as those who might lack prior experience due to factors such as a payer or a patient mix that's inconducive to model participation. Another consideration is that of community partners. Essential hospitals work closely with these partners to facilitate care coordination and to address social determinants. We believe that models should support integration of both medical as well as nonmedical services but also recognize there's still many communities across the country who lack community-based services. Finally, we encourage the Innovation Center's continued mindfulness about the evolving nature of the U.S. health care system, as well as current workforce and infrastructure challenges that are especially acute for safety net providers, and while it seems like our challenges continue to mount, we do believe that we are standing before a very exciting opportunity to finally move the needle on health equity.

America's Essential Hospitals and our 300 hospitals around the country are eager to partner with leadership from the Innovation Center, CMS, and the Biden-Harris administration to make great strides toward a more equitable health care system. Thank you again for your time today.

>>Tequila Terry, CMS: Thanks so much, Erin. That was terrific, and you touched upon so many things that I actually have a few questions, and I could probably spend all day talking to you about some of the items that you referred to, but I'll narrow my questions to a couple of areas.

So, one of the things I'm curious about, you mentioned the work that safety net essential hospitals do to support patients around health-related social needs, and I'm just wondering, how might the lack of consensus on the definition or whatever definition we end up using -- How might that impact the ability of participants in our model to address those health-related social needs that are often the source of many of the disparities? So really thinking about that in the context of the definition and how that comes through in terms of the actual impact to beneficiaries.

>>Erin O'Malley, America's Essential Hospitals: Oh, that is such an important question and one that we're thinking quite a bit a lot about as an association and, you know, the nomenclature that we use. You know, for example, when we look at quality improvement initiatives, we know how to address a central line blood infection as an example. There are best practices, and we execute. You know, when it comes to social determinants of health, each community is different, and those needs evolve over time.

And so, you know, I think CMMI, the Innovation Center, has a really unique opportunity to test and to figure out what are those best interventions, and while one intervention might be best in one community, it might not work for others. Again, this is, I think, where we're hoping that a demonstration project can go, recognizing that while we might have a lack of standardization, that trial and error and then dissemination of best practices is, you know, before us, a really great opportunity.

>>Tequila Terry, CMS: Excellent. And then you mentioned that we should be sensitive to the approach that we use to design outcome measures when it comes to safety net providers. Can you talk a little bit about that? What implications that might have and any ideas that perhaps America's Essential Hospitals has been thinking about in that space?

>>Erin O'Malley, America's Essential Hospitals: Sure, so in looking at some of the existing both outcomes as well as costs and quality measures, you know, we have concerns that essential hospitals are penalized disproportionately.

If you take, for example, hospital readmissions, it is going to be a challenge to ensure that a homeless patient, for example, does not become -- does not be readmitted to the hospital, and so we believe that in a number of the outcomes measures that would be included in future models as well as existing models that many of these measures should be risk-adjusted, you know, taking into account the fact that there are a number of scenarios, mostly social factors, even financial factors, that are barriers for our patients, and so unfortunately without that level of risk adjustment, as I noted, you know, there's that disincentive or unfortunate reaction where we will get penalized and have more resources pulled from our needed communities should there not be risk adjustment.

>>Tequila Terry, CMS: Excellent. Thank you so much. That's very insightful. Thank you for your wonderful comments.

I'm now going to ask our third speaker to share her perspective. Dr. Michelle Morse is the Chief Medical Officer and Deputy Commissioner for the Center for Health Equity and Community at the New York City Department of Health and Mental Hygiene. She's the first Chief Medical Officer in the agency's history and has the deep expertise in public health, social medicine, antiracism education, and activism from her work at Partners in Health and founding EqualHealth and the Social Medicine Consortium. Please go ahead, Dr. Morse.

>> Dr. Michelle Morse, the New York City Department of Health and Mental Hygiene: Thank you so much for the opportunity to be with you all today. It's a real honor to get to share some reflections from New York City's experience and, again, just very, very excited that CMMI is prioritizing this topic, especially in this particular moment in history where COVID, again, has shown us just what the cost of inequity is in this country and globally.

I want to start just by contextualizing my comments in the fact that it's been 20 years since the publication of previously an Institute of Medicine's report on equal treatment, and as many of us know, unfortunately we have not seen the progress on racial inequities in health that we would like to see, and specifically COVID has made those inequities even worse. The data that was published last year showing

the changes in life expectancy just in 2020 led to a 2.7-year decrease in life expectancy for Black Americans and a 1-year decrease in life expectancy for white Americans, both of which are tragedies and, in fact, worsens the gap in life expectancy between Blacks and whites in this country even further. So, with that context, we're particularly excited to share some reflections from what we saw in New York City in general and during COVID and how we've been thinking about the critical, critical and foundational nature of safety net hospitals in this city in particular.

I want to just start by briefly describing the public health law that was passed in 2020 actually describes and defines safety net hospitals using an enhanced safety net hospital definition and basically breaks safety net hospitals down into three categories, and this is for New York State. So private safety net hospitals are defined as having not less than half Medicaid or uninsured, not less than 40% of inpatient discharges that are Medicaid, 25% or less of discharged patients are commercially insured, and not less than 3 percent are uninsured. And then public safety net hospitals are considered hospitals are defined as hospitals that are operated by a county, municipality, public benefit corporation or the state of New York, and then critical enhanced safety net hospitals are those that are federally designated as critical access or sole community hospitals.

So with those definitions in mind, of course, what we saw over the past several years during COVID in particular was that our private enhanced safety net hospitals, public enhanced safety net hospitals, and critical enhanced safety net hospitals suffered a tremendous burden during the COVID pandemic, and during every peak, in every wave of the pandemic over the past 4 years, these are the hospitals that have suffered from critical staffing shortages and critical shortages in space and beds as well unfortunately.

But I also want to describe the definition of health care segregation, which is separate but connected to safety net hospitals, and the way that we've defined health care segregation and the definition we're using the New York City Health Department is, health care segregation is the degree to which two or more groups receive care separately from one another in different parts of the health care environment, which is a very general definition, and yet it has tremendous impact.

So, I just want to highlight one example from wave one of the COVID pandemic here in New York City. One of our safety net hospitals, the publicly run safety net hospital, actually did a study looking at what happened during wave one of COVID in New York City in terms of surges and in terms of load balancing and what the impact of that surge, that very first surge in the spring of 2020 was on patient outcomes, and what they found was, you know, perhaps not surprising, you know, especially in New York City where we were so profoundly hard hit by that first wave.

They found that patients admitted to ICUs that had higher surge scores were at greater risk of death, and I think it's very, very important and courageous that they published this data because it helps us to understand what we need to do better to make sure that there is a resilient health system for safety net hospitals, public hospitals, and all of our hospitals, and what I think is also particularly important is that even though this particular study that I just cited showed that the safety net -- this particular safety net system, the health and hospital system -- looked at the impact of surges on mortality. That is a separate system from some of the private nonprofit systems and is separate from private academic hospitals and

private safety net hospitals as well, and so it's pretty difficult to get a full picture of what might have happened if those different systems were more interconnected to allow for even more effective load balancing.

I also want to share just one more example and then a couple of suggestions again because we're really, really intrigued and excited to see CMMI focusing on this.

The other example I want to share is a recent study looking at the wealth and capital of minorities serving institutions, and again, I both define safety net hospitals and health care segregation to get at the point that these two things are, again, critically important, connected but somewhat distinctive in some ways. And this particular study looked at the wealth of minority-serving institutions and defined minority-serving institutions as the top decile of taking care of Black or Hispanic Medicare inpatients, and they were defined as Black-serving or Hispanic-serving, and this is amongst over 4,400 Medicare-participating hospitals across the country. And what they found in this study was that hospitals serving people of color had lower capital assets, lower recent purchases, and were less likely to offer 19 of 27 specific capital-intensive services, and these are all things, again, that are critical in terms of thinking about both safety net hospitals as well as health care segregation.

So finally, as CMMI is reflecting on demonstration projects and models to consider, we would, you know, of course, encourage CMMI to consider looking at a model that includes safety net hospitals that are also minority-serving institutions and look at the resources available to those institutions, including their ability to staff and maintain staffing and resiliency throughout waves of COVID going forward, their ability to offer capital-intensive services, to operate within a reasonable margin and perhaps more importantly to address health inequities and how that -- they may be able to impact city-wide population health outcomes and targets and goals because of their ability to do this work and serve populations that we know must be the priority going forward. Thank you very much again for the opportunity.

>>Tequila Terry, CMS: Thank you so much, Dr. Morse. That was incredibly helpful and really fascinating, the history that you described. You know, one of the questions that, came to mind for me as you were talking is, as we think about future model design, what steps can CMS at the Innovation Center take? What steps can we take to really mitigate some of the effects of those historical racial inequities that are really in part attributable to this idea that there's been an inconsistent definition of safety net providers? Are there things that come to mind from your standpoint?

>>Dr. Michelle Morse, New York City Department of Health and Mental Hygiene: That's the trillion-dollar question, in so many ways, and, yes, it's a very challenging one, but I think part of how I might respond to it -- and, you know, again, would love to continue this conversation, of course, with some of the safety net-hospital leadership from New York City as well. They have some great ideas.

But part of the challenge here, of course, is, you know, when you are as a hospital fully, you know, mostly dependent on taking care of patients who are publicly insured, the financial resources that are available to you in terms of being able to pay, you know, for nurses who are working as locums, for example, or to be able to staff up in a time when you need to expand services such as during a surge in

COVID, those are all things that require capital, and those are all things that require, you know, additional resources, and when, you know, a hospital is functioning on a far more slim margin like most of our safety net hospitals are, again, because of the, you know, the fact that they serve mostly publicly insured and uninsured patients, that is a profound challenge when it comes to being able to mobilize capital.

And so, I guess what I would say is that those capital needs are really, really important in being able to effectively serve communities of color, which most of our safety net hospitals in New York City do.

>>Tequila Terry, CMS: So that's a really perfect comment that will set us up for the second panel that we have, so thank you so very much, Dr. Morse, for that, and thank you to all three panelists for sharing your perspectives.

You know, now we'd like the audience to give us some input on this topic. We have several hundred people on the webinar with us today, and we really want to get you engaged in the conversation, so we have a polling question that's just come up on the screen. Our first polling question asks for audience input: On this issue of definition, how do we define safety net providers? So, we'd ask that you please select an option or provide a suggestion in the Q-and-A box. When we think about our model portfolio and the design of models, what is the most important consideration in defining safety net providers for purposes of maximizing their participation in CMMI models?

So, we'll ask the audience to make a selection of what you believe is most important, and while the audience is doing that, I'm going to take, moderator's privilege and maybe ask the three group of panelists just one more question. Again, as you know, we have been thinking about this definition of safety net providers and how that really does influence who will be able to participate in our models, who will be able to, you know, render services, who can be part of transformation efforts, and so, again, you know, sort of similar to the question that I posed for Erin, I'm really interested in understanding, you know, how might the lack of consensus around the definition of safety net providers impact our ability to really get that transformation happening across the country, whether it be for, you know, health-related social needs or addressing disparities? How important is defining the idea of who is in that category of safety net providers?

So, I welcome any comments from any of our panelists.

>>Benjamin Money, National Association of Community Health Centers: Yes, I would like to say that, for federally qualified health centers, the definition, the criteria, the identification of FQHCs is very precise and is very clear, and FQHCs have a unique role in the health care safety net. They also have a unique and statutorily designed payment methodology that is appropriate for building upon as we move towards value-based care. So, I think that, you know, from the standpoint of FQHCs, it really is clear who is within that construct.

>>Tequila Terry, CMS: Go ahead. Thank you. And, Erin, please jump in.

>>Erin O'Malley, America's Essential Hospitals: Sure. I would just add, from the hospital perspective, unfortunately we don't have that construct, you know, analogous to the federally qualified health care centers, and so while we do believe that having a solid definition is really important, I really can't help but go back to it is the patients. It's the patients that we serve. It's our mission. You know, if it wasn't for the mission to serve anyone and everybody who comes in, you know, those margins of safety net hospitals would most likely be higher. We wouldn't be investing in social determinants of health to the level that we are now.

And so, you know, very eager to work with leadership within the center to define essential hospitals, and I know there are work that we're doing as an association as well as other entities have been thinking a lot about this, especially because it is such an important step towards actually moving the needle on equity to be able to define this group of hospitals.

>>Tequila Terry: And any closing comments, Dr. Morse for you?

>>Dr. Michelle Morse: Thank you. Support what's been said already about the importance of definitions as well. I think the New York State definition that I described is the really interesting and meaningful starting point to consider for safety net hospitals or enhanced safety net hospitals as it's defined in New York State law. And the final thing I'll just mention is that, again, I feel so strongly that grounding this conversation in the current experience of hospitals through COVID is tremendously helpful for us as we continue to define this work and want to just close by saying that what we found also in New York City was that, during the Omicron wave, Black patients, Black New Yorkers had a 2 times higher rate of hospitalization than white New Yorkers, and those Black New Yorkers were mostly, again, because of the demographic served, at safety net hospitals, so, you know, each wave of COVID does present an additional burden in many ways to our safety net hospitals, and it's, again, part of the reason why the New York City Health Department has truly, truly tried to center the experience, needs, and priorities of safety net hospitals for that and many other reasons.

>>Tequila Terry, CMS: Thank you for that. Well, it looks like we might be having some technical difficulties with the poll, so we haven't been able to pull the results up. However, for any of our audience members who are still interested in providing your input, please do put your comments, response to the polling question in the Q-and-A. We would love to have your input as we think about follow-up steps from today's session.

Again, I want to thank all of our panelists for their wonderful remarks in this first round of the discussion. We really appreciate you sharing your perspectives, and now we would like to -- I'm going to turn it over to my colleague, Dr. Dora Hughes, to take us to the next panel.

>>Dora Hughes, CMS: Thank you. Thank you, Tequila. That was a fantastic discussion and in so many ways a perfect segue for this panel that will focus on financial incentives, structures and supports.

We know we have heard from our partners, from so many of you who would describe yourself as safety net providers, that the financing is a critical consideration, particularly given the underserved patient populations that many of us serve may require different levels of quality, different levels of access

certainly in some cases. In addition to the clinical, we have to think about the social services, all of that which requires us to be very deliberate and intentional in thinking about the financial support that's needed to recruit safety net providers into our models.

Like Tequila, I'm going to provide a too short introduction to our speakers, all amazing speakers, but their full bios can be found online. Panelists, please unmute and turn on your videos, and we will go ahead and get started with our first speaker, Dr. Amol Navathe. Dr. Navathe is an Assistant Professor of Health Policy and Medicine and a Commissioner of the Medicare Payment Advisory Commission, or MedPAC. Dr. Navathe, please go ahead.

>>Dr. Amol Navathe, MedPAC: Hey. Thank you so much. Thank you, Dr. Hughes, Dr. Fowler, and the planning committee. It's a pleasure to be here and good to participate.

I think, as we've heard in the previous panel introductory remarks, it's very clear that this intersection of health equity, safety net policy, and payment policy are both just critically important, and so I would like to talk a little bit about value-based payments because it has been a great emphasis. We've seen announcements recently of the ACO REACH model. We've seen the strategic vision of the center and other payers, quite frankly, that has center sort of put value-based payments as the centerpiece, and I think that's for good reason. If we think about in the context of marginalized populations, if we think about in the context of the safety net, it's intended -- Value-based payments are intended -- to give flexibility of care models to allow for better investment, investment in capabilities, infrastructure, managed populations as well as to create greater amounts of accountability for results moving towards the notion of value.

So that all sounds good, and I think if you do a full stop there, we could say, "Hey. You know what, we're done. Value-based payments are awesome. Let's zoom forward and not worry about anything."

But the question, I think, that truly with respect to safety net populations inequity is, so is there any reason to worry about value-based payments and its intersection with the safety net and equity? And I would argue, yes, I think there is, and in one broad conceptual form that we've written about, I think what we're worried about to some extent is not disparate treatment, meaning that we're going to treat different populations inherently differently, but rather disparate impact, which is that the same policy that's well intentioned and applies uniformly to different populations, may, in fact, have a perverse impact on disparities, for example, between the two groups.

So, it's more nuanced. It's harder to get at, and I think it's part of what we're chasing, if you will, that's trying to really reorient value-based payments to address this disparate impact problem to some extent. I think there are three reasons I'm going to outline and briefly discuss that we need to worry about equity effects on the safety net population otherwise in value-based payments: number one, accountability; number two, risk adjustment; number three, what the empirical evidence has already told us.

So, let's take each in turn. What do I mean by accountability? So value-based payment models really as part of their DNA are trying to pass down greater accountability for financial and quality-type outcomes

to the health care organizations, delivery systems and clinicians that are caring for patients, and to some extent, that accountability puts the clinicians in health care organizations in the crosshairs of allocating resources in a way that could compromise, at least in concept, could compromise equitable outcomes, and we'll talk a little bit about the evidence in a moment.

Secondly, on risk adjustment, why do we worry about risk adjustment? Well, risk adjustment, particularly for populations that are in the safety net, is notoriously incomplete, and so if we start to finance programs using risk adjustment that we're worried about is incomplete, then again, we're setting the providers up, the clinicians and hospitals and health care organizations, to potentially be in the crosshairs here, and so let me step back here really quickly and give some examples in the context of accountability. We saw early experiments in the 1990s where New York State, for example, put out report cards for heart-bypass surgery and very well-intentioned policy. What happened unfortunately as part of the policy effects, not the only effect, was that Black patients had a tougher time getting a heart-bypass surgery in the state of New York.

Medicare's own hospital readmissions reduction program, while I think the preponderance of evidence suggests that it made positive effects on reducing readmissions, there's some suggestive evidence that we might worry that hospitals that are caring for more marginalized populations, racial minorities and low-income patients may, in fact, have been subject to more penalties or disadvantage in the program. Similarly, if we take now the second bucket in the context of risk adjustment, we have issues around infrastructure. We know that populations and organizations that serve safety net populations generally don't have as much or an intensive of infrastructure to code, and so we have that problem. We have the problem of those populations are more likely to have social factors that don't really get reflected in codes appropriately that also play a role, and we have this complex intersection between the medical system and the social safety net as well and how those interact, and we don't want to view the social safety net only through the medical lens, so risk-adjusting through medical alone probably not doing us justice.

There is evidence that these are potentially challenging issues, so we look at voluntary programs, and this is writ large Medicare and others. We have seen disproportionate participation in more affluent communities, lesser participation in more marginalized communities. In fact, when we look at mandatory-type models, we also get the stratification just based on where quote-unquote financial opportunity lurks, so we have to be very thoughtful about this.

Is this all doom and gloom? No, I don't think so. I think that there are examples. We have the ACO Investment Model. We have the Pennsylvania Rural Health ACO Model. Now hopefully we have ACO REACH model that will make progress on this. We have the ESRD Treatment Choices Model, which is directly trying to affect equity in transplantation and home dialysis. So, I think we do have silver linings here that we can really build upon.

What are the core lessons? And I'm going to try to wrap up here relatively quickly. I know I'm stepping up on time.

So first thing is, we have to be really clear about how we identify these organizations. I think we heard from safety net institutions in the first part of the panel. We're doing work at MedPAC that suggests that the disproportionate-share approach to identifying safety net organizations may not be complete. We may need to widen our aperture there, think about other ways. I particularly worry about identifying clinician-type groups, not hospital facilities but clinician-type groups. There's no consensus methodology right now on that. It's work that we're doing in my research group because we're really worried about this and think that the ambulatory safety net that extends beyond FQHCs is really fundamentally important.

Second principle that we're learning is, we have to design models and tracks explicitly for these types of providers so we can account for their specific challenges, help them amp up the care-model flexibility that we need to address social services as well, make these models a clear path to a foundation. I think ACO REACH does that in part, things like SDOH data collection that ACO REACH is emphasizing, and then I think we need to just plain and simple as administration has done make equity an explicit goal. We need to pull it up to the top and say, "You know what? Can we really have success and value without success in equity?" And then we can argue that probably the answer is no, and therefore we have to elevate equity as a goal.

I think Dr. Hughes and Dr. Fowler, others have done that already, and we're starting to see momentum. It's part of why we're having this work group, so I think that's fantastic. That means that we have to put dollars towards it. We have to finance it and emphasize it.

Last point, to raise awareness around these issues, I have together with colleagues and about 170 other experts started something called healthequitypayment.org. Please visit there. It's intended to raise awareness exactly of the issues that we're talking about today, and in fact, there's an initiative to partner with public and private payers. We would welcome anybody's involvement there. So thank you so much. I'll stop here.

>>Dr. Dora Hughes, CMS: Thank you so much. That was just a very helpful and a perfect way to kick off our panel.

I think for sake of time, just to make sure, I'm going to go through all the panelists at once, and then we'll look and see what time is left because there's so many different questions I could ask in follow-up, no doubt, and I expect that'll be true for all of our panelists. So, with that, I'm going to move to our second panelists, Dr. James Sinkoff, who also brings a wealth of expertise on delivery systems. James Sinkoff is the Deputy Executive Officer and Chief Financial Officer at Sun River Health. In this role, he oversees Sun River Health's finance and business operations and strategy, technology informatics, value-based payment strategies in managed care organization contracting, population health, capital financing management. I'll stop there, but his bio sketch continues. We are so grateful to have you on the panel. Please go ahead.

>>James Sinkoff, Sun River Health: Thank you, Dr. Hughes, and so good to be with everyone to discuss this issue. I'm going to speak really about transformation and evolution in this space, especially specifically in the Medicaid space. At Sun River Health, we are in a Medicare ACO and have done a lot of

learning in that space and have actually seen real improvements in quality and in cost savings that have helped to, you know, bring real value to this entire conversation.

But what I really want to spend some time with you all talking about is predictability. Unlike the Medicare space, the predictability in the Medicaid space is very different, and it should be different, and we should acknowledge those differences because acknowledging those differences, I think, will then lead us to what my colleague, Dr. Navathe, just sort of highlighted in terms of risk adjustment, accountability, and resource allocation. It is not simply a conversation of payment reform, but it's transforming our health systems around a set of strategic goals and imperatives, and so we -- As we look at our space from an FQHC lens, we can really trace our lineage in this work right back to our founding of Dr. Geiger and Dr. Gibson and really being community-focused, community-centered organizations in designing our systems to amplify that work. And so, the resources that are needed to amplify that work are, first and foremost, how well can we define the population that we're trying to serve?

And this goes to predictability. I've had the opportunity on different occasions to talk on this issue, but I want to stay very much at the ground level here for the audience. Attribution is probably one of the key issues in trying to understand how to impact real change along the quintuple aim, which does call out very specifically equity. There's some good JAMA articles and other articles that are now referring to the quintuple aim of health care, very appropriately so.

And so, as we think about transforming our system of care, it is not simply sufficient any longer to think about just a medical model or a mental health or a behavioral-health model but an integrative model that begins to break down the barriers that trace their lineage around systematic racism within our work, and that means we have to reach out to our housing partners, our partners in the social-services space, to begin to organize the system beyond the four walls. And so as we think about our attribution of lives through a managed-care lens, which is the most typical way in a state environment, we have to now think about how we enjoin other nonbillable service providers in this work. That is essential because there are many care-management agencies.

There are many social services agencies and other nonbillable Medicaid agencies that have significant influence over building trusting relationships with the patient population, but in order to do that work, we need to now think about things outside of a fee-for-service lens. Even in our MSSP work, we are still undergirded by a fee-for-service construct.

In other words, we're still incented to get paid for doing more in certain elements of our health care system, and if we are incented to do less but do better with less -- In other words, let's not overutilize inappropriate services but begin to build care management around simple things like better housing, and I don't mean better housing in terms of building new housings per se but the quality of that housing.

We know this is -- There's a plethora of evidence on these issues, but it is hard for us to overcome the division and the silos in our health system when we're not unifying our resources to invite disparate partners to engage in the single premise of the quintuple aim.

So, we are looking at attribution and predictability, and what does that mean?

That means that when we are working with a highly complex patient population that has mental health and behavioral health problems, we want to be able to sub-attribute that. This is very detailed work, but I think it highlights theory and then practice. We want to be able to sub-attribute that population to the appropriate agencies that are doing this highly complex, persistently mental ill work for the patient population.

Moreover, and I saw in the chat, we have many of our providers who are in the developmentally disabled space. This is not the traditional space for federally qualified health centers, but it is a key area, and there is a lot of really fine work that's being done with dual eligible and the disabled populations, but it requires a real transformation approach to then redesign.

So let me pause for a moment and then just shift very briefly as I'm sure my time is coming to an end. In the construct of predictability, it's not a conversation solely about data, but it's a conversation about information management. It is not simply a conversation about claims, and do we have claims data, but do we have information on the multiple disparate touches that are occurring in our patient population? I'm often reminded of the work that was done in Camden and the Camden Coalition where they actively pursued understanding what was happening in the 9-1-1 system. They understood what was going on in the Section 8 systems and started to build real understanding of what was going on in terms of the community, and I think this is a key area of evolution and growth and transformation. This is a continuing ongoing process in order to evolve our health care system.

So as a last point, and I'll turn back over to you, Dr. Hughes, I think we need more demonstration projects emanating out of CMMI in states around the country that are not solely focused on state waiver processes, and if they are solely focused on state waiver processes, I think it would be absolutely wonderful if, through CMMI and the Medicaid managed care regulatory environment, we could start to define attribution very, very clearly. Assignment of a patient from a payer to a provider is only one level of attribution. Because we have a lot of fluidity in the patient population, we need to be more sophisticated about those definitions which will lead to more predictability. That predictability, I think, will lessen the anxiety of providers around assuming more risk, to drive quality up and to reduce the cost of care.

Last point is that when we think about our patient population, broadly we need to do a better job of improving the total quality of care that is being rendered to our patient population, and we need to identify those barriers that are systemic in nature to really break down and improve on quality. Thank you so much.

>>Dr. Dora Hughes, CMS: Thank you. Thank you. That was extremely helpful to hear, and I, along with others, no doubt, are taking a lot of notes for both internal thinking but also follow-up.

We are going to move to our third and final panelist today, Rachel Tobey. She is the director of JSI California and a project director on a wide variety of projects related to health policy research, development implementation with a focus on systems serving Medicaid populations. She is also co-director of the Delta Center for a Thriving Safety Net, an RWJF-funded initiative dedicated to improving

care for Medicaid beneficiaries to advance value-based payment and care for primary care and behavioral health safety net providers. Thank you so much, Ms. Tobey, and the mic is yours.

>>Rachel Tobey, JSI California: Thank you so much, Dr. Hughes and other panelists.

I'm going to focus a lot of my comments on health centers because we have worked at JSI for decades with health centers and have been listening to them very carefully over the years as they have experimented with early entries into value-based payment and care transformation, and my comments will also reflect experience that we've had through the Delta Center with community-based behavioral health providers as well as research that we have done with public hospitals. I think you will find that many of these notions that are centered around health centers actually do apply much more broadly.

The first is that financial incentives should be multilayered, should include up-front investment, allow for flexible use of funds, sometimes more money, and when it comes to risk, be mostly upside only.

We have found that it is very helpful to think about the way that optimal payment will happen for safety net providers will actually be multiple payment arrangements operating simultaneously with each payment serving a slightly different function. So, when we've conceptualized this, we talk about base payment, which is basically where safety net providers receive the majority of their revenue today, and this is, yes, largely rooted in volume-based care, a second layer of investment in new services and infrastructure that other panelists have referred to and then incentives, and these incentives can be upside or downside. I want to emphasize that when we talk about changes to health center base payment, they are mostly looking for more flexibility in what types of care team members and what types of modalities of care that they can use to deliver care through prospective flexible per member, per month population-based payments.

When it comes to the second layer, we have seen programs like Health Homes and waiver programs that provide upfront dollars to help safety net providers invest in hiring care management teams, hiring community health workers and peer support specialists to go out and build trust and engage with patients in critical ways, and in fact, every provider that we've talked to in the safety net that has been part of ACO programs has highlighted the need for these upfront investments in care management and case coordination, in particular, and data infrastructure and analytics as well.
But those are critical things if the goal is to actually reduce downstream costs in ER or in-patient settings.

And then in the third layer, we do see mostly upside incentives to improve quality, increasingly to reduce disparities, and only in very select cases are safety net providers successfully taking downside risk. I want to emphasize that when we're talking about health centers, it's actually also very important to acknowledge the Prospective Payment System, or PPS, model that they get paid under today. It was originally designed to give FQHCs an amount of money that was tied to the cost of delivering care and that by guaranteeing a minimum per visit amount, PPS actually protects the federal government's grant dollars that are designed for health centers to care for the uninsured and protects health centers that would otherwise be subject to the whim of state Medicaid budgets, including when those budgets

fluctuate, and sometimes states will decide to take a blunt-knife approach to slashing Medicaid payment rates.

So, it is codified in the Social Security Act that FQHC alternative payment methodology, or APM, has to meet two criteria, that the health center gets paid at least what they would have under PPS and that they agree to the new payment methodology with the state, often through a state plan amendment. So, this voluntary nature of base payment reform for health centers is critical to designing new models that will be attractive in terms of how they can clearly help to improve care delivery while not compromising their financial stability.

I also want to make a note about the incentive layer. I will venture to say that downside risk for safety net primary care and behavioral health providers generally doesn't make sense and could be construed as counterproductive to the goal of promoting and achieving health equity. If required, downside risk needs to be minimal and designed very carefully. Safety net providers are in the business of providing as much access to care and services as they can with the money that they have, and financial penalties or even the prospect of them will likely drive many safety net providers away.

The second is it's important to not conflate payment reform with simply needing to invest more money in some parts of the health care system. So, while changing payment can help to provide flexibility to deliver care or can incentivize new outcomes, no amount of changing payment can substitute for an overall level of revenue that is simply insufficient to achieve the desired outcomes. This is especially true for behavioral health, which has been systematically underfunded for decades, and certified community behavioral health clinics, or CCBHCs, are attempting to fix this historical underinvestment. Many health centers will also say that their PPS rates, inflated by MEI, have simply not kept up with their costs of delivering care. So, adding important new expectations to reduce health inequities and disparities along racial and urban or rural lines in particular will likely require more dollars, not fewer.

I also want to note that our experience shows that it takes money to save money. So, part of this is that upfront investment notion that's required to generate savings downstream, as I mentioned before, but the second is that it's difficult to save money when there's less spending in the first place. While this may seem mathematically obvious, it's especially relevant in light of Dr. Morse's data on the health care segregation and under-resourcing of those very institutions that are serving predominantly Black and Latinx populations as well as the national studies out of UChicago and NORC that showed that health center patients' total Medicaid cost was about 23 percent less than non-health center Medicaid patients.

When we studied a Medicare ACO led by a health center in California, they didn't achieve any shared savings, and it was only within the first year -- after the first year of being in that Medicare ACO demonstration that they got their total cost-of-care claims data and realized that they were in the lowest four Medicare ACOs in the nation in terms of baseline spending for their patients, very hard to achieve savings when you're in the bottom 4. Another example of this is that in 2018, 12 states with active Medicaid ACO programs, 8 of them were in the top 16 states in terms of total Medicaid spending per capita.

So, I realize that drivers of the differences in spending per capita in Medicaid has to do with a lot of things of benefits and various populations covered, and there's always opportunity to improve, but we have to recognize that it is harder to realize total cost-of-care savings with providers or in states that start by spending the least compared to those who are spending the most.

In terms of structures, I will emphasize 4 things.

One has been mentioned before, which is that very tight coordination or integration of behavioral health and primary care.

The second is acknowledging the importance of size, that if there's going to be any requirement for downside risk, size is essential for spreading that risk as well as for having the deep pockets or capitalization that is sufficient in order to accept it safely. Many community health centers and community behavioral health providers are simply too small on their own to bear any downside risk safely. CMMI can acknowledge this by looking to structures such as clinically integrated networks, HCCNs that Ben Money mentioned earlier and independent practice associations that can help smaller safety net providers to collaborate and bear some limited risk while also sharing best practices, data collection, and analytics, and contracting with MCOs' capabilities.

The third is data sharing. We've heard this over and over again, but data sharing between primary care and behavioral health is essential as is sharing data with hospitals and health plans.

And the fourth one is time, that we've heard this before, but acknowledging that moving to new payment models takes significant planning, preparation, and implementing new infrastructure and practices, and all of these tasks take time. So, having a lead-up period of at least a year before any go-live in a new model could be essential to ensure that the requisite data sharing infrastructure and care transformations are ready before any evaluation begins.

>>Dr. Dora Hughes: Thank you. Thank you so much, Rachel, hugely helpful.

I would have to say that all three of panelists went well over their 5 minutes, but I could not bring myself to rush any of you along because your comments -- It's simply just been just truly fantastic, so helpful to hear. If all of the panelists could turn their videos back on, I also understand we are going to launch the next poll for our audience to weigh in that picks up on some of the questions, the suggestions mentioned by our panelists, I won't read it here, but please put in your answers, and at the conclusion of this panel, we will certainly read out the results.

I had a number of questions for each of you, but I think, if we do a round-robin of responses, two questions that jumped out at me that I would love you to speak to one or the other or both. Of all the different issues that you've mentioned, are there clear priorities? Are there certain aspects or elements discussed here that you would say if we had to prioritize, this is the area that would be most beneficial for safety net providers? And I don't know if the option is, whether that's focusing on the risk adjustments, focusing on the advance payment, if it's focusing on the thinking of upsides. Whatever the

case may be, I would love to hear if there are certain areas that, for our next model, if we're really going to bring in safety net providers, it must have, what that might be.

And the other, we have talked about the whole range of safety net providers from this panel to the second panel. Are there any considerations that are unique to one type of safety net provider versus the other that we should be mindful to, whether that be an essential hospital or a community health center or a behavioral health clinic, or whatever the case may be, I would love to just hear quick thoughts on that, and so perhaps we'll start back in order. Amol, do you want to go first?

>>Dr. Amol Navathe: Sure, happy to. So, I think it's a great question. You know, where do we start?

What's the most tractable first step, if you will, with our next model? I think, you know, to me, risk adjustment, while it's absolutely paramount in the long run, I think it's going to be extremely hard to fix in the next model, right?

So, I personally think we have to try to take baby steps, continually improving our data collection to get there. It's not the place that we want to hang our hat and say, we have to fix this before we get to the next model. I would say, what we do want to really encourage, and it's kind of a two-part answer to your question is, I think we really want to create the right attributes in a model to encourage participation because unfortunately, if we take -- if we zoom out a little bit and look at the landscape of VBP participation, we just don't see as much across all safety net organizations for a number of the reasons that Rachel and James have outlined the, you know, potential bugaboos in models. And so I think if we can address a couple of these in a very tangible way, I think we should be making direct investments to try to help build infrastructure, allow the use of additional community-based providers, like community health workers or others, you know, allow the care models to be more flexible but also link some funding to them to make participation more attractive. That is where I would start as kind of a very core piece to try to address this participation issue and then link it to, basically, the flexibility part.

>>Dr. Dora Hughes, CMS: Thank you. Jim, do you want to go next?

>> James Sinkoff, Sun River Health: Sure. What I would say is that -- There are a couple of things that I would mention that I think are worthwhile.

Certainly, in the FQHC but I would also say in the community physician space, the models of care have evolved to include many services that were not first contemplated when the BIPA was passed in '99/2000, and therefore the resources to do this transformative work are anchored in a very, very old reimbursement system. With that being said however, I would want to look at it prospectively, and I look forward to speaking with Rachel some time offline because I do think there is an opportunity to evolve over a contractual term, a reasonable contractual term, to go from upside to shared savings and downside risk and ultimately to a percent-of premium.

But what that also means, at least for safety net providers in the community space, not safety net hospitals per se, because I really can't speak to that, is that we have to begin to think about our referral patterns, our multispecialty connections so that we're really keeping our patients sort of in an entrusted

ecosystem because right now, we're still working in a two-tiered system, and partly what we have to do in the Medicaid space is begin to evolve models that start to break down this two-tiering of our system where the commercially insured get access and better appointment scheduling, and those on Medicaid get worse scheduling, or they happen to be seen by the residents and not the faculty practice in a hospital setting. There are many of these kinds of models that I think can be broken down.

And last but not least, what I would also say is that the investment in information systems and, really, information about the patient population cannot be underscored enough, because we, in many ways, are health care providers, but we're also in the information business, and our business has moved and advanced into the information space. So, I would offer that.

>>Dr. Dora Hughes, CMS: Thank you for that.

And, Rachel, you have the final word.

>>Dr. Rachel Tobey, JSI California: I actually concur very much with the other panelists.

I would say, again, reiterating, making it attractive to start, and that is going to mean sort of some additional dollars in the beginning to hire new staff, to train those new staff, to implement that new EHR that interacts seamlessly with the hospital system or the HIE in your environment or the behavioral health providers in your world is essential, and I would say that the second is also to acknowledge that we are in a critical point in evolving care right now.

We are coming off of a global pandemic where we had the most massive test of telehealth in the United States ever. And patients and providers alike recognize that both audio and video telehealth was an effective way to deliver some physical and behavioral health care, and they are going to want to continue that into the future in addition to going back to seeing their provider in person some of the time, that telehealth is an example of that evolution that Dr. Sinkoff is pointing to, that that didn't exist in 1999, 2000 in the way that it does today.

There will be future evolutions and that new models need to continue to promote innovations in care and use care as the North Star for why we are doing this, and that's probably where I would end is that, where do we start? We have to start with creating a North Star of, this is to improve care and to improve outcomes, and I also concur about elevating the need to highlight improving equity as an explicit outcome and that payment change is a strategy to get to that better care and outcomes, and that's what's going to inspire people who went into the business of serving under-resourced communities for their profession, oftentimes taking salary cuts, et cetera, to do so to want to participate.

>>Dr. Dora Hughes, CMS: Thank you. Thank you so much, and that, in many ways, is a perfect segue to our next panel where they will continue the discussion on some of these infrastructure issues that you've mentioned here. We are going to share the results of the poll, as I understand it, while we are transitioning over to our next panel. Tequila, I am handing over the mic to you.

>>Tequila Terry, CMS: Excellent.

Thank you, and what a wonderful discussion that was, and it does dovetail very nicely into our final panel, which is focused on our last question of the day which is, what types of technical assistance, data and workforce are needed to sustain safety net participation in CMS innovation models? What are effective mechanisms for addressing these infrastructure needs?

So, we heard a lot from the prior panelists and would love to get thinking from this group of panelists on that question. Our first speaker is Dr. Hector Flores. Dr. Flores is the medical director for the Center for Hispanic Health and Adventist Health White Memorial and a co-director of the Adventist Health White Memorial Family Medicine residency program. He co-founded and serves as medical director of Family Care Specialists Medical Group and has more than 25 years of experience in medical education. And so, Dr. Flores, you have the floor. We would be delighted to hear from you.

>>Dr. Hector Flores, Adventist Health: Well, thank you so much, Tequila. I appreciate the invitation, Dr. Hughes, Dr. Fowler, and the whole team.

So, what I wanted to cover are kind of three quick areas. One is to suggest that we need learning communities to actually implement the transformation. The second is to address some of the technology needs to do that. I'm sure there will be some support from the other speakers on that issue. And the third is to look at workforce and how we should be looking long-term at workforce and where CMMI can actually leverage its funding to partner with other federal, state and even philanthropic agencies.

In my own practice, we're a private practice group established in 1988. About 40 percent of our patients are Medicaid, and about almost 70% are below 200% of the federal poverty level. So those that are a dollar too rich for Medicaid, we manage to enroll them into Covered California, and one of the proposals I'd like to make to this group is that we also consider what I call the hidden safety net. It's not only the classic safety net of public institutions and FQHCs and rural health centers, but there's also private doctors who are working in underserved areas, serving large Medicaid populations, such as ours, and one of the greatest triumphs of affirmative action was that Black, Latino, Native American, Southeast Asian physicians are actually doing what they said they would do if they were given a chance to become a doctor, and that's to work in underserved areas. But we were trained at a time when there were no models like the community clinics that had viability from our perspective over what we were being taught in medical school and residency. So, most of us adopted a private practice model, which is for-profit, and many policymakers kind of tend to see the for-profit as not needing help, and quite frankly, in underserved areas, everybody needs help, so I call this group of doctors the hidden safety net. And in California, half of all the Medicaid visits are actually provided by private physicians in our state, and that also includes specialists that both the safety net and the hidden safety net need access to, and those specialists are also quickly diminishing because of the difficulty in engaging in a practice like this. So, what I mean by learning communities or learning collaboratives is that the experience of the safety net and the hidden safety net participating with initiatives from CMMI, like the transforming clinical practice initiatives, some of the practice transformation networks, is that they were able to learn what it is they needed to do, but they didn't have the capital to actually implement.

So, I want to echo what others have said already, that the safety net needs access to capital, but beyond that, it also needs access to management services because if they're not able to manage the resources they get, they could actually end up not utilizing them optimally.

We saw that happen with the $11 billion that the ACA put in to double, perhaps triple the number of safety net providers in the country, and it didn't really quite happen as successfully as we envisioned because they didn't have the management infrastructure to be able to invest those dollars in a sustainable way. So, part of that is access to management and capital. Secondly is the learning community, and I'll use the medical model. When we get trained as physicians and we're learning procedures, we have this old adage that we see one. We do one. We teach one.

And what the practice transformation networks were able to do was to be able to let everyone see what could be done. Some went on to actually do it, but now there are some that have been successful who actually can start teaching others how to make that transformation around not only the practice of health and all the integration that's been talked about, but also bringing in the ability to move from volume to value.

One of the greatest triumphs of PPS is it gave the community clinics the resources they needed to be able to take care of their patients and provide enabling services above and beyond. But now they're basically constrained to the PPS and it's hard for them to make that transition. Over the past 25 years, I've done a lot of work with the federally qualified health centers, helping them understand what we've learned as not being an FQHC ourselves being able to understand how to maximize the dollars that are coming into patient care. So, one of the pieces there is a learning community to share that information.

Secondly, moving from volume to value means that we also need to define value. Currently, value is being told, taught to us, or forced upon us by the intermediaries, whether it's an intermediary from Medicare or whether it's an IPA in the HMO construct.

We need to be able to develop this ourselves and engage the health plans and being our partners. Now one of the things we have been able to do over the past 25 years because of our relationship with health plans is we've actually gotten financial support from companies like Anthem Blue Cross, Blue Shield of California, L.A. CARE, which is the largest local initiative for Medicaid, and also Health Net, which is part of Centene, partners that we would not normally look on as partners because we have this kind of divide between provider and the health plans and it's not always the most friendly relationship. We need to transcend that.

One of our earlier speakers talked about alignment with health plans, and I think that's really, really important. I think it was Mr. Money that talked about being able to align with the health plans. That is really critical.

The second part is on technology. This is where health plans can also be helpful to us is that not only do we need to have proficiency with the EMR and be able to have health information exchanged that's reliable, but we need to also now move towards telehealth, not depending on the emergency

regulations but actually being able to envision what telehealth should look like in the future with remote patient monitoring and other forms of services in the home as we're looking at moving services out of the hospital setting into the community and to the home. We need to be able to have that facility. We also have to recognize that there is a digital divide. And so, looking at where the Build Back Better program comes back because it has significant amounts for expansion of access to bandwidth and broadband and technology and the hardware itself. But there are opportunities where we can start to leverage private sector. For example, in California, AT&T is making a huge investment in bridging that digital divide because they believe that today's population that they help eventually becomes stable in a new economic model and new jobs and they're able to actually become a customer that they can rely on for the future. So, they see this as a very important social investment.

The last thing is workforce. We train family physicians, nurse practitioners, PAs, and we've recently started training community health workers. And our most recent initiative is mental health. It's training social workers who are pursuing their licensure as LCSWs. And that's to populate the needs of the local community. We need to be able to understand how the transformation of health care includes team-based care. One of the models that has shown us how effective that can be is the FQHC and community health center model, which has been doing it on a shoestring budget for many years. We now understand team-based care, everyone working at the top of their license, everyone working at the top of their training, if they're lay personnel, have to be a key part of this development. And that I think will also reduce the burden that physicians and clinicians working in underserved areas feel, which is they feel a burden that not only they're providing medical care, but they also have to advocate on the phone to try to get social services for the patients. FQHCs have taught us how to do that very effectively. We need to now generalize that across the board, including in the hidden safety net.

Finally, it's really looking at how our institutions should be changing and helping that transformation to occur. So, as I mentioned, looking at health plans not as the enemy, but as partners. Looking at each other not as competitors, but as collaborators to improve the care of the services that are needed. What I have noticed working with community health centers is they need to make that transformation. The big hurdle is getting away from PPS. And so, I like what others have suggested is that we cannot pull the rug out from under them and expect them to transform overnight. The access to capital and management and only upside. One of the jokes amongst us between FQHCs and private doctors like ours is that we've always taken downside risk from the very day that we started our practice because there is always a shortage of money and great news on our patients. So, I should be upside, and I think that that will create the transformation that health care needs across the board. So, I'll be happy to be part of that conversation later on. Thank you again for the invitation.

>>Tequila Terry, CMS: Dr. Flores, thank you very much for those comments. Those are really very helpful. And some really great takeaways. Learning collaboratives and this idea of hidden safety net is intriguing to me, so I'd love to dig into that a little bit more. The technology, the management services, partnerships with health plans. In particular on that hidden safety net concept that you referred to, can you talk a little bit more about those providers who they are?

>>Dr. Hector Flores: Yes. So, one of the fortunate components of the ACA was to define something called essential community provider, which included not only the FQHCs, rural health centers, county

facilities, for example, as the classic safety net, but they also included the hidden safety net as an essential community provider. And that's the docs that are providing, as I mentioned earlier, half the care to Medicaid patients in California. They need access to capital and management themselves because most of them adopted solo and small practices. And they're part of bigger systems by default through the independent practice association relationship with health plans, but they really don't have the infrastructure to support them.

So, as we look forward to a collaborative that creates infrastructure for the safety net, we should also be able to translate that to both primary care and specialty physicians that Medicaid patients depend on as well.

>>Tequila Terry, CMS: Excellent. Thank you so very much for that. Those were really very insightful comments. I would now like to ask our second speaker to share their remarks.

Ms. Amanda Pears Kelly, you now have the floor. She is the CEO of Advocates for Community Health, where she spearheads the coalition's work to advance the delivery of health care to underserved populations and achieve health equity for communities in need. A fierce advocate for health equity, Amanda is also the Executive Director of the Association of Clinicians for the Underserved. So you can feel free to go ahead. We'd love to hear from you.

>>Amanda Pears Kelly, Advocates for Community Health: Thank you so much, Tequila. And I want to start by saying I'm so inspired by the work that you guys are doing and very grateful for the leadership and trying to take on this very big and complicated, complex issue. So, I appreciate the time today and I'm very inspired by a lot of the comments and remarks of the other speakers on the panels today. So, you know, we're scratching the surface today. I can't wait for the work ahead.

The one thing that I would say before I dive into remarks here is that it goes without saying, but I do want to kind of always bring the focus back to patients, that this really is about as much as we're looking at, yes, we need transformation and it's about cost savings and returns, but it's also about improved outcomes and it's about patients fundamentally. And I appreciated Rachel and several other comments sort of bringing it back to the fact that we got into this work and the providers got into this work for that reason. So, I appreciate always kind of coming back to that as one of our north stars as we're doing this work.

ACH is relatively new. So just for those who are just hearing about us, we are a national membership organization for FQHCs focused on visionary and innovative policy in order to affect positive change. And I would agree with other speakers who have commented on FQHCs that we're really uniquely positioned for value-based care with a focus on and an accountability for health of the whole patient. So today -- and again, I want to be conscious of time because there is so much to say -- but I know we want to focus on technical assistance data. And I will call out Jim's comment earlier that it's data and information and then workforce.

So, in terms of technical assistance, there is a few pieces that I would call attention to. So just to kind of level set a little bit, in terms of financial modeling, true value-based care arrangements with an upside

and a downside risk are not as common for health centers. Most of them are still in an alternative payment based on some form of capitation. And so, the plan for value-based care arrangements needs to ensure solvencies for health centers and needs to assist in terms of predicting key variables, specifically patient attribution projections and patient risk stratification and associated costs.

So, a few things to note and some recommendations. Many of the predictive modeling described requires that the use of existing data, which frankly lives across a lot of different systems -- I think we know that -- needs to be brought together. And so, one thing that CMMI might consider as we're doing this work is what support can be provided to help FQHCs to assess vendors, for example, to draw on existing patient and claims data and support population risk stratification and other key components that we need to be taking into consideration. Another piece would be for CMMI to offer clinical integration and support with other providers. So, for example, acute or post-acute. And then the last piece that I would say just in terms of access to claims data is another area. Not all federally qualified health centers have access to all payer claims in their states. This is obviously going to differ depending on where they are. But that makes patient management all the more challenging. And so, I think as we're looking at this and what could change and sort of assist in this area, anything that's going to assist in facilitating that access is going to be a huge, huge component for that.

In terms of data and information, right off the bat, one of the key challenges is with the disparate data sources, and so adding to that sort of a lack of standardization around everything from social determinants of health, but then I think some other key data elements.

So, there are several things that we could do or consider for data integration and warehousing. So one would be to help support safety net providers with integrating existing data streams and then to also be recommending at the same time warehousing models and dashboards that are going to assist in this space. I think providing real-time integrated feedback on patients participating in value-based care arrangements in a way that can be actionable. And so, I think what is the next step that we can take as we're bringing this information in and sort of for redirection. And then the last piece is that if CMMI were to set common social determinants of health elements at least across models, it would go a long way toward achieving true integration and a path for success.

And then the last piece here in terms of workforce. You know, Hector actually spoke to this. Dr. Flores spoke to this, and I think several others have, too. But again, just to level set a little bit, health centers rely on integrated care teams to provide that comprehensive quality primary care to all of their patients. A primary advantage to value-based care is the ability to offer services based on the patient's need presented at a visit and offering that warm handoff to behavioral health or social services. And essential roles in terms of the workforce piece for value-based care models that can help is in the pharmacy space, nursing, and chronic disease educators.

And then another piece that I would bring up is that, at least for our ACH members who have successfully participated in value-based care models, community health workers, patient navigators and other peer support staff and workforce have been absolutely critical. It has to do with that shared and lived experience and cultural congruence. And that's part of what creates that meaningful impact on care and quality and patient engagement. So, I think something that we need to think about is what are

we doing to support that kind of workforce in taking this type of initiative and that path forward on. You know, it's wonderful and we're all committed to doing so, but it does require time, resources, support, technical assistance, coordinating the data, all of it. And there is a workforce component to that that's really important, too. I would say one segment on the patient-facing side and the other sort of internal in terms of how do you facilitate and make all these things connect internally.

So, I think that kept me in time, Tequila. So, I'll stop there. I know there is bound to be questions, and I want to make sure I'm respectful to the next panelist, too.

>>Tequila Terry, CMS: Yes, of course. Thank you, Amanda. I do have one follow-up for you. You talked about this idea of setting common social determinant of health elements across all models. Can you talk a little bit more about what you're thinking in that area? Any suggestions you might have?

>>Amanda Pears Kelly, Advocates for Community Health: Well, I think -- so yes and no. And I will also say that I have lots of people working with me who might have great suggestions. But I think it's mostly just getting specific, Tequila. Right now, everyone is doing their best and they're trying to get at as many different components as they can. And so, I think creating specific measures and creating a standard so that we can look across the entire model or system. I think also aligning across payers would be another big one. So those are the two right off the top of my head, but I think there are many others that would probably chime in with additional offerings on that, too.

>>Tequila Terry, CMS: Excellent. Thank you so much, Amanda. Really very helpful comments. I'd now like to turn to our final speaker.

Kathleen Noonan is the Chief Executive Officer at the Camden Coalition of Healthcare Providers, a non-profit health care innovator that recently launched the National Center for Complex Health and Social Needs. Ms. Noonan cofounded Policy Lab at Children's Hospital of Philadelphia to connect clinical research with real-world health policy priorities. Ms. Noonan, you have the floor.

>>Kathleen Noonan, Camden Coalition of Healthcare Providers: Great. Thank you so much. So let me just start by making sure everyone knows that a lot of what I'm going to talk about is based on our experience with a randomized control trial that was done by Jay Powell at MIT based on our care management intervention. And that study found that basically a null effect on hospital readmission. We did find -- although it doesn't get a lot of discussion -- a statistically significant effect on SNAP benefits. So, people in our intervention group had a greater connection to SNAP benefits. And that makes sense to us because we actually are someone that looks across all benefits for our patients.

My comments, though, also come, I just want to say as someone who spent 10 years at not a safety net provider at the Children's Hospital of Philadelphia at a very, very well-endowed research institute. And so, it's fascinating to be able to go from that to a 75-person community-based organization.

So let me say that it is essential if you're going to have safety net providers -- and we consider ourselves a safety net provider -- be involved in CMMI studies, which we were, that they have real input into the design of the study. And let me say that we have a great relationship with Jay Powell. We had a very

good experience in the study. But we were newbies. I actually wasn't here at the time that we started this study, but we were newbies. So, I think that that's really, really important.

I think the second thing is that, you know, it's really important that you're a safety net provider. You're not involved in research. You don't know how it goes. You need access to a peer forum that can actually help you think about what should you be thinking about. We could give so much advice now -- and by the way, ask us and we will -- to safety net providers. We will encourage them to participate in research, but we will give them a lot of advice based on our experience. And we just think that those kinds of peer exchanges could be really, really important and helpful. Our study, just to give you an example, only involved administrative data. We really wanted to collect patient-reported data, but that wasn't part of the study design. And so you know again, thinking with other people that have been part of studies like this I think could be very helpful.

The next thing I'll say is that I really do think that CMMI needs some kind of readiness assessment for safety net providers where you're really trying to figure out not, are they ready in a way that will disqualify them, but if they're not ready, but we really need research in place like this. Do we have TA that can be offered on the data side? Do we have TA that could be offered on whatever the infrastructure side is so that they can participate? So, I think that some kind of readiness checklist is really necessary.

The next thing I'll say is there really should be a QA plan for this. We did our study. We waited 2 years for results. We've spent 2 years diving into our data and looking at what we learned from subpopulations. No QA plan funded. As a community-based organization, it's actually been impossible to get any studies funded on our segmentation of the RCT data. And I really feel like thinking about do we want the safety net provider to continue this, whatever the result is, and who is going to help with that sort of QA plan.

And then the last thing I'll say is funding around sustainability. When I designed a study at CHOP -- And I'm a policy person and a lawyer, but I was involved in study design because I was sort of merciless about the sustainability of whatever we were doing. And we were putting in a new community-based intervention in three community-based programs in the city, and you know really outside of the hospitals, it's the providers who are doing developmental disabilities, behavioral health, substance use, and that's where we were going. And we decided that we were not going to use any study money to pay for the intervention, that we were actually going to first get the state Medicaid office to approve the intervention and make sure that we had a diagnostic code for it so that after we finished the study, they could actually continue doing what we had set up in their community-based organizations. This added 18 months to the study to get Medicaid approval. We could only do it because we had a foundation that was willing to let us put the study on hold for 18 months. We could never have done that with a federal grant. But it meant that at the end of the study, we had three community-based organizations all with certified interventionists in what was an evidence-based practice. So, I really think if we're going to change things, we have to really think about those pieces. So, let me stop there. And just thanks again for having me.

>>Tequila Terry, CMS: Thank you so much. Those were tremendously helpful comments. Certainly, our thinking is that we absolutely want to get input early on, which is one of the reasons that we are having these types of sessions. But, both you and Dr. Flores talked about this need to form peer forums, learning collaboratives, so I'm wondering if you can talk about any successful structures that perhaps you're aware of that work really well or any best practices that you may be able to share as we think about the opportunity for building out peer forums or learning communities specifically for safety net providers.

>>Kathleen Noonan, Camden Coalition of Healthcare Providers: Yeah. Well, I mean, I think the thing that hospitals have as a matter of practice whether it's M-and-Ms, or a research institute will just have brown bags where people sort of pick things apart. I think we have the models. They're somewhat informal, but they just provide an opportunity for people to come together to sort of think about things. And that's what I'm thinking about. I mean, nothing more formal than that. I mean, an M-and-M can be a pretty formal process. A brown bag picking over research design isn't so much. But I'm thinking something that's much more informal. What we've done at the Camden Coalition that has been extremely helpful to us is actually sort of developed our own research advisory. So, we didn't have research advisors from outside the Camden Coalition, and we only had the researchers that we were working with, who were fabulous. But it's helpful to have other researchers or other organizations that have just been involved in research studies so you can get their take on it, too. And then you know make sure to involve the people who the work is affecting. So, our community advisory committee was very much involved in our study. I brought them back the results. We explained to them the null effect of the RCT. And I have in my phone one of the things that one of our community advisory members said to us because it just inspires me every day. And he said, "Well, you were obviously measuring the wrong thing."

And so, I don't know. They gave us lots of ideas about what we should have been measuring, which was as good a conversation about measurement of variables as a lot of conversations I've been in. So, I would say those things are really important as well.

>>Tequila Terry, CMS: Okay. Excellent. That was really very helpful. And I want to thank all three of our panelists for sharing your perspectives on this last panel. And now I'm going to turn it over to Dr. Hughes to close us out and talk about our polling results.

>>Dr. Dora Hughes, CMS: Thank you. Thank you so much. Just to clear this up briefly and being mindful of time, we did want to launch the final poll in terms of follow-up to this conversation, really focusing on, as you read here, what are some of the biggest non-financial barriers to safety net providers, select one. We'd like to just know where people, how they would rank, what would be the most concerning, keeping you up at night if you're a safety net provider participating in a model.

And then while you're making your selection, in closing, we really just wanted to thank all of our panels. All of them were just such rich conversations. We're excited to continue to work with all of our panelists and others who have provided feedback through the Q-and-A mechanism or comments through our other mechanisms.

If you can move to the next slide.

Here we do encourage you, again, if you have additional input, please, please e-mail your comments and feedback. We read all of the comments. We do take them into consideration. They are very helpful. Also on this slide, there are other resources, certainly our Innovation Strategic Direction web page, our health equity blog that was just published a couple weeks ago in *Health Affairs*. And certainly, here as you see, there are different ways that you can sign up. Before we formally close this out, I do want to show the results of the polls, if we can pull those up.

There we have it. Those are the results for the polling question number three. All right. And with that, I want to thank my co-moderator, Tequila Terry, for her excellent facilitation of two panels, as well as thanking our leadership, Dr. Liz Fowler. And of course, we are forever grateful for the support of our administrator, Chiquita Brooks-LaSure. So, with that, thank you so much, and we hope you'll be in touch.

>>Tequila Terry, CMS: Thanks, everyone, for joining. Take care.

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