CMS Innovation Center Listening Session – Second Roundtable on Safety Net Provider Participation in CMS Innovation Center Models

Nov 3, 2022

>>Dr. Christine Ogbue, CMS: Good afternoon everyone, and welcome to the Second Roundtable on Safety Net Provider Participation in CMS Innovation Center Models. Next slide, please.

My name is Dr. Christine Ogbue, and I am a senior advisor at the CMS Innovation Center. Before we get started, I have a few administrative items to address. First, I want to let you know that this session is being recorded. Second, closed captioning is available for this event by clicking on the CC button at the bottom of your screen. And third, I want to point out that there is a Q&A function available during this meeting and encourage you all to use it. Due to the size of this event, we may not be able to respond to everyone's questions but we will be monitoring the Q&A closely and plan to follow up after our meeting. You can also send an email to our Strategic Refresh Inbox if you have more comprehensive feedback. Lastly, if there is any press on this call, please submit questions through the CMS Media Inquiries Portal. That link is being shared now via the chat function. Next slide, please.

Now I will walk us through the agenda for today's roundtable. First you will have brief opening remarks from the CMS Deputy Director and Director of the CMS Innovation Center, Dr. Liz Fowler. Then Dora Hughes, who serves as the Chief Medical Officer at the CMS Innovation Center and leads our health equity strategies will give a brief overview and update on the Innovation Center's work in this area. After that, I will share our progress and discuss the tasks we have competed in order to inform our safety net provider strategy. Then Tequila Terry, the CMS Innovation Center's State and Population Health Group Director will discuss our lessons learned and next steps, facilitate the discussion with our roundtable participants, then provide closing remarks.

Our roundtable participants are thought leaders who will share their perspectives and recommendations for the CMS Innovation Center on increasing safety net providers' participation Innovation Center models. Now I will hand it over to Dr. Liz Fowler for opening remarks. Next slide, please.

>>Dr. Liz Fowler, CMS: Thanks so much, Christine, or, I should say, Dr. Ogbue. And, good afternoon from the East Coast. We really appreciate everyone joining us for this update and discussion on how to increase safety net provider participation in Innovation Center models as a way to better reach underserved communities. Next slide please.

Today's roundtable is a follow-up to the safety net provider roundtable we had in March. At that roundtable we discussed the white paper that detailed our vision for attaining a health system that achieves equitable outcomes through high quality, affordable, person-centered care. During the March session we started to explore barriers that safety net providers face with Innovation Center models. Today, we will share our progress and gather additional feedback that will continue to inform our safety net provider engagement approaches. As Dr. Hughes will share in more detail, our desire to include safety net providers and CMS Innovation Center models is part of our overarching equity strategy. We believe it's critical to have participation from providers that serve a high proportion of underserved and rural beneficiaries. Achieving our vision to have a health system that achieves equitable outcomes through high quality, affordable, person-centered care will require continued

partnership with patient advocates and beneficiaries, community-based organizations, as well as providers, payers, purchasers, and states.

We sincerely appreciate your time and input so our work can align to create a health system that better serves our communities, and especially underserved populations. So that's it from my end, and I'm going to turn things over now to Dr. Hughes to provide an update on the CMS Innovation Center's health equity strategy. Thanks again for joining. Next slide, please.

>>Dr. Dora Hughes, CMS: Thank you Liz. The CMS Innovation Center has been holding listening sessions and roundtables following the October 2021 launch of the Strategy Refresh. We are so excited for this continued engagement with today's focus on safety net providers. Next slide, please.

To level set, 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 and Medicare, Medicaid, and the Children's Health Insurance Program while spending the same or less. On a practical 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 cost.

As described in much greater detail in the white paper, Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade, that was released in October 2021, in the coming decade the Innovation Center will be focused on building a healthcare system that achieves equitable outcomes through high quality, affordable, and person-centered care. To achieve this vision, the CMS Innovation Center here has committed to the five strategic objectives pictured here in this graphic. Today, we are focused on the Advancing Health Equity strategic objective. Next slide, please.

The Innovation Center intends to advance health equity by focusing on four domains. First, CMMI will develop new models and modify existing models as feasible to address health equity and social determinants of health. Second, we will increase the number of beneficiaries from underserved communities in our models, in part by increasing the providers that serve, them, including Medicaid providers and those in FQHCs. 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, or SOGI. 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 blog released earlier this year in Health Affairs.

Since the last roundtable discussion, the Innovation Center has made progress on our equity pillar, as you will hear more about. As one example, and relevant to this discussion today, the CMS Innovation Center is partnered with HRSA to discuss strategies to encourage more FQHC participation in our primary care models. As a second example, we've also explored how health bias may have contributed to under-representation of low-income beneficiaries and racial minorities in our models. To learn more about our implicit bias analyses check out our Health Affairs blog that we released in July.

As mentioned before, the Strategy Refresh white paper, articulated the CMS Innovation Centers commitment to increase the number of patients from historically underserved populations and safety net providers in its models. We are here today to reassure you all of our continued commitment and

ensure our work can be informed by the insight of safety net providers, stakeholders, and experts. I'll now turn it over to Christine to share more about our progress thus far. Next slide, please.

>>Dr. Christine Ogbue, CMS: Thank you, Dora. I'm going to share the activities that we've completed since the last roundtable to inform our safety net provider strategy. Next slide, please.

From April to June 2022, this year, the Innovation Center conducted in-depth one-on-one stakeholder interviews. The interviews were conducted in a closed-door setting to help further uncover and understand existing perceptions, experiences, reasons, providers serving in underserved communities might not apply or participate in CMS Innovation Center models, and to identify potential adjustments to model and application designs that may foster greater participation rates. For stakeholder interviews, the stakeholders interviewed included executive-level leadership and providers from Federally Qualified Health Centers, or FQHCs, university health systems, Rural Health Clinics, and community-based nonprofits. Next slide, please.

This slide shows some of what we asked and heard during the one-on-one stakeholder interviews. Please note, this is a snapshot, not a comprehensive list of all the things we asked and heard. We began these interviews with questions about Innovation Center model awareness. Then we asked how we could support potential safety net model participants. We also ask how current or upcoming models can be tailored to support safety net provider participation.

We heard that levels of awareness for Innovation Center models can vary greatly across safety net provider organizations, that deficiencies and staffing and health IT resources can make applying for and implementing CMMI models a heavy lift, and that readiness assessments and technical assistance during the application process could be particularly helpful for safety at organizations. Next slide, please.

In addition to the stakeholder interviews, we conducted internal analysis on our model application requirements to identify additional opportunities to modify model requirements and encourage safety net provider participation. We approached this qualitative analysis with four hypotheses for why there aren't more safety net providers in our models, or why there isn't more safety net provider participation. The first hypothesis was that there is a lack of awareness and a need for more widespread education on Innovation Center models. The second hypothesis was that the application process itself is burdensome. The third hypothesis was that the eligibility requirements for some models exclude safety net organizations. For this hypothesis, eligibility was not just based on provider or facility types but also extended to specific model requirements for organization infrastructure and data reporting. The last hypothesis considered that the level of effort required for implementing models was high and stretched the bandwidth of providers too thin to encourage participation.

Now I'll turn it over to Tequila Terry to discuss the lessons learn from our stakeholder interviews and our model application analysis. But, not before our first poll question. Next slide, please.

I want to take a quick poll with our audience. The poll question is: What do you think is the greatest barrier to safety net provider participation in CMS Innovation Center models? Is it awareness, meaning safety net providers are not aware of Innovation Center models and the potential benefits of model participation? Is it the application process, meaning the administrative burdens of the application process is too great? Is it eligibility requirements, so model requirements for infrastructure or data

reporting are not feasible for some safety net facilities? Or, the level of effort for implementing a CMS Innovation Center model is too great?

Thank you all for participating and providing us with your feedback. It looks like the greatest barrier is the level of effort for implementing a CMMI model. This aligns well with our strategy moving forward, and the barriers we plan to prioritize. So, thanks for that reassurance.

Now I will turn it over to Tequila Terry to share more about lessons learned and our initial safety net provider definitions. Next slide, please.

>>Tequila Terry, CMS: Thanks so much, Christine. I am delighted to be with you today to really share the overarching themes and lessons learned from those stakeholder interviews and model application analysis that we just discussed. First, though I want to share the framework we are using to categorize our lessons, our lessons learned. Next slide, please.

We decided to categorize the lessons learned from the stakeholder interviews and the model application analysis using a framework that was created by the Health Care Payment Learning and Action Network's Health Equity Action Teams. Some of you may know this group by LAN HEAT for short. This framework is the Theory of Change for Advancing Health Equity through Alternative Payment Models or APMs. According to the LAN HEAT's framework, alternative payment models really leverage three interrelated features that are especially important for advancing health equity. And those are what you see on the screen: Care Delivery Redesign; Payment Incentives and Structures; and Performance Measurement.

We are applying this framework because it is intended to provide stakeholders generally with actionable guidance to leverage APMs to advance health equity in ways that are both aligned and tailored to meet their community's needs. For example, by incentivizing and supporting care delivery changes that make care more equitable, intentionally designed alternative payment models can mitigate the negative impact that things like explicit or implicit biases and structural racism have had on historically marginalized communities and the providers that serve them. Thereby, driving better patient outcomes, reducing disparities, and advancing health equity. Next slide.

Now let's walk through some of the lessons we learned. Keep in mind, this is not a comprehensive list, but it's a summary that provides some key instructive themes that we uncovered. The focus of these lessons really are to improve health equity and increase safety net provider participation.

So first, starting on the first section on the left. In the payment incentive structure category, we learned that in order to increase safety net provider participation, we should consider offering tailored technical assistance, and/or a two phased application process. We also saw consistent themes related to the need to define safety net providers to measure inclusion in our models, to determine the feasibility for providing more upfront in infrastructure investment for safety net organizations. Really to learn more about the accounting for safety net organization, financing and how that might interact with an alternative payment model. And then, encouraging the creation of networks that ease value-based care financial burden on smaller providers, or look for opportunities to pool financial risk.
So in this first category, those are some of the key lessons learned.

In the second category, for Care Delivery Redesign, the themes for strengthening safety net provider participation were focused on, first designing models that are responsive to community conditions. So

recognizing that the design has to align with what communities need, incentivizing and leveraging community resources, and promoting team-based care approaches, and then encouraging engagement of again sort of smaller community-based providers in care transformation.
And then moving to the final set of themes and lessons learned. Last, we heard several themes related to opportunities to address performance measure barriers. For example, the need to develop models that allow sufficient time to observe hypothesized changes, particularly in underserved populations.

So making sure that we really are being diligent about thinking about the timing that we consider for our models. And then secondly, designing measurement approaches that both recognize not only health care access improvements, but also health care outcomes. So, looking both at access improvements and outcomes as part of our design. Next slide, please.

So before I move to our next section in the discussion, I want to take another audience poll. This question really is intended to help us understand how we might be able to prioritize some of the barriers that we identified in our analysis, and what we have heard about through stakeholders. So, the question is: How should the CMS Innovation Center prioritize addressing the following barriers to participation: Should we focus or prioritize Payment Incentives and Structures; Care Redesign; Performance Measurement; or are there other ideas that you have that you can certainly share with us by entering information in the Q&A box. So we are going to ask you to rank the order of these respective barriers so we better understand your perspective.

Excellent, well thank you everyone for your thoughtful responses. It looks like we've just gotten our poll results, and it looks like a large majority of the audience has ranked Payment and Incentives Structure as the number one item that we should focus on. Then, followed by perhaps Care Redesign and Performance Measurement. So, this is really instructive for us to understand where the opportunities are, and where we should focus. It's also notable that it looks like we had several responses of “Other”. So we are looking forward to seeing your messages in the chat to help us better understand what the other opportunities may be.

Thank you for your participation in that poll, and now we will move forward to the next portion of our session. We appreciate your feedback and we are looking forward now to discuss how we plan really to get our expert panelists involved in the conversation. And so next slide, please.

Now before getting to our panelists, though, we're going to discuss how we plan to start measuring our progress towards increasing safety net provider participation. To measure progress, we need to create a safety net provider definition. So part of what we talked about in the March roundtable was really starting to think about that concept with many experts from around the country. And so today, we want to be able to share a preview of our latest thinking. So next slide, please.

As we can start to consider an appropriate safety net definition, we developed a definition for both a facility level and a provider level. Safety net facilities include hospitals, and that includes short-term hospitals and Critical Access Hospitals, that serve a baseline threshold above the 75th percentile for all congruent facilities who bill Medicare for beneficiaries with dual eligibility or Part D Low Income Subsidy, and Federally Qualified Health Centers, Rural Health Clinics, and Community Mental Health Centers. So, as we're thinking about the facility level, that's the definition that we would be using.
On the provider level, our safety net provider really is defined as those who serve above a baseline threshold of beneficiaries with dual eligibility or Part D Low Income Subsidy.

I will say that the definitions that you see here are a starting point to enable the Innovation Center to capture and quantified safety net provider participation in our models. Moving forward, we will revisit the inputs to the safety net provider definition to include more types of facilities and providers who serve Medicaid beneficiaries. We know it will be critical to collaborate with and solicit feedback from states and other external stakeholders to develop a measurable definition for Medicaid safety net providers, to align quality measurement and payment policies across payers, and really to attract and ultimately retain safety net providers across a range of models. Next slide, please.

So, one more poll for the audience before we move to our roundtable discussion with our panel of experts. We really want to get your input on this definition, and really criteria that we should be using as a basis to help ensure that we include providers that serve Medicaid beneficiaries. So, the poll question is: What are the most important considerations for defining safety net providers to ensure that we maximize the inclusion of providers that serve Medicaid beneficiaries?

So again, we're going to ask you to rank several different areas of consideration. So first, should it be based on a Federal provider or facility designation? For example, a Critical Access or a Disproportionate Share Hospitals, Federally Qualified Health Centers, Rural Health Clinics, so that federal designation. Second, should it be based on a geographic location or service area? For example, providers who focus on health professional shortage areas, area deprivation, or social vulnerability index areas. Third, should it be based on ease of measurement and consistency across regions, and states? So, making it easier to be able to consistently measure across the country. And then, finally, should it be based on aligning with the Marketplace definition that refers to the concept of essential community provider? And then you also have the option to add an “Other” item. And so if you opt to do “Other”, you can feel free to enter ideas in the Q&A box. So we'll give our audience members some time to consider those options and think about, again, a ranking on this question. Just to make sure that you can see all poll options, please maximize the polling window on your screen.

Excellent, so it looks like our poll has wrapped up, and we have a variety of responses included. But it looks like overwhelmingly most in the audience selected option A, to use the federal provider or facility designation as the best way to ensure that we are maximizing the inclusion of providers that serve Medicaid beneficiaries. And it looks like it's followed by a close second maybe, of geographic location or service areas. And then, again, we have, looks like some folks who have entered ideas in the Q&A box. So we really appreciate that input from our audience. Thank you all for participating in the poll. Next slide, please.

Now we will begin the panel discussion portion of our event. And I'm so excited about this part of our agenda, because we're going to hear from some of the most foremost safety net provider experts from around the country. Next slide.

So our first panel will include several renowned experts from around the country: Chris Salyers from the National Organization of State Offices of Rural Health; Erin O'Malley from America's Essential Hospitals; and Ana Gallego, from the New York City Department of Health and Mental Hygiene. And this first panel will include, or will be focused on, a question around really prioritization and focus on barriers. So, the specific question that we will be asking this group to respond to is: How should the CMS Innovation Center prioritize the following barriers to participation?

So we talked about, you know, this idea that awareness may be an issue, that there is just not enough information flowing to safety net providers so that they know about CMS Innovation Center

opportunities. We talked about the application process and that the application process was daunting. We talked about eligibility requirements, and that they made the threshold for eligibility could be too high. And then finally we talked about implementation level effort, and the tremendous amount of resources that safety net providers perceive that are needed.

So I'm going to start by giving the floor to Chris Salyers for this question. So, Chris, I'll turn it to you to get your perspective. Next slide, please.

>>Chris Salyers, National Organization of State Offices of Rural Health: Well thank you so much, and thank you for having me and allowing me to represent the 50 State offices of rural health today. I first want to start by saying I appreciate the level of effort that CMMI is taking here to really dig in and try to prioritize these efforts and really listening to all of us, and what we are saying.

With that in mind, you know this is a big question, and it's you know, what part of the elephant do you start with? So I'm sure others, and I look forward to hearing my peers and colleagues, hear what they have to say to. But from my perspective, I would say that you kind of have to do two things concurrently. It's the application process and eligibility as the starting point for me. Truly it's about making more facilities and provider types eligible, but also thinking about non-traditional locations of care. So maybe it's not in the clinic. Maybe it's in a church or things like that, that may not be considered now.

I particularly like the comment that somebody made around helping with pre-determination. That was, I think, that was a very helpful comment. And kind of drawing on what we saw happen with the rural emergency hospitals. You know, there was some research done that said, “Hey here are the hospitals that might be eligible, and benefit from participation.” Right, so before they even walked into this conversation, they had some data that said, hey, this might actually benefit me and my practice and my facility, and I think that that was, you know, a really good thing that they could be replicated here.

So once you’ve worked on those application pieces and stuff, then I think it is that that implementation level of effort. I saw something in the Q&A that really resonated with what I was going to say. It's not just, you know, can your IT system support it, right? It's also training the staff. It's getting people, to everybody that's there, to kind of be working in the same direction. And so, there's training and other things that that aren't going to be funded, that are going to be big barriers for facilities’ participation. So, I would also kind of take a look at that.

And then lastly, on awareness, it's not just simply awareness, I think it's really an understanding. And the reason I prioritize that last is because yeah, once you get a few people going, and then they start going to their local conferences and stuff and talking about what it is they're doing, they can help drive that awareness within their peers. But we can, we need some early wins, so that people can really see “Hey, this is beneficial, and I should be at the table.” So thank you for a couple of minutes today, and really appreciate the time.

>>Tequila Terry, CMS: Thank you, Chris. That was very informative, and you know it really has made me reflect on sort of this idea in particular, of non-traditional locations of care and starting to think about how we really get in the mindset of, you know, sort of what communities need and that the fact that it's not necessarily always a clinical location. These other non-traditional locations that we should think about as an opportunity to engage safety net providers. So really appreciate your perspective. Excellent, really want to thank you for your response.

Next, I want to transition to our next speaker, Erin. So, Erin you have the floor, from America's Essential Hospitals' perspective.

>>Erin O'Malley, America's Essential Hospitals: Wonderful, thank you. And thank you to CMS Innovation Center leadership, for including us in this ongoing and very important conversation.

So 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 have greatly appreciated being part of this ongoing conversation about ways to ensure that safety net providers are not left behind in the development of innovative care as well as payment models. Thank you for sharing the findings that you have been exploring over the last few months through stakeholder engagement.

Thank you, Chris. I appreciate your comments right before mine, and agree with a lot of your points. What I wanted to do over the next few minutes is go into the four areas of your hypotheses and attempt to prioritize within each of those.

So, starting with awareness, as we think of models, and in particular models where safety net providers can thrive and move the dial on equity, we would strongly encourage the Innovation Center to ensure that all of the outreach is targeted to all of the entities who might be participating in a model. So outlining roles and responsibilities, opportunities as well as objectives of the models, and being really clear about how both medical and non-medical partners can fit together and work together, in a structure to advance care.

So thinking then about the application process, we strongly urge the Innovation Center to ensure that the process is not overly burdensome. Safety net hospitals, including essential hospitals, are under tremendous burdens these days from workforce considerations to financial stress. One of the top ideas that we have, our recommendations, is to reduce burden by allowing for a generous application window, as well as technical assistance allowing safety net institutions to take adequate time to assess their readiness, to be able to apply as well as to thrive in models that they apply for.

Turning to eligibility requirements, we have several ideas here. In particular, we would strongly encourage that models target essential hospitals, and these models would also be encouraged to seek out alignment between existing models that could ensure smooth transitions as well as an ability to build off of systems of care redesign that are already in place. Additionally, flexibilities and models designed should not be limited to one particular participant. So as an example, earlier this week, we saw that CMS has announced for the first time ever upfront payments for ACOs in the Shared Savings Program. However, those investment payments will be limited to low revenue ACOs that do not include essential hospitals.

And then finally, in thinking about the level of effort associated with implementation, we believe that essential hospitals would benefit from additional technical assistance, whether it's in the form of technology or data reporting, even information sharing. We also encourage an acknowledgement of the fact that there are low Medicaid payment rates and those low rates do leave little room for savings to be actualized. Our members, the essential hospitals care for a high portion of low-income patients, and we strongly encourage an option for them to be able to participate in models that would place more of an emphasis on improving patient care outcomes, and less of an emphasis on reducing total

cost of care. Also related to implementation, we strongly encourage the Innovation Center to ensure that essential hospitals are not penalized for the characteristics and patients that they see, and the performance metrics and evaluation criteria accurately measure differences in provider efficiency and quality.

And finally, we do caution that, as of today, there is no formal codified federal definition of an Essential Hospital. Unlike Critical Access Hospitals, or even Disproportionate Share Hospitals (DSH), as a payment mechanism, but not a formal Federal definition. We caution that with the auto codified definition of an essential hospitals, the Innovation Center will not be able to target models or engage in outreach to this critical class of provider, or be able to direct resources or tailor policies to ensure that safety net providers can thrive in value based care. So again, this definition we think is critical to the foundation of moving forward. And America's Essential Hospitals stands ready to partner. Thank you.

>>Tequila Terry, CMS: Thank you for that, Erin. That was incredibly helpful, and your point resonated with me about ensuring that we don't have too much burden, and really allowing for generous timing. You know, one of the things, this is one of the things that we have been thinking about, and so really and interested in understanding any concrete steps you think we could take around reducing burden. Is there anything specific that comes to mind when you think about eliminating burden for providers during that application process?

>>Erin O'Malley, America's Essential Hospitals: I'm sorry. I just got the notice that my camera was not on previously. I apologize for that.

So in the context of the application process, again, we hear a lot from our members that, you know, not only are they short staffed and there are plenty of individuals within an essential hospital who need to weigh the ability to participate in the model, but you know thinking about factors such as how safety nets are financed to be able to even make a projection to ensure that it that they can make the upfront investments needed to even be able to feel confident in applying for a model. But then thinking about what will happen if we don't meet the milestones, and how will we be able to adjust in the short and long term for any savings that we do not actually see in return. So, the financial aspect for safety net hospital is one that requires that longer extended period of time. And as I noted, any technical expertise, you have access to individuals within the Innovation Center who can give advice, connection to peers who have been in a successful model to date I think would also be another great example of trying to ease some of that initial burden, especially for essential hospitals who have never participated in a model to date.

>>Tequila Terry, CMS: That's very helpful. Thank you so much, Erin, we really appreciate your perspective. Next slide, please.

Next, we're going to ask for Ana Gallego to provide her perspective. So Ana, I will turn it to you.

>>Ana Gallego, NYC Department of Health and Mental Hygiene: Thank you Tequila, and thank you CMMI for the fantastic work that you are doing to improve health equity. That presentation of my fellow speakers, it's a tall order to have additive comments today.

So to start, I want to acknowledge that safety net probably evokes a different picture in our minds, depending on where we are, especially, when we compare dense urban cities with more suburban or rural areas. When I was in South Carolina the safety net to me were the community health centers and

the rural hospitals and clinics. And here in New York City there are many more flavors of safety net. There is an eleven hospital, multi-clinic public health care system, with fantastic analytics, mid-size hospitals that serve racially segregated neighborhoods, and solo practices that run on paper and speak the language of the ethnic enclaves that they serve. All of these flavors of safety net have one thing in common, and is that they have been systematically disinvested in for decades. So I will focus my comments today on the smaller, non-public safety net providers because most of them have little excess capacity, and they, their main priority, every day, is to keep their lights on, and the staff employed. So, I would summarize the presentation that you have, and my fellow speakers' comments in saying, that when a CMMI model comes up the safety net needs to believe that the squeeze is worth the juice. And that applies to applying. So, if they make the effort of applying, they have an actual chance of getting selected, and then, that if they put in the effort to do all that it takes to run a CMMI model, they will not only succeed, but it will help them stay open both in the short term and in the long term.

So, there are a few things that I want to highlight in terms of how to make that implementation effort worth a squeeze. The first thing is to acknowledge that because the safety net has been disinvested in for decades, the CMMI model is not only an opportunity to innovate, but also an opportunity to undo that disinvestment. So, there are many places in the health care system that need to be controlled for cost, but not necessarily the safety net. It is okay if the total cost of care goes up for safety nets. Benchmarks and payments should account for that. And it should go beyond the patient and community risk as adjustments, because this specific safety net system has been disinvested in as well in addition to the challenges that their patients in the community have. If there is a shared savings model, the size of the savings in a moderate success scenario needs to be meaningful. I spoke to a safety net provider colleague that has a budget gap in the double digit millions every year. They were participants of an ACO and they netted $20,000 after a major overhaul of their entire care delivery system. They cannot afford to participate in a CMMI model going forward. So cash up-front and no downside risk are also some of the additional care design components that would be helpful for the safety net.

Second, evaluation and documentation requirements, they really need to be the minimum necessary. And there needs to be technical assistance provided to them at every step of the way, from the awareness, creation, to the evaluation. Because when you have a system that doesn't have much excess capacity some external help is really helpful to connect the dots, build capacity, and assist with tasks. At the health department here in New York City, we do that for hundreds of safety net practices through a rich network, but we're not the only ones. The offices of rural health, the primary care associations, they're fantastic to support their members.

And finally, the safety net is more likely to participate if the model is designed with them, and for them. So, in the eligibility criteria you mentioned that you want to include the safety net, I would ask that not only that the safety net is included, but that they aren't competing with systems that aren't their peers. If you are included in the definition, but you're still going to be competing with the major academic medical centers that are very well-resourced, that doesn't give you a sense that you're actually going to be able to implement the model. So the eligibility criteria is an opportunity to signal it very clearly for the safety net, the prospective applicants need to see very rapidly that they will be competing with peers that face similar resource limitations. Because then, if they see that, they know that the effort that will go into writing the application is going to be worth it, even if it is a simplified application that's being created for these models.

One last comment, if I have time, is that we would love to see, we love that CMMI is trying to attract the safety net, and we would love to see that there is a special focus on racial equity and focused models that are co-designed with the minority serving institutions. In New York City in particular, we have institutions that have 80 or 90% service to Black and Latino populations alone. And it is really important to invest in these institutions and invest in the quality of care that's being provided, and in the outcome improvement that's needed in these communities. Thank you.

>>Tequila Terry, CMS: Ana, thank you. That was amazing, and so much good feedback you've provided. I love the idea of focusing on, you know, is the juice worth the squeeze. You know, when we think about providers and putting ourselves in the shoes, recognizing the razor-thin margins that they operate under, so absolutely appreciate your input on that.

You know one of the things that you said that really jumped out is, you know, sort of this idea of really needing that upfront cash investment, and then you know, not having downside risk. That is an area that we have continued to sort of think about. You know by statute, Innovation Center models have to be either budget neutral or produce savings. And so, it makes it challenging for us to imagine a model where you know there are investments from the Innovation Center without you know some offsetting cost savings generated in the model. That being said, I think certainly risk-based approaches are one key strategy, but certainly not the only strategy. And I think you are highlighting a really important point thinking about, to focus on what are the alternative strategies that might exist, and that could be applied to safety net providers. So, thank you again for that really wonderful insight. Appreciate it, and we will continue to think about those opportunities in particular. Next slide, please.

Now, I want to transition to our next set of panelists, who will be again giving us some fantastic input. And so next slide, please.

So our second topic for discussion will include, or rather our second panel will include, several key subject matter experts from around the country: Carrie Cochran-McClain from the National Rural Health Association; Dan Derksen from the University of Arizona Health Sciences; and Aditya Mahalingam-Dhingra from the Community Care Cooperative. All three are going to be considering the question that you see on your screen. And that is: Based on the lessons learned that we've just shared, and they span Health Care Redesign, Payment Incentive and Structures, and Performance Measurements, based on those categories, are there additional categories, we should be thinking about opportunity or specific strategies we should consider to better engage safety net providers in our models?

And so I'm going to give Carrie the chance to respond to this question first. So next slide.

>>Carrie Cochran-McClain, National Rural Health Association: Well, good afternoon, Tequila, and thanks so much to CMMI and CMS leadership for having us and ditto all the fabulous kind of kudos to you on the work that you're doing in this space.

So diving right in, I'm with the National Rural Health Association. Our membership consists of a really broad umbrella of individuals and organizations who share the common bond of an interest in rural health. And so I'm coming from both the provider and kind of consumer patient perspective, and I think I was very pleased with the initial lessons learned that you all shared in the overview. And I just want to kind of echo and support for a few of those and then a couple of additional suggestions.

So, when we're talking about payment incentives and structure, and I agree with the poll that this is probably one of the biggest issues that we hear about from our rural providers, so seconding comments we heard earlier upfront support for funding for infrastructure is critical. And kind of just doubling down on the fact that without the infrastructure to participate, it's very challenging to kind of get that commitment from rural providers. If you don't have the health information exchange, and it's not even provider-specific always. Sometimes it's a broader kind of regional or community issue. So really spending some time doing an assessment and work on those needed infrastructures to support engagement. Definitely tailored technical assistance and folks who understand what's like to practice in the setting that you're talking to whether that's rural or inner-city, or some other safety net.

And, I would say kind of two other things that I wanted to emphasize in this space. One is we saw a lot as folks were being brought together to participate in models like CHART, kind of this creation of the network itself. The potential players in the demonstration or innovation, especially when you're thinking kind of the global budgeting or all payer, there really almost needs to be resources available for planning and developing those relationships just to bring people to the table. We heard from folks who were interested in states and participating, but couldn't necessarily get all the required folks to the table, to talk about what that engagement look like.

I would also say with that said, I would say really requiring or incentivizing that broad range of players to be part of the demonstrations is really critical. We've also heard that using levers like federal, other federally funded programs like grants or others, is a really a good way to again bring the necessary set of players to the table to talk about what this looks like from kind of the provider level, whether that's individual to larger provider or kind of different players within this space.

One thing I would add in the payment space is really thinking about, especially from a rural perspective, but I think this is relevant from a low volume too, is that payment incentives really should be, should remove volume from the equation. We talk a lot about wanting to move away from fee-for-service payment, and when we are in this halfway space where we're predominantly fee-for-service, it makes it very difficult to shift only part of care delivery to be part of the model. And for rural providers or other safety net providers that are frequently paid on kind of an alternate payment methodology, you're dis-incentivized from bringing one of those higher cost providers like a Rural Health Clinic or a Critical Access Hospital into your model because of that higher payment rate. And so really looking more, I think with models like global budgeting, or others that allow you to kind of get away from that volume-based kind of equation.

Quickly, in care delivery redesign I think you're spot on some of the lessons you learned you shared. I would say community involvement is really important as we're talking about care design or redesign. And so making sure that we have the participants from the community reflected in the conversation of what that redesign looks like. And again, incentives or requirements to bring those folks into the table or to the table.

I would also say, from a system perspective, really thinking about, and I'm not talking like health care system, I'm talking like larger, or how we should be operating as at the health care infrastructure, not within one system, how do we incentivize systemized regional participation. So that we're moving patients from the one provider to the next, based not on ownership, but on what's really right for the value of care and the and the type of care.

And then lastly, in the performance measurement space I would say, this isn't a surprise to anyone, but safety net providers are always risk adverse due to the inadequate financial stability that the previous speakers spoke about. So anything you can do to delay downside risk, kind of accommodate, or lower, make a less of aggressive returns on investment thresholds. Or kind of lower, I would say, more delayed cost savings is going to be important because it just given where a lot of these the deficits that a lot of these folks are operating from it's just going to take a little bit longer to show that impact. And lastly, always make sure that we're using relevant measures for the type of work that's done in the safety net setting. So this is really relevant and important to rural. We are not going to have the full range of services in our communities. So making sure we are measuring folks for what is relevant for the care they are receiving in that facility and holding them accountable for the care that is being provider there.

>>Tequila Terry, CMS: Wow, that was terrific, Carrie. Thank you so much for that, and so many good suggestions there. You know, really thinking about the opportunity to tap into federally funded grants outside of you know sort of the traditional funding that we use. You know, recognizing sort of this balance that has to be in place between, you know, a part of the business that may be fee-for-service, and the desire to move to an alternative payment model and really recognizing that you know that multi-payer strategy has to be in place and really in order to achieve that I think is what you're getting at there. And then finally, you know this idea of a measurement strategy that is unique to rural communities and understanding the unique nuances that exist for providers that are operating in that. I would love to probably spend many more sessions with you talking about that. But we'll leave that there for now, and certainly will look into that more. So, thank you for that.

Up next, I would like to transition to our next speaker, who I know is ready, so if we could go to the next slide. We have Dan Derksen, and I want to turn it to you. Dr. Derksen.

>>Dan Derksen, University of Arizona Health Sciences: Thank you, Tequila, and it's good to be part of this. I've been learning so much, and am eager to hear some of the ideas of the expert panels and folks who introduced this all to this concept earlier.

So first a little bit, I direct our State Office of Rural Health for Arizona. I am also the principal investigator for our area Health Education Center program. So, we work very closely with the 175 or so Federally Qualified Health Centers in our state, the 47 tribal operated and Indian Health Service clinics and hospitals, our 39 Rural Health Clinics. These are all federal designations and most of those 39 Rural Health Clinics are affiliated with the 16 Critical Access Hospitals in the state. They form a very important part of the strands of our safety net, especially in rural, but also urban underserved Arizona. There's about 2.4 million Arizonians on Medicaid, that represents about 33% of our population. Rural Medicaid covers about 38% of our population. So the pandemic in Arizona really unmasked some of the weaknesses in our system, especially when it comes to a very threadbare safety net in rural areas. If a single ICU nurse became ill in one of our Critical Access Hospitals and a hospital had to hire a visiting nurse, or had to bring in a substitute physician, because the pulmonary physician could no longer provide care, that became a huge expanse for the hospitals, but it also affected the quality, and access to care.

So, I want to talk about four strategies with specific examples of what I think we could do to really engage safety net providers. And the first one has to do with, how do we move to a category of including the pathways to practice? I think Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals are an incredible inter-professional milieu for training for health professionals,

far more relevant, I think, for today's practice and the important work and training that we do in our large urban tertiary care centers. Seventy-five percent of our graduates in these programs go into practice in these outpatient ambulatory and other practices, and we need to help move that training pipeline to areas of need. So, there's a continuous training, recruitment and retention, so that we grow our own. We recruit folks in the community, they're much more likely you don't have a practice there. So, I think that's important. And our model is really based on the Teaching Health Center. And I remember Liz Fowler and course Dora Hughes being very involved in that, in the days of the drafts, of the Affordable Care Act. But the Teaching Health Centers an incredibly important model and Arizona did a very important thing two years ago. They now allow Federally Qualified Health Centers to be sponsoring institutions for Medicaid graduate medical educations. Now there is a non-federal share that has to come up within our state doesn't have a cap on Medicaid GME. So, it would be really wonderful if we figured out models, so that that nonfederal match was paid for if you're in an area that's a very high health profession shortage area designation, and I combine it with the Social Vulnerability Index that the CDC has done so much work on. Those two criteria came together. If you looked at those two criteria in Arizona, that's where we really saw our highest morbidity and mortality in rural, when those communities that had that legal combination of a high SVI and a very high HPSA. So if we could figure out ways to bring those together, and incentivize that kind of training to move the pathways to practice closer to areas of need were there.

And related to that, is that we need to reduce or eliminate the fiscal barriers, to pursuing health professions and education. I think it's one of the things we have to really pay close attention to is a category of if we want a diverse health workforce to represent the diversity of our populations in need. Then we need a diverse health workforce, and we need we need to remove the major barrier to doing that, which is the cost of health professions education. We don't want our graduates to come out swimming in debt, where the only place they feel like they can go into practice is in an urban area.

And the final two I'm just going to mention very quickly. In Arizona, we did just create a tribal AHEC Regional Center last month, which we're very excited about. I visited the ones that I think in Alaska that also are tribal serving organizations. We think that's a better way to help grow our own, especially in our 22 federally recognized tribes.

And lastly, I think we need to augment our primary care workforce with others to define it more broadly, so that we are creating incentives and models and innovations. Then include our family nurse practitioners, our advanced practice registered nurses. Really important for Arizona, our certified nurse midwives, and others that can really help augment the care that we deliver an inter-professional manner in communities. And I think there's ways to do that through Medicaid Enhanced Federal Medical Assistance Percentage, like recently has been done with expansion of home and community-based services. And Arizona also I just, we did create housing and link some of the Medicaid strategies or waivers, too, to improve housing because that is a huge issue in our rural and urban underserved areas. So with that I'll close and thank you for the opportunity to share some of those.

>>Tequila Terry, CMS: And thank you for that perspective because you have introduced another category around workforce that I think we can definitely sort of think about. Whether it be, you know, sort of thinking about the current workforce or the workforce of the future, thinking about opportunities to design, to incorporate some of those elements is really helpful. I appreciate that.

Next, I want to transition to our next speaker, Aditya, if we could go to the next slide, please. Aditya, you have the floor.

>>Aditya Mahalingam-Dhingra, Community Care Cooperative: Thank you to Tequila. Can you hear me okay?

>>Tequila Terry, CMS: We can. Your camera is not on, but we can hear you.

>>Aditya Mahalingam-Dhingra, Community Care Cooperative: I don't seem to be able to enter my video and saying the host needs to turn my video on. Here we go alright. Can you see me? Great thanks so much for that introduction too, and thank you for having me. This is an incredibly thoughtful discussion, and a lot of what I want to say has already been touched on by my colleague, so I will try to be brief and just lend my plus one to a lot of the items that have already been raised.

A quick introduction, I am Aditya Mahalingam-Dhingra. I am the Chief Business Officer at the Community Care Cooperative, or C3. C3 is a not-for-profit ACO that is owned entirely by, and is comprised of, Federally Qualified Health Centers in Massachusetts. We're the only independent, non-system based nonprofit ACO in the state and we are the largest Medicaid ACO in the state. We've had a huge amount of success in Massachusetts Medicaid ACO program, which launched in 2018. We beat benchmarks every year. We're on track to beat the market performance by about 5% on total cost of care this year, and we are starting to move into other lines of risk contracting business. So we are in, we have a few of our health centers in Direct Contracting. Next year we will be participating in the ACO REACH, and we have a contract with our state's largest commercial payer Blue Cross Blue Shield in Massachusetts in their ACO model as well. We're also starting to explore opportunities to help federally qualify health centers in other states, replicate some of the success that we've had in Massachusetts.

Just quick personal background, prior to joining C3, I joined in September of this year, I actually spent about 10 years at the Massachusetts Medicaid Agency, where I led the payment and delivery system reform efforts there including designing Massachusetts Medicaid ACO program. So I'm very familiar with that program from both sides now.

Federally Qualified Health Centers are, I'll mainly speak to kind of their role in this process, although a lot of these themes are applicable to other types of safety net providers, FQHCs are uniquely positioned to succeed and create value and risk-based contracts. And we spend a lot of time talking about barriers, but I find it helpful to anchor the discussion my first talking about the opportunity here, because it really is massive. And I think what C3 and Massachusetts has been able to accomplish is a really good illustration of that. Federally Qualified Health Centers tend to deliver care that is more efficient, high rates of primary care and generally better quality and member satisfaction then a lot of the care that we'll get in systems. They are really used to doing integrated primary care. A lot of the things that our system is trying to move the direction of doing, integrating primary and behavioral health, strong focus on preventive care, dental care co-location, team models of care. FQHCs have been doing that stuff forever, and that represents a really amazing opportunity to actually capitalize on a lot of expertise that exist in the community.

FQHCs are also absolutely vital to any program that is serious about health equity. They serve low income and minority populations to a greater degree than pretty much any other provider type. And as a result, unfortunately, they do face some real challenges. So that's kind of the opportunity side. But on the challenges side, as we know, FQHCs historically, have not had the same kind of investment that other provider types have had. So they have less infrastructure, less capital. They tend not to have the

negotiating power with managed care organizations and other payers that larger systems do, or for-profits do. And you know, they're often fighting highly individual state-by-state battles about fee-for-service rate parity, and that really sucks the oxygen out of what could be a much more collaborative discussion about how to do something innovative on value-based payment.

So you kind of put all those things together. They tend also to be substantially funded by fee-for-service revenue, which makes it really difficult for staff to spend time on advancing the model of care. And, it makes it really difficult for them to participate in value-based payment. So I think that it's on a lot of the themes that we've talked about today. And value-based payments have not to really been designed with FQHCs in mind.

With all that being said, I think there's a few recommendations that I would love to suggest for this group. Some of them are directly applicable to CMMI. Some of them maybe go a little more broadly into things that CMS could think about or things, that CMS in partnership with State Medicaid agencies could be thinking about.

One real, really key piece is designing the payment model in a way that allows FQHCs to succeed. So specifically, total cost of care risk models that have material upside potential where the benchmarks are set based on the market average performance, so you're not just fighting against yourself every year, especially providers that are already really low cost, I think that's a really key feature. Social risk adjustment that accounts for the acuity of the population that safety net providers serve, but factoring things like housing instability or nutritional insecurity, or you know, census-based data on neighborhood stress scores. That tends to do a much better job of predicting the actual cost in a predominantly safety net population. Having material health equity accountability as part of the program. Those kinds of model design features tend to create a real opportunity for FQHCs to sustainably win and create value year over year, and we've been able to do that here in Massachusetts.

Second theme is aligning with Medicaid where possible, so ideally in ways that don't require FQHCs to have to negotiate value-based deals with multiple Medicaid Managed Care Organizations. So, for example, Medicaid agencies having really strong requirements and their managed care RFPs for contracting with safety net providers in a consistent way. CMS and states may be partnering around features of 1115 Waiver design that great pathways for states to contract directly with FQHC-based ACOs and kind of avoid that, MCO remediation. Things like that which kind of get to the Medicaid portion, because that’s such a large portion of the population that FQHCs serve.

Third is allocating infrastructure investment, this was said a bunch today. So FQHCs, there's a historically inequitable funding base, and these are a predominantly minority population. So recognizing that, you know, that's the result of systemic racism and different types of inequality in our system. And if we're serious about bringing safe net providers up so they can participate and succeed in these models we need to provide them with funding that starts to correct that imbalance.

Fourth is ideally moving to primary care sub-capitation, or other types of payment features that start to get away from fee-for-service payment. And then, lastly, anything that the federal government can do in partnership with HRSA to provide clearer directions of states around PPS rates, so that FQHCs and Medicaid agencies can stop fighting about fee-for-service baseline and actually start collaborating on value-based payment opportunity. Thank you for your time and thank you again for including me.

>>Tequila Terry, CMS: Excellent. Thank you for so many good things there. But one of the things that jumped out is this, the theme of collaboration across federal agencies, and so really appreciate that perspective. I'm going move us forward to our third and final panel. So we can go to the next slide.

We will have: Amanda Pears Kelly from Advocates for Community Health; Sarah Rosenbaum from the George Washington University Milken Institute School of Public Health; and then Rachel Tobey, from JSI California. And so, these experts will provide insight on a really important question, if we go to the next slide.

Really looking at what are the key considerations for the CMS Innovation Center as we develop the safety net provider definition that maximizes the inclusion of providers that serve Medicaid beneficiary. So I shared the definition that we're starting with, but we want to make sure that we continue to build on that. So what are the inputs and key considerations that we need to keep in mind in order to maximize the inclusion of providers that serve Medicaid beneficiaries? So Amanda, I'm going to turn it to you to get us started.

>>Amanda Pears Kelly, Advocates for Community Health: Thank you so much, Tequila. It's really great to be here, and just, you know another round of thank yous to you and the CMMI and CMS leadership. I just, you know, it's been really wonderful to be a part of the conversation today. And I just think there's so much good that can be done, but I appreciate your leadership in convening all of us, and continuing to press forward with the work. I know we're getting short on time, so I want to be fair to my other two panelists, who I know will have really fantastic comments to come as well.

Quickly, background on ACH, or Advocates for Community Health, we are a national membership organization. We're geared at larger, Federally Qualified Health Centers, and we're focused on health equity and innovation to drive health care systems and policies and changes across the system as a whole. Collectively our members are serving just over 2.3 million people. We are across 11 states and Puerto Rico, and we across our membership cover about 21,000 or more full time employees.

So, we're really excited to be a part of the conversation. There's already been some great background, provided. Lots of plus ones on some of the feedback then that has come up already. Just in the context of workforce, and then, actually, just you just prior, in terms of the comments about what are some of the barriers that health centers are facing specifically. But I do want to just call out kind of four or five key takeaways, one or two that I'll go into a little bit greater depth in the context of the conversation here.

So I think one of the key elements that health centers need in order to be participating in this space is data from everywhere, from every corner. That includes Medicaid Managed Care Organizations. And it needs to be timely, it needs to be digestible, and especially for quality reporting requirements.

Another piece here that I would call out is that FQHCs require explicit public facing guidance for provider overlap policies and beneficiary attribution and overlap policy. So basically, specific guidance of overlaps for participants versus preferred providers is a really key part of this going forward.

Another one is that FQHCs really need that upfront investment This is something that's already come up. So, I would just echo that the upfront investment for infrastructure and flexibility for health equity spending is a really key component to this.

And then, lastly, just that the Innovation Center should work with, or our recommendation would be that you guys work with, the Center for Medicare and the Center for Medicaid and CHIP to ensure that health centers are included in the policy discussions. I think anytime you can enable that participation to get that direct feedback in perspective it's going to lead to greater participation, and fewer barriers in terms of success overall. I'm mindful of time. So I'm going to stop there, Tequila, and turn it back to you and happy to answer questions.

>>Tequila Terry, CMS: Thank you so much, Amanda. That was really helpful, and your point on data, I think that's one of the first times we've heard that today, so we definitely appreciate that perspective. And, you know, really want to think more about what opportunities exist in that space in particular.

Up next, I want to transition to our next speaker. So Sara Rosenbaum, you have the floor.

>> Dr. Sara Rosenbaum, George Washington University: Thank you so much and thank you for including me in today's meeting. It's been an incredibly rich discussion, and so many relevant issues have been put on the table already about participation.

I want to focus on one, and that is the patients themselves. That is, I think, the most important issue for CMMI is providers that can ensure their patients' continuity of care. Medicaid is an unstable insurer to begin with. We have gone through three years where we've gotten used to Medicaid operating somewhat differently, and my guess would be the in the early new year we are about to see the continuous enrollment guarantees end. And the question for me always with safety net investments is whether this is a provider that will do as much for its patients when the patients are uninsured as it does for patients who are insured. And quite frankly, that applies probably to relatively few providers. But I think it's a commitment that CMS needs to keep in mind, because there is no point making terrific investments for Medicaid beneficiaries for the eight to nine months on average, that they are enrolled in the program normally. And that means that you've really got a focus on where you're investing can stabilize care, can stabilize staffing, can give providers a regular source of funding such that they can then adjust other funding sources to keep those patients in care.

>>Tequila Terry, CMS: Excellent, and Sarah thank you for that. Because you know, I think this idea of commitment to beneficiary health, regardless of payer type, regardless of coverage type, is really important theme that matters to us. And so that is something we will think about how we might incorporate criteria that considers that vantage point.

Excellent, and now I'll move it to our final panelist of the day. Next slide.

We will have Rachel Tobey from JSI California. Rachel you have the floor.

>>Rachel Tobey, JSI California: Hello! And good morning, or good afternoon to everybody. And again, being last in this august lineup, you are going to hear some similar themes in my commentary.

So I'm going to start with the consideration that is very much on the heels of what Dr. Rosenbaum just said, which is that safety and health care is in many ways a public good, and needs sufficient funding in order to serve in this function. We don't need to go any farther than to look at how many vaccines health centers delivered during the pandemic. I mean just to give a couple of numbers, I think, and they are, in one year from February 2021 to 2022, there are over 19 million vaccines delivered by health centers, and two thirds of those patients were from racial or ethnic minority populations.

In rural health care, I will say that this notion of public good is especially relevant, and I'm going to quote a paper that we wrote a few years ago, but that there's really a need to rethink value-based payment in rural areas to acknowledge the primacy of simply maintaining access to care. That rural context today in many ways violate some of the premises of value-based payment and care that assume that you have adequate patient volumes, data and IT infrastructure and the workforce to provide better access to ambulatory care, care management and delegation of financial risk, which could all help lead to reduce total cost of care.

But in many rural practices which tend to be small, and oftentimes are also tending to be a key employer in their local communities they're operating on thin financial margins. And if we, if what we absolutely need them to invest in additional services and take financial risk, it isn't feasible on the small margins that they take. And as many of other speakers have highlighted, going out of business is simply not an option for their communities, and thus it's not okay to move into these types of arrangements that have downside risk in particular or hoping to save money in in the long run, rather than invest in primary care.

The second consideration that I'll highlight is that payment models will likely need to incorporate rather than replace safety net provider payment protections, such as PPS. Especially in the notion that PPS was created as a way to maintain sufficient funding from Medicaid, and to not have health centers, have to dip into their 330 grants in order to support low Medicaid reimbursement payments.

So I would argue that, based on our experience of working with over 20 States in the Delta Center for a Thriving Safety Net program, that's a RWJF funded program that brings together primary care and behavioral health state associations to advance policy and practice in their states, that there are many states that are thinking about a multi-layer payment model in order to have some aspects of the payment model that all providers might be able to participate in and a base payment that might actually continue, but transform. So, if you're a health center that gets PPS and a volume-based payment method now, like the states of Oregon, Washington, and increasingly California, is pursuing an alternative payment methodology that preserves that protection, the level of funding in PPS, but transitions it to a per member per month type of payment that provides some critical flexibility in terms of what types of care team members can deliver care as well as what types of modalities can be used. And this includes flexibility to deliver telehealth services via both tele-audio and tele-video which is an essential component of any new payment program that we are going to implement in the wake of the Covid 19 pandemic.

I will note that the notion of investing in primary care and investing in health equity is a theme that has come up multiple times in this discussion. And I will simply echo that there is a tremendous amount of research that says that investing in robust primary care and behavioral health will ultimately beget savings in the broader health system, and in fact outside the health system as well. So I would challenge CMMI to really think about not trying to have primary care payment models be cost neutral, but rather looking at total cost of care and evidence from programs like the recent Maryland primary care program that by literally almost doubling investment in primary care they saw 20% decreases in inpatient care and in Covid infections and deaths in the practices that were participating in such a program.

And then finally I will highlight the notion that many safety net providers are small in size and are going to require infrastructure supports. Whether that be for data, whether that be for project management,

whether that be for practice coaching or whether that be for acknowledging that they may need to actually have some of their infrastructure supports located in a different entity, such as a network or an IPA. And with that, I know we are at time. And thank you so much to everyone who's participated today.

>>Tequila Terry, CMS: Yes, thank you, Rachel. I really appreciate that perspective, and you know there are a number of pieces that jump out at me. But you know, the idea that the primary goal in rural communities is to maintain access, that is such a really important point to make, during all of the different points that you made, so thinking about rural communities and the uniqueness that they have as part of our thinking.

Well, I want to thank you, and all of our panelists for really an amazing discussion, with great insights, provided by all. It's hard to believe that we are nearly out of time. But before we close, I'd like to thank all of our audience members and panelists for joining today's roundtable. The insights from today's dialogue will inform the Innovation Center safety net strategy moving forward. And as we explore a safety net provider definition and new approaches to maximize the inclusion of providers that serve Medicaid beneficiaries, we want to thank each of you for weighing in whether it was through the polls, the chat box, or as panelists.

There were so many really great themes that emerged from today's session that will inform our thinking, and we're really grateful for the safety net provider community's willingness to help us work towards greater health equity for all, and appreciate how vital safety net organizations are for reaching underserved communities. We are reassured and motivated by really the great thoughtful insight provided today. So thank you, again. If you could go to the next slide.

As you prepare to leave this roundtable, we'd ask everyone to please participate in the survey for today's event by clicking on the link that is popped up in the chat window. And we also ask that you please, send any additional input that you may have on today's session for the concepts that we have covered to CMMIStrategy@cms.hhs.gov with "Safety Net Roundtable #2" in the subject line.

We also want to highlight some additional opportunities to continue to engage and learn more about the Innovation Center's work. You can visit the CMS Innovation Strategic Direction webpage. You can sign up to receive CMS Innovation Center email updates, including upcoming events and model participation opportunities. And then you can follow us on Twitter, at @CMSinnovates. Next slide, please.

And so with that said, that concludes today's roundtable. Thank you again for joining, and I hope you have a good rest of your day. Take care.

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