CAPITOL STREET

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Value-Based Care: CMMI Priorities

3-4 New Models Coming: Primary Care, Specialty Care, Behavioral Health

Relevant Companies

We attended the PrimaryCares23 meetings in Washington DC today at the National Press Club (here). Highlights from the morning sessions can be found below.

Our Take & Next Up

New models (3-4) are coming on (1) advanced primary care (capitation) and (2) total cost of care/specialty care (3) behavioral health and others are expected this year. The agency has discussed over the last year as well as today its major initiatives such as incentivizing states to implement models that may work well, as well as . CMMI also wants to put more innovation into MSSP, and is trying to attack the behavioral health crisis in the US via potential new community-based models.

Key Points

Overall themes. CMMI wants to involve safety net providers into its pilots and demonstrations (FQHCs, Community Health Centers) in value based programs. CMMI also wants to use the MSSP (shared savings program) as a chasse for innovation. Future ACO models are likely, building on ACO REACH. CMMI is looking at specialty specific models testing new delivery models that tie into total cost of care, using dementia as an example.

3-4 new VBC pilot programs -- advanced primary care, behavioral health & specialty care models -- are likely coming from CMMI. Timelines for launch may vary but the agency has held listening sessions and issued RFIs as well as surveys over the last couple of years on all of the aforementioned topics (here).

Other highlights:

- To increase CMMI participation, across the board, health systems are baseline experiencing hardships (clinical workers, inflation, etc.) The agency is trying to balance predictability and accuracy, and is implementing guardrails as needed. CMMI

designs models to meet quality, cost and access parameters.

- For primary care, CMMI has learned from advanced primary care. Think CPC, CPC+ and PCF. When practices obtain stable upfront revenues they can change the way they provide care. RTAs may be reduced going forward, in our view. *See below for details.*
- Behavioral health and primary care parity is needed. CMMI is envisioning newer primary care models as the agency wants to support practices and its building blocks. Community based behavioral health provider models are needed, per CMS.
- Prescription drug costs and specialty services are key impediments for primary care providers. CMMI has put forward three model concepts, per Biden's EO last fall, and areas for research to guide model development. (1) High value $2 drug list (150 generic drugs in Part D plans) (2) cell and gene therapies (Medicaid) (3) Accelerated approval drugs (in consultation with FDA).
- Specialty care needs are being explored, and CMMI welcomes input with an RFI forthcoming. Data & transparency on specialist performance would help to inform referrals from PCPs to local specialist referrals. Shadow bundles are discussed, and does that work with certain specialists? RFI is coming out on specialty strategies on episode m=based payment models. Specialist models may be a *shorter* bundle.

ACO REACH: There are likely to be fewer negative RTAs going forward. COVID was the likely culprit, and should be a mitigating factor going forward. We have said this before and CMMI alluded to it today at PrimaryCares. Retrospective Trend Adjustment (RTA) irks ACO participants. Model participants have voiced annoyance also by the frequency of adjustments, despite pay refinements in nearly all CMMI programs. The RTA is a ratio based on the adjusted national average cost per Medicare beneficiary and a direct contracting reference population, which has led to downward pay for some participants.

On its health equity focus, CMMI noted that benchmarks have increased and opportunities emerge to refine indices. CMMI is adjusting benchmarks in oncology and other CMS payment models. Underserved areas are key priorities. CMS is looking at quality measures. Are they disparity-detecting measures? CMMI is learning from participants as they grapple with behavioral health needs. CMS wants to close gaps and measure payments, with robust data generation.

Ipsita Smolinski

Managing Director | Capitol Street

ipsita@capitol-street.com

900 19th Street, NW 6th Fl
Washington DC 20006

202.250.3741

www.capitol-street.com

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