ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

INTELLIGENCE BRIEF | JANUARY 2022

Current State of the Value Movement and Expectations for 2022

The 2021 Health Care Payment Learning & Action Network Summit provided insight and thought leadership from CMS and others who champion value in health care. This brief summarizes the discussions and the results of the latest Measurement Report for reporting years 2019 and 2020, charting slow but steady progress in the adoption of alternative payment models.

The year 2021 did not provide the respite from societal disruption that many had hoped – the COVID-19 pandemic has continued, requiring the constant attention of healthcare stakeholders and policy makers. However, the coming year will represent an important inflection point for the value movement. As we reach a sense of normalcy with the endemic phase of COVID-19, the healthcare system can begin to recover and resume efforts to build a system more firmly grounded in value-based principles. Under the second year of the Biden Administration, the foundational planning and policies developed in 2021 will begin to take effect and the industry will begin to react to the messaging and direction from leaders that is clearer than it was last year. After a period of major disruption, investment, and market consolidation, providers and payers who were previously "fence-sitting" will realize they need to adapt to survive and will begin to find their place in the value movement.

This brief explores the current state of the value movement by sharing the Health Care Learning and Action Network's (LAN) adoption data for 2019 and 2020, supplemented by additional data exploring the adoption of payment models by providers and geographically. Next, the brief outlines expectations for the future of the value movement, based on comments from Centers for Medicare & Medicaid Services (CMS) and CMS Innovation Center (CMMI) leadership, learnings from the 2021 LAN Summit, and other industry insights.

> *"It is kind of a reckoning time for…the value-based care movement. We're going to keep moving towards care models that are paid on a basis other than fee-for-service and shift the focus of care away from downstream facility-based procedures and complication management into upstream, more personalized, digitally based, home-based care and extend the boundaries of how we think about healthcare."*
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> *– **Mark McClellan, MD, PhD**, Robert J. Margolis Professor of Business, Medicine, and Policy, and founding Director of the Duke-Margolis Center for Health Policy at Duke University*

Alternative Payment Model Adoption Progress

Health Care Payment Learning & Action Network Measurement Effort

One of the most prominent efforts to promote and measure the growth of value-based payment (VBP) and alternative payment models (APMs) is that of the Health Care Payment Learning & Action Network (LAN). The LAN creates and publishes goals to move away from fee-for-service (FFS) payments and towards APMs in accordance with its mission to "to

lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability." Additionally, in collaboration with AHIP, the Blue Cross Blue Shield Association (BCBSA), and CMS, the LAN conducts an annual survey of health plans to measure the growth in quantity and types of VBP from year to year. Emphasized in both the goals and survey efforts of the LAN is the adoption of downside risk or "shared accountability" arrangements (i.e., Categories 3B and 4 in the LAN APM Framework). Following the release of survey data in 2019, the LAN highlighted this priority for increased participation in downside risk by establishing new goals for each line of business (LOB; Figure 1). At the time of the announcement, the goals were considered quite aspirational, although the LAN had reported strong years for APM adoption in both 2018 and 2019.

▶ Figure 1: LAN Shared Accountability Goals

GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

Survey data for measurement years 2020 and 2021 have thus been highly anticipated. In addition to these reports being the first since the new goals were announced, these years were significantly affected by the COVID-19 pandemic. While the data for measurement year 2020, which includes payments made in 2019, reflects a year largely unaffected by the pandemic, the LAN allowed for an extended reporting period to ease the burden on respondents while coping with pandemic-related challenges. Survey respondents were given the option to report 2019 data before the end of 2020 or to report the last two years together in the 2021 measurement effort. The resulting data were combined into a single APM Measurement Report from the LAN covering both years.

More impactful than changes in reporting were the modifications made to major VBP programs during 2020. One of the largest VBP efforts, the Medicare Shared Savings Program (MSSP), implemented a number of flexibilities allowing participants to adapt to the uncertainties and demand of the pandemic. As part of the Extreme and Uncontrollable Circumstances Policy, CMS took measures to mitigate shared losses such as reducing or forgiving the losses of accountable care organizations (ACOs) during the Public Health Emergency. Quality reporting was also adjusted to allow for some ACOs to assume the mean performance score rather than reporting measures individually. Additionally, following the recommendation of the Medicare Payment Advisory Commission, CMS allowed ACOs to remain in their current agreement periods for an additional performance year.

While the headwinds of the pandemic spurred on health plans and CMS to make necessary changes to their VBP arrangements, many avowed that the pandemic had and would continue to accelerate VBP and APM adoption. Some insurers, including Humana, reported that patients in VBP arrangements connected with physicians more frequently and had better outcomes. Collectively, the new goals set forth by the LAN, the delayed reporting of the 2020 measurement year, and the immense impact of the COVID-19 pandemic has turned the most recent LAN Summit report into an important juncture in the future of VBP.

Adoption by APM Category

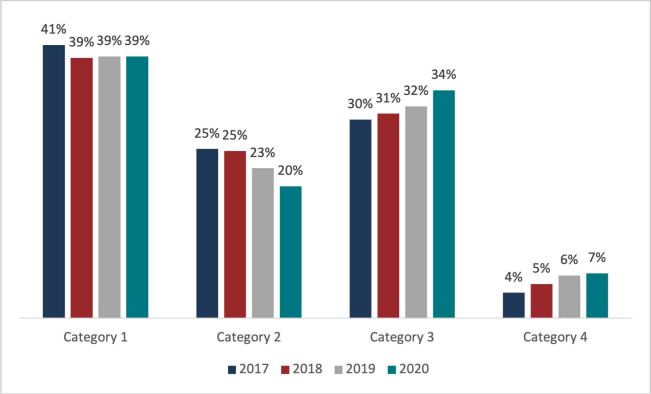
For the latest report, the LAN survey engaged with 69 health plans in 2020 and 73 health plans in 2021, including commercial, Medicare Advantage, Medicaid, and traditional Medicare plans. The survey captured more than 200 million of the nation's covered lives in each of the years and in 2021 encompassed more than 80 percent of the current health care market. In 2019, payments made through Category 3 (APMs built on a FFS structure) or Category 4 (Population-Based Payments) arrangements comprised 38.2 percent of all payments made by survey respondents. In 2020, that figure totaled 40.9 percent of all payments made by health plans.

This slow but steady growth of APM adoption is encouraging on the surface, but when compared to the initial goals of the LAN is underwhelming. At its inception in 2015, the LAN set a goal of having 30 percent of US health care payments flowing through APMs by 2016, and 50 percent by 2018. While the 2016 goal was narrowly missed (29%) and the most recent results are nearly double the 23 percent reported in the inaugural LAN report, three years after 2018 the 50 percent goal is still elusive.

Notably, APM adoption growth in 2020 exceeded that of 2019 despite the obstacles presented by

the COVID-19 pandemic. Of particular note, growth in Category 3 rose by 2.4 percentage points after multiple years of growth at or below one point (Figure 2). The increase in this category was impacted nearly equally by growth in subcategories 3A and 3B. Shared savings arrangements (3A) experienced a 1.3-point increase, and downside risk arrangements (3B) grew by 1.1 points (Table 1).

▶ Figure 2: Aggregate Category Growth - LAN Data



▶ Table 1: Downside Risk APM Growth

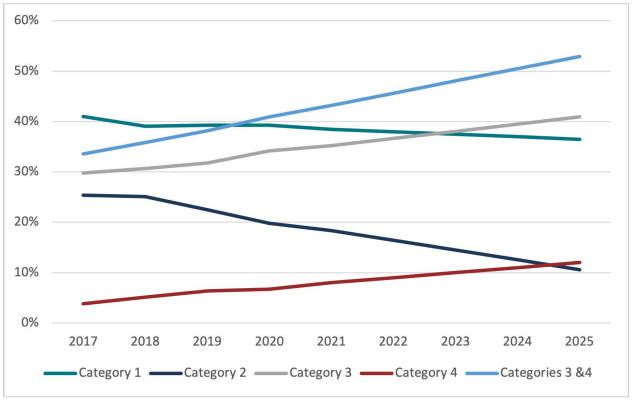
LAN APM Category	2017	2018	2019	2020
All shared accountability models (3B & 4)	12.5%	14.5%	16.5%	17.9%
3B: Shared savings and downside risk (includes two-sided bundles payments and ACOs)	8.7%	9.4%	10.1%	11.2%
4A: Condition-specific population-based payment	1.5%	1.8%	2.4%	2.0%
4B: Comprehensive population-based payment	2.2%	2.9%	3.6%	4.1%
4C: Integrated finance & delivery systems	0.1%	0.4%	0.4%	0.6%

In contrast, Category 4 experienced its lowest growth in 2020 since the LAN started tracking it separately in 2017. Growth of population-based payment arrangements grew by 1.3 percentage points in 2019 but only 0.3 points in 2020. In total, payments tied to downside risk (3B & 4) have grown to encompass 17.9 percent of payments in 2020, up from 12.5 percent in 2017.

Recent growth in payments with greater accountability is largely due to contracts shifting away from Category 2 (FFS – Link to Quality and Value) payments toward more advanced contracts, rather than shifting away from Category 1 (FFS – No Link to Quality and Value). Between the first LAN reports for 2015 and 2016, the percent of payments tied to Category 1 models dropped by nearly 20 percent, from 60 percent in 2015 to 43 percent in 2016. Since this dramatic shift between 2015 and 2016, payments in Category 1 have stagnated, holding at roughly 39 percent of all health care payments for that last three years.

Based on adoption in recent years, projections do not anticipate growth of Category 3 and 4 payments to surpass the 2018 goal of 50 percent until the year 2024 (Figure 3). Growth in the near term will also certainly be impacted by recent changes made in the face of the pandemic. For example, the MSSP paused the entry of new ACOs for the year 2021 which will likely reduce growth in the number of payments being made by early entrants, usually through shared savings arrangements. Additionally, ACOs that were in arrangements which included requirements for incremental assumption of risk, such as those associated with the Pathways to Success models, were allowed to "freeze" their participation level for performance year 2021. While these were voluntary options, given the significant disruption the pandemic had on the health care system, it is likely that a non-trivial number of ACOs may opt to remain in a lower level of risk.

▶ Figure 3: Projected APM Growth – LAN Data



On the other hand, the COVID-19 pandemic highlighted the ability of VBP arrangements to insulate providers and health plans from the financial strain of unpredictable pandemic spending. Those in such arrangements were better able to adopt the care delivery requirements necessary to care for patients and had predictable funding streams, allowing them to fare better. While telehealth utilization rose nationwide, it rose especially quickly for individuals enrolled in Medicare Advantage plans. Providers and health plans in Medicare Advantage arrangements had the ability to quickly adapt and may have already been better positioned to deliver care remotely, even before the conditions of the pandemic necessitated it. Many industry leaders continue to believe that the COVID-19 pandemic may serve as an inflection

point, spurring on future growth. Overall APM adoption has been deeply impacted, but a clear picture of whether that impact is positive or negative is yet to be seen.

Adoption by Line of Business

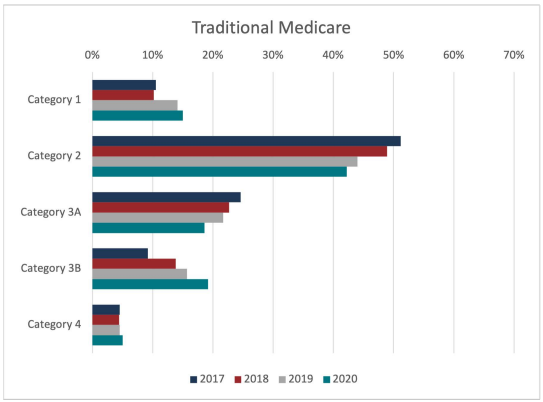
As in previous years, the adoption of APMs varies dramatically by the type of health plan. Unsurprisingly, both traditional Medicare and Medicare Advantage led the way in broad APM use as well as the use of models incorporating downside risk. The ability of CMS to use its vast market share to encourage or even mandate participation in certain models has and will continue to influence APM adoption.

Traditional Medicare

Traditional Medicare has seen steady growth in the adoption of Category 3 and 4 arrangements since 2017, growing by more than 4 percentage points to a reported 42.8 percent in 2020. Additionally, traditional Medicare grew its portion of downside risk APMs more in 2020 than any other line of business. Between 2019 and 2020, the proportion of payments made through Categories 3B and 4 grew 4.2 percentage points finishing at 24.2 percent. When asked about this increase, Chief Strategy Officer for the CMS Innovation Center, Purva Rawal, credited much of the growth to the MSSP and the downside risk tracks of the Comprehensive End Stage Renal Disease (CEC) and Bundled Payments for Care Improvement-Advanced (BPCI-A) models.

The 2020 MSSP ACO Results reiterate these points. While the number of ACOs with risk-bearing contracts was stable from 2019 to 2020 (192 and 190, respectively), the number of risk-bearing contracts those ACOs took on more than doubled. Roughly 20 percent of the MSSP attributed lives were covered by entities that bore financial risk for their cost and clinical outcomes. Unfortunately, as mentioned above, most of this increase seems tied to decreases in Categories 2 and 3A rather than those having no link to quality or value (Category 1). In fact, traditional Medicare is the only LOB to see an increase in the proportion of payments it makes to Category 1 FFS arrangements. Between 2017 and 2020, traditional Medicare saw an increase in FFS payments of more than 9 percent annually. Some of the recent uptick in Category 1 payments may be tied to the modifications made during the pandemic as well as ACOs that exited the MSSP. As many as 14 percent of ACOs in Category 3A and 10 percent of ACOs in Category 3B exited the MSSP at the beginning of 2019.

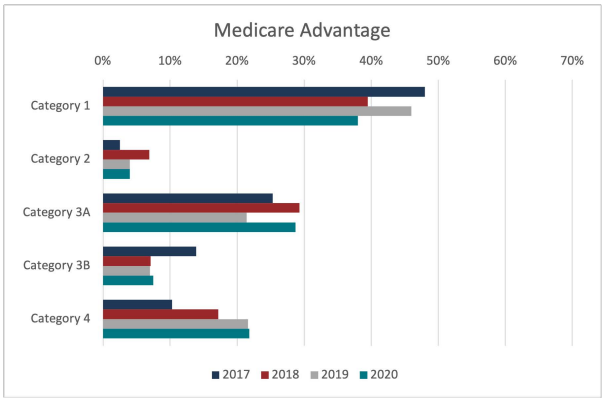
▶ Figure 4: Traditional Medicare APM Adoption – LAN Data



Medicare Advantage

Medicare Advantage continues to lead the adoption of the most progressive (Category 4) APMs. While no other line of business saw more than 6.5 percent of its payments in 2020 made through these arrangements, Medicare Advantage surpassed 20 percent in 2019. It has also seen the proportion of its payments made to Category 1 decrease by nearly 6 percent since 2017 and, in addition to traditional Medicare, has less than half of payments tied to these arrangements. Medicare Advantage is also one of two LOBs nearing the goals set by the LAN. With 29.3 percent of payments in Categories 3B and 4, Medicare Advantage is only 0.7 percentage points away from meeting the 2020 goal of 30 percent. At the LAN Summit, Chief Medical Officer of Humana, Dr. Will Shrank said with regards to the success of Medicare Advantage in moving to value, “the structure of the Medicare Advantage program is organized in a way that makes sense for APMs.” Dr. Shrank highlighted the resources afforded by Medicare Advantage programs such as connections with community-based organizations (CBO) and targeted data for providers to readily identify and address patient needs.

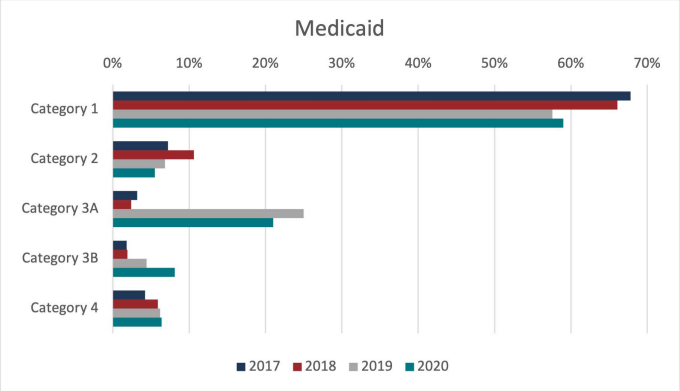
▶ Figure 5: Medicare Advantage APM Adoption – LAN Data



Medicaid

Medicaid and commercial LOBs have seen slow growth in APM adoption in 2019 and 2020 when compared to traditional Medicare and Medicare Advantage. As of 2020, both have 35.5 percent of their payments flowing through Categories 3 and 4. However, while commercial health plans have seen stagnant growth in payments through downside risk arrangements (9.9% in 2017 and 10.8% in 2020), Medicaid has more than doubled its proportion of payments in Category 3B and 4 models, from 6 percent in 2017 to more than 14 percent in 2020. Between 2019 and 2020 Medicaid saw its largest year over year increase of nearly 4 percent, landing just shy of its 15 percent goal in 2020. A portion of this increase is attributed to growth in the number of states implementing managed Medicaid programs, with at least 40 states using managed Medicaid for at least some portion of their Medicaid population in 2019. Though managed Medicaid programs do not always require a shift to value, several states have made significant efforts to incorporate VBP principles into their Medicaid programs. Included in these efforts are at least 30 states that incorporate team-based care as part of their regulatory structure, 22 of which specify the use of value-based payments for behavioral health, and 29 states that require contractors to use value-based payments related to primary care effectiveness. Notably, the Washington State Health Care Authority has published bold goals to have as much as 90 percent of payments made by Managed Care Organizations (MCO) funneled through VBP arrangements by 2022. However, many of these efforts in Washington and other states have targeted payments within Category 2 or 3A, rather than downside risk arrangements.

▶ Figure 6: Medicaid APM Adoption – LAN Data

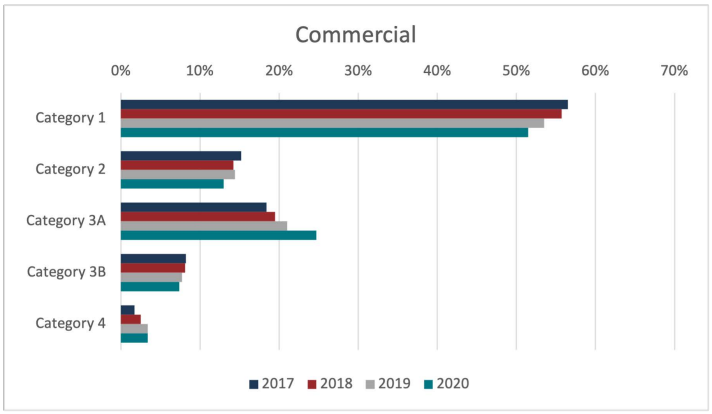


Commercial

APM adoption growth among commercial payers has lagged behind the other segments since measurement efforts began. Slow but steady reductions in FFS payments are laudable but movement towards higher risk arrangements lags by comparison. While payments towards shared savings (3A) arrangements have increased by more than 7 percent annually since 2017, commercial payers join Medicare Advantage as the only two LOBs to have a decrease in downside risk arrangements in Category 3B over that time period. Unfortunately, while Medicare Advantage more than offset its decrease by doubling its participation in Category 4 arrangements, commercial payers had only 3.4 percent of payments through Category 4 models in 2020.

When asked why commercial health plans lag behind other payers in VBP adoption, Geisinger Chief Medical Officer, Dr. John Bulger, posited that concerns with risk adjustment and patient attribution may be stumbling blocks. Dr. Bulger added that while commercial payers will likely always lag behind the other segments, changes that increase adoption by other payers will certainly influence future adoption of commercial APMs. A report using data from the American Medical Association (AMA) Benchmark Survey noted that 43 percent of physicians were in a practice which belonged to a commercial ACO as of 2020, ahead of both Medicare and Medicaid ACOs. Of the 44 million lives covered by ACOs in 2020, 60 percent were found within commercial ACO contracts.

▶ Figure 7: Commercial APM Adoption – LAN Data



Health Plan Sentiments Towards Future APM Adoption

In addition to quantifying the adoption of APMs, since 2018 the LAN measurement effort has included qualitative survey questions in an effort to better understand the perspectives of health plans on the future of VBP and APM adoption. Responses to the most recent surveys mirrored the viewpoints of respondents in past years. As many as 87 percent of health plans felt that the use of APMs would increase over the next 24 months. Specifically, respondents indicated that shared risk arrangements (3B) would be the most likely to see increases over that time period. When asked about what will facilitate future growth, health plans indicated that their own interest and readiness as well as providers' interest and readiness will work alongside government influence to shape adoption. Interestingly, the responding health plans also point to providers' lack of interest and readiness as being one of the prominent obstacles preventing the adoption of APMs, in addition to their lack of willingness to take on financial risk and ability to operationalize.

The move toward APM adoption has always been driven by the promised outcomes of lower costs, better care coordination, and higher quality. Health plans continue to feel strongly that the adoption of APMs will drive these causes forward. In each case, at least 85 percent of health plans felt that APM adoption would bring about these ends. However, despite this encouraging outlook, some fear that value-based care may be spurring consolidation within healthcare. Calls for monitoring have been made as some data suggests that even "soft" consolidation through the use of ACOs may increase the price of services. Less than half (44%) of health plans surveyed felt that APM adoption would lead to greater consolidation in health care and even fewer (8%) believe that it would result in higher prices.

The focus on health equity and disparities has only been heightened through the course of the COVID-19 pandemic and it has had a growing impact on APMs. Many payers see APMs as an effective tool for moving toward more equitable delivery of health care. The LAN survey included questions about what health plans were doing to advance this cause relative to their APM efforts. While most are still in early stages, more than half (58%) were using value-based arrangements to incentivize the collection of sociodemographic data. Additionally, of those using APMs to improve health equity, a majority were screening for socioeconomic health barriers and instituting care and CBO coordination strategies to address them. APMs that emphasize and reward equity are a critical lever for reducing health care disparities. Some reports have indicated that hospitals and clinicians with more racial and ethnically diverse patients fare worse in VBP programs. The development of health equity measures in APMs and efforts to hold providers accountable for closing gaps in these measures may not only improve care, but it may also help prompt hospitals and clinicians to adopt them by rewarding providers that spend more on upstream health factors and ultimately reduce disparities within their populations.

Supplementing the LAN Measurement Effort

The annual efforts of the LAN provide valuable insights into how health plans distribute their payments through APMs. However, this tells only a portion of the story when it comes to the advancement of VBP and is subject to several limitations, which are acknowledged by the LAN. For instance, these survey data reflect only data gathered by health plans, not by providers or other stakeholders, reflecting a less than comprehensive view of progress. Additionally, participation in the survey is voluntary, so results may suffer from selection bias, with more advanced health plans and states willing to report their progress. Imperfect or incomplete data systems may be limiting for some survey respondents – as health plans do not categorize their own data according to the LAN framework, respondents must retrieve data and categorize payments to the best of their abilities. Lastly, reporting of 2020 payments potentially include those made as COVID-19 stabilization and retainer payments. While the LAN provided guidance on how these payments should be categorized, some health plans may have miscategorized such payments or simply excluded them from their reporting.

In order to supplement the data collected by the LAN and give a more complete picture of the status of APM adoption, data exploring adoption by different provider types and adoption by geography are shared below. These data have been compiled from various surveys as well as by Torch Insight®.

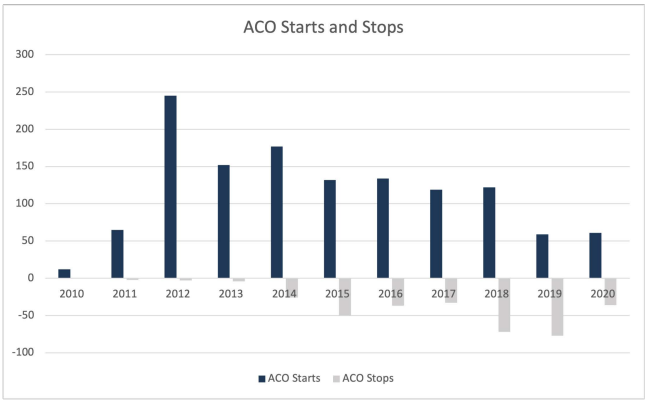
Provider Adoption

A comprehensive view of APM adoption requires an understanding of how other key stakeholders in

addition to health plans are participating in these efforts. Just as acceptance has grown among health plans, traction among health systems has increased. Data from the AMA indicate that more than half (54.9%) of physicians participated in an ACO and nearly a third (32.3%) participated in a medical home in 2020, up from 44 percent in 2016. In 2020, 44.5 percent of physicians received payments based on a pay-for-performance arrangement, 21.5 percent received shared savings, 40.1 percent received bundled payments, and 23.8 percent received some form of capitation. In all, a majority (67%) of physicians reported receiving at least some payment through an APM. Recent gains should be applauded but understood within the broader context: for a vast majority of physicians and health systems, FFS makes up nearly three quarters of their payments according to the AMA data.

The landscape of participating ACOs has also seen dramatic variation over recent years. Data from Torch Insight® shows a peak in ACO performance in 2018, which saw as many as 1,015 ACOs across all payer types, and which has dropped by 6 percent as of the first quarter of 2021. These modest reductions in the total number of participating ACOs may also belie the recent sizable increase in the number of ACO dropouts. While 2019 saw a net reduction of only 18 ACOs, a total of 77 decided to end their arrangements (Figure 8).

▶ Figure 8: ACO Starts and Stops – Milliman Torch Insight® Data



This decrease in the total number of ACOs may be mitigated by the fact that those which remain have increased the number of VBP contracts in their portfolios. The average number of contracts per ACO as of the first quarter of 2021 (1.76) has increased by nearly 30 percent since 2014. The actual impact of fewer participating ACOs remains to be seen. This trend may be problematic if the ACOs leaving these arrangements are doing so in already underserved areas and do not have adequate replacements. However, reports indicate that experience matters when it comes to VBP. Those ACOs that remain may be better equipped to realize savings while maintaining desired outcomes due to their maturity in programs like the MSSP and others.

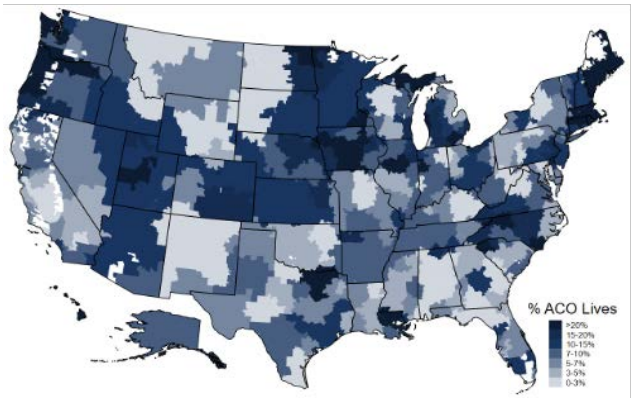
Questions remain about how and in what forms health systems will continue to move toward value in the future. Data from an executive survey conducted by the Healthcare Financial Management Association provide some insight. When health systems were asked about plans to advance their presence in VBP in 2022, as many as 59 percent stated that they plan to strengthen their positions in Medicare Advantage. A majority (52%) also indicated that they would be taking on more commercial VBP contracts in the form of upside and downside risk arrangements as well as capitation. Perhaps unsurprisingly, the major barriers to adoption reported by health systems mirror the opinions expressed by health plans in the LAN report. Just as health plans said that provider interest and readiness served as an obstacle for APM adoption, health systems believe that creating strategic partnerships with payers remains a major barrier.

In a recent listening session following the strategy update made by CMMI, providers detailed the obstacles that are preventing greater APM adoption, including the lack of actionable data from payers and the need for more upfront payment to offset early capital needs as primary barriers to adoption.

Geographic Adoption

VBP and APMs have found differing levels of traction throughout the country. Based on data from Torch Insight®, areas in the Northeast, Northwest, and Midwest have shown a greater level of APM adoption (Figure 9).

▶ Figure 9: ACO Penetration by Hospital Referral Region - Milliman Torch Insight® Data



Past trends also seem to be continuing with regard to urban versus rural adoption – urban areas of the country tend to have the highest percent of their population covered by ACOs. Similarly, participation in bundled payment programs, such as the BPCI-A program, also tend to be disproportionately found in urban settings. However, high APM penetration is not exclusive to urban areas. For example, while North Dakota is among the states with the fewest number of ACOs, the state has more than 20 percent of its population covered by an ACO. Some variation may be due to the manner in which state agencies, i.e., Medicaid, have chosen to incentivize participation in VBP arrangements. However, some areas of the country may be inherently disadvantaged due to the demographic makeup of their regions. Efforts such as that found in the CHART Model, recently released by CMS, may incentivize future adoption in localities that have previously forgone participation.

Expectations for the Value Movement in 2022

CMS leadership has outlined their plans for the future of the value movement, through comments made at the LAN Summit, a Health Affairs Blog post, various webinars, and the Innovation Center Strategy Refresh whitepaper and supporting materials. The strategic objectives outlined in the whitepaper can be seen in Figure 10. CMS, in step with the broader Biden Administration, has emphasized the importance of health equity throughout its portfolio of value-based payment models. Additionally, after a thorough evaluation of models and participant experience over the last decade, CMMI is applying lessons learned to current and future models with the intent to simplify participation and make models more effective. Federal players are not the only leaders in the value movement – state and private sector actors are announcing new models and programs aimed at advancing the adoption of VBP and are leaving their fingerprints on the movement. Based on statements and actions from across the healthcare sector, the following priorities will guide the direction of the value movement in 2022.

▶ Figure 10: Innovation Center Strategic Objectives

Drive Accountable Care	Increase the number of people in a care relationship with accountability for quality and total cost of care.
Advance Health Equity	Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.
Support Care Innovations	Leverage a range of supports that enable integrated, person-centered care.
Improve Access by Addressing Affordability	Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.
Partner to Achieve System Transformation	Align priorities and policies across CMS to aggressively engage stakeholders to improve quality, achieve equitable outcomes, and reduce health care costs.

Health Equity and Social Determinants of Health

The Biden Administration and CMS and CMMI leadership have emphasized the need for all programs to advance health equity, including value-based efforts. For providers, this means offering greater supports in health professional shortage areas, medically underserved areas, and rural areas, to ensure they have the expertise and resources necessary to take advantage of opportunities presented by value-based models. For beneficiaries, this means more models built specifically to address the social determinants of health (SDOH), models targeted to increase access in underserved communities, and greater efforts to measure and address the health equity impact of models.

Health equity will be made a priority in future CMMI models, but existing models are also being evaluated to better understand the impact they have on different communities. End-Stage Renal Disease Treatment Choices (ETC), an episode-based model

that became mandatory for many providers in January of 2021, was recently modified to reward providers for improving key kidney care outcomes in lower income beneficiaries. With this, it has become the first CMMI model to directly address health equity, but it certainly will not be the last.

In the Strategy Refresh whitepaper, the CMS Innovation Center highlighted key lessons learned, as well as next steps for addressing the issues and challenges associated with redesigning APMs to reduce health inequities (See Table 2).

In tandem with this strategic focus from CMMI, the LAN recently introduced its own effort to address health equity, the Health Equity Advisory Team (HEAT). Through this effort, the LAN hopes to facilitate the design of models that are person-centered, culturally appropriate, and that measure and hold providers accountable for the reduction of health disparities.

Greater Medicaid and State Involvement

Throughout the pandemic, Medicaid saw huge growth in enrollment and is now the largest single health coverage program in the US, covering one in five Americans. In previous years, while Medicaid has certainly played a role, CMMI's portfolio has primarily focused on Medicare. In the coming years, CMMI leadership plans to modify some existing models to include a greater number of Medicaid beneficiaries and to launch additional models specifically focused on Medicaid and dually enrolled beneficiaries. Daniel Tsai, the Director of the Center for Medicaid and CHIP services (CMCS) has emphasized the need for these programs to collaborate with states as a first step to innovation and urged programs to understand that payment should not be the "end all be all" of value, but that payment should drive behavior change that improves the experience of care for patients.

The LAN recently introduced their own effort to help states become more involved in the transition to value, called State Transformation Collaboratives (STCs). These collaboratives will bring together providers, purchasers, patient advocates, and community organizations in states and regions to design alternative payment models that address the needs of local populations and expand ongoing efforts to advance health equity within states.

Several states have already made significant efforts to advance value for their residents, some of which were highlighted during the LAN Summit. Kelly Crosbie of North Carolina Medicaid discussed the state's efforts to transition to a whole-person managed care model, highlighting their Healthy Opportunities Pilot which will link NCCARE360, a platform used to connect providers with community resources for patient referrals, with the state's advanced primary care program. The Colorado Department of Health's Payment Reform Manager, Trevor Abeyta, shared Colorado's efforts to bring value to its Medicaid program through maternity bundles, advanced primary care with partial capitated payment, and the exploration of mandatory value-based payment models. Colorado's Office of Saving People Money on Health Care is working to bring multi-payer alignment to these payment models. Additionally, the governor of Utah recently announced the Utah

▶ Table 2: Informing the CMS Innovation Center's Future Directions - Key Learnings

Lesson Learned	Issues and Challenges	Next Steps
Ensure health equity is embedded in every model.	▶ The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models to date. ▶ Medicare-focused models have limited reach to Medicaid beneficiaries and safety net providers. ▶ Models have not been systematically evaluated for impacts across beneficiaries with different.	▶ Better understand facilitators and barriers to participation in value-based payment models so that future models are designed to target and increase participation among providers that care for underserved populations. ▶ Ensure all beneficiaries have access to providers engaged in care transformation to deliver high-quality care by addressing issues such as implicit bias in model design, implementation and evaluation. ▶ Launch more Medicaid-focused models and/or modify existing models to include additional Medicaid beneficiaries. ▶ Require a more deliberate and consistent approach within the Innovation Center, as well as across CMS, in quality measurement and evaluation to assess the impact of models on underserved populations and to close disparities in care and outcomes.

Sustainable Health Collaborative, an effort to reduce health care costs and improve health outcomes in the state. The Collaborative plans to convene a broad group of stakeholders to pilot different care delivery models across the state. Going forward, states will continue to deepen their commitment to value-based principles and design payment models and care delivery reforms to address the needs of their populations.

Simplified and Streamlined Models

One of the learnings that emerged from CMMI's evaluation of its model portfolio was the drawback of the size of the portfolio, with many complicated and overlapping models. Going forward, CMMI plans to simplify its offerings to reduce opposing incentives and simplify the experience for participants engaging in conflicting models. As part of this effort, the Center also intends to focus less on specialty models tailored to particular disease groups or subpopulations, and more on broad models that emphasize the total cost of care, according to CMMI Director Liz Fowler.

Expanding Successful Models

As part of streamlining its portfolio, CMMI will focus on expanding existing models that have proven to be successful. Since its inception, CMMI has launched over 50 model tests. As of September 2021, six of these models have demonstrated statistically significant savings and four have met the requirements for expansion outlined under Section 1115A(c) of the Social Security Act (see Figure 11). The Home Health Value-Based Purchasing Model, one of the models that has both shown statistically significant savings and met the statutory requirements for broader adoption, was expanded nationwide as of January 1, 2022. Looking forward, we may see more of these successful models, or elements of successful models, expanded and adopted into permanent payment policy.

Figure 11: Models with Statistically Significant Savings or Meeting Requirements for Expansion under Section 1115A(c) of the Social Security Act

- Maryland All-Payer Model
- Repetitive, Scheduled, Non-Emergent Ambulance Transport (RSNAT)
- Home Health Value-Based Purchasing Model (HHVBP)
- ACO Investment Model
- Pioneer ACO Model
- Medicare Care Choices Model
- Medicare Diabetes Prevention Program

Mandatory Models

CMMI leaders have hinted recently that more mandatory models may be necessary to adequately test model design and to eliminate selection bias among providers. At a press briefing last year, Fowler said, "voluntary models are subject to risk selection, which has a negative impact on the ability to generate system-level savings. Providers that aren't generating the extra revenue tend to exit the program, and those that are tend to stay." This effect hinders the ability of models to demonstrate significant savings and makes it difficult to understand the impact each model would have were it expanded nationwide.

Despite an intent to move away from specialty models, CMMI will be continuing with two mandatory specialty models, ETC, which was launched in January of 2021, and the Radiation Oncology Model (RO), the launch of which was delayed by both legislative and CMS action. The RO model has been the recipient of much stronger industry pushback than ETC and has most recently been delayed again by the Protecting Medicare and American Farmers from Sequester Cuts Act.
Going forward, CMMI may announce additional mandatory models, though these will likely focus on the total cost of care rather than specific disease states. Mandating participation in value is not limited to Federal policymaking – Colorado is working to expand its value commitment in Medicaid through the introduction of mandatory models, pending legislative approval, and other states may follow suit.

Supporting Providers Where They Are

Though CMS leaders have expressed interest in mandatory models, these models are unlikely to require high levels of downside risk, as evidenced by recent remarks by CMS Chief Operating Officer, Jon Blum, which cautioned against asking providers to bear risk before they are ready. At the LAN Summit, Liz Fowler echoed Blum's comments, saying, "the journey to value is a marathon, not a sprint" and emphasized the need to support providers wherever they are in the value journey. This was also a learning highlighted by CMS leaders during an evaluation of past models – providers struggle to take on downside risk without being given the necessary tools to change care delivery. Going forward, CMS intends to introduce models that foster success for a broad group of providers, and will introduce support – including technical support, waivers, and model design elements –

to enable providers, particularly those serving underserved beneficiaries, to implement care delivery changes while taking on risk.

Headwinds and Tailwinds to the Value Movement

Like 2020, 2021 proved to be highly disruptive to the healthcare system. Some of the stressors of the last two years may facilitate the adoption of value-based payment models (tailwinds) while others will delay the value movement while the healthcare system recovers (headwinds). Here we list several tailwinds and headwinds that will shape the value movement in 2022.

Value Tailwinds	Value Headwinds
► The economic imperative to reform the healthcare system, which is even greater after the financial strain of the pandemic ► Sustained bi-partisan and cross-stakeholder support for the value movement as the most attractive solution relative to other more drastic alternatives ► The pandemic-exposed unpredictability of a FFS-based system and the stability of models providing predictable cash flow (e.g. capitation) ► Continued growth of Medicare Advantage and Managed Medicaid ► Practice consolidation and growth of employed physicians ► Advancements in technology and the maturity of the vendor market offering solutions that enable population health ► The announcement of CMMI's 10-year vision ► Growth of mandatory APMs and the expectation for more to come ► The increased adoption and maturity of value-based contracts among large national payers ► Increasing interest for value among employers, particularly those seeking to curb rising healthcare costs while competing for talent ► Growing attention to public health and the need for upstream prevention	► A system built entirely on a FFS foundation means the transition to value is highly disruptive to current operational infrastructure, business models, and culture ► A lack of attainable VBP options, with providers struggling to find payer partners, and payers struggling to find provider partners ► Competing priorities among health system leaders, particularly while many are still dealing with the fallout from the pandemic or still relying on a capacity-driven revenue model ► Lack of consumer awareness or demand for value-based models ► Underwhelming or mixed performance among current APM participants ► Many providers' lack of sufficient access to capital for upfront investments, ongoing transformation efforts, and financial reserves to bear downside risk ► Confusing and varied methodologies across payers, programs, and years ► Underwhelming outcomes from mandatory federal programs like the Merit-based Incentive Payment System and the Hospital Value-Based Purchasing Program

Priorities of the Accountable Care Learning Collaborative

As we begin a new year and reflect on the past, the ACLC is cautiously optimistic for the future of value-based care. Our healthcare workforce and care delivery systems have been battered by the pandemic and real healing is necessary to stabilize and continue on the path of recovery. COVID-19 has taught us much about ourselves as individuals and as a society, and we will use those lessons to improve care and outcomes for all, but especially for the most vulnerable amongst us. Value-based payment is the key to success, along with a well-trained, qualified, and culturally competent workforce that mirrors the diverse population it serves. We have already seen how VBP can enable innovative care delivery models and help our health system weather challenges, especially our critical primary care system. As noted above, the most recent reports from the HCP LAN on APM adoption show continued progress, but there is much more work to be done to accelerate the transition to value.

In our recent interview with Liz Fowler, she indicated that "advancing health equity has become one of the most important areas of focus for the Innovation Center, and for CMS and HHS more broadly. When we talk about embedding equity into all aspects of our models, this means increasing 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." At the ACLC, we are aligned with all of the CMMI strategic objectives listed in Figure 10, but especially the first two: Drive Accountable Care and Advance Health Equity. Equity and quality of care are inextricably tied together, and fundamental to value-based care.

The ACLC is focused on accelerating the move to value-based care and if you are not already a member, there has never been a better time to join us.

At the ACLC, we believe both value and equity in healthcare are contingent on the competency of the care team. Competency-based curriculum and peer learning are levers for advancing value transformation. In recognizing that educating and reskilling the workforce will be central to the success of the value-based care movement, we are launching new certificate programs in Value-Based Care and Population Health Equity in February 2022. Both of these certificates are industry-

validated and competency-based to drive scalable, high impact transformation of the healthcare workforce. In mid-January 2022, we are unveiling a new, virtual Community where ACLC members can collaborate in online discussion groups, access our market intelligence, and learn from and contribute to our growing network of like-minded industry professionals. And there are more announcements to come, so we look forward to collaborating with you. Together, we can leverage the tailwinds and mitigate the headwinds to advance health value in the coming years.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of health care organizations to succeed in value-based payment models. Founded by former Secretary of Health and Human Services, Gov. Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services, Dr. Mark McClellan, the ACLC serves as the foundation for health care stakeholders across the industry to collaborate on improving the care delivery system. To learn more about the ACLC, visit accountablecareLC.org.