

HIGH-VALUE COMPREHENSIVE CARE FOR INDIVIDUALS, FAMILIES, AND COMMUNITIES:

A Vision and Strategy for the Centers for Medicare and Medicaid Services In Collaboration with States, Payers, and Purchasers

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Introduction

The nation's health care system has more capabilities than ever to improve health, but is falling short in terms of addressing longstanding challenges in quality, outcomes, and high and rising costs. Closing these gaps requires intentional and accelerated steps to support more comprehensive and flexible models of care, in particular through alternative payment models (APMs) that bring greater transparency and accountability for results. A range of factors are converging to create urgency and opportunity to accelerate the shift toward comprehensive care models and APMs now.

COVID-19 has led to significant disruptions in the United States (US) health care system, and the reliance on fee-for-service (FFS) payment exacerbated the challenges facing health care organizations. Declines in in-person health care visits during the early days of the pandemic spurred significant growth in the adoption of new [telehealth](#) and [home-based care models even for complex conditions](#), but truly comprehensive models of care centered around people at home and in their communities requires greater attention to remote monitoring, digital technology integration, team-based care, and care coordination that is very difficult to sustain under FFS payment.

Inequities in care [access](#), [quality](#), and [outcomes](#) are not new in US health care. But the [stark disparities in COVID-19's impact on minority populations](#), on top of the large pre-pandemic outcome differences, have helped make health equity a top priority for the [Biden Administration](#), [Congress](#), [states](#), and [private sector stakeholders](#). While intentionality and accountability are required to assure that care reforms truly reduce disparities, doing so will require the expansion of APMs that enable health care organizations to meet every person where they are and that address the most important obstacles to their health and well-being, including the social drivers of poor health like food insecurity.

These urgent pressures add to other key challenges in the US health care system that more comprehensive models of care could address, including:

- overemphasis on medical (i.e., physical) needs and “sick care” and underemphasis on delivering [preventive and effective chronic disease management services](#) and addressing other needs (e.g., behavioral, social) impacting health and well-being;
- overemphasis on hospital-based care when other sites and forms of care could accomplish as much or more at lower cost;
- fragmented, complicated care without transparent, easy to understand prices that make it [notoriously difficult](#) for individuals and their families to navigate and receive convenient, coordinated, and affordable care;
- [poor performance on key indicators](#) such as life expectancy, rates of avoidable death, chronic disease burden, and obesity, with much higher health care costs and generally lower satisfaction compared to other OECD countries;
- high expenditures—[health care spending accounted for 17.7% of US growth domestic product in 2019](#), with contributions from [high prices](#) and [inefficient practices](#) – with spending growth expected to rebound in 2021 without further reforms; and
- administrative burdens associated with care and payment fragmentation, and a mismatch between what is reimbursed and what really matters for patients, that contributes to provider burnout and cynicism regarding value based payment (VBP).

The fundamentals of biomedical and digital innovation are also driving in the direction of more person-centered, comprehensive care. Advanced diagnostics, big data, and biologic and other treatments that intercept disease progression or provide cures make more prevention-oriented precision medicine possible. Pushed by the pandemic, digital technologies are enabling not just telehealth visits but integrated virtual care models with extensive remote monitoring and behavioral health integration, resulting not only in more 24/7 convenience but also the capacity to provide home-based services for cancer care, chronic kidney disease care, and other types of relatively intensive “hospital at home” services. Improving data infrastructure and experience in coordinating advanced primary care teams with social service providers and community supports are enabling further “upstream” interventions to address the social drivers of poor health that account for the bulk of poor health outcomes and health disparities among both individuals and populations. Improvements in secure data sharing, and in collecting information directly from patients, enables both better coordination around patient needs and much more transparency about how clinicians, medical practices, and health systems are doing in improving outcomes and keeping costs down.

Recent proposals have highlighted the potential for value-based payment and care reforms to address the health care system’s challenges, including, importantly, those [related to persistent disparities in health care quality and outcomes](#). These proposals reflect [broad support in the private sector](#) for advancing payment reforms that move away from fee-for-service (FFS) and toward more comprehensive, efficient, and flexible ways of financing care. The Administration intends to advance these efforts, with [a major review and new strategic plan in development at CMS](#) for accelerating value-based care. A range of proposals, including from the [National Academy of Medicine](#), and the [Commonwealth Fund](#), and [Medicare](#) and [Medicaid](#) reform proposals from a range of health policy experts, also support a CMS-led national strategy to advance more effective care models.

At the same time, fundamental questions exist about the impact of payment reforms implemented so far to support such reforms in care, especially at the Center for Medicare and Medicaid Innovation (CMMI). The mostly voluntary and incremental models implemented by CMMI have generally shown only modest and incremental effects, with the payments required to support investments in care transformation often exceeding (at least modestly) the savings that the models achieved, especially from the viewpoint of costs to the government. Concerns about consolidation and excess market power and pricing have understandably shifted some policy emphasis toward more direct government interventions, rather than just market forces, to reduce prices in the hope of improving affordability and access.

To address these challenges amidst the urgent need for progress in addressing the fundamental US health care challenges, we propose a vision for *high-value comprehensive care* and a set of steps for achieving it. While much of the detail of our report involves payment reforms and related policies, we believe a clear linkage of such policy reforms to their practical impact on Americans’ health, health care, and medical costs is essential for accelerating change. Our vision builds upon previous efforts to define high-quality health care, such as the [Institute of Medicine’s Six Aims of Health Care Quality](#) and the [Institute for Healthcare Improvement’s “Triple Aim”](#) (better care for individuals, better health for populations, and lower per capita costs). It describes an approach to care that is high-quality, holistic, reliable, and affordable to individuals and meets individuals’ needs and those of their families and communities.

Our proposed pathway to this vision also builds on the experiences of the pandemic, lessons learned during the past decade of reforms, and recent [interest](#) in and [movement](#) toward VBP models. These models can provide the accountability and redirection of resources needed to address many of the current system’s challenges, and findings from the past decade of VBP experimentation can provide guidance on which model approaches are most likely to yield significant improvements in health care delivery quality and outcomes.

The reforms required to achieve our vision are not easy. While they have notable bipartisan support, they require organizational change and there will be continued pressure to go slow to avoid disruption, and to spend more rather than spend differently to accomplish them. But these steps are feasible, the opportunities to implement them have never been better, and it is time to move beyond the payment models and related policies that have contributed to the US health care system's current dysfunction, to enable health care providers to deliver high-value comprehensive care.

High Value Comprehensive Care: Characteristics and Goals

The characteristics of high value comprehensive care are described in Table 1. This care can withstand the challenges of public health emergencies such as COVID-19 and deliver affordable, timely, and effective services that address the physical, mental, social, and other needs of an individual, family, or community. It emphasizes the delivery of services geared toward the prevention of downstream disease and disease complications, the coordination of care across providers (particularly between primary care and specialist providers) and settings, the achievement of outcomes that matter to individuals, all with the equitable use of digital technologies – and sustained through stable value-based payment models and an infrastructure that focuses on whole-person and population needs.

TABLE 1. Characteristics of High-Value Comprehensive Care

Characteristic	Description
Comprehensive and Longitudinal	Supports the delivery, coordination, and management of services addressing the whole range of an individual's health needs (e.g., physical, mental, behavioral, social, etc.) and the development of long-term relationships between providers and the individuals and communities they serve.
Multi-Professional and Team-Based	Utilizes multi-professional teams of medical providers (e.g., physicians, physician assistants, nurses) and community-oriented roles (e.g., community health and social workers) working collaboratively within and across settings, including in the home and community.
Inclusive	Provides care that is personalized, linguistically and culturally sensitive, wealth-agnostic, and incorporates the voices and participation of individuals, families, and communities at all levels of governance, operations, and design.
Proactive	Delivers care and services aimed at preventing poor health and health outcomes and fosters the development of long-term relationships between providers and individuals and communities that enable effective delivery of preventive care and services.
Community-Centered	Collaborates with schools, community social service organizations, law enforcement and criminal justice, housing and food agencies, ageing supports, and more, and facilitates individuals' connections to appropriate resources to address wider social factors that may impact health and well-being.
Home-Based	Prioritizes the delivery of care in, or very near, an individual's homes, if safe and appropriate. Examples include use of virtual care, hospital-at-home, and home-based long-term and rehabilitation services (rather than institutional care).
Accessible, Seamless and Customer-Oriented	Makes care easily accessible (in-person, video visits, apps, etc.), tailored to individuals' preferences, and enables seamless navigation through the health care system.
Sustainable	Ensures cost efficiency through optimization of care delivery including appropriate use of services and technology, anticipation of needs, reduction of overuse of ineffective care, avoidance of administrative waste, and promotion of competitive pricing.
Aware of and Accountable for What Matters to Individuals and Communities	Collects data on measures to assess and improve care, shares meaningful information with individuals about what matters to them (e.g., patient-reported outcomes), and shares performance on measures to provide transparency to the public.
Reliable and Resilient	Uses value-based payment models that can support providers to meet individual and community needs during times of economic, social, and medical crisis and create accountability for total cost of care and health outcomes.

The goals of high-value comprehensive care and specific measures that could be used to assess progress toward delivering this kind of care include:

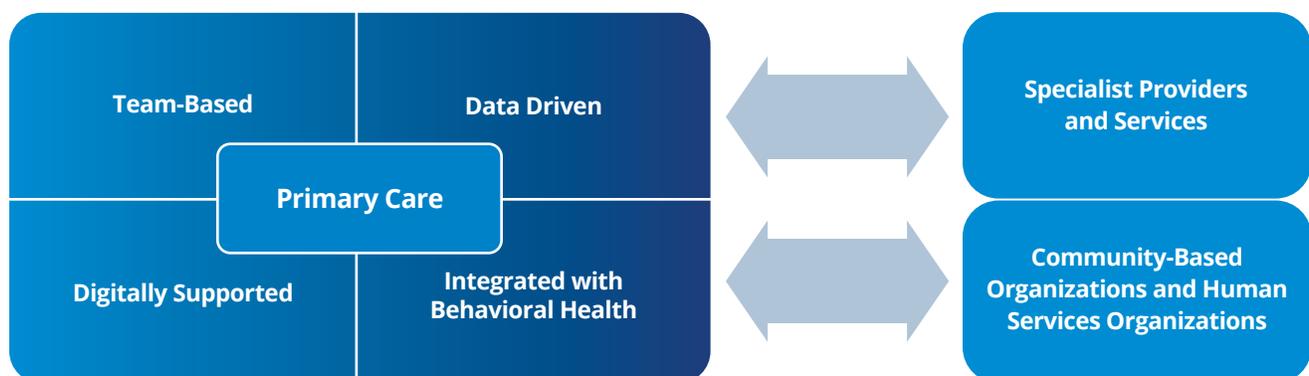
- *Improved health and health outcomes for individuals and families:* improved measures of health status, patient-reported functional status, and condition specific outcome measures (e.g., maternity care, cardiovascular disease, behavioral health);
- *More convenient, timely, and easy to navigate care for individuals and families:* increased access to care and improved coordination across primary and specialty care providers, as reflected in patient assessments of care access and experience, including primary care, behavioral health care, common specialized care needs, and meeting social needs like food insecurity;
- *Increased equity in health care and health outcomes, including those related to COVID-19:* increased voluntary vaccination rates and reduced inequities in vaccinations and COVID-19 hospitalizations; access, experience of care, and outcome measures stratified by race, ethnicity, geographic region, gender, and socioeconomic status; and
- *More affordable healthcare:* slower rate of growth and eventual reduction of health expenditures (e.g., benchmark growth rate equal to GDP growth rate or less), share of household income spent on health care, per capita health spending, and health spending as a share of GDP.

A Pathway to High-Value Comprehensive Care

Many policy reforms can contribute to this vision for care: updating scope of practice laws; better aligning primary care supply with community needs; expanding coverage efficiently; strengthening the community health workforce; promoting competition and price and quality transparency; improving data infrastructure and interoperability; reducing reliance on hospital-based care; and facilitating coordination of health and human services. We focus here on practical steps in payment policies and related infrastructure reforms to accelerate and sustain the adoption of effective comprehensive care models.

High-value comprehensive care includes a strong foundation of advanced primary care capabilities that are team-based, data driven, digitally supported, and adequately integrated with behavioral health in order to meet under-addressed mental and behavioral health needs (see Figure 1). Primary care services alone cannot address all of an individual's health needs. Comprehensive care models should also include ongoing coordination and collaboration with specialist providers equipped with the capabilities to address advanced and specialized medical care needs, as well as connections with social service and community-based organizations to address key social needs impacting health and well-being.

FIGURE 1. Key elements of high-value comprehensive care models.



Implementing such primary-care based high-value comprehensive care models is challenging, given limited resources and [the financial impacts of the pandemic on primary care providers](#), particularly [small and rural providers](#). Greater participation in advanced VBP models, through participating in Medicare's evolving models for [accountable care organizations \(ACOs\)](#), [Primary Care First](#), [Direct Contracting](#), and similar models in commercial and Medicaid plans, would help providers obtain more stable and substantial payment support and to develop the capabilities needed to deliver high-value comprehensive care. Organizations participating in such VBP models before and during the pandemic have been more likely to adopt:

- broad telehealth use as part of more comprehensive virtual care models;
- site-of-service shifts to meet patient needs and preferences more conveniently and at a lower cost;
- expanded coordination with or integration of behavioral health services;
- coordination and joint care plans with specialists delivering timely and efficient care for distinct and advanced patient needs;
- coordination with social and community service providers, and direct support for some social needs like access to nutritious foods, to address root causes of poor health and health disparities; and
- use of care models for chronic diseases and risk factors that avoid hospitalizations and other costly complications.

Indeed, while Congress and states are currently considering proposals to expand coverage of services such as telehealth that have proven valuable during the pandemic, providers in existing advanced VBP models already have broader financial flexibility to provide such services.

But payment reforms to date have generally had limited systemwide impacts and have been insufficient to provide broad access to high-value comprehensive care. To accelerate availability of such care, we can draw on some of the collective lessons learned (see [here](#), [here](#), and [here](#)), in the past decade of health care reform, specifically:

- [small shifts away from fee-for-service generally have had small impacts](#), with larger shifts from FFS to person-based payment giving providers more flexibility to deliver care in innovative ways as well as more accountability for results;
- [meaningful investments of time and resources \(e.g., capital, staff\)](#) supported by person-based, non-FFS payments are needed to build the capabilities (e.g., data infrastructure, care coordination workflows) needed to be successful in redesigning care and succeeding in VBP models; and
- [aligned multipayer models](#), with participation from Medicare, Medicaid, states, employers, and commercial health plans, reduce the burden of VBP model implementation and increase the impact of individual payer efforts.

The expansion of payment models supporting high-value comprehensive care will also support and accelerate reforms in specialized care. CMS and many payers and purchasers are implementing person-focused reforms in maternity care, kidney care, musculoskeletal care, cancer care, surgical conditions, and other areas where amenable to improving outcomes and lowering costs. These specialized care models are easier to implement when they are linked to strong primary care systems that are better able to coordinate with specialists in delivering effective care, and that have shared accountability for better outcomes and lower overall costs.

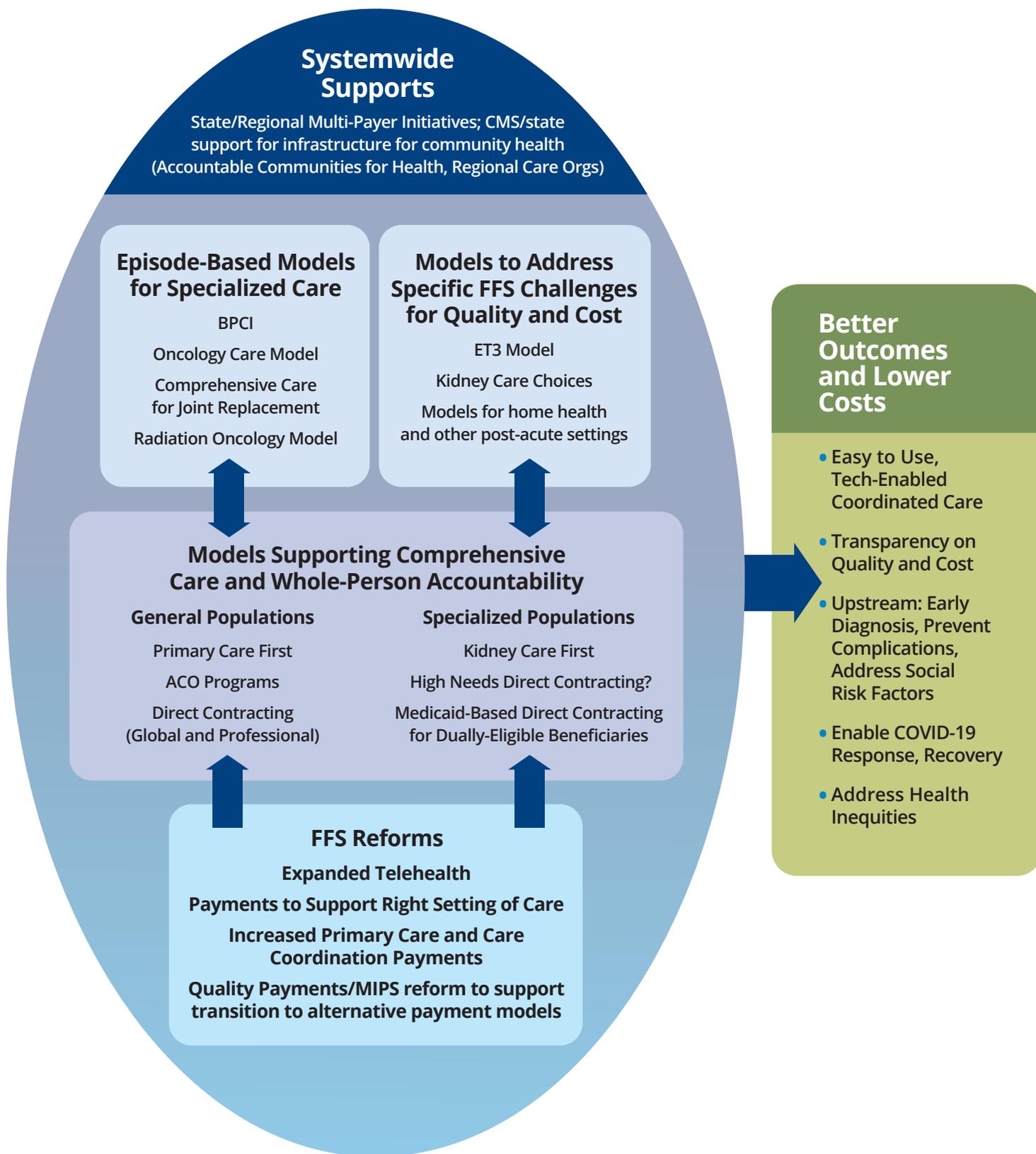
Figure 2 illustrates how a range of ongoing payment reforms could come together to support the delivery of high-value comprehensive care. VBP reforms designed to support comprehensive care with whole-person accountability serve as the core payment reforms. Key features of these models include prospective, population-based provider payments, provider assumption of downside risk, and accountability for quality, costs, and outcomes. While different comprehensive care model features may be suitable for different types of practices (e.g., small and large medical groups, integrated systems) and patient populations (e.g., people with specialized needs like dually-eligible beneficiaries or people with chronic kidney disease, urban or rural populations), each such model variation should be viewed as components of a coherent set of models to achieve the aim of all beneficiaries having access to care in practices able to deliver high-value comprehensive care.

Models to support specialized care needs should complement comprehensive care models. The specialized care VBP models should also have common aims and core features, as part of a coherent overall approach to support specialists in their critical role in delivering high-quality services efficiently, coordinating care, and avoiding complications. They could build on existing episode-based models, such as for cancer care or joint replacements and other major procedures, to focus on conditions rather than short-term episodes. Because advanced primary care practices can help avoid favorable selection in such models – the primary care practices would be accountable for the resulting increases in spending – the models could allow broader scope and participation when the participating patients are part of an advanced primary care model.

Despite their promise, these comprehensive care and specialized care models have proven difficult to implement successfully and at scale. Additional systemwide supports are also needed to make it easier for health care providers to succeed. In particular, payment reform adoption should include: expansion of regional and state multipayer models with aligned performance measures and data sharing, technical support programs, and infrastructure to facilitate coordination to address the common social drivers of poor health, by enabling data and resource sharing between medical providers and community-based and social service organizations. CMS and states have substantial new resources as part of pandemic relief programs that could support investments in these areas.

Finally, FFS reforms are needed to address payment inefficiencies to make high-value comprehensive care more attractive relative to FFS care, and that facilitate providers' transition into the aligned VBP payment models. These include direct FFS reforms, such as expanded telehealth and care coordination payments, though such payments will be limited by their relatively higher potential for overuse or misuse in FFS. These also include "focused" alternative payment models that address key inefficiencies in FFS, such as modifying regional ambulance payments to encourage treatment on site or at alternatives to emergency rooms, if medically appropriate (i.e., CMMI's ET3 model).

FIGURE 2. Supporting payment reforms for high-value comprehensive care.



Short- and longer-term steps by payers, purchasers, and states can implement this pathway to reliably deliver high-value comprehensive care to Americans. Most important is Federal leadership, starting with CMS. But in our public-private health care system, all stakeholders have an important role. The following sections emphasize the critical leadership needed now from CMS and the Federal government, but also describe key actions by every group.

CMS Actions and Federal Leadership Achieve High-Value Comprehensive Care

Programs at the Centers for Medicare and Medicaid Services (CMS) set the tone and frame for health care payment approaches in the United States. To advance comprehensive care delivery, CMMI and CMS should align, simplify, and expand its existing reforms with the explicit goal of working together and continuing to evolve to better advance high-value comprehensive care. Figure 2 above illustrates how many CMMI reforms could contribute to this goal, as CMS implements the next phase of its payment reform strategy. Most important is updating and aligning the Primary Care First and Direct Contracting (DC global and professional) Models and the Medicare Shared Savings Programs. These multiple models aim to provide pathways for a wide range of organizations to make progress on delivering advanced primary care and supporting comprehensive care. However, at present, these models are generally not taking new applicants, they are only partially aligned, and the future of several of them is uncertain. Consequently, the Administration's commitment to effective value-based care reform is not yet translating into increased adoption.

To address this, CMMI's emerging strategic plan should provide a clear path forward to greater participation in a set of APMs that have accountability for key health outcomes and total cost of care. Short-term steps should include adjustments in existing ACO programs so that organizations in discontinued or paused programs (like the Next Generation ACO program) have an interim path to avoid dropping back to less comprehensive models, and clarification of the key goals of the Direct Contracting Model and other advanced ACO models along with a process and timeline for turning these goals into an aligned model structure. This *clear pathway to comprehensive care* could include:

1. *A coherent pathway for all types of primary care organizations to develop and enhance comprehensive care capabilities, through further shifts from FFS. [Evidence shows](#) that this pathway should differ for primary care and physician groups from hospital-based organizations, in that the former can achieve savings and support care reforms with less risk bearing. For example, in Primary Care First, 50% "upside" savings coupled with up to 10% downside risk related to hospitalizations may be sufficient to create substantial new financial resources for physician-led care reforms. In contrast, success in integrated and hospital-based organizations has been associated with more substantial payment shifts away from FFS with more downside risk.*
2. *Incorporating a highly advanced VBP model with global payments and full risk-adjusted capitation as a priority element in the overall pathway. A growing number of organizations, both integrated systems and advanced primary care practices, are showing that it is possible to thrive under global payments – but such payment arrangements are generally not available in traditional Medicare. While CMS provides a path forward for a wide array of participating providers at diverse levels of readiness for success in VBP arrangements, it should have a clear opportunity for providers ready to end reliance on FFS to do so.*
3. *Reaching all beneficiaries served by CMS, particularly those who depend on "safety net" providers, by expanding VBP opportunities in Medicaid and programs funding community health centers. Many Medicaid programs have lagged behind their Medicare and commercial counterparts in the adoption of VBP models. Safety-net providers caring for many Medicaid beneficiaries are less likely to have the resources or infrastructures to succeed in achieving the goals of high-value comprehensive care, not only because of tight budgets but also because of the higher acuity of non-medical factors including low socioeconomic status, higher exposure to environmental risks, and other aspects of structural racism. CMS has provided [guidance](#) and [approved waivers](#) that have enabled some states to bring substantial VBP models into Medicaid. CMS should take a more active and intentional*

approach to providing examples and technical support for such models, particularly for dually eligible beneficiaries who have only limited access to truly coordinated care across their Medicare and Medicaid benefits. Similarly, CMS could collaborate with the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to pilot more person-focused VBP models to better support comprehensive care through community health centers. In addition, as we describe below, successful reforms require more infrastructure to engage communities in identifying the best ways to address poor outcomes and disparities, and to help integrate health care providers with community and social resources.

4. *Facilitating care transformation while still meeting CMMI's mandate to pilot and expand particular reforms that achieve outcome improvements and cost reductions.* In particular, CMMI could specify the major components of an aligned set of comprehensive care models along the lines we have described – performance measures and benchmarks, risk sharing over time, supporting data infrastructure, intended participants, etc., – linked to clearly stated transformation goals. CMMI should note that these components will continue to evolve, with as much transparency and predictability as possible, with evaluation mechanisms focusing on assessing the impact of these components on key outcomes and spending to guide the further adjustments. The components can be adjusted over time to help meet the CMMI mandate. This is not without challenges: clean evaluations of payment reforms are very difficult to implement given the breadth and diversity of reform efforts now underway, so actuarial assessments that pull together multiple sources of evidence will be needed. But given the broad shift and commitment to support advanced comprehensive care models, “one-off” add-on models that require individual up or down decisions about discontinuation, with no clarity about long-term progression, are unlikely to lead to care transformation.
5. *Recognizing the importance of resources for organizations to invest in building out their capabilities to succeed.* One approach is up-front payments for smaller practices that have little access to capital. For example, building on the success of the ACO Investment Model (AIM) for physician-led ACOs, CMS should prioritize the implementation of a program like the Community Health Access and Rural Transformation (CHART) Model's ACO Transformation Track as a key component of its comprehensive care strategy. The substantial relief payments associated with recent COVID-19 legislation, and proposed legislation for infrastructure development at the Federal and state level, also provides an opportunity to help providers not only recover but develop these new capabilities to avoid the COVID-19 health care challenges in the next public health emergency.
6. *Including mechanisms for partners with technical expertise or capital to provide needed resources for practice transformation.* For example, the DC model's intent was to enable health care practices to partner with supportive, value-adding, non-provider organizations to move more rapidly into partially or fully capitated models of care delivery. Rather than prohibiting such supports, [CMMI should consider modifications to this program](#) – for example, to encourage participation in underserved populations – to enable potentially important partnerships and needed capital for care transformation.
7. *Complementing the provider payment reform strategy for advanced comprehensive care with an aligned strategy to support similar goals through the payer-focused programs at CMS, including Medicare Advantage and (in partnership with states) Medicaid managed care and the exchange programs.* Most of these health plans already have considerable accountability for total cost of care, and especially in Medicare Advantage and increasingly in Medicaid managed care, plans are developing digital health, virtual care, and care management capabilities to augment and complement providers' efforts to develop the competencies needed for comprehensive care. Steps like better aligned performance measures and payment incentives, such as aligned STAR ratings and VBP performance measures where feasible in Medicare Advantage, will help achieve the goal of broad access to comprehensive care.

8. *Incorporating aligned models for populations with distinct health-related needs as critical components of an overall payment reform strategy for comprehensive care.* CMMI and CMS have a range of models for people with distinct health care needs that are generally managed outside of a typical primary care practice, including programs for patients with advanced medical needs (e.g., Independence at Home), dually-eligible beneficiaries, and beneficiaries with serious illnesses such as chronic kidney disease.
9. *Linking this strategy to meaningful and explicit goals for improving performance and reducing costs, and to greater transparency for Americans and their clinicians to assess how health care organizations are performing.* CMS has an extensive quality measurement enterprise, with a wide variety of programs and reporting requirements, and is continuing a set of initiatives to make such measures more meaningful, timely, and less burdensome. By focusing on implementing a limited number of performance measures that are consistent across its strategy for comprehensive care, CMS can reduce administrative burden while increasing the ability of beneficiaries and their clinicians to engage in payment reforms. Such measures should include: patient experience, including whether a patient has access to comprehensive primary care; functional status; key health risk factors such as cardiovascular disease risk; and total cost of care. As part of streamlining payment reform models and performance reporting, CMS should accelerate implementation of consistent and reliable methods for risk adjustment, and for reporting by race, ethnicity, disability, and other measures of social vulnerability. To help clinicians understand and improve performance in these models, Medicare should also enable access to timely bulk “Blue Button” data sharing from patients who allow it. CMS should also publish the algorithms it uses for these measures, and work to give clinicians increasingly timely and complete updates on their measured performance.

Several other strategic action areas are needed to complement this pathway to high-value comprehensive care and help assure its success. As described in Figure 2, these include an aligned path for VBP in key areas of specialty care and promoting systemwide supports for addressing social drivers of poor health and engaging other payers and purchasers in similar VBP reforms.

Reflecting the framework described in Figure 2, CMMI and CMS can take further steps to develop more advanced specialty-care models that align with the primary-care and population health reforms. Some specialty care involves high-cost services that may need only limited coordination with providers involved in care for a person’s other health needs, such as organ transplantation, CAR-T therapy, or many surgical procedures. In these cases, episode models for specialists could follow a similar framework to what we have described for high-value comprehensive care, but focusing on quality, outcomes, and total costs within the specialized episode. For integrated organizations performing such procedures, the same performance metrics could be used for their specialty providers.

But less costly alternatives with better patient experience and outcomes are possible in most areas of specialized care, including steps to prevent the progression of chronic disease and steps to assure that patients are effectively engaged in shared decision-making for conditions where their preferences matter. For example, many opportunities exist to avoid joint replacement procedures, heart failure complications, and less convenient and more costly approaches to long-term monitoring of cancer survivors – if specialized care providers as well as primary care providers have stronger financial support for coordinating care. Especially in conjunction with the adoption of VBP models for comprehensive care, current procedure- or admission-based models where some savings have already been observed in voluntary reforms, such as for joint replacement, but could be [extended to a condition rather than procedure focus](#). Further work is needed to enable effective model savings to be shared between the accountable primary and specialty care groups. As an initial step, to complement the measurement and transparency steps just described, CMS could advance transparency around quality and cost of common specialized care episodes, by producing episode spending estimates and key performance measures (including measures related to disparities) for each specialty care provider. Such transparency could also support the development of better guidance and technical assistance for coordinating primary and specialty care and guiding the further development of specialty care payment models.

To address the social drivers that have a substantial impact on population health and health disparities, CMMI and the Center for Medicaid and CHIP Services (CMCS), in collaboration with other HHS agencies, should [expand effective strategies to enable health care providers to partner with community-based and social service organizations](#). CMMI should build on lessons learned thus far from the [Accountable Health Communities model](#), to create broader opportunities to engage community members and community resources in achieving the intended population health and affordability goals. CMCS should build on existing Medicaid guidance and waivers for developing state infrastructure to address population health goals through data sharing and coordinating multiple funding sources. These efforts should help states use COVID-19 relief funding to build out regional infrastructure to support coordination across health care, behavioral, social, and community-based services. Initial key [transparency measures](#) here might include whether at-risk patients have [food insecurity](#) or [housing insecurity](#), since there is considerable evidence that both are associated with worse outcomes and higher medical costs. CMMI could lead efforts to braid together the currently siloed funding streams from Medicaid, SAMHSA, HRSA, the Administration for Children and Families (ACF), the Centers for Disease Control and Prevention (CDC), and other agencies that support safety-net providers, so that they have a more holistic view of their patients' needs and a clearer path to address those needs.

In addition to engaging beneficiaries and their communities in creating a better path to high-value comprehensive care through developing local infrastructure, CMS can also support efforts by VBP providers to do so through additional benefits. Participants in advanced VBP models are already able to offer additional benefits, such as broader use of telehealth and home- and community-based services. However, many providers have not yet offered such benefits, and further steps are needed to create a "waiver process" to do so that is straightforward and nonburdensome.

CMS should also drive greater alignment across multiple payers and purchasers in implementing VBP models and in providing more transparency about quality and cost performance. Through convenings and public-private collaboratives such as the [Health Care Payment Learning and Action Network](#), CMS has developed resources with input from states, commercial payers, providers, purchasers, and consumers to align key technical components of VBP programs for primary care, such as moving to consistent performance measures and benchmarks. The LAN is now planning to support pilot efforts to accelerate multipayer alignment, particularly around advanced primary care and addressing health equity. CMS should collaborate with the states, regions, and purchaser groups that have made progress in multipayer alignment to develop a set of common measures, data sharing best practices, and other resources that will reduce the cost of extending such models to other regions and purchasers that wish to participate. While regional and purchaser needs differ, this can both speed multipayer reforms and avoid the emergence of unnecessarily diverse VBP measures and components – a source of administrative burden and diminished impact of reforms across providers. As this work advances, CMS could also leverage the collaborative pathways to advance specialty care VBP reforms and promote more consistent, meaningful, and reliable measures of specialty care performance across payers.

Finally, CMMI should develop a framework for introducing mandatory value-based payment models. CMS has had some success in implementing mandatory regional pilots, which could be expanded if successful. This would address the problem of selection bias leading to difficulties in achieving savings in model participation. These mandatory models should recognize that up-front resources and supports will be necessary for providers to develop VBP infrastructure, as we have described.

Table 2 reviews many of these actions and some additional actions that CMS can take to support wider availability of high-value comprehensive care. Most of these actions can be implemented administratively, but they could achieve more momentum through legislative support. For example, to support the goal of a comprehensive approach to leading value-based care transformation, Congress should also link any future provider relief payments to movement into accountable VBP models. This will enable providers to be more resilient in public health emergencies, and do more to support public health goals like COVID-19 vaccination

and addressing the alarming trends in substance use disorders, mental health disorders, and declines in the use of preventive care during the pandemic. Legislation granting CMS the authority to retain flexibilities implemented during the public health emergency, such as expanded telehealth, should include broader extensions for providers in advanced VBP models and could be linked to other supports to help providers move into VBP models. Expanding effective VBP models to support comprehensive care will lower the budgetary costs of payment reforms intended to expand virtual care and support care coordination, and will increase the impact of any such reforms.

TABLE 2. CMS Actions Needed to Support High-Value Comprehensive Care

Develop and implement a coherent pathway for all types of primary care organizations to develop and enhance comprehensive care capabilities, through further shifts from FFS.
Develop and incorporate a highly advanced VBP model with global payments and full risk-adjusted capitation into the pathway to comprehensive care.
Expand VBP opportunities in Medicaid and programs funding community health centers to reach all beneficiaries served by CMS, particularly those who depend on “safety net” providers.
Facilitate care transformation by specifying the major components of an aligned set of comprehensive care models that can be adjusted over time to meet CMMI’s mandate to pilot and expand particular reforms that achieve outcome improvements and cost reductions.
Recognize that organizations must invest in building out their capabilities to succeed in VBP and offer support (e.g., capital) to help providers, particularly smaller providers, develop their capabilities.
Include mechanisms within VBP models that allow partners with technical expertise or capital to provide needed resources to providers that can enable practice transformation.
Complement the payment reform strategy for advanced comprehensive care with an aligned strategy to support similar goals through the payer-focused programs at CMS (e.g., Medicare Advantage).
Incorporate aligned models for populations with distinct health-related needs (e.g., chronic kidney disease, dually-eligible beneficiaries) as critical components of an overall payment reform strategy for comprehensive care.
Link this comprehensive care strategy to meaningful and explicit goals for improving performance and reducing costs, and to greater transparency for Americans and their clinicians to assess how health care organizations are performing.
Develop more advanced specialty-care models that align with primary-care and population health reforms by expanding to focus on conditions and including incentives for coordination care and shared decision-making.
Support collaborations across CMMI, the Center for Medicaid and CHIP Services (CMCS), and other agencies (e.g., Medicaid, SAMHSA, HRSA, AFC, CDC) that are focused on expanding effective strategies enabling health care providers to partner with community-based and social service organizations.
Support efforts by VBP providers to engage beneficiaries through additional benefits (e.g., broader use of telehealth and home- and community-based services) and simplify administrative processes required to offer these additional benefits.
Drive greater alignment across multiple payers and purchasers in implementing VBP models and in providing more transparency about quality and cost performance through public-private collaboratives (e.g., LAN).
Develop a framework for introducing and expanding mandatory value-based payment models.

State Actions to Achieve High-Value Comprehensive Care

States are increasingly taking steps to promote better care by shifting from paying for specific health care services to [paying for health](#) through better care models. State actions are particularly important for low-income and minority individuals and families who are facing increased health risks and greater health disparities as a result of the pandemic. Table 3 summarizes key areas where states can take critical actions now. States can [leverage the contracting process in their own Medicaid programs or through managed care organizations to promote greater investment in comprehensive primary care through the adoption of VBP models](#). States are also well-positioned to advance alternative payment models in [exchanges](#), and more broadly across health care payers. For example, [Washington State's Multi-Payer Primary Care Transformation Model](#) is implementing advanced primary care reforms and payment models across public and private payers in the state. As we noted above, multipayer models can reduce the burden of model participation for providers and may increase the likelihood of the model improving quality and achieving cost savings by leveraging payer reforms that might otherwise be fragmented. Moreover, as we described above, recent Federal relief programs have not only improved states' fiscal position but provide funds that can be used to provide the infrastructure and support to enable health care organizations to succeed in shifting to VBP reforms. Especially if CMS takes the further actions outlined here to encourage and enable these state reforms, states can play a major role in advancing higher-value comprehensive care and improving health equity.

TABLE 3. State Actions Needed to Support High-Value Comprehensive Care

Build on CMS guidance and successful state models to develop a plan and time frame for shifting payments from FFS to VBP with accountability on total cost of care and outcomes, with a clear vision for progress on using high-value comprehensive care models to improve key measures of health and health equity in the state.
Utilize funds from the American Rescue Plan and other emergency state assistance to develop infrastructure to enable high-value comprehensive care, including systems to help health care providers address social drivers of poor health, and data sharing and technical assistance to address key state health priorities such as COVID-19 recovery and reducing health disparities.
Convene an advisory board or commission that can set goals, formulate shared action plans, and guide broader quality and cost transformation efforts in the state.
Encourage multipayer alignment to drive VBP reform and care transformation through promoting the adoption of common performance measures and other key VBP features, and provide incentives and requirements for data sharing and transparency on quality and cost performance.

Commercial Payer Actions to Achieve High-Value Comprehensive Care

Many commercial payers are already implementing primary care-focused initiatives that are advancing comprehensive care, including [Blue Cross Blue Shield of North Carolina's](#) Accelerate to Value program, Blue Cross of Massachusetts' longstanding Alternative Quality Contract, United's investment in capitated population health programs, [Humana's](#) announced participation as a payer partner in the Primary Care First model, and [Blue Cross and Blue Shield of Minnesota's](#) recent partnership with Minnesota Healthcare Network to accelerate independent primary care clinics' transition to VBP.

Further actions that payers can take to support progress toward the delivery of high-value comprehensive care are shown in Table 4. Such actions include participating and providing leadership in collaboratives such as the [Health Care Payment Learning and Action Network \(HCP-LAN\)](#), which can help facilitate payer collaboration with other stakeholders and amplify payers' actions around VBP. Additionally, public commitments to transition to VBP through initiatives such as the [LAN Healthcare Resiliency Collaborative](#) can help payers signal to providers and purchasers their willingness to partner on designing and implementing VBP models.

TABLE 4. Payer Actions Needed to Support High-Value Comprehensive Care

Participate in multistakeholder initiatives to align key technical standards like performance measures for ACOs and direct contracting models, and implement aligned approaches, to limit model burden on providers and increase impact on health system performance.
Link relief payments for primary care practices to a commitment and supports to transition to advanced alternative payment models.
Encourage the use of value-based insurance design that aligns out-of-pocket payments with VBP and that eliminate barriers to carve outs.
Support multi-stakeholder initiatives (e.g., employer, regional, or state initiatives) that advance VBP models for primary care. Support regional quality improvement programs to align provider outreach.
Commit to sharing data with VBP model participations in a timely and effective manner including data for mental health and substance use.

Purchaser Actions to Achieve High-Value Comprehensive Care

Purchasers are facilitating the shift to enhanced primary care and comprehensive care through initiatives such as the [Purchaser Business Group on Health's \(PBGH\)](#). Mechanisms for this investment include adjusting contract terms with plan administrators to require a greater focus on primary care, and shifting to direct contracting using non-FFS, value-based payment models with clinics and providers interested in delivering advanced primary care. Some employers are implementing these models through direct contracting with providers in regions where they have a significant presence. PBGH and its members and collaborators, including Walmart and Boeing, have also implemented person-focused specialized care reforms through the expansion of local Centers of Excellence programs. By leveraging common priorities for value-based care across purchaser groups, and by aligning with similarly-directed public and private initiatives, purchasers can help drive progress on payment reform and meaningful performance goals in their contracts with payers and providers. These and other actions purchasers can take to support progress toward the delivery of high-value comprehensive care are summarized in Table 5.

TABLE 5. Purchaser Actions Needed to Support High-Value Comprehensive Care

Declare a commitment and timeframe to shift the commercial contracting strategy from FFS discounts to VBP based on total cost of care and outcomes, with a clear goal of providing high-value comprehensive care for all employees through such contracts.
Support the expansion of successful Center of Excellence networks and direct contracting for primary care and population health, through requiring adoption, use, and transparent reporting of patient-reported outcomes, total cost of care and patient experience performance measures for primary care and common priority areas of specialized care.
Collaborate through CMS, state, and regional initiatives to develop and adopt consistent measures and approaches across payers and regions, to reduce administrative burdens and increase leverage of purchaser reforms.
Link these high-performing models to employee engagement initiatives and value-based insurance design to increase participation with high-value providers and networks.
Support purchaser-backed entities that can manage data, program design, and contracting support to ease employer participation.
Develop policies to encourage purchaser adoption of "prepaid" value-based payment models, with shared savings opportunities, over incurred fee-for-service claims payments.
Hold payers accountable for their value-based payment and price transparency commitments, and for the associated actions to improve outcomes and reduce costs.

Conclusion

The experiences of the COVID-19 pandemic have highlighted critical gaps and inequities in health care, which reflect longstanding underlying challenges within the US health care system. Recent experiences with comprehensive primary care models with enhanced capabilities and better integration with specialized services and community supports show that a better, more effective way of delivering care is possible. Our vision for high-value comprehensive care and our proposed pathway to achieving that vision builds on these experiences and describes feasible actions that CMS and other stakeholders can take right now to enable both COVID-19 recovery and care delivery transformation. These actions will enable faster and less costly adoption of the care reforms needed to achieve more efficient, equitable, and effective care that improves health outcomes across individuals, families, and communities. With better evidence on what works and with the unique circumstances created by the pandemic and interest in emerging from it with a more resilient health care system that delivers better value and greater equity, now is the time to act.

