Emily Brower: Hello, I'm Emily Brower, President and CEO of the National Association of ACOs, and I'm thrilled to be joined today by Abe Sutton, Deputy Administrator of CMS and Director of the CMS Innovation Center.

We will check in on Innovation Center strategy and reflections on a flurry of new models and new directions. So, Abe, thanks for joining me today, and thanks so much to your team for joining us at our spring conference in Baltimore.

At the spring conference, we're going to take a deeper dive in all the ways that we can grow accountable care and the results these models achieve.

Moving more patients into value-based arrangements, while evolving care to be more holistic, patient-centered, and cost-effective. So, thanks for joining me, Abe.

Abe Sutton: It's truly a privilege to get to be in conversation with you, Emily. The partnership with NACOS for the Innovation Center team, and frankly, for all of CMS, is an invaluable one that helps shape our work and helps us understand where hospitals, where, independent practices, where people participating in the accountable care arrangements that we, enable, are, and I truly appreciate the opportunity to engage with the community.

Emily Brower: Great, thank you. Love the spirit of that. Always appreciate it. So, to start, let's, let's zoom way out and talk about the big picture. You've described this moment we're in pivotal moment for the Innovation Center. What has fundamentally changed and changing about CMMI's role in healthcare delivery and payment under your leadership?

Abe Sutton: So we remain grounded in the statutory authority and its focus, which is improving quality and lowering the cost of care. In essence, how we make care more affordable, more accessible for people. So that remains true. That's been true of CMMI, the Innovation Center, under every director, under every administration, that's been trusted with stewardship of the Innovation Center and its grant of authority from Congress.

What's exciting now is, I think, changes in the outside world, combined with learnings on how to use CMMI and a willingness to do so. So let me talk about each of those three factors and why they combine, for some pivotal transformation that the Innovation Center can play a role in.

The first is changes in the outside world. We have seen advances in terms of artificial intelligence and different technology tools that enable new ways of augmenting and complementing

Physician and clinician-delivered care. We're able to do things that can be more affordable and more accessible for people if we find the right on-ramps into the system, and use technology as a way of containing costs, as opposed to just a way of inflating costs. I'm sure we'll touch on that as part of today's conversation.

I similarly see promise in new gene therapies, in new advancements in the biotech community and what they have driven forward, where if we can find the right way to pay, we will incentivize development, we will incentivize innovation. More generally, on drug pricing, this is something the President has focused in on, and says, how can we encourage innovation while ensuring that Americans are paying their fair share for prices and no more? Because other countries are stepping forward and paying their fair share.

And so, I would highlight the twin pillars of technology and biotech as areas where I see promise for making care more affordable and accessible for people.

The second thing I highlighted is learnings on how the center's authority is used. And we now have you know, we're in 2026, so let's call it around 16 years of history of the Innovation Center, of different interventions. We see what's worked and we see what has not, and that has shaped how we've been approaching it. So learnings on the opportunity to have arbitrage between models, and how we've thought about benchmarking, is a lesson we've learned from prior models.

Learning on what motivates changes in behaviors, what the physician community is looking for from us, what enables hospitals to jump in, what worked or did not work in the context of engaging Medicare Advantage plans, and what lessons that holds for us as a center.

Those are all things where it is very reasonable that the Center looked and did an experiment and concluded, you know, we need to experiment in a different manner. We learned something, we learned that some aspect of this did not work, and we could reform.

I have the benefit of coming into a center that has a long history of innovation now, over 16 years, and is able to really ensure that policies are fine-tuned to get at the issue that they're addressing.

While still being willing to embrace innovation and do things like Maha Elevate that bring in fresh and new ideas to get at the core problems of prevention that we want to confront as a society.

The third thing that I will highlight is there is a willingness to use the Innovation Center not as saying. Let's run a science experiment here, and a science experiment there, to get a technical improvement in this factor, or that factor, but rather to say, no, the innovation center should be a tool to make the healthcare system better for the American people. To do experiments that, if they prove out and are certifiable, will mean that the healthcare system looks different a decade from now. It's one where care is more accessible, it's one where care is more affordable, and where people have the information they need to take control of their own health journey. And so. Our models are really meant to complement one another and complement the existing payment structures that govern our care delivery system through the incentives, etc.

And so, we're really thinking about using CMMI as, as Dr. Oz puts it, the nuclear reactor of CMS. The idea generator that's putting in place approaches to get at the core challenges that we're facing as a society. And so, those three things combined, new capabilities in the outside world, learnings and expertise on how we use our authority, combined with a willingness to get at the heart of the challenges that we are facing, and how to make care more affordable, can bind for a robust agenda from the Center.

Emily Brower: So that's really helpful context, and I know you'veâ€¦ you've shared some of that purpose and vision before, but if we think about, you know, often, people talk about the dozens of models over the past over all those years, with a few that have scaled, but it seems to me that what you were just speaking of provides some context, and maybe you could drill down a little bit with some of the decisions you've made with regard to accountable care models and related, both the decisions around what scales and what, you know, what you can bring to scale, and models that you have ended. So, just drill down a little bit more on the models, you know, that many of our members have participated in, or the providers in their organizations have participated in. And, speak to some of that criteria, how what that vision and purpose shows up in some of the criteria, that goes into, those decisions.

Abe Sutton: As you noted, there have been a number of models that have been certified. We have four existing certified models. There are other models that have influenced the system and scaled in some way, despite a lack of formal certification.

And so, the Pioneer ACO model was obviously one that had a certification end, but other learnings from models have been embedded within the Medicare Shared Savings Program without a formal certification.

We've seen an aspect that works, and we pick up that aspect and drop it in.

I mentioned VBID earlier. VBID was a model that ended up being quite costly, but some of the flexibilities that it pioneered in the first Trump administration over the subsequent years were picked up by the Center for Medicare and made available to all Medicare Advantage plans. And so.

That is another form of scaling. It's not our true aim when we're setting out to do a model, but it is a version of success as well, to see, as we, as we put out policies, a transformation of the core program itself, just through the adoption of something that maybe was done as a model because we wanted to see if it worked, and now we know it worked, and so we'll adopt it in the existing statutory authority. So, just to call out that not every model has historically, in every aspect, needed CEMAI authority. It's been more about running a true test, and so those insights, scale through the direct existing statutory authority.

I also see some lessons to get at the heart of your question, Emily, on how to design models well to ensure that we are in a better position in terms of likelihood of being able to scale that.

We pay a lot of attention to the criteria for certification and how that has been set in place based off the statute. So the Office of the Actuary plays a large role in the determination of if a model has saved money when we get up to the stage of certification. We have our evaluation team, but ensuring that we mirror the actuary approach that the Office of the Actuary will use in how we look at the evaluation will help ensure that there's not a misstep when it comes time to certification.

One way we're able to do that, beyond the methodological approach of staying grounded in a sound actuarial approach, is to say that when setting out to do a model, and run the test initially in what we call a Phase 1 model, not a certified model.

We want to ensure that OAC expects the model to be a saver, or at least not be a cost.

And so, looking at what OLAC terms the mid-case scenario, so not the high case, that is, everything goes right, not the low case where everything's gone wrong, but their reasonable expectation of what will likely occur, we want to hew very much to a world where we see, our models in a savings scenario, or not a loss scenario in that mid-case, because that means the model is less likely to need to be tweaked, and less likely to Run into a scenario where it's not possible to certify a model.

I also think that there's some important learning in portfolio construction for the center. We want to get at a mix of models, some of which we look at and say, oh, these are likely, in most circumstances, to be something that we can move to certify, and this is one that's taking a bit more risk, still in the mid-case scenario saver, but we're not certain what the impact will be completely, and have some of our portfolio be models that get at larger questions in that manner. And so, I think of what we've set up In the lens of certifiability and lessons learned as a portfolio strategy that has some higher risk and some lower risk models.

Emily Brower: So, that's helpful, that portfolio strategy, thinking about Medicare. Picking up on that, how do you take some of that thinking, or how does some of that infuse your thinking around multi-payer models, so stepping beyond Medicare?

Abe Sutton: We have formal multipayer models, and then we also have informal approaches that turn into multiplayer approaches. Maybe the best example of a formal multipayer approach is the AHEAD model.

And AHEAD as a model, has some interesting components. It has the approach focused on hospitals, where the hospital, in essence, is an ACO, getting attribution based off engagement with patients, and getting a, benchmark set for it based off the historic spend on the patients it engages with for Medicare, and then the state is assigning Medicaid risk in a similar manner to the hospital, and also, the state uses its authority to ensure that at least one commercial plan is coming into the arrangement.

And so HEAD is set up for 6 states. We have an open call, we want more states to come in and partner with us via HEAD, and this is a formal, multi-payer approach, using our authority plus state's authority to get at Medicare, Medicaid, and commercial lives, for the hospital, primary care capitation for physicians.

In AHEAD states, we also will have lead function as an option for physicians that want to take on risk, at least on the Medicare portion. I'll note LEAD offers the potential for two states to work with us on assigning Medicaid risk to the lead entities as well, and so that is something that can layer in, whether it's in an ahead state or a non-ahead state, of course. And then we'll get into what happens with the unattributed lives there. And the unattributed Medicare lives, we have GEO ahead.

Where, for those participants, who, are the hospital or the HCO in the state, or others a health plan, a technology company, they can come in and say, I will take on accountability for these lives that are unattributed to a care provider based off the existing attribution methodology, and I will engage them, give them preventive services, help them achieve control of their healthcare journey.

And take on the accountability in the way that a provider or a hospital would normally do so for that book of business. Hospitals are welcome to bid.

Independent provider groups forming ACOs can bid as well. It is open fairly broadly. Like, you know, we are not putting barriers there. Importantly, it's an Original Medicare program. There's not restrictions on patient access to services, but if you could come in and engage people proactively to look at them, that is a good thing.

Stepping back from that more formal AHEAD program, we also have efforts that we might pioneer as a Medicaid program, or as a Medicare program that can be picked up by others and scaled. And so, the best recent example of this is the ACCESS model.

Access is a model that focuses on technology companies, where we ask them to come in as Medicare Part B enrolled providers and deliver care with patients that they engage directly via an app, via some sort of tool or solution, where what they are doing is helping a patient manage a chronic condition. So we've got an early cardio-kidney metabolic health track, we have one for more advanced cardio-kidney metabolic health, we have an MSK track, and a behavioral health track.

I say it's a technology model, it's not formally a technology model, but in the way we pay for achievement of outcomes in this track, what we have set up is something where, in essence, you really do need a very cost-efficient structure for it to be profitable to come in and do this, but we envision, and what we've received applications from, is many tech-forward providers coming in with a plan to engage people and deliver care.

Now, the reason why I'm bringing this up in response to your question on multi-payer alignment is we followed up the access announcement with conversations with health plans. And we went to them and we said.

This is something we see as logical. We think it's a good incentive structure, we think it will be deflationary for the healthcare system to pay for technology-enabled care in this manner, and we think it will help people take control of their healthcare and achieve these outcomes.

Would you consider adopting a similar outcome-aligned payment approach? We'll open source everything in our design. So, we have a payer resource handbook that's available for people who have signed the Access Pledge on behalf of their plan.

And our intent is, based off the pledge, that every one of these payers, by January 1st of 2028, the year and a half after Axis launched, will have set up and launched their own outcome-line payment approach.

Some, I'm sure, will pick our tracks up and do a similar approach to it. Others will customize and have different approaches and conditions they prioritize. But what will have changed is that when you're a health tech company that's looking to innovate, there will now be this open market where you can go direct to consumer and engage people from not just Original Medicare, but Medicare Advantage, and Medicaid plans, the MCOs, and commercial plans as well.

Coming together to say. We think this makes sense for our patients, we think this makes sense for the people we are accountable for, and we are giving open access and a broad incentive for the industry. And being able to capture a higher share of mindshare from a physician practice, or a higher share of mindshare from an innovator coming in to look and create a new model of care, I think increases the incentive to come in and build.

To come in and do these transformation work that is hard, to improve people's lives.

Emily Brower: Let's talk about access for a minute. It's one of the new models. It clearly, to pick up on what you were saying earlier about what has changed in this time we're in, and what's driving some of the change, certainly the, the changes in the outside world and technology, in particular advances in AI.

So, so let's drill down on access for a minute, because, it's a super interesting model. And In the launch of that model, you and your team talked a lot about technology enabling patients to drive their own healthcare goals, which is a theme, again, a theme I think we see, with your team and your leadership, not just in access and other models as well, butâ€¦ but clearly front and center in Access.

So, how do you see that? What do you anticipate happening in practice along that, sort of, patients driving their own healthcare goals that is specific to this model, but, you know, could be broader?

Abe Sutton: you're right, this is an intentional theme. We believe that multiple offerings for people, helps them take control of their career journey, and be a bit more of an empowered consumer, where there's a fight to give you the information, rather than feeling like the information is hidden for some reason, whether that is HIPAA, or that is just a business practice of an entity.

We want to get to a world where you are empowered, where you have the information, where there's a fight to serve you and give it to you, so that you then Can be engaged and take control of the journey and achieve better outcomes.

I envision Just like in a market where somebody is willing to pay their own money, out of pocket, cash pay, whatever term you want to use, for an app to help them manage their behavioral health or their mental health, or something to help track their diabetes.

I envision a world where those same companies say, I will jump into Medicare for the first time, and I will serve Medicare beneficiaries, and try and engage them as well. And so there will be a fight to say, download my app, or download her app.

My text-based solution versus somebody else's app, and say, I can help you achieve that. And so you, as the consumer, Emily, initially have the choice of, what brand are you going with?

Now, to some extent, this might be something where your doctor helps intermediate that for you, on your behalf, and says, this is pretty good, I looked up the results, I think you should use this thing. Now.

We built in the option for these participants to waive Part B cost sharing on their service. So they'll absorb the financial hit of doing so, but you could actually make this available completely for free if you choose, and I'm sure some people will, which makes suddenly a free offering for the Medicare Part B beneficiary for this service available.

But downloading the app or signing up for a text-based relationship is not the final step, because then the payment is really based off engagement with the patient, and then based off achievement of the results. So you have to deliver a baseline measure. What is the patient's A1C level, or BMI?

And then, we will look a year later to see, have you achieved it? And so, there is suddenly the minds that have worked on engagement with patients, thinking through, how do I engage somebody and not just keep them engaged for its own sake, but engage them and drive improvement on that outcome. And so we have set up a clear incentive where you need to work through the approach to say.

Just like you'd optimize on engaging somebody in a social media app, or you'd optimize on engaging somebody, how do you solve the problem of engaging somebody for their benefit with their health?

And to get them to stay active, to get them to choose to take on a physical activity, or change their diet, or to get them to, when necessary, go and engage with the actual healthcare provider who they have a relationship with, who they might not realize they need to go in and see because something is urgent. And so, that approach, whether you're monitoring to flag and refer out and connect with the physician or whether it's about getting the patient to take activity, there could be different strategies that emerge. But we are setting up the incentive where engaging the patient and driving the improvement on the outcome is what matters, and the company that it comes in to participate can figure out the best strategy. There's one other requirement that I want to highlight here, which is a requirement that the participant push information actively.

To the doctor that the patient has designated as their primary doctor, if the patient has done so.

That information needs to be available in a common API, but we are requiring an active push, not just a wait for a pull from the doctor here, and then we are reimbursing the doctor for ingesting that data and looking at it, and allowing them to charge what we're calling a co-management payment, under the model.

Emily Brower: Thanks, that was a lot of detail on access, and I know, our members, and probably all ACOs, certainly, out in front in terms of digital health, AI, remote monitoring, where, you know, it'sâ€¦

You know, because you have sort of the double incentive. For things, you know, where fee-for-service codes are introduced that can cover some of the, sort of, workflow change and adoption. But ultimately, it's the accountability for total cost of care and clinical outcomes that has, that has provided the incentive for many of our members to innovate in that space. It's a big focus of our April conference.

So, how do you expect ACOs to respond to this one?

Abe Sutton: I'm glad you highlighted the role of ACOs in broadly thinking through, due to the total cost of care accountability, how to push forward innovation. And that theory of ACOs makes a ton of sense, and is one of the reasons why we made some changes in the design of LEAD to enable this in a broader basis.

We intentionally cabined access in some ways. There is not total cost of care accountability for technology companies coming in as participants. That is reserved for the local care delivery systems, for healthcare systems, and for, independent physicians who have banded together via ACOs, and we say, take on that accountability in the total cost of care arrangement, and do the interventions you think are right.

Augment your workforce, so that one physician can help somebody navigate a condition without them needing to come in multiple times. Do not worry about the fee-for-service billing here, because you are set up with a stable benchmark.

That we will not rebase for a decade. Look at the structure that's been set up here, and see that some of the things that may have disincentivized taking those steps under prior ACO models

LEAD has incorporated to make it workable to take costs out of your structure. Whether that's some of the tools in administrative benchmarking that have been laid out, some of the add-ons that occur where we say.

That we're putting some plus-ups to account for prior savings that you've taken out of the structure. This works for high-cost historic groups, as well as people with experience and risk now. And so, the healthcare system, a hospital or a physician group, is actually empowered to do a lot more than what access enables folks to do.

I do, to your question, though, see ACCESS is a very helpful complement for health systems that are looking to do this, and want to engage Access participants. For the first year and a half of Access, the cost of the payments to the ACCESS participant does not count against the benchmark spent.

Starting January 1st of 2028, under a lead, that will change. And we will count the payments to the participants against benchmark spend. So at that point, you want to have figured out which of these participants is a helpful tool in helping somebody manage costs, and I want to ensure that I have a strategy to ensure my patients are engaging with that one as opposed to the other. We will make this easier by taking information on the outcomes achieved by the different participants and posting it on our website as CMS to ensure that you have that information.

But I've heard some pretty innovative strategies from different ACOs.

Where they're setting up a pilot approach, where they're taking 5 different sites and pushing 5 different types of access participantsto those patients that are engaging in those sites in this trial period, in essence, and they're going to figure out which one works best for their providers, which one is one that seems to be driving the outcomes they're looking for in their patients, and then they'll make that their preferred solution

For the, you know, early cardio-kidney metabolic health track.

And so, that's really how I envision this playing out, but I do think that the core question of, like, the lead entity can actually do a lot more is a true one, and that is by design, because we don't want the technology company to come in and take on total cost of care. That's reserved for the local physicians, in the existing care delivery structure.

Emily Brower: Yeah, and I think even more so, you know. so much of what an ACO does is to reduce fragmentation of care. Like, all day, every day, right? We call it lots of things. We call it care coordination, we call it population health, we call it managing total cost of care, but on sort of the day-to-day frontline work is really to reduce fragmentation of care. And, so, you know, access and the introduction of the market in some way in. Direct outreach to patients, and certainly you've heard this from us before. There is a concern about re-fragmentation of care, and so you know, one response, as you mentioned, is to try and get out in front of it and establish those relationships. Another is, can an, you know, sort of an ACO then create an entity that can be the access provider, where they've already put in some of these tools and technology, so Iâ€¦ so folks are certainly looking at all those options, but it's less about managing the cost, specifically given the price point and the timing of that, and it's really more. Sort of, trying to make sure that we're not re-fragmenting care that ACOs have worked so hard to knit together for people.

Abe Sutton: Yeah, and there's been a lot of effort to make sure this is complementary and really moves forward that goal of, in fact, having more coordination. So I mentioned the data sharing element, Emily, which was important for us to build in. The other aspect is that we want to ensure that the patient is empowered, and this is something that the patient chooses. If the patient doesn't choose this, this doesn't show up. as a part of their experience in engaging with the care system. But if they're looking for something like this and not getting it today. opening up this really new benefit in some ways to people enrolled in Medicare was important to us, given what we're seeing of people who, can afford to really choosing to pay for this.
We wanted to see, if paid in a deflationary manner, if we could do a test to show that giving more coordination and more support and helping people manage their condition in the time between visits is something that would drive savings for the system.

Emily Brower: Sure, understood. You mentioned LEAD, so, and that, is the model, that, has the most, interest and excitement from our members right now, and, so let's, let's spend, some time on, on that one. So, You, just to tie back to, sort of, the vision and purpose of the Innovation Center and the evolution of models.

I just want to connect that to your own experience, both at the Innovation Center during the time of the development of REACH and the kidney care models, which you have obviously had a direct impact on, but also in the intervening time operating within a REACH ACO.

So, what's when you think about that, both the design of prior models and the operations of the most recent, ACO model within the Innovation Center, ACO REACH, what are you trying to address with LEAD? Like, what are the key things? You mentioned the benchmark, right? So that long-term, more sustainable benchmark, which people certainly appreciate, you know, still working through the details of that, but, appreciate that, sustainability piece.

So talk about some of the You, you know, speak to that, but also some of the other components that you really see. both having been involved in REACH and also having operated a REACH that you think is really a game changer for folks.

Abe Sutton: REACH and its predecessor, direct contracting, I think were an important evolution for the original Medicare program.

Not because ACOs were new. They weren't. They had been introduced. We have the shared savings program. It delivers an incredible amount of value for the participating physicians and the patients who benefited from the increased coordinated care that the SSP program offers.

What direct contracting and REACH introduced was a global total cost of care option where you could really capture savings to have the full incentive with the discount applied to the benchmark, which is structurally different than even what the enhanced track of SSP offers.

I thought it was really important, at its core, that we preserve that option, that we have something that gets at that.

I also thought that the innovations in terms of cash flow for participants to fund upfront investments in the workforce, in having a dietitian on site, in having a care coordinator that you can afford to pay for to close those care gaps, were important as well.

I thought the flexibility to engage patients and offer different beneficiary enhancements mattered, and the safe harbors from Stark and anti-kickback really were transformative for how we as an ACO, when I was outside, and I'm sure for your members as ACOs today, as hospital-led, physician-led, are able to engage with their, patients and support them.

]t its core, that's what matters, and LEAD preserves all of that.

We did try and close some gaps when it comes to things like benchmark arbitrage, which there was a degree of, to be fully transparent, but what we see, if we look at the data between the Shared Savings Program and what REACH offered. And so, LEAD is going to change that dynamic to some extent.

We also did not offer the same ways to win, in terms of how, benchmarks were, reworked, and how years from savings in the past were blended in, there were some things that were hard.

Put some, limitations on choosing the high needs track or the standard track. And now we've moved beyond that to say, actually, engage with the high needs populations as high needs populations, but also engage with your patients who are healthier than that, to help prevent them from reaching that criteria, don't force a false choice on the participant.

At the same time, we moved away from the combination of TIN and MPI, which is another area where there was arbitrage against us, and moved to a different model where there is not an opportunity. So, I think of what we did as closing some of the things that we saw.

We did an experiment on. It wasn't a good idea because it was hard to operate in the context of a voluntary model. Instead, what we're going to do is see some degree of convergence with SSP to avoid arbitrage on the criteria.

Close some of the other loopholes, and then open up new flexibilities that we are testing here, that I'm pretty excited about when it comes to Part B cost sharing and what you can do there to take those costs out. I think that'll be something particularly impactful for hospital participants in ACOs. When it comes to starting 1129, buying down Part D costs and getting a larger share of savings from us if you take that on.

Which is think that matters to buy down Part D premiums, because it's something that the Medicare Advantage program has done, but in original Medicare, no one's had a reason and path to do. If we share more of savings with an ACO that's doing that in order to finance that, I think ACOs on 1129 in good standing will choose to take this on. And there are a number of other flexibilities that are spelled out in the RFA that I'm sure

Your members are ingesting and thinking through what they want to do with. I do want to highlight one other model that I'm hoping your members are excited about as well, Emily, because I know LEAD is top of mind as the successor to direct contracting and REACH, but our newest ACO model, is the Aspire model.

And that's a Medicaid-focused model, focused on the pediatric population with high and rising risk. We are seeking 5 states to partner with us within Aspire to set up

ACOs for this population. It can be done through an ACO, it could also be done through an MCO if the state wants to work that way for the approach, we are open to that. But taking this same coordinate approach, to pull out the fragmentation that you called out that we've seen in Medicare.

Our aim is to do that in Medicaid for these families that are having to navigate between the behavioral health specialists that they see, and the physician that they see for primary care, and maybe a physician they see for a chronic condition a child has.

Plus the person from the school or the camp who's coordinating their health when they're there, and holding that all together, and getting into speech therapy. There is a mess that you have to navigate as a family.

On Medicaid with a child with high and rising risk. And helping address and manage these complex conditions, or a place where care navigators, care coordinators, whatever term the particular ACO or MCO puts in it, can make a world of difference for those families and change the life outcomes for these children. And so I'm excited about our newest ACO model as well, and I hope that people with experience taking on the management of a Medicare population through this structure, consider engaging with states to encourage participation, and also participating themselves as ACOs in this Medicaid space as Aspire launches.

Emily Brower: Right, that, certainly we have a lot of interest in that. As you mentioned, you know, our members have been engaging in Medicare models, but, you know, many of the primary care, the sort of center of a lot of this transformation, is family practice, and so the ability to move beyondâ€¦ many of our members are engaging locally with their state or their local MCO, and sort of taking the lessons learned in Medicare and saying, different population, you know, different problems to solve, but at the core, that same approach about reducing care fragmentation, managing total cost of care, being able to pull different levers inside a different payment model, is, you know, is very interesting, and people are digging into that and, thinking about how to prepare for that. We've, I think, pretty we've covered a lot, not everything, but we've covered a lot, and, certainly, I don't expect anything to slow down, Abe, based on what we've seen. There's a ton out there, and I'm sure, the, the work will continue apace, and we certainly appreciate all the engagement from your teams. Let's do, like, a little bit of a fun, quick lightning round.

If you will, as we as we finish up. So, so quick responses here. What's one misconception about CMMI that you'd like to correct?

Abe Sutton: I think people don't understand that we are sometimes looking at big transformative things as opposed to a small thing. People think, oh, the small thing might be easier for you to get behind, but if it's

not fixing a big enough problem, it's hard for us to dedicate staff time to it, and so, we're less likely to engage. Whereas if you pitch what you're coming to us with as this changes the system fundamentally, it's easier for us to see and get behind the idea.

Emily Brower: That's great, and we certainly hear that, both from you and your, colleagues at the Center for Medicare. So, you want the big ideas, and, and, we're definitely, we and our members are here for that.

What is the biggest barrier to scaling, right? Theseâ€¦ you're looking for big ideas, big change, that involves scale.

Abe Sutton: it's hard to maintain the discipline necessary in designing a model, to ensure something will be certifiable and scalable. And so Whether that's through adoption of mandatory models, which are a valuable tool in order to move forward our mission and ensure participation, or through itsâ€¦ the design in a voluntary model of a structure that is disciplined enough on margin while attracting participants, we have to stay grounded in that and keep in mind the criteria for certification.

Emily Brower: So, what if you could be free from thatâ€¦ grounding is helpful, but, right, you also, I know, look for ways to, toâ€¦ to really think about those broader transformation. Whatâ€¦ what's one policy lever you wish you had?

Abe Sutton: It would be incredibly exciting to get at some of the core problems that I think we run into as a country, that just cannot fit within the savings mandate that we have.

Because it would cost money to do, but I think it's, like, a really reasonable ROI to make in terms of the quality improvement, but I don't have the authority. And if Iâ€¦ I know this is a lightning round, but if I could sneak on one more thing that I wish we had, is we're limited to Medicare and Medicaid. There's a massive affordability, challenge that confronts the employer market. I wish we had a more direct way to engage and confront that.

And help make sure that premiums plus the pre-deductible amounts don't continue to rise year after year and burden American families.

Emily Brower: Yeah, boy, amen to that. So, now we've gone broad, we've gone narrow, we've talked about new models. If we were to zoom forward for 3 years, we're here in these squares 3 years from now, what do you hope we're talking about?

Abe Sutton: So I think 3 years from now, we're beyond this term, if I'm doing the math correctly. So I'm not out. We're doing a post-mortem.

I hope that we're looking at, one, continuity, where models that have worked are continuing to function and have the impact in the system. I hope we've seen that we have made care more affordable, and that the conversation has shifted, somewhat, to focus on, alright, now let's just really improve quality in all aspects and focus on that, because affordability is there. There are different offerings that people are getting, getting access to. The physician shortage that we are confronting as a country has been mitigated. These PAs and MPs using these different tools are entrusted to do more, and we are now looking at, alright, let's optimize and improve quality within that contract.

Emily Brower: All right, I'm down for, that conversation. Let's, schedule that.

So thanks again, Abe, for, joining me and, speaking to, our members through this, recorded forum. Really appreciate that, and all the, theâ€¦ how accessible, you and your team are, and all the work that you're doing, partnering with us to make accountable care and value-based payment models, more available to providers, to patients, so that we can improve care for the people and the communities that we all serve. So, really appreciate your leadership and your collaboration and your clear commitment to those goals.

Abe Sutton: I am so grateful for the invitation to join you, Emily, and truly, I am grateful for the work that your members do. Investing in primary care and supporting primary care physicians and hospitals in their work so that they can serve the communities that they are a part of is incredibly important for us as a country, and so I'm grateful to the people who are doing that work. interacting with patients every day, and looking to improve the standard of care that they can offer to their patients. So your members are those who have stepped forward to say, I want to do this the right way, I want to deliver care, not off of a fee schedule, but based off what I know is right and will be best for those patients, and I'm just so grateful to your members, and so thankful for the opportunity to join you in this conversation with them.

Emily Brower: Well, thanks, Abe. Until next time, we will, say goodbye and, have a great day.