Patients Over Paperwork

We are working with the private sector towards patient-centered care and market-driven reform that:
- empowers beneficiaries as consumers
- provides price transparency
- increases choices and competition to drive quality and improves outcomes.

CMS support of health care will result in patient-centered, market-driven reforms that drive quality and improve outcomes.

Key characteristics
- Producer-centered
- Incentives for volume
- Unsustainable
- Fragmented Care

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Market-driven
- Coordinated care
### CMS has adopted a framework that categorizes payments to providers

<table>
<thead>
<tr>
<th>Category 1: Fee-for-Service – No Link to Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on the volume of services and not linked to quality or efficiency</td>
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<table>
<thead>
<tr>
<th>Medicare Fee-for-Service examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital volume based on a hospital's utilization of services.</td>
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</table>
| Accountable Care Organizations and other models linked to reducing costs.

<table>
<thead>
<tr>
<th>Category 2: Fee-for-Service – Link to Quality</th>
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<tbody>
<tr>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
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<thead>
<tr>
<th>Alternative Payment Models Built on Fee-for-Service Architecture</th>
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</thead>
<tbody>
<tr>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
</tr>
<tr>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
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</tbody>
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<thead>
<tr>
<th>Category 4: Population-Based Payment</th>
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</thead>
<tbody>
<tr>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
</tr>
<tr>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
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<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Limited in Medicare fee-for-service.</td>
</tr>
<tr>
<td>Majority of Medicare payments are linked to quality.</td>
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</table>

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<tr>
<th>Medicare Fee-for-Service examples</th>
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<tr>
<td>Hospital value-based payment models.</td>
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<tr>
<td>Accountable Care Organizations.</td>
</tr>
<tr>
<td>Bundled payments.</td>
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<tr>
<td>Comprehensive Primary Care Initiative.</td>
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<tr>
<td>Comprehensive ESRD.</td>
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<tr>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model.</td>
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### Overview

**CMS Innovation Center**

The CMS Innovation Center Statute

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care furnished to individuals under such titles"

Three scenarios for success from Statute:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.
The Innovation Center portfolio aligns with broader CMS goals

Pay Providers
- Medicare Shared Savings Program (Innovations Center)
- Pioneer ACO Model
- Comprehensive Primary Care Initiative (CPCI) & CPCI-SI
- Bundled Payment for Care Improvement (BPCI) Programs
- Shared Savings Initiative for Medicare Beneficiaries (SSI-MB) Program
- Federal Community Health Care Integration Project

Deliver Care
- Multiple Innovation Models
- Community Health Improvement Initiative
- Primary Care Transformation
- Accountable Care Organizations (ACO) Models
- Comprehensive Primary Care for Duals
- Accountable Health Communities

Institute Information
- Medicaid Improvement Initiative
- Million Hearts Community-Affordable Risk Reduction Model

> 18 million

> 207,000

Innovation Center programs
- CMS Innovation Center models impact over 18M beneficiaries in all 50 states
- Over 200,000 health care providers and provider groups across the nation are participating in CMS Innovation Center programs
Overview

What Prevention and Population Health Approaches is CMS taking to tackle diabetes?

Health Care Innovation Awards: delivery system innovations

<table>
<thead>
<tr>
<th>Focus</th>
<th>Round 1</th>
<th>Round 2</th>
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<tbody>
<tr>
<td>Broad range of delivery system innovations</td>
<td>107</td>
<td>39</td>
</tr>
<tr>
<td>Four themes to drive innovations</td>
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</tbody>
</table>

The projects from HCIA Awards are:
- generating ideas for additional tests,
- providing promising ideas that are also being integrated into future models, and
- projects are spurring ideas to be adopted by the private sector.

Results and Metrics

- Approximately 760,000 Medicare, Medicaid, and CHIP beneficiaries served in Round One
- Projects funded in all 50 states, the District of Columbia and Puerto Rico

* Darker colors on map represent more HCIA projects in that state
Spotlight: Health Care Innovation Awards, Foundation for California Community Colleges

The Foundation for California Community Colleges (FCCC) is a Round One Health Care Innovation Awards serving high risk/high cost Medicaid and Medicaid-eligible individuals with chronic conditions released from prison.

Services made possible by HCIA investment:

- Comprehensive health care system navigation
  - Project worked with the Department of Corrections to identify patients with chronic medical conditions prior to release, and used Community Health Workers (CHWs) trained by FCCC to help these individuals navigate the healthcare system, first primary care and other medical and social services, and coach them in chronic disease management.

- Successful Community Health Workers
  - CHA funding sparked continued efforts to finance CHW positions and CHW web-based curriculum for CHW certification and continuing education.
  - Project successfully worked with Johns Hopkins to develop a CHW training guide (available for public download) and a CHW focused online textbook.

Medicare Diabetes Prevention Program (DPP) Expanded Model

DPP is a structured behavioral intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of pre-diabetes.

Timeline:
2012 – CMS Innovation Center awarded Health Care Innovation Award to The Young Men’s Christian Association of the USA (YMCA) to test the DPP in >7,000 Medicare beneficiaries with pre-diabetes across 17 sites nationwide.
2016 – DPP announced as the first ever prevention model to meet statutory criteria for expansion. The Secretary determined that DPP:
  - Improves quality of care for beneficiaries lost about five percent body weight
  - Certified by the Office of the Actuary as cost-saving, projected net savings of $186 Million to the Medicare Program over a 10 year period
  - Does not alter the coverage or provision of benefits

2016 –2017 – National expansion established through rulemaking, with policies to create a new supplier class finalized in CY 2017 PFS Final Rule and additional policies related to performance-based payment proposed in CY 2018 PFS Proposed Rule.
April 2018 – National availability of MDPP set of services to Medicare beneficiaries.

Million Hearts® Cardiovascular Disease Risk Reduction Model will reward population-level risk management

Heart attacks and strokes are a leading cause of death and disability in the United States. Prevention of cardiovascular disease can significantly reduce both CVD-related and all-cause mortality.

- Participant organizations
  - 516 awardees (256 Control Group and 260 Intervention Group) from 47 states, the District of Columbia and Puerto Rico.
  - 19,000+ practitioners serving over 3.3 million Medicare beneficiaries.
  - Private practices, community health centers, hospital-owned practices, hospital/physician organizations.

- Participant responsibilities
  - Systematic beneficiary risk calculation* and stratification
  - Shared decision making and evidence-based risk modification
  - Population health management strategies
  - Reporting of risk score through certified data registry.

Payment Model
- Pay-for-outcomes approach
- Disease risk assessment payment
  - One time payment ($10 per beneficiary) to risk stratify eligible beneficiary
- Care management payment
  - Monthly payment to support management, monitoring, and care of beneficiaries identified as high-risk
  - Amount varies based upon population-level risk reduction.

* Uses American College of Cardiology/American Heart Association (ACC/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator.
Comprehensive Primary Care initiative: 2012-2016

Four-year multi-payer model designed to strengthen primary care

BACKGROUND

- 474 practices in 7 regions supported by 38 public and private payers
- Practices enhanced care delivery by providing care management, coordinated care, and engaging patients
- Diversified support: PBPM care management fees, shared savings opportunity, learning and data feedback

KEY FINDINGS

- Reductions in Part A and B expenditures, driven by reduced hospital inpatient and SNF spending
- Favorable effects on patient experience and provider satisfaction
- Practices underwent significant transformation in the delivery of primary care

Comprehensive Primary Care Plus (CPC+)

CMS’s largest-ever initiative to transform how primary care is delivered and paid for in America

GOALS

2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality, access, and efficiency of care.

PARTICIPANTS AND PARTNERS

- Advanced primary care practices in two rounds:
  - Round 1: 2,893 practices in 14 regions
  - Round 2: Up to 1,000 practices in 4 regions
- Two tracks to accommodate diversity of practices
  - 62 public and private payers in CPC+ regions
  - Health IT vendors partner with CMS and Track 2 practices
- 5 year model: 2017-2021, 2018-2022

FUNCTIONS

- Access and continuity
- Care management
- Comprehensive care and coordination
- Patient and caregiver engagement
- Planned care and population health

PAYMENT REDESIGN COMPONENTS

- PBPM risk-adjusted care management fees
- Performance-based incentive payments for quality, experience, and utilization measures that drive total cost of care
- For Track 2, hybrid of reduced fee-for-service payments and up front “Comprehensive Primary Care Payment” to offer flexibility in delivering care outside traditional office visits

Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- 561 ACOs (of which 120 are risk-bearing) have been established in the MSIP, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes 81 more ACOs in 2017 than in 2016, covering 12.3 million assigned beneficiaries.
- These ACOs together cover 12.3 million assigned beneficiaries.

* As of June 30, 2017
** Source: CMS
Spotlight: Pioneer ACO Model, Monarch HealthCare

Monarch is Orange County, California’s largest association of private physicians with approximately 20,000 beneficiaries.

Disease Management Program
- Developed COPD, heart failure, diabetes, chronic kidney disease and chronic pain programs for beneficiaries at all levels of acuity
- Educated beneficiaries and caregivers about warning signs and needed action to prevent hospital admissions

Outcomes Success
- Improved outcomes and experiences for beneficiaries, earned impressive quality score of 85.70 out of 100 in 2014
- Generated 3.96% in gross savings in 2014 and is one of the highest financial performers among Pioneer ACOs

Accountable Health Communities Model addresses health-related social needs

Key Innovations
- Systematic screening of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Tests the effectiveness of referrals and community services navigation on total cost of care using a rigorous mixed method evaluative approach
- Partner alignment at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs

Model Tracks
- Assistance Track
  - Bridge Organizations in this track provide community service navigation services to assist high-risk beneficiaries with accessing services to address health-related social needs
- Alignment Track
  - Bridge Organizations in this track encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries

Innovation Center – 2018 Looking Forward

We are focused on:
- Implementation of Models
- Monitoring & Optimization of Results
- Evaluation and Scaling
- Integrating Innovation across CMS
- Portfolio analysis and launch new models to round out portfolio
Questions?

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