CMS Innovation

Approach to Diabetes: Perspectives from CMS

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Agenda

- What is CMS
- The CMS Innovation Center
- Importance of diabetes to CMS
- Prevention and Population Health Approaches to tackle Diabetes

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Centers for Medicare & Medicaid Services

- FY 2020 Requested budget of approx. $826 million
- Medicare
  - People age 65 or older, under age 65 with certain disabilities, all ages with End-Stage Renal Disease
  - AKA “Original Medicare”
  - About $38.7 million[1]
- Medicare Advantage
  - Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare. Medicare pays these companies to cover Medicare benefits.
  - If you join a Medicare Advantage Plan, the plan will provide all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage
  - Almost $20 million[1]

1 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2017/Downloads/MDCR_ENROLL_AB/2017_CPS_MDCR_ENROLL_AB_1.pdf

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Centers for Medicare & Medicaid Services

- Medicaid
  - In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In some states the program covers all low-income adults below a certain income level.
  - Approx. 36 million[2]
- Children's Health Insurance Program (CHIP)
  - A State-Federal program offering free or low-cost health coverage for eligible children and other family members
  - 9.6 million[2]
- Federal Health Insurance Exchange
  - The ACE created a competitive private health insurance market, providing Americans and small businesses with "one-stop shopping" for affordable coverage
  - At the close of 2019 open enrollment period, 8.4 million[3]

2 Data Source: Statistical Enrollment Data System (SEDS) Combined CHIP Enrollment Total Report and Form CMS-64.EC (As of 5/1/2019)
3 https://www.cms.gov/newsroom/press-releases/cms-releases-final-snapshot-2019-federal-exchange-open-enrollment-period

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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.*

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

Evolving future state

Public and Private sectors

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

Key characteristics
- Patient-centered
- Incentives for outcomes
- Sustainable
- Market-driven
- Coordinated care

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CMS has adopted a framework that categorizes payments to providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals

Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

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Overview

CMS Innovation Center

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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

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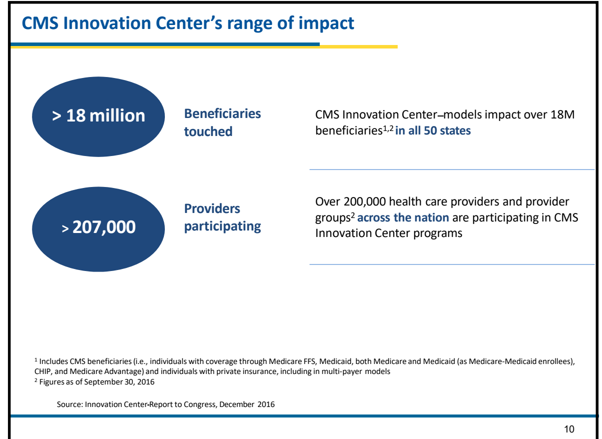

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Innovation Center all-inclusive portfolio

- ACO Investment Model
- Accountable Health Communities Model
- Advance Payment ACO Model
- Advanced Primary Care Initiatives
- Bundled Payments for Care Improvement Models 1-4
- Bundled Payments for Care Improvement (BPCI) Advanced
- Cardiac Rehabilitation (CR) Incentive Payment Model
- Community-based Care Transitions Program
- Comprehensive Care for Joint Replacement Model
- Comprehensive ESRD Care Model
- Comprehensive Primary Care Initiative
- Comprehensive Primary Care Plus + Round 2
- Emergency Triage, Treat, and Transport (ET3) Model
- Financial Alignment Initiative for Medicare-Medicaid Enrollees
- FQHC Advanced Primary Care Practice Demonstration
- Frontier Community Health Integration Project Demonstration
- Graduate Nurse Education Demonstration
- Health Care Innovation Awards: Round 1, Round 2
- Health Plan Innovation Initiatives
- Home Health Value-Based Purchasing Model
- Independence at Home Demonstration
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase Two
- Innovation Advisors Program
- Integrated Care for Kids (InCK) Model
- Maryland All-Payer Model
- Maryland Total Cost of Care Model
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for the Prevention of Chronic Diseases Model
- Medicaid Innovation Accelerator Program
- Medicare Acute Care Episode (ACE) Demonstration
- Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
- Medicare Advantage Value-Based Insurance Design Model
- Medicare Care Choices Model
- Medicare Coordinated Care Demonstration
- Medicare Diabetes Prevention Program Expanded Model
- Medicare Health Care Quality Demonstration
- Medicare Hospital Gainsharing Demonstration
- Medicare Imaging Demonstration
- Medicare Intravenous Immune Globulin (IVIG) Demonstration
- Million Hearts
- Million Hearts: Cardiovascular Disease Risk Reduction Model
- Multi-Payer Advanced Primary Care Practice
- Next Generation ACO Model
- Nursing Home Value-Based Purchasing Demonstration
- Oncology Care Model
- Part D Enhanced Medication Therapy Management Model
- Partnership for Patients
- Pennsylvania Rural Health Model
- Physician Group Practice Transition Demonstration
- Physician Hospital Collaboration Demonstration
- Pioneer ACO Model
- Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE)
- Regional Budget Payment Concept
- Rural Community Hospital Demonstration
- Specialty Practitioner Payment Model Opportunities
- State Innovation Models Initiatives
- Strong Start for Mothers and Newborns Initiatives
- Transforming Clinical Practice Initiative
- Vermont All-Payer Model

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The Innovation Center portfolio aligns with broader CMS goals

Pay Providers

Test alternative payment models

- **Accountable Care**
  - ACO Investment Model
  - Pioneer ACO Model
  - Medicare Shared Savings Program (housed in Center for Medicare)
  - Comprehensive ESRD Care Initiative
  - Next Generation ACO
- **Primary Care Transformation**
  - Comprehensive Primary Care Initiative (CPC) & CPC+
  - Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
  - Independence at Home Demonstration
  - Graduate Nurse Education Demonstration
  - Home Health Value Based Purchasing
  - Medicare Care Choices
  - Frontier Community Health Integration Project
  - Medicare Diabetes Prevention Program Expanded Model
- **Bundled payment models**
  - Bundled Payment for Care Improvement Models 1-4
  - BPCI Advanced
  - Oncology Care Model
  - Comprehensive Care for Joint Replacement
- **Initiatives Focused on the Medicaid Population**
  - Medicaid Incentives for Prevention of Chronic Diseases
  - Strong Start Initiative
  - Medicaid Innovation Accelerator Program
- **Dual Eligible (Medicare-Medicaid Enrollees)**
  - Financial Alignment Initiative
  - Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents
- **Medicare Advantage (Part C) and Part D**
  - Medicare Advantage Value-Based Insurance Design Model
  - Part D Enhanced Medication Therapy Management

Deliver Care

Support providers and states to improve the delivery of care

- **Learning and Diffusion**
  - Partnership for Patients
  - Transforming Clinical Practice
- **Health Care Innovation Awards**
- **Integrated Care for Kids (InCK) Model**
- **Accountable Health Communities**
- **State Innovation Models Initiative**
  - SIM Round 1 & SIM Round 2
  - Maryland All-Payer Model
  - Pennsylvania Rural Health Model
  - Vermont All-Payer ACO Model
- **Million Hearts Cardiovascular Risk Reduction Model**

Distribute Information

Increase information available for effective informed decision-making by consumers and providers

- **Information to providers in CMMI models**
- **Shared decision-making required by many models**

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CMS has engaged the health care delivery system and invested in innovation across the country

Sites where innovation models are being tested
Models run at the state level

Source: CMS Innovation Center website, December 2017

Why is diabetes important to CMS?

- Diabetes affects roughly 1 in 5 Medicare beneficiaries aged 65 years and over[4]
- Beneficiaries with type 1 or type 2 diabetes were two to three times more likely to report fair or poor health than those without diabetes[4]
- Beneficiaries with type 1 or type 2 diabetes averaged more inpatient admissions per 1,000 beneficiaries (443.0 for type 1 and 349.5 for type 2) than those without diabetes (215.3)[4]
- Out of pocket health care costs were higher for beneficiaries with diabetes[4]
  - Including prescription out of pocket costs

4 Jennifer Hasche; Christopher Ward; Nicholas Schluterman. Sept. 2017. Diabetes Occurrence, Costs, and Access to Care among Medicare Beneficiaries Aged 65 Years and Over. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/Diabetes_DataBrief_2017.pdf

Overview

Prevention and Population Health Approaches at the CMS Innovation Center that tackle diabetes

Health Care Innovation Awards: delivery system innovations

	Round 1	Round 2
Projects	107	39
Focus	Broad range of delivery system innovations	Four themes to drive innovations

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

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.**

* Darker colors on map represent more HCIA projects in that state

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Spotlight: Health Care Innovation Awards, Foundation for California Community Colleges

The Foundation for California Community Colleges (FCCC) is a Round One Health Care Innovation Awardee 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, find primary care and other medical and social services**, and **coach them in chronic disease management**
- Successful Community Health Workers
  - HCIA 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 text book**

Success with Community Health Workers
With the help of a CHW, approximately 70% of Transition Clinic Network patients in San Francisco who sought housing in 2013 signed a lease by year's end. Here, A TCN CHW helps a newly housed patient reconcile his medications.

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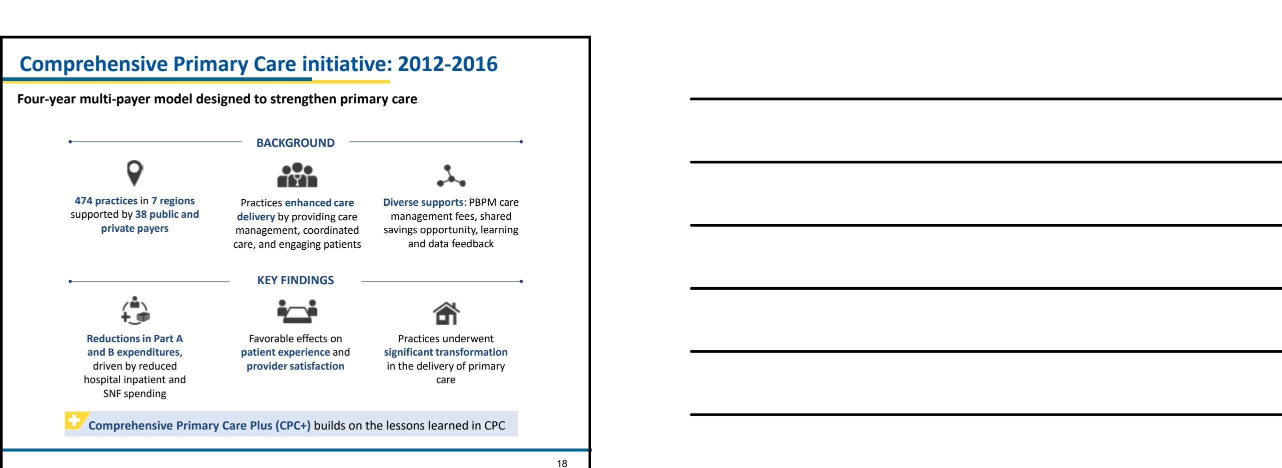

Comprehensive Primary Care initiative: 2012-2016

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
- **Diverse supports**: 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+) builds on the lessons learned in CPC

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Comprehensive Primary Care Plus (CPC+)

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

GOALS

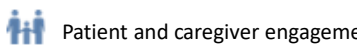
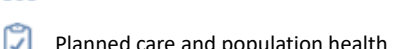
1. Strengthen primary care through multi-payer payment reform and care delivery transformation.
2. Support clinicians to provide comprehensive care that meets the needs of all patients.
3. Improve quality, access, and efficiency of care.

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

CARE TRANSFORMATION FUNCTIONS

- Access and continuity
- Care management
- Comprehensiveness 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

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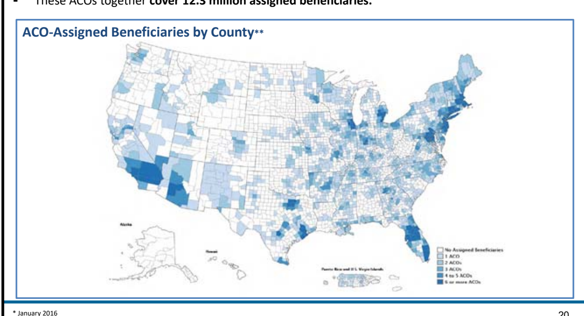
Accountable Care Organizations: Participation in Medicare ACOs growing rapidly

- **561 ACOs (of which 120 are risk-bearing)** have been established in the MSSP, Next Generation ACO and Comprehensive ESRD Care Model programs*
- This includes **85 more ACOS** in 2017 than in 2016. covering **12.3 million assigned beneficiaries.**
- These ACOs together **cover 12.3 million assigned beneficiaries.**

ACO-Assigned Beneficiaries by County**



* January 2016
** Last updated April 2015

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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

Monarch HealthCare ACO

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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

Beneficiary enters Doctor's Office
Beneficiary enters Hospital
Beneficiary enters FQHC
Beneficiary enters Behavioral Health Facility
Bridge Organization
Community Service Provider
Community Service Provider
Community Service Provider
Community Service Provider

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

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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 (ACA/AUA) Atherosclerotic Cardiovascular Disease (ASCVD) 10-year pooled cohort risk calculator

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Medicare Diabetes Prevention Program (DPP) Expanded Model

MDPP 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 ⟹ 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.

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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

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- Questions?
- Contact information:
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