CMS Innovation Center

Update on Seriously Ill Beneficiary Model Portfolio

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview

Innovation Center History & Scope

Our ‘Strategy Refresh’ and New Vision

Seriously Ill Portfolio Example Models

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

CMS Innovation Center all-inclusive portfolio

Accountable Care
- ACO Investment Model
- Comprehensive End Stage Renal Disease (ESRD) Care Model
- Medicare Health Care Quality Demonstration
- Next Generation Accountable Care Organization (ACO) Model
- Vermont All-Payer Accountable Care Organization (ACO) Model
- *Kidney Care Choices Model*

Episode-based Payment Initiatives
- *Bundled Payments for Care Improvement Advanced*
- Bundled Payment for Care Improvement
- Comprehensive Care for Joint Replacement Model
- *End Stage Renal Disease (ESRD) Treatment Choices Model*
- Oncology Care Model
- *Radiation Oncology Model*

Primary Care Transformation
- Comprehensive Primary Care Plus Model
- *Direct Contracting Model Options*
- *Geographic Direct Contracting Model**
- Graduate Nurse Education Demonstration
- Independence at Home Demonstration
- *Primary Care First Model Options*
- Transforming Clinical Practice Initiative

Initiatives Focused on Medicare-Medicaid Enrollees
- Medicaid Innovation Accelerator Program
- Financial Alignment Initiative for Medicare-Medicaid Enrollees
- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, Phase Two
- *Integrated Care for Kids Model*
- *Maternal Opioid Misuse Model*

Initiatives to Speed the Adoption of Best Practices
- Health Care Payment Learning and Action Network
- Medicare Diabetes Prevention Program Expanded Model
- Million Hearts®
- Million Hearts: Cardiovascular Disease Risk Reduction Program
- Partnership for Patients

Initiatives to Accelerate the Development & Testing of Payment and Service Delivery Models
- Accountable Health Communities Model
- *Artificial Intelligence Health Outcomes Challenge*
- *Community Health Access and Rural Transformation Model*
- *Emergency Triage, Treat, and Transport Model*
- Frontier Community Health Integration Project Demonstration
- *Home Health Value-Based Purchasing Proposed Model*
- *International Pricing Index Proposed Model*
- Maryland All-Payer Model
- Maryland Total Cost of Care Model
- *Medicare Advantage Value-Based Insurance Design Model*
- Medicare Care Choices Model
- Medicare Intravenous Immune Globulin Demonstration
- Part D Enhanced Medication Therapy Management Model
- *Part D Payment Modernization Model*
- *Part D Senior Savings Program Model*
- Pennsylvania Rural Health Model
- Rural Community Hospital Demonstration

Blue text: Announced in 2018-2020
*Currently under review

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Vision: What's to Come Over the Next 10 Years

Five Strategic Objectives

Increase the number of people in a care relationship with accountability for quality and total cost of care.

Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Leverage a range of supports that enable integrated, person-centered care such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

Five Strategic Objectives

Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

Align priorities and policies across CMS and aggressively engage payers, purchasers, providers, states and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs.

CMS Innovation Center Strategy – Moving to Implementation

Stakeholder Engagement (last 3-6 months)

- White paper launch (October 2021)
- Listening sessions with beneficiaries, health equity experts, primary care, safety net, specialty providers, states, and payers (2021-22)
- 2021 LAN Summit (December 2021)
- LAN Health Equity Action Taskforce (Ongoing)

Stakeholder Engagement (next 6-24+ months)

- Outreach to communicate and share strategy via conferences, podcasts, and learning events
- Launching a stakeholder engagement strategy across the life cycle of models
- Sharing model test data with external researchers to contribute to learnings
- Leveraging existing and new mechanisms to enhance engagement with patients, providers, and payers and improve transparency in model design/implementation

Model Opportunities that Inform Strategy and Transformation

- Advancing Health Equity: Community Health Access and Rural Transformation Model
- Accountable Care: Initial cohorts for Primary Care First (PCF) and Global/Professional Direct Contracting (GPDC)
- Accountable Care: ESRD Treatment Choices Model
- Addressing Affordability: Part D Senior Savings Model

Examples of Model Opportunities that Advance Strategy and Inform Transformation

- GPDC Second Cohort
- PCF Second Cohort
- Kidney Care Choices model
- Radiation Oncology model

Examples of Efforts to Address Cross-Model Issues

- Health equity data collection
- SDoH screening and referral
- Benchmarking
- Risk adjustment
- Provider performance data platforms

Model Types that Drive Transformation

- ACO model tests that create accountability for total cost of care and outcomes
- Advanced primary care model tests
- Specialty care model tests that supports integrated, whole-person care
- State accountable care model tests
- Model tests that engage safety net providers and others that have not historically participated in models

CMS Innovation Center Strategy Serious illness Focus to Date

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Our Goals

Evaluation and Results

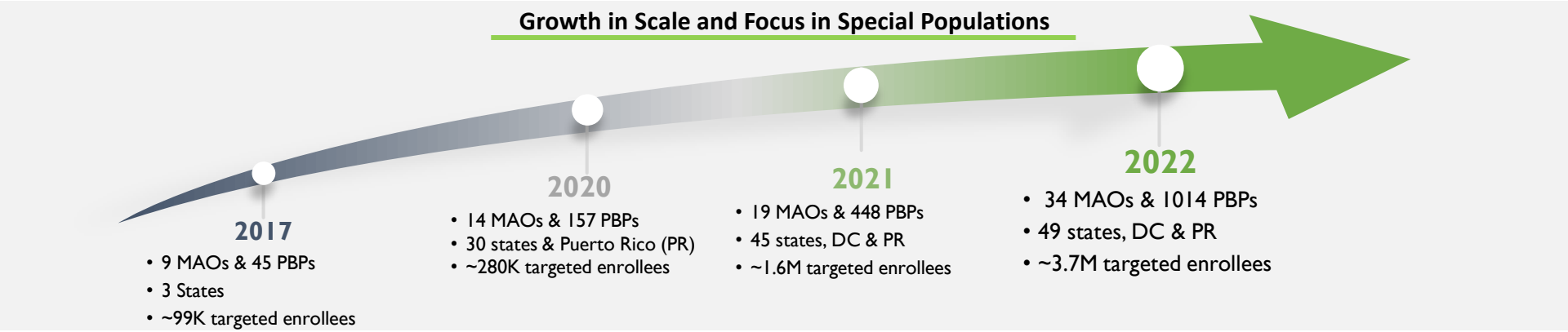
Seriously Ill Portfolio Example Models

Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Tests Additional Flexibilities to Address Needs of Underserved Enrollees

Health Plan Innovation for Low Income Enrollees: Tests a broad array of MA health plan innovations designed to enhance the quality of care for Medicare beneficiaries – including those with low income, such as dually eligible beneficiaries and those qualifying for Low Income Subsidy (LIS) – as well as to reduce costs for enrollees and the overall Medicare program

Social Needs Interventions: Tests offering targeting of additional supplemental benefits, reduced co-payments, and/or rewards and incentives that are anticipated to improve health and health equity by meeting social needs – such as food and transportation – to engage enrollees in improving their care by receiving high-value services or participating in health-related activities, and to reduce financial barriers to access

Hospice Benefit Innovation: Tests the impact on payment and service delivery of incorporating the Medicare Part A hospice benefit, alongside offering of comprehensive palliative care services, transitional concurrent care and hospice supplemental benefits, with the goal of creating a seamless care continuum for enrollees in the MA program for Part A and Part B services



Closer Look: VBID-Hospice Benefit Component

Enables a seamless care continuum that improves quality and timely access to palliative and hospice care in a way that fully respects beneficiaries and caregivers

1. Maintains the full scope of the current Medicare hospice benefit

2. Focuses on improved access to palliative care

3. Enables transitional concurrent care for enrollees

4. Introduces additional hospice-specific supplemental benefits

5. Promotes care transparency and quality through actionable, meaningful measures

6. Maintains broad choice and improves access to hospice

7. Utilizes a budget neutral payment approach to facilitate all of the above aims

Primary Care First

Foster Independence, Reward Outcomes

Primary Care First (PCF) includes payment model options for practices ready to accept increased financial risk in exchange for flexibility and potential rewards based on performance, including support for practices serving high-needs populations. PCF began implementation on January 1, 2021.

Practice Risk Groups 1-2* (HCC < 1.2)	Practice Risk Groups 3-4* (HCC >1.2)

Goals:

1. **Reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. **Improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

Primary Care First

Function	PCF Care Requirement (Groups 1 & 2)	PCF Care Requirement (Groups 3 & 4)
Access and Continuity	• Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR.	• Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. • Ensure timely callbacks for high-risk patients with complex care needs.
Care Management	• Provide risk-stratified care management for all empaneled patients • Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations, as clinically indicated.	• Provide risk-stratified care management for all empaneled patients. • Ensure all patients receive timely follow-up contact from your practice after ED visits and hospitalizations, as clinically indicated. • Collaborate with all high-risk patients to develop and maintain documented personalized care plans addressing their goals, preferences, and values.
Coordination and Comprehensiveness	• Integrate behavioral health into primary care services. • Assess and support patients' psychosocial needs.	• Integrate behavioral health into primary care services. • Assess and support patients' psychosocial needs. • Ensure coordinated referral management through formal relationships and/or agreements with specialty groups and other care organizations for your high-risk patient population.
Patient and Caregiver Engagement	• Must implement a regular process for patients and caregivers to advise practice improvement	• Must implement a regular process for patients and caregivers to advise practice improvement. • Must engage families and caregivers in patient care for all beneficiaries.
Planned Care and Population Health	• Set goals and continuously improve upon key outcome measures.	• Set goals and continuously improve upon key outcome measures.

Groups 3/4 not Groups 1/2

Comprehensive ESRD Care (CEC) and Kidney Care Choices (KCC) improve coordination of care for ESRD beneficiaries

CEC sought to incentivize partnerships with palliative care organizations but did not impact hospice use[1]

- CEC Model launched in 2015 and is in its final year, with 33 ESCOs, including 29 LDOs and 4 non-LDOs, serving 65,000 beneficiaries nationwide
- Initial focus of several ESCO's was to focus on hospice referrals and establish palliative care resources

"When we asked [care coordinators] who was comfortable having conversations [regarding end-of-life care], about a third of them said they were comfortable, but when we asked how many of them could think of a patient in their dialysis clinic who would benefit from having this conversation; everyone raised their hand - so we know there's a need [for more training]."

– ESCO Site Visit Participant

KCC resolved this with conditional waiver of Medicare hospice benefit requirement to give up 'conventional care'

- Began Jan 1st 2022, including 9/65 participants in California

10%

of ACO's nationally considered palliative care their top priority in 2019[2]

All results displayed focus on seriously ill beneficiaries

[1]Comprehensive End-Stage Renal Disease Care (CEC) Model 5th Annual Evaluation Report. Lewin Group, Jan 2022

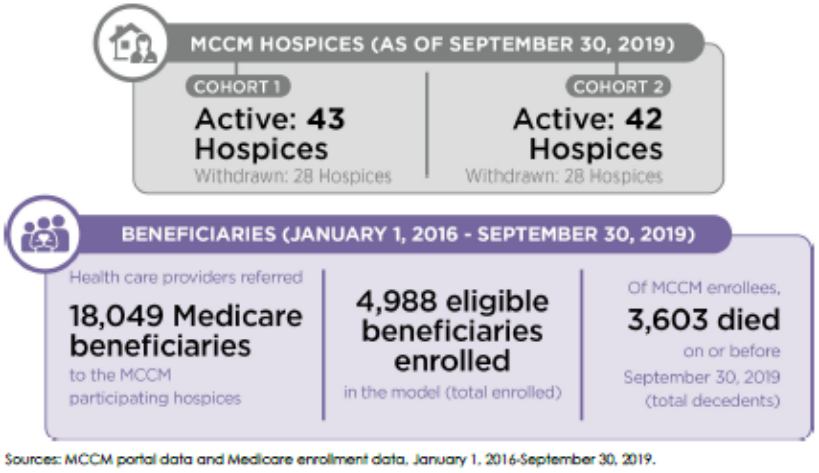
[2] "How Are ACOs Prioritizing Palliative Care And Other Serious Illness Strategies?", Health Affairs Blog, January 7, 2020.

Medicare Care Choices Model (MCCM) provides options for hospice eligible beneficiaries

MCCM allowed Medicare beneficiaries who qualify for hospice to receive **supportive care services while receiving care for their terminal condition.**

MCCM was designed to:

- **Increase access to supportive care** services provided by hospice;
- **Improve quality of life** and patient/family satisfaction;
- Inform new payment systems for the Medicare and Medicaid programs.



Sources: MCCM portal data and Medicare enrollment data, January 1, 2016-September 30, 2019.

- Hospices are paid **$200** if the beneficiary is enrolled into the Model for less than **15** days of service & **$400** if 15 or more days during the calendar month
- 6 year model, phased in over 2 years with **80+ participating hospices** randomly assigned to phase 1 or 2

Questions and Answers