

CMMI Update



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CMS Innovation Center's range of impact

> 26 million

**Beneficiaries
touched**

CMS Innovation Center-models impact over 26M beneficiaries^{1,2} **in all 50 states**

> 967,000

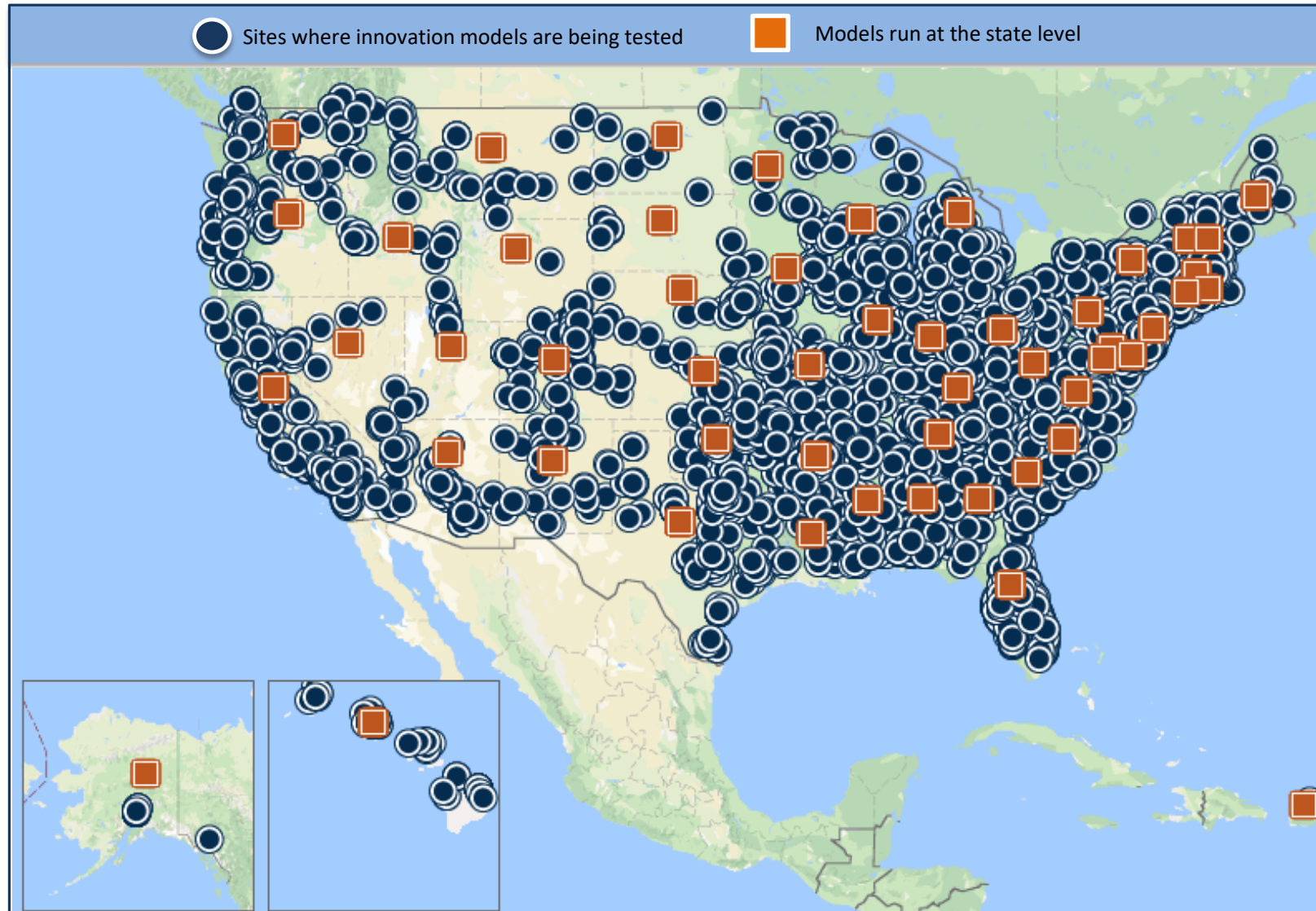
**Providers
participating**

Over 967,000 health care providers and provider groups² **across the nation** are participating in CMS Innovation Center programs

¹ Includes CMS beneficiaries (i.e., individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage) and individuals with private insurance, including in multi-payer models

² Figures as of December 2018

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



Value Considerations for Model Development and Testing

Focus Areas



Patients as Consumers



Payment for Outcomes



Providers as Navigators



Prevention of Disease

Priority will be given to proposed models that meet the following criteria:

QUALITY

- ✓ Reduce avoidable events by at least 10 and/or mortality by at least 2%

COST

- ✓ Reduce expenditures by \$10 billion/year upon expanding nationally

BENEFICIARY CHOICE

- ✓ Empower beneficiaries by increasing choice and access



CMS Innovation Center all-inclusive portfolio

Accountable Care

- ACO investment Model
- Comprehensive ESRD Care Model
- Medicare Health Care Quality Demonstration
- Next Generation ACO Model
- Vermont All-Payer ACO Model
- *Voluntary Kidney Model*

Episode-based Payment Initiatives

- *BPCI Advanced*
- BPCI Models 2-4
- Comprehensive Care for Joint Replacement Model
- *ESRD Treatment Choices Model Proposed*
- Oncology Care Model
- *Radiation Oncology Model Proposed*

Primary Care Transformation

- Comprehensive Primary Care Plus
- *Direct Contracting Model (3 voluntary model options)*
- Graduate Nurse Education Demonstration
- Independence at Home Demonstration
- *Primary Care First*
- Transforming Clinical Practice Initiative

Initiatives Focused on the 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 Accelerate the Development & Testing of Payment and Service Delivery Models

- Accountable Health Communities Model
- *Artificial Intelligence Health Outcomes Challenge*
- *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*
- Pennsylvania Rural Health Model
- Rural Community Hospital Demonstration

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

Blue text - Announced in 2018-2019

Bundled Payment for Care Improvement Advanced (BPCI Advanced)

BPCI Advanced is a voluntary bundled payment model that qualifies as an [Advanced Alternative Payment Model \(Advanced APM\)](#) with payment tied to performance on quality measures.

- Runs **October 1, 2018** through **December 31, 2023**
- Single payment and risk track, with a 90-day episode period
 - 29 Inpatient Clinical Episodes
 - 3 Outpatient Clinical Episodes
 - Preliminary Target Prices provided prior to the start of the Performance Period

Who can participate?

- **Convener Participants** (Medicare enrolled or non-Medicare enrolled providers)
- **Non-Convener Participants** (Medicare enrolled providers only)

Who are the Episode Initiators?

- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)

Comprehensive Care for Joint Replacement (CJR) Model

The CJR model started on **April 1, 2016** and is currently in its second performance year. It is scheduled to run for 5 years in total; ending December 2020.

CJR is an [episode-based payment model for lower extremity joint replacement \(LEJR\)](#) procedures for Medicare fee-for-service beneficiaries. CJR episodes include:

- Hospitalization for LEJR procedure assigned MS-DRG 469 or 470 and 90 days post-discharge.
- All Part A and Part B services, with the exception of certain excluded services that are clinically unrelated to the episode.


CJR model was implemented in **67** metropolitan statistical areas (MSAs)

- All participant hospitals in these selected MSAs are acute care hospitals paid under the IPPS & not currently participating in Model 1 or Models 2 or 4 of the Bundled Payments for Care Improvement (BPCI) initiative for LEJR episodes
- Initial Evaluation Results for PY 1 are anticipated to be available in the fall of 2018.

Oncology Care Model: emphasis on specialty care

1.6 million people annually diagnosed with cancer; a significant proportion are over 65 years

- Major opportunity to improve care & reduce cost starting July 1, 2016, through June 30, 2021

 **192** participating practices
3,200+ oncologists
14 participating payers
155,000+ Medicare FFS beneficiaries/year, estimated
\$6 billion in care included in 6-month episodes

- Model Objective: Provide beneficiaries with **improved care coordination to improve quality and decrease cost**
 - Implement six practice redesign activities
 - Create two-part **financial incentive** with \$160 pbpm payment and potential for performance-based payment
 - Institute robust **quality** measurement
 - Engage **multiple payers**

Practice Redesign Activities

- 1) Patient navigation
- 2) Care plan with 13 components based on IOM Care Management Plan
- 3) 24/7 access to clinician with real-time access to medical records
- 4) Use of therapies consistent with national guidelines
- 5) Data-driven continuous quality improvement
- 6) Use of certified EHR technology

Next Generation ACO Model builds upon successes from Pioneer and MSSP ACOs

Designed for **ACOs experienced** with coordinating care for patient populations

- **41** ACOs will assume **higher levels of financial risk and reward** than other Medicare ACO initiatives
- Model **will test how strong financial incentives for ACOs can improve health outcomes** and reduce expenditures
- Greater **opportunities to coordinate care** (e.g., telehealth & skilled nursing facilities)



**41 ACOs spread
among 23 states**

Source: Centers for Medicare & Medicaid Services

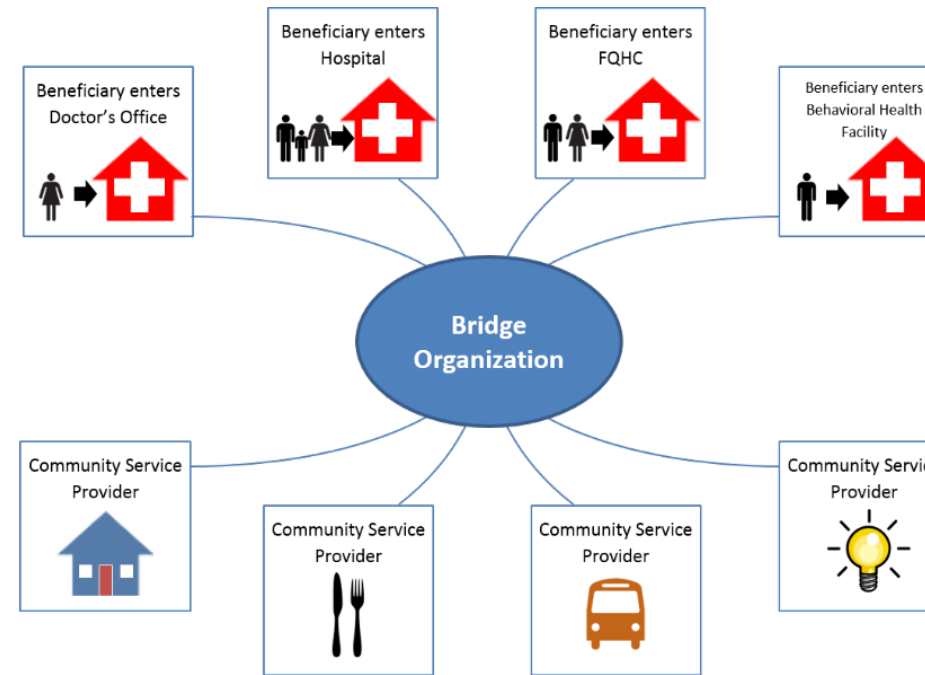
Model Principles

- Prospective attribution
- Financial model for long-term stability (smooth cash flow, improved investment capability)
- Rewards quality
- Benefit enhancements that improve patient experience & protect freedom of choice
- Allows beneficiaries to choose alignment

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

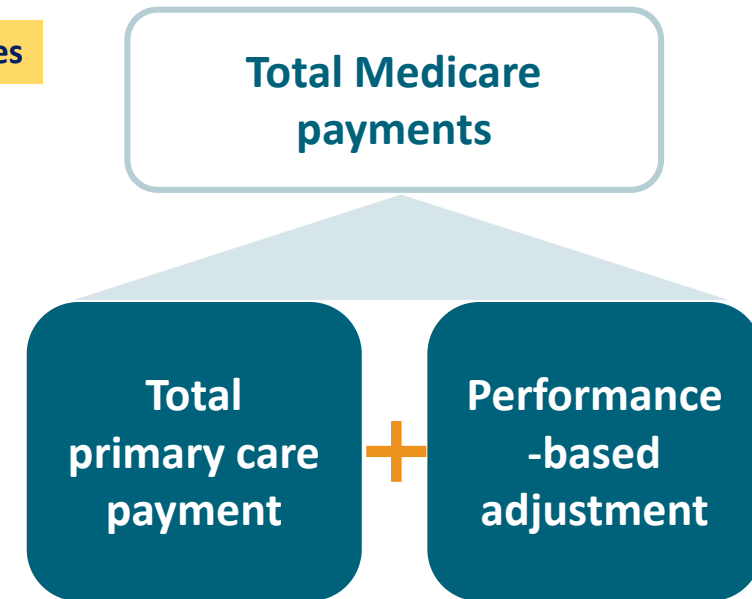
Primary Care First

Foster Independence, Reward Outcomes

Primary Care First includes two 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

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



Request for Applications anticipated Fall 2019

Direct Contracting

Direct Contracting offers new forms of capitated population-based payments (PBPs), enhanced payment options, and flexibilities to increase the tools available for providers to meet beneficiaries' medical and non-medical needs.

Goals:

- 1 Transform risk-sharing arrangements** in Fee-for-Service Medicare
- 2 Empower beneficiaries** to personally engage in their own care delivery
- 3 Reduce provider burden** to meet health care needs effectively

Option	Risk Arrangement
Professional PBP	50% Savings/Losses
Global PBP	100% Savings/Losses
Geographic PBP (proposed)	100% Savings/Losses

Letter of Intent for Professional and Global PBP options open now
RFI on Geographic PBP option closed May 30, 2019
Request for Applications for Professional and Global PBP anticipated
Fall 2019



Integrated Care for Kids Model

Addresses the impact of the opioid crisis on children



The **InCK Model** is a child-centered *local service delivery* and *state payment model* aimed at **reducing expenditures** and **improving the quality of care** for children covered by Medicaid and CHIP, especially those with or at-risk for developing significant health needs.



Goals:

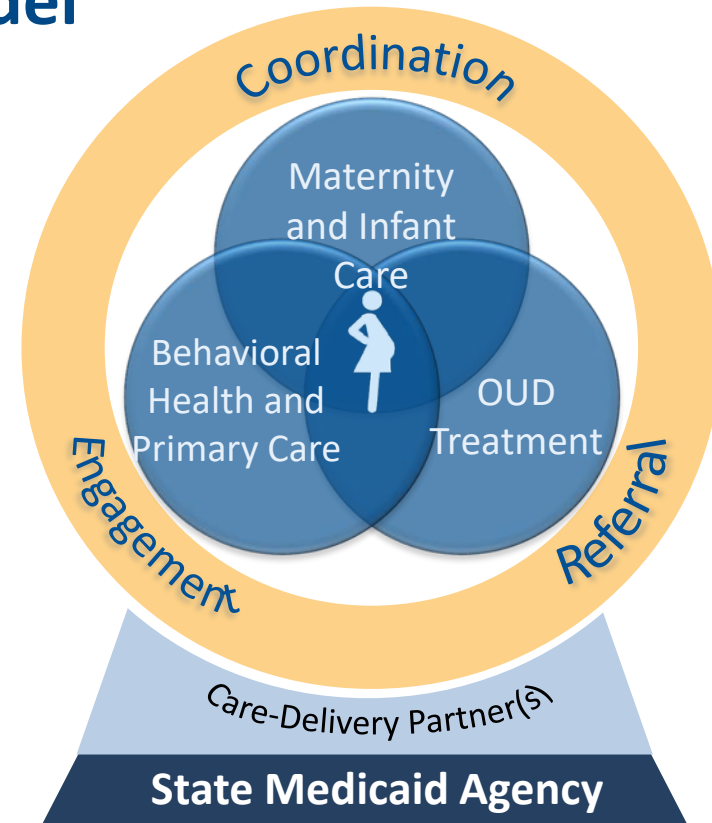
- 1 Improving performance on priority measures of child health
- 2 Reducing avoidable inpatient stays and out-of-home placements
- 3 Creation of sustainable Alternative Payment Models (APMs)

Notice of Funding anticipated Early 2019

Up to 8 cooperative agreement awards anticipated Late 2019

Maternal Opioid Misuse (MOM) Model

The MOM model is a **patient-centered, service-delivery model**, which aims to **improve the quality of care** and **reduce costs** for pregnant and postpartum Medicaid beneficiaries with OUD and their infants through **state-driven care transformation**.



Goals:

- 1** **Improve** quality of care and reduce costs
- 2** **Expand** access to treatment, service-delivery capacity, and infrastructure
- 3** **Create** sustainable coverage and payment strategies

Anticipated Notice of Funding Opportunity Release: Early 2019
Anticipated Application Period: Spring 2019

Emergency Triage, Treat, and Transport (ET3) Model

Appropriate care, at the right time, in the right place

The **ET3 Model** provides greater flexibility to ambulance care teams responding to 911 calls, aimed at **reducing expenditures** while **preserving or enhancing quality of care** for beneficiaries

Goals:

- 1** Provide **person-centered care** and give beneficiaries greater control of their care
- 2** Encourage **appropriate utilization of services** to meet health care needs effectively
- 3** Increase **efficiency in the EMS system** to more readily respond to high-acuity cases



Treatment
On Scene



Alternate
Location



Hospital

Request for Applications anticipated Spring 2019
Notice of Funding Opportunity anticipated Late 2019



Thank you!

Questions?