CMS Innovation Center

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Building from Lessons-Learned

CMS Innovation Center models have provided valuable insights to inform the design and development of subsequent models or other models with common approaches.

Early model testing at the CMS Innovation Center supported enhanced and **integrated care with minimal financial risk.**

Newer models include higher standards in **quality reporting**, more opportunities for **shared savings**, and **integration** of clinical treatment and social services.

Comprehensive Primary Care Plus (CPC+) Model

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.

Payment Innovations Supporting CPC+ Practice Transformation

- PBPM risk-adjusted care management fees to support augmented staffing and training for delivering comprehensive primary care
- Performance-based incentive payments reward practices on utilization and quality of care
- For Track 2 practices, hybrid of reduced fee-for-service payments and up-front "Comprehensive Primary Care Payment" to reduce dependence on visit-based FFS

Evaluation Results (Years 1 and 2)

- Small favorable effects (<1.3%) on Medicare service use, including reduction in the rate of ED visits and slowing the growth of ambulatory primary care visits for practices in both tracks
- Small improvements (<1%) on selected claims-based quality measures, including increases in the percentage of beneficiaries who received various recommended services for diabetes, the percentage of female beneficiaries who received breast cancer screening, and the percentage of beneficiaries who received hospice services
- No change in Medicare expenditures when excluding CMS' enhanced payments provided to CPC+ practices in addition to usual payments for services; increase in expenditures by 2 to 3 percent when including those payments

Five Functions Guide CPC+

-Access & Continuity
-Care Management
-Comprehensiveness & Coordination
-Patient & Caregiver Engagement
-Planned care & Population Health

Participants & Partners

Cohort 1 (2017-2021)
2,655 practices in 14 regions
Cohort 2 (2018-2022):
154 practices in 4 regions

Track 1: 1317 practices
Track 2: 1493 practices

52 public and private payers in CPC+ regions

Health IT vendors partner with CMS and Track 2 practices

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. Participants can also select a third "hybrid" option to simultaneously participate in both the PCF and Seriously Ill Populations payment models. PCF began implementation on January 1, 2021.

Option 1	Option 2	Option 3
PCF Payment Model	**PCF High Need Populations Payment Model**	**Hybrid Option**

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

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.

Option	Risk Arrangement
Professional PBP	50% Savings/Losses
Global PBP	100% Savings/Losses

Participants: 51 Direct Contracting Entities (DCEs)
Implementation: October 1, 2020 – March 31, 2021
Performance Period: April 1, 2021 – December 31, 2025

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

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

MCCM allows Medicare beneficiaries who qualify for hospice to receive **supportive care services while receiving care for their terminal condition.** Evidence from private market shows that concurrent care can improve outcomes, patient and family experience, and lower costs.

MCCM is 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.

Model characteristics:

- 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

Services

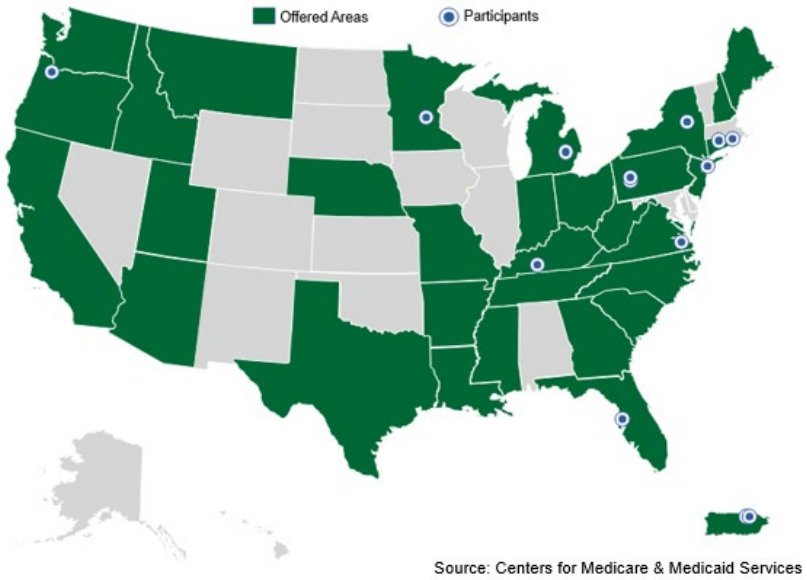
The following services are available 24 hours a day, 7 days a week:

- Nursing
- Social work
- Hospice aide
- Hospice homemaker
- Volunteer services
- Chaplain services
- Bereavement services
- Nutritional support
- Respite care

Medicare Advantage (MA) Value Based Insurance Design (VBID) Model offers more flexibilities to MA Plans for Plan Year 2021

For Plan Year 2021, CMS is continuing to test how Medicare Advantage Organizations (MAOs) can better target supplemental benefit design to enrollees based on chronic condition and/or socioeconomic characteristics, as well as Part C and D rewards and incentives and wellness and health care planning. Additionally, for

- For plan year 2020, the Model has 14 participating MAOs offering plan benefit packages in **30 states and Puerto Rico**
- **1.2 million enrollees** are in model PBPs, with over **280,000 enrollees** expected to benefit from the Model.
- Participating plans will engage all enrollees in structured **wellness and health care planning**, including advance care planning.
- In 2021, for the first time via the VBID Model, CMS will test carving in the **Medicare hospice benefit into MA**.



Source: Centers for Medicare & Medicaid Services