Center for Health Care Strategies
Better care where it's needed most

Texas MCO SDOH Learning Collaborative: Phase Three

Session 3 -- Federal Perspective: The Innovation Center's Commitment to Equitable Outcomes through High-Quality, Affordable, Person-Centered Care

May 20, 2022

Made possible through support from the Episcopal Health Foundation

Agenda

- Welcome and Introductions
- Health and Human Services Commission Welcome
- The CMS Innovation Center's Strategic Objectives
- Facilitated Q&A
- Wrap Up and Next Steps

Center for Health Care Strategies

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.

Center for Health Care Strategies

Meet Today's Presenter

Dora Hughes, MD, MPH
Chief Medical Officer
CMS Innovation Center

Center for Health Care Strategies

Welcome & Introductions

Center for Health Care Strategies

Advancing Equity through the CMS Innovation Center

Dora Hughes, MD, MPH
Chief Medical Officer
Center for Medicare and Medicaid Innovation

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."

Alternative Payment Models can apply to a specific:

- **Health condition**, like end-stage renal disease
- **Care episode**, like joint replacement
- **Provider type**, like primary care providers
- **Community**, like rural areas
- **Innovation** within Medicare Advantage or Medicare Part D

CMS Innovation Center 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

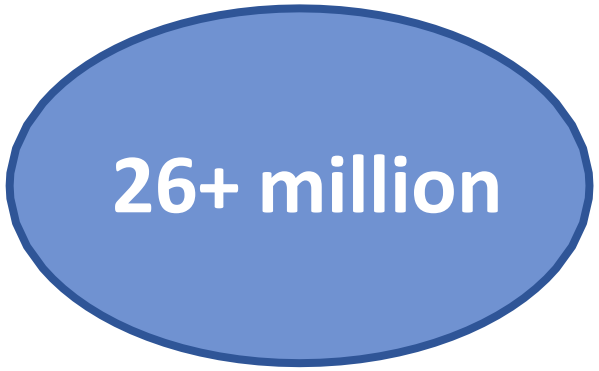
- Health Care Payment Learning and Action Network
- Medicare Diabetes Prevention Program Expanded Model
- Million Hearts®
- Million Hearts: Cardiovascular Disease Risk Reduction Program
- Partnership for Patients

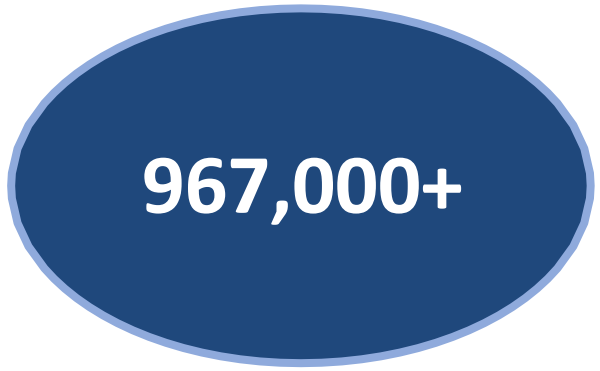
Initiatives to Accelerate the Development & Testing of Payment and Service Delivery Models

- 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

CMS Innovation Center's Range of Impact





Beneficiaries touched*

CMS Innovation Center models impact over 26M beneficiaries **in all 50 states**[1, 2]

Providers participating*

Over 967,000 health care providers and provider groups [2] **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 2019

* Data represents only 2 years of CMMI impact not all affected beneficiaries and providers over the entire CMMI experience, to date

Source: Innovation Center-Report to Congress, December 2018

Lessons Learned From the Past 10 Years

- Not enough focus on health disparities or Medicaid
- Too many models, some of which overlap
- Voluntary models result in increased spending due to risk selection
- Too many providers reluctant or unable to accept downside risk without inducement (or assistance)
- Challenges in setting appropriate financial benchmarks have undermined models' effectiveness
- Success of models too narrowly defined
- Appropriate focus on provider and health system input but lack of patient or beneficiary perspective

Vision: What Is To Come Over the Next 10 Years

Advancing Health Equity

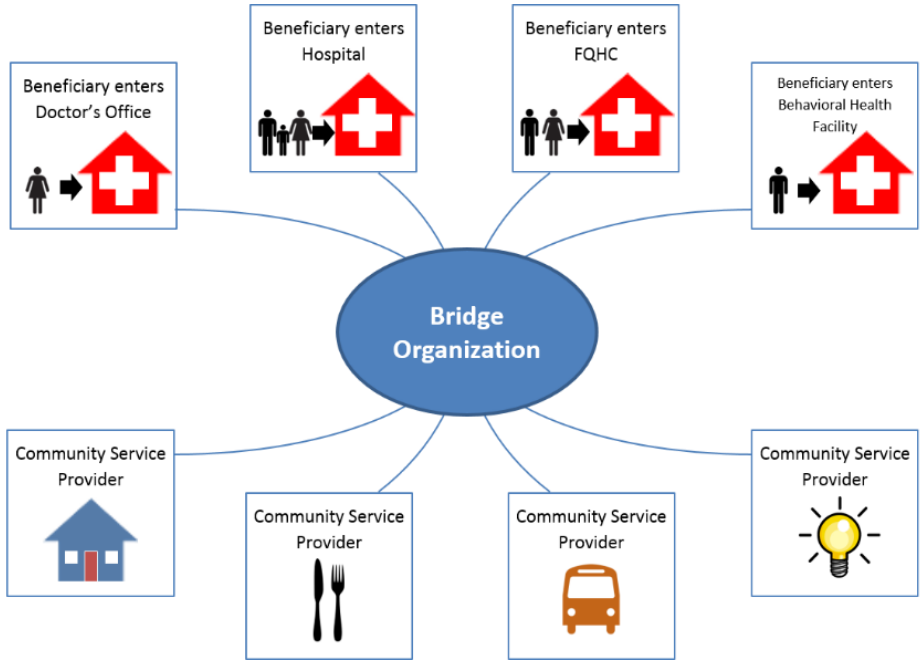
- **Develop new models and modify existing models** to address health equity and social determinants of health;
- **Increase the number of beneficiaries from underserved communities** who receive care through value-based payment models by increasing the participation of Medicare and Medicaid providers who serve them;
- **Evaluate models specifically for their impact on health equity** and share data and "lessons learned" to inform future work; and
- **Strengthen data collection and intersectional analyses** for populations defined by demographic factors such as race, ethnicity, language, geography, disability, and sexual orientation/gender identity to identify gaps in care and develop interventions to address them.

Model Highlights

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 (HRSN)
- 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



Of the first 750,000 completed screenings:
63% were Medicaid beneficiaries
37% were Medicare beneficiaries
67% reported no core HRSN
33% reported at least one core HRSN

Of the reported Health Related Social Needs, food was the most commonly identified HRSN (67%). Followed by Housing (47%); Transportation (41%); Utility (28%); and Safety (5%)

Integrated Care for Kids

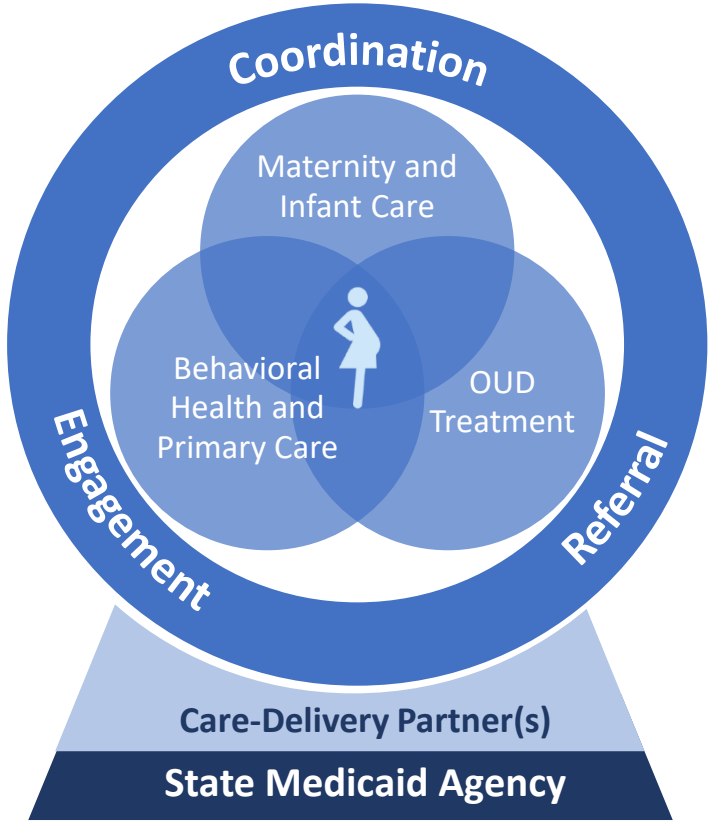
The **Integrated Care for Kids (InCK) Model** is a child-centered *local service delivery* and *state payment model* aimed at **reducing expenditures** and **improving the quality of care** for children covered by Medicaid and CHIP, especially those with or at risk for developing significant health needs.

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)***

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

State awardees: Colorado, Indiana, Louisiana, Maine, Maryland, Missouri, New Hampshire, Tennessee, Texas, and West Virginia

Period of Performance: January 1, 2020 – December 31, 2024

CHART Model Overview

The **CHART Model** is a voluntary model that will test whether **aligned financial incentives, operational & regulatory flexibilities, and robust technical support** will help rural providers **transform care** on a broad scale.

The CHART Model consists of **the Community Transformation Track** for rural communities to **implement an Alternative Payment Model (APM)** to improve access to high quality care and reduce costs:

Community Transformation Track

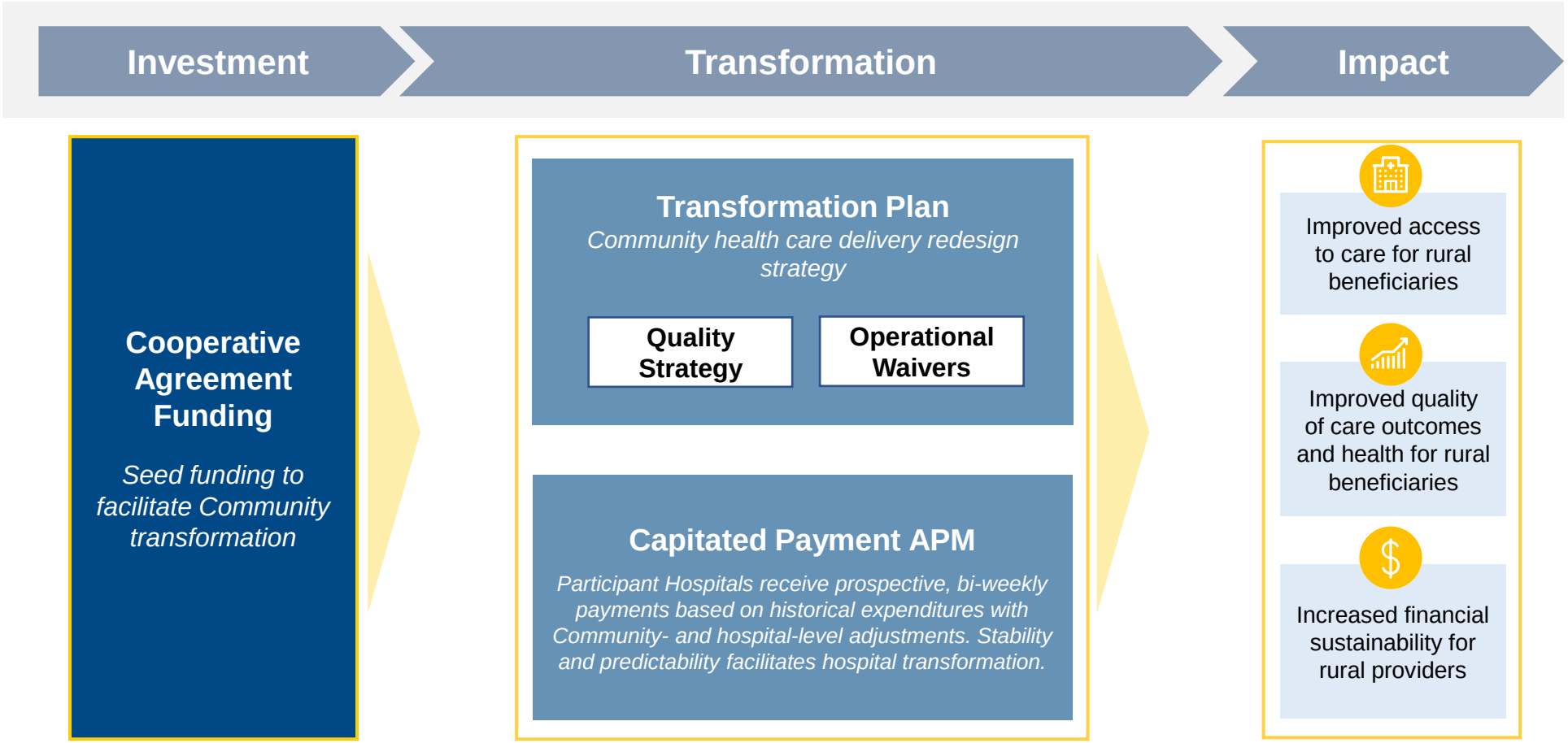
Communities receive **upfront funding**, **predictable finances** through a capitated payment amount, and **operational flexibilities** through benefit enhancements and beneficiary engagement incentives.

Model Goals:

- **Improve access to care in rural areas**
- **Improve quality of care and health outcomes for rural beneficiaries**
- **Increase adoption of APMs among rural providers**
- **Improve rural provider financial sustainability**

Community Transformation Track

The CHART Model Community Transformation Track aims to encourage modernization of rural health delivery systems through upfront funding, operational flexibilities, and APMs.



Primary Care First Rewards Value and Quality Through an Innovative Payment Structure

Primary Care First Goals

1. To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions.
2. To **improve quality of care and access to care** for all patients, particularly those with complex chronic conditions.

Primary Care First Overview

- **5-year** alternative payment model.
- Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants.
- Payment options for practices that specialize in **patients with complex chronic conditions.**
- Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer.

PCF

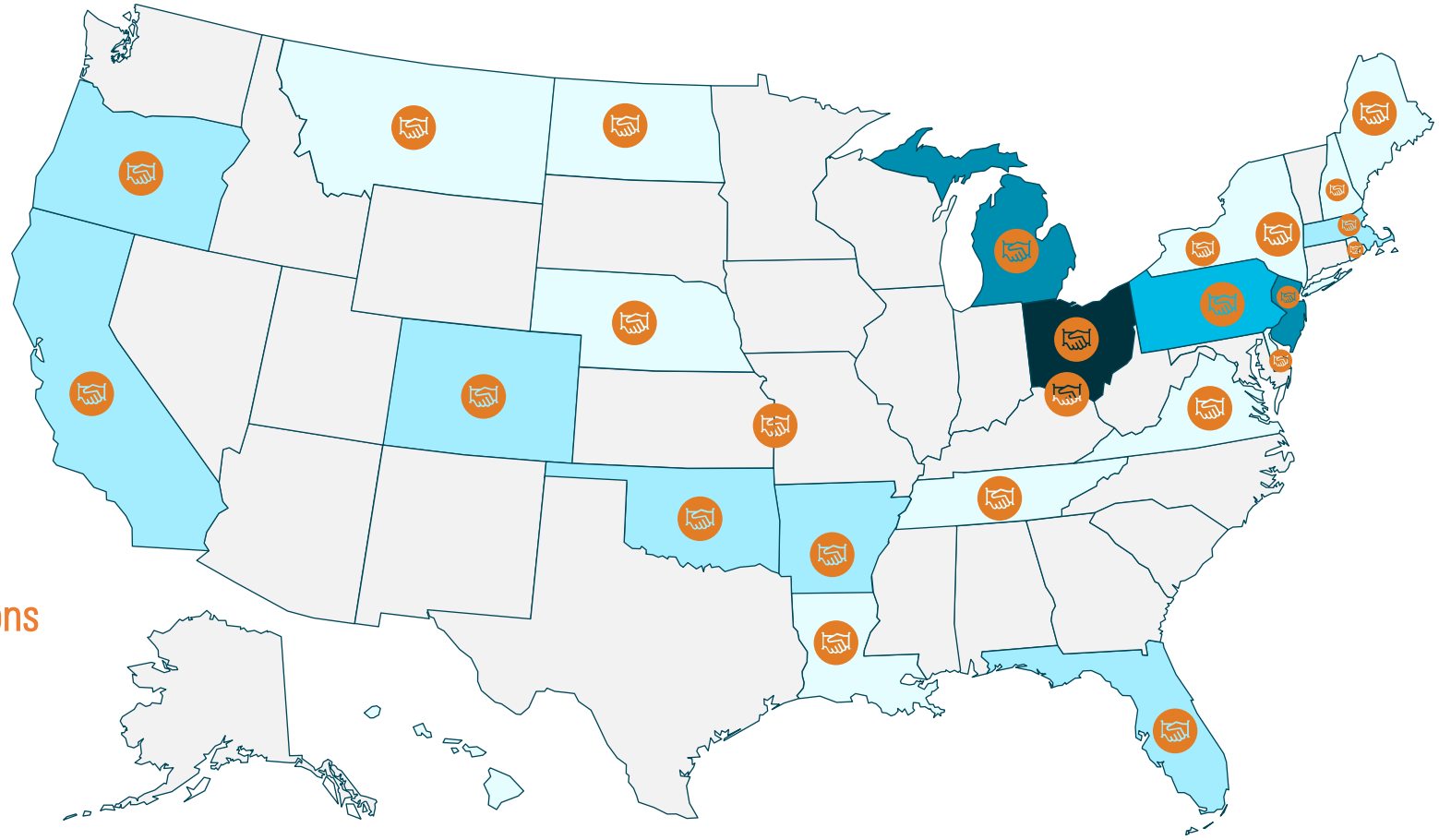
Who's in PCF: *A Geographic Overview*

PCF is offered in 26 regions and includes two cohorts of participating practices and payer partners.

730
Cohort 1 Practices

2,219
Cohort 2 Practices

47
Payers across 25 regions



PCF

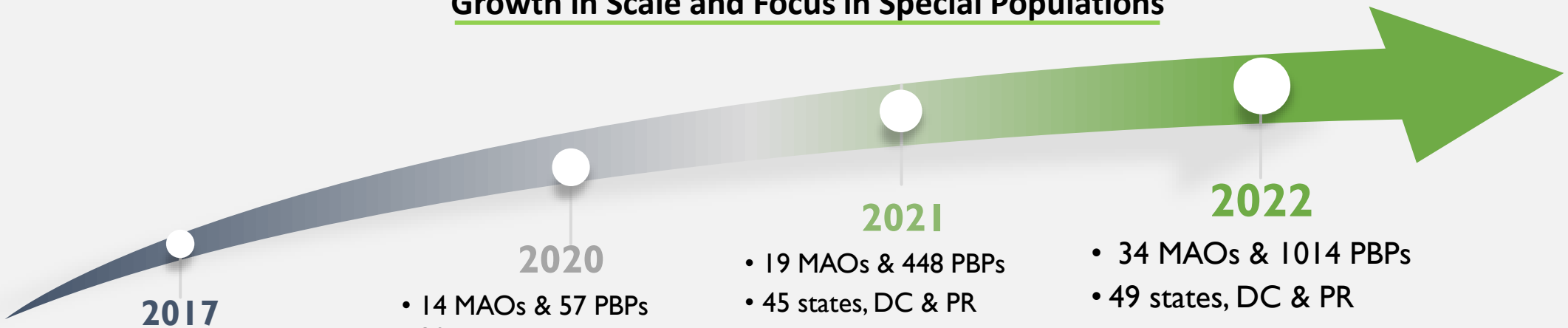
Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model Tests Additional Flexibilities to Address Needs of Underserved Enrollees

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

Growth in Scale and Focus in Special Populations



2017
- 9 MAOs & 45 PBPs
- 3 States
- ~99K targeted enrollees

2020
- 14 MAOs & 57 PBPs
- 30 states & Puerto Rico (PR)
- ~280K targeted enrollees

2021
- 19 MAOs & 448 PBPs
- 45 states, DC & PR
- ~1.6M targeted enrollees

2022
- 34 MAOs & 1014 PBPs
- 49 states, DC & PR
- ~3.7M targeted enrollees

ACO Realizing Equity, Access, and Community Health (ACO REACH) Model

New Focus on Health Equity

To promote Health Equity and expand the availability of accountable care to underserved communities, ACO REACH includes the following provisions:

Health Equity Provision	Description
Health Equity Plan	REACH ACOs will be required to develop and implement a Health Equity Plan starting in 2023 to identify underserved patients within their beneficiary population and implement initiatives to measurably reduce health disparities
Health Equity Benchmark Adjustment	A beneficiary-level adjustment will be applied to increase the benchmark for those REACH ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations

New Focus on Health Equity (Continued)

Health Equity Provision	Description
Health Equity Data Collection Requirement	REACH ACOs will be require to collect and report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries for purposes of Model monitoring and evaluation
Nurse Practitioner Services Benefit Enhancement	A new Benefit Enhancement will be offered to help reduce barriers to care access, particularly for beneficiaries in areas with limited access to physicians. Under this Benefit Enhancement, Nurse Practitioners will be able to assume certain responsibilities or furnish certain services with physician collaboration such as certifying the need for diabetic shoes or hospice care
Health Equity in Application Scoring	To encourage participation by provider groups with demonstrated direct patient care experience and/or demonstrated successful experience furnishing high quality care to underserved communities, discrete points will be attached to application questions related to these categories of experience

Thank You

- Contact Information: Dora.Hughes@cms.hhs.gov

- CMMI Resources:
  - https://innovation.cms.gov/
  - The recent blog in *Health Affairs*

Disclaimers

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This presentation is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Questions?

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Next Steps

Center for Health Care Strategies

MCO SDOH LC Phase III: Learning Sessions & Workgroups

Learning Sessions

February: Introduction to Health Equity

May: The CMS Innovation Center

Upcoming: Introduction to Maternal Health Disparities *(tentative)*

In-Person Meetings

April: Reconnecting in 2022

Upcoming: Fall session

Workgroups

Upcoming: Focus on whole-person care models for people who are pregnant and post-partum, and alternative payment models *(tentative)*

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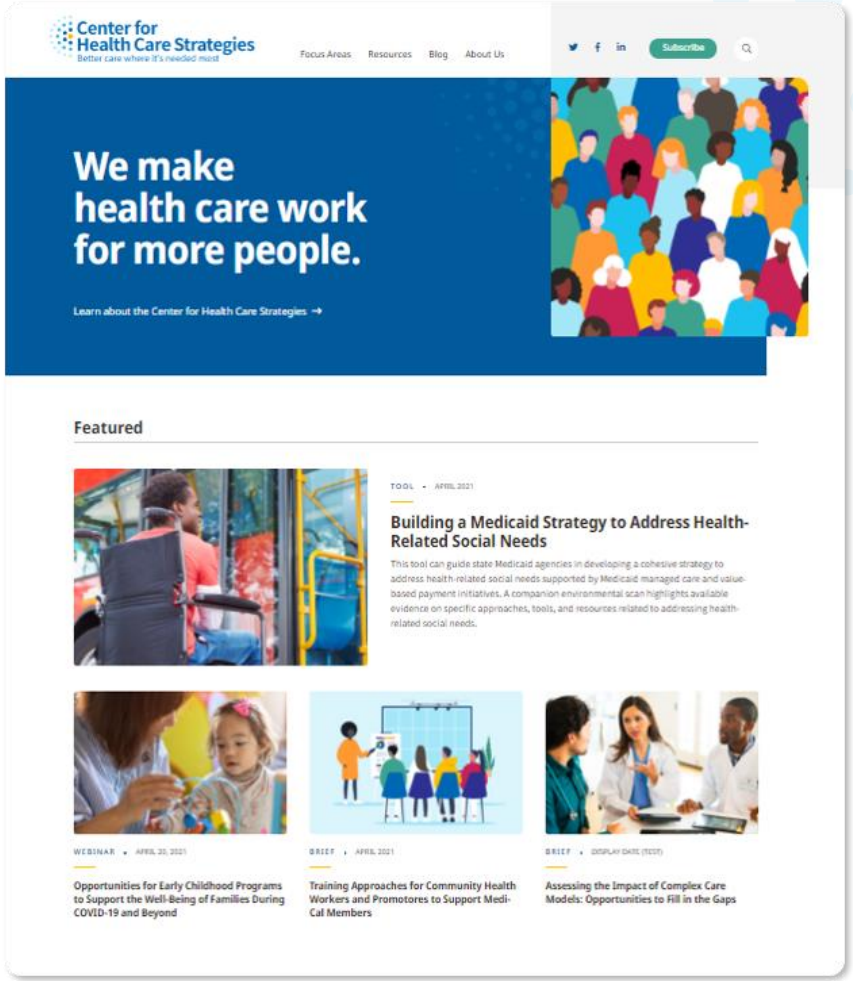
Visit CHCS.org to…

- **Download practical resources** to improve health care for people served by Medicaid.
- **Learn about cutting-edge efforts** from peers across the nation to enhance policy, financing, and care delivery.
- **Subscribe to CHCS e-mail updates**, to learn about new resources, webinars, and more.
- **Follow us on Twitter** @CHCShealth.



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