

CMMI Serious Illness Portfolio
CMS Panel Discussion

Physician-Focused Payment Model Technical Advisory Committee

CMS Panelists

Subject Matter Experts:

- [Susannah Bernheim, MD, MHS](#) – Chief Quality Officer and Acting Chief Medical Officer, the Centers for Medicare & Medicaid Services (CMS), Center for Medicare & Medicaid Innovation (CMMI)
- [Jacob Quinton, MD, MPH](#) – Medical Officer, Patient Care Models Group, CMS/CMMI
- [Suzanne Wensky, PhD](#) – Director, Division of Health Systems Research, Research and Rapid Cycle Evaluation Group, CMS/CMMI
- [David Nyweide, PhD](#) – Social Science Research Analyst, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Independence at Home Demonstration, CMS/CMMI
- [Julia Driessen, PhD](#) – Economist, Research and Rapid Cycle Evaluation Group, and Evaluation Lead, Medicare Advantage Value-Based Insurance Design Model, CMS/CMMI
- [Meghan Elrington-Clayton, MPH](#) – Director, Division of Financial Risk, CMS/CMMI
- [Laura Missett, MPA](#) – Model Lead, Kidney Care Choices Model, Seamless Care Models Group, CMS/CMMI
- [Tonya L. Saffer, MPH](#) – Director, Division of Healthcare Payment Models, Patient Care Models Group, CMS/CMMI

Introduction

Susannah Bernheim, MD, MHS

Chief Quality Officer and Acting Chief Medical Officer, the Centers for Medicare & Medicaid Services (CMS), Center for Medicare & Medicaid Innovation (CMMI)

Jacob Quinton, MD, MPH

Medical Officer, Patient Care Models Group, CMS/CMMI

Goal of Panel Discussion:

The CMS Innovation Center (CMMI) has implemented a series of models to address the needs of seriously ill Medicare beneficiaries or those with complex chronic conditions.

CMMI also has current models operating addressing the needs of beneficiaries with serious illness or complex chronic conditions.

The goal of the panel discussion today is for CMMI model operational and evaluation staff to **share key findings from both prior models** that have been **evaluated and describe newer models** recently announced or currently operating.

Outline:

Introduction / Goals of Discussion

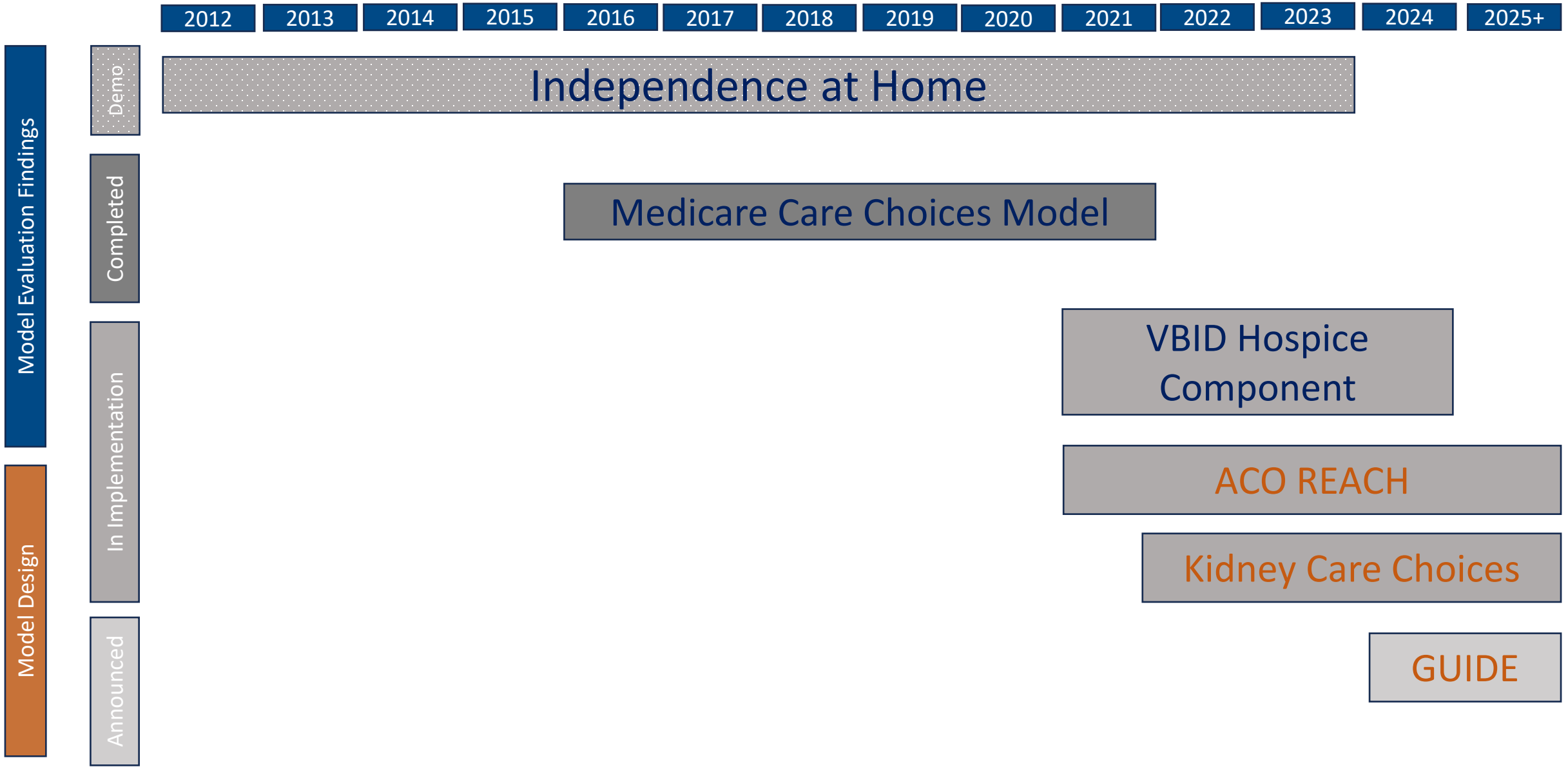
CMMI Models implemented with evaluation findings

- Medicare Care Choices Model (MCCM)
- Independence at Home Demonstration (IAH)
- Value-Based Insurance Design Hospice Component (VBID Hospice)

CMMI Models announced or in operation

- ACO REACH High-Needs
- Kidney Care Choices
- GUIDE

Timeline of Models & Demonstrations Being Discussed



Model Evaluation Findings

Model Design

Demo

Completed

In Implementation

Announced

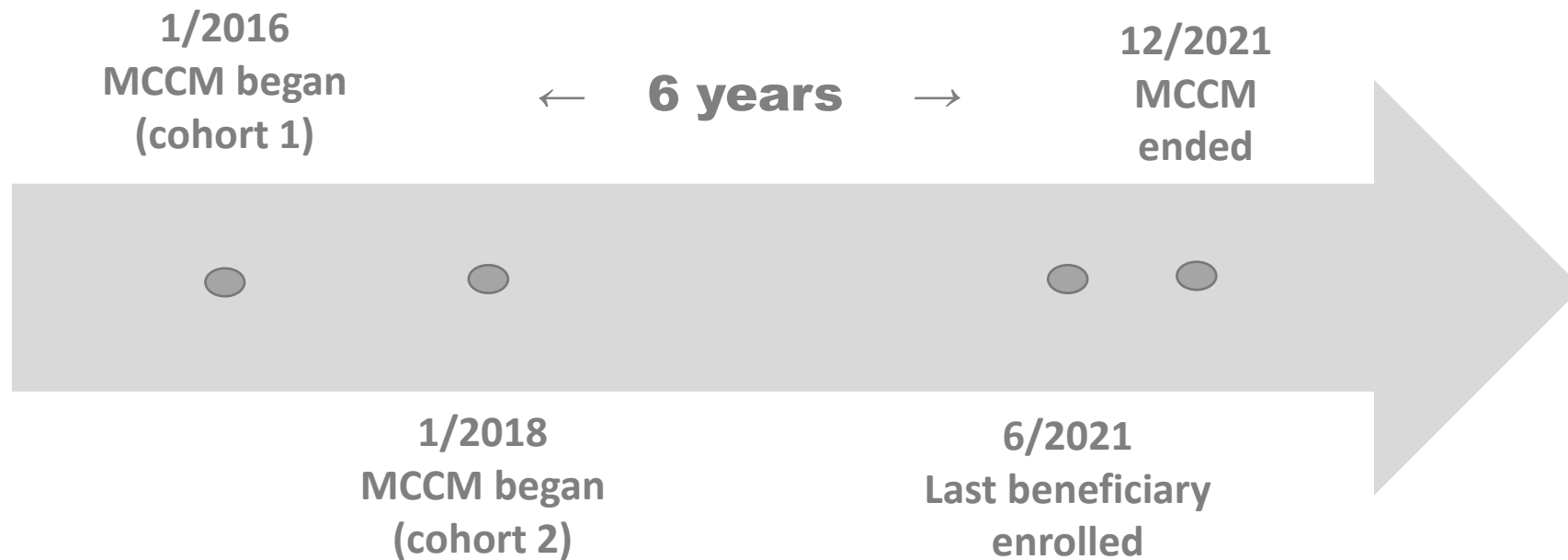
Medicare Care Choices Model (MCCM)

Suzanne Wensky, PhD

Director, Division of Health Systems Research, Research and
Rapid Cycle Evaluation Group, CMS/CMMI

Overview

- MCCM tested a new option for Medicare beneficiaries to receive **treatment for terminal conditions along with supportive care** from participating hospices.
- **7,263 beneficiaries** enrolled in MCCM. The impact analysis included those that died through 12/2021 (when the model ended) and matched comparators.

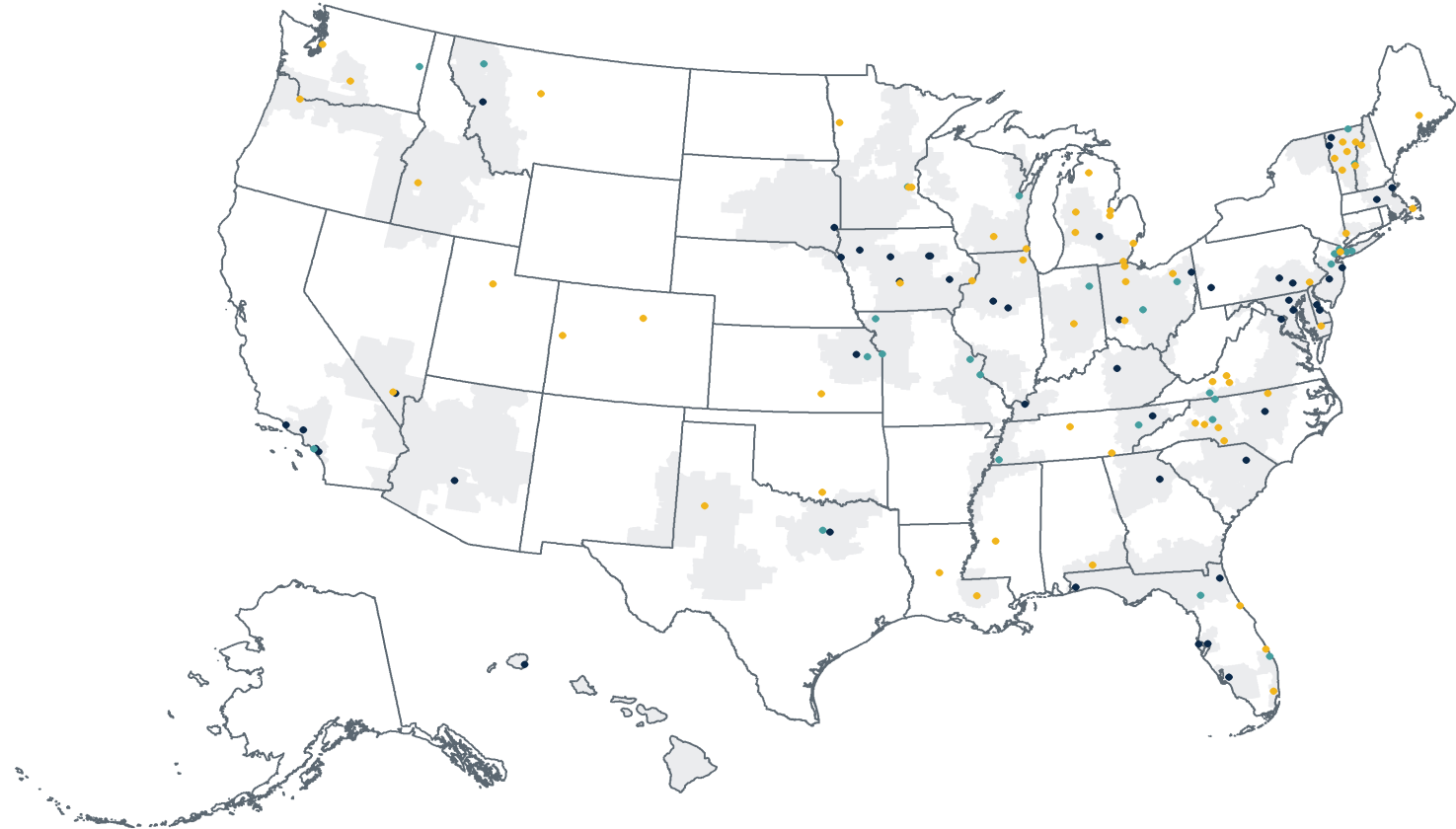


Key Takeaways

- MCCM
 - **Improved enrollees' quality of life and care** through less aggressive life-prolonging treatment at the end of life.
 - **Reduced Medicare expenditures** mainly by decreasing hospitalizations and increasing hospice use earlier in the disease trajectory.
 - **Led to high levels of satisfaction** for enrollees and caregivers who reported that they received care consistent with their wishes.
- *Low model uptake and low market penetration limited generalizability of these results.*

Implemented in 141 hospices across 41 states

- **3% of all hospices** nationwide participated in MCCM
- MCCM hospices tended to be **large, non-profit, non-rural**, founded before 2000
- **5 hospices enrolled 46%** of all beneficiaries in MCCM
- **44 hospices (31%)** participated through the end of the model test



- Market areas of hospices with paid MCCM claims
- Participated in 2021 extension
- Participated through December 2020
- Withdrew from model

Exemplar hospices identified keys to positive findings

- Implementing a “**no wrong door**” referral policy
- Gaining enrollees’ **trust**
- Engaging enrollees and caregivers in **ongoing education**
- Giving enrollees someone to call **after hours**

Lessons Learned

- Although CMS did not expand MCCM, given concerns about generalizability, **MCCM is a promising approach to transforming care delivery** at the end of life.
 - 5 hospices enrolled 46% of all beneficiaries in MCCM
 - Only 31% of MCCM hospices remained through the end of model test
 - MCCM enrollees were 27% more likely to use hospice than matched comparators and spent more than twice as many days in hospice (42 versus 19 days) before death
- Palliative care and concurrent hospice care **continue to be tested** in:
 - ACO REACH
 - Kidney Care Choices Model

Independence at Home (IAH) Demonstration

David Nyweide, PhD

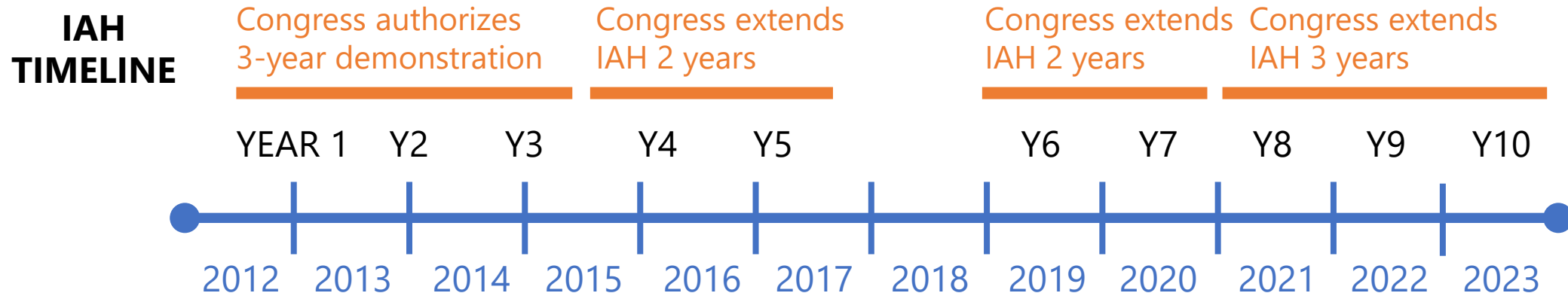
Social Science Research Analyst, Research and Rapid Cycle
Evaluation Group, and Evaluation Lead, Independence at Home
Demonstration, CMS/CMMI

IAH WAS A STATUTORY DEMONSTRATION NOT TESTED UNDER THE INNOVATION CENTER'S AUTHORITY

- IAH was authorized by Congress to provide an incentive payment to practices specializing in delivering home-based primary care to chronically ill and functionally limited fee-for-service Medicare beneficiaries
- Its key goals were to reduce total spending and improve quality of care

Patient eligibility criteria:

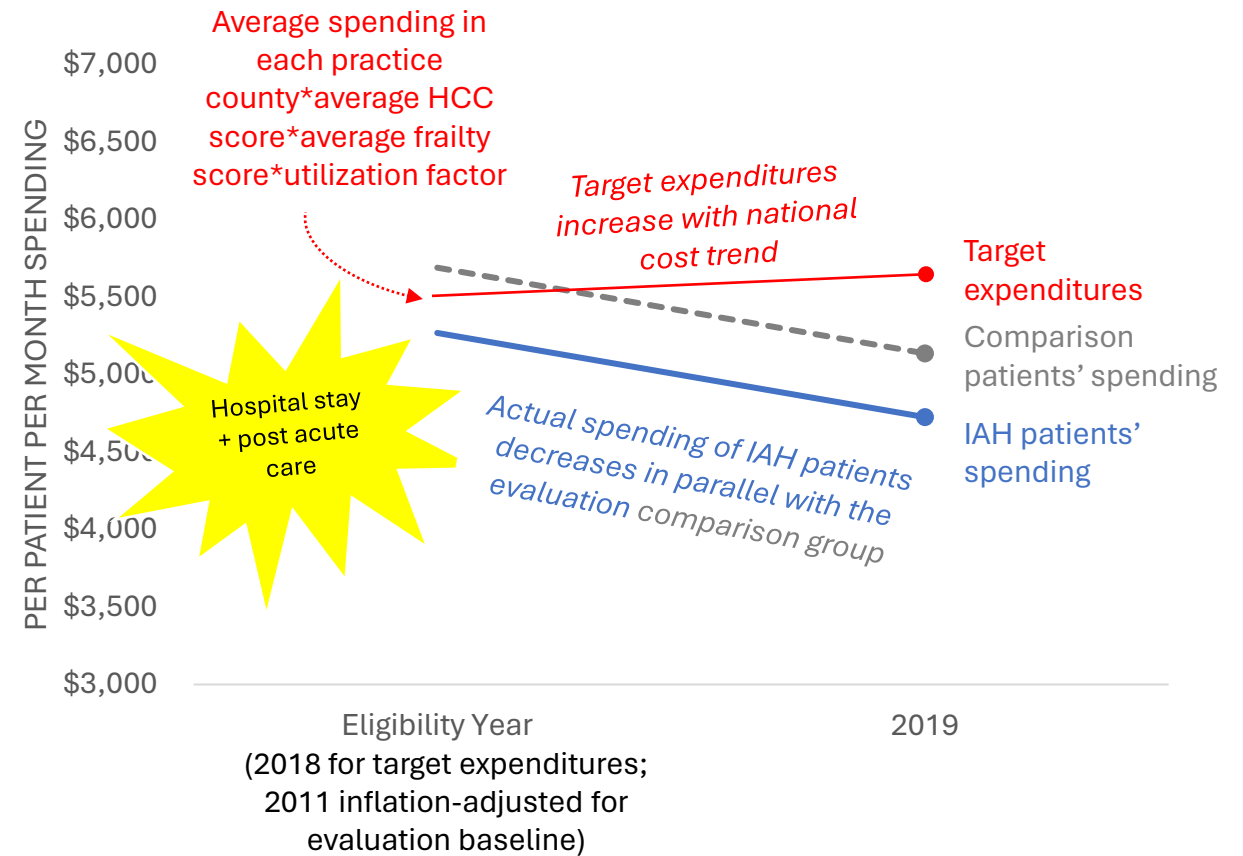
- Enrollment in fee-for-service Medicare
- Not in long-term care or hospice
- At least two chronic conditions
- Require human assistance with at least two activities of daily living
- Hospitalized and received acute or subacute rehabilitation services in the prior 12 months



EVENT-DEFINED ELIGIBILITY CREATES DIFFICULTY SETTING SPENDING TARGETS

- Since eligibility criteria depend on having expensive hospital and post-acute care prior to performance year, expect a downward trend in spending the following year, which the evaluation tries to account for with its comparison group but not target expenditures
- Small numbers of high-cost patients have volatile spending year-to-year, so harder to predict accurate target expenditures for practices
- Three different methods were used to calculate target expenditures over the course of the demonstration

IAH YEAR 6 (2019)

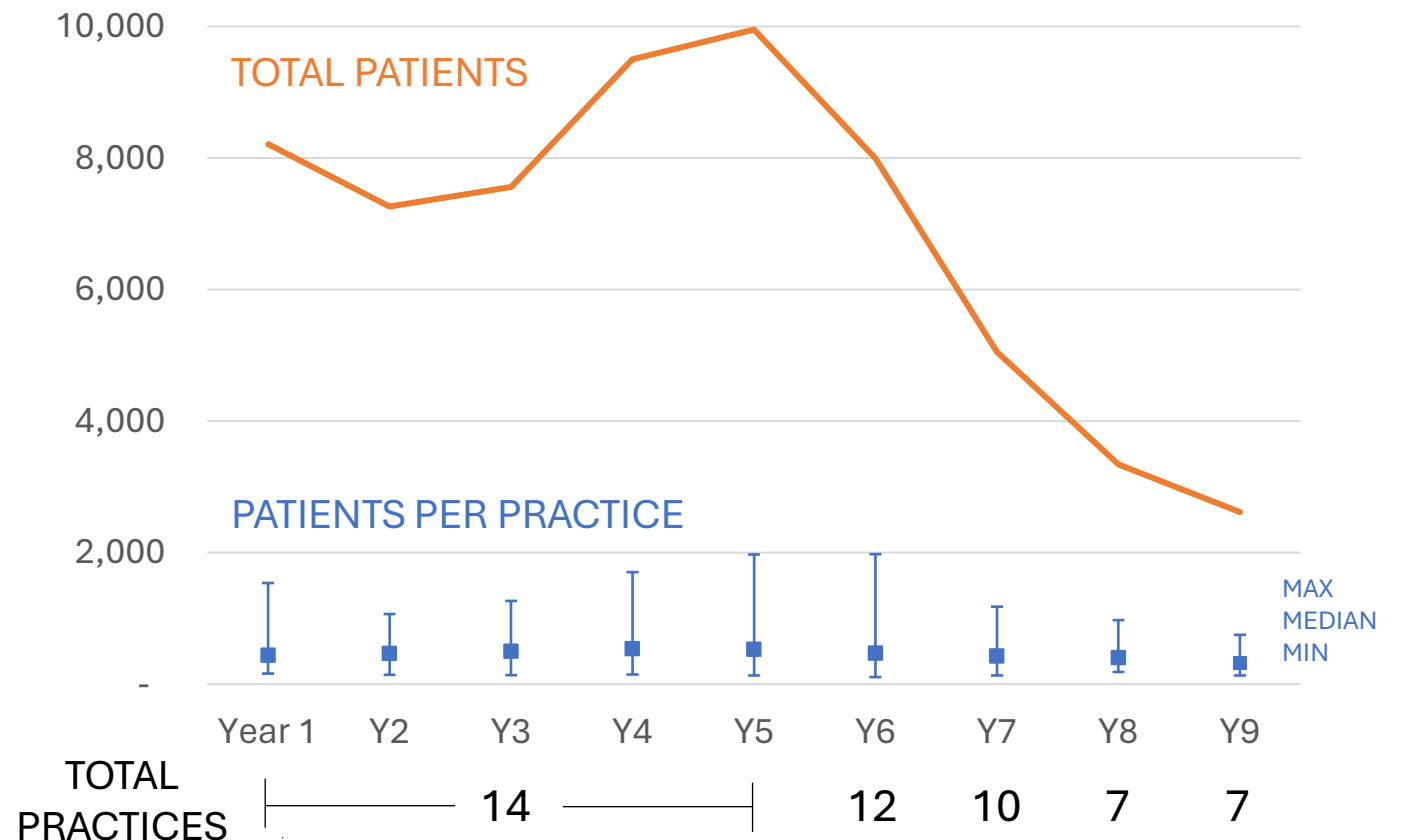


Using the revised actuarial methodology in Year 6, practices received \$11 million in incentive payments but only lowered spending by an estimated \$3.2 million, which was not statistically significant.

SMALL NUMBERS HAVE MADE IAH DIFFICULT TO EVALUATE

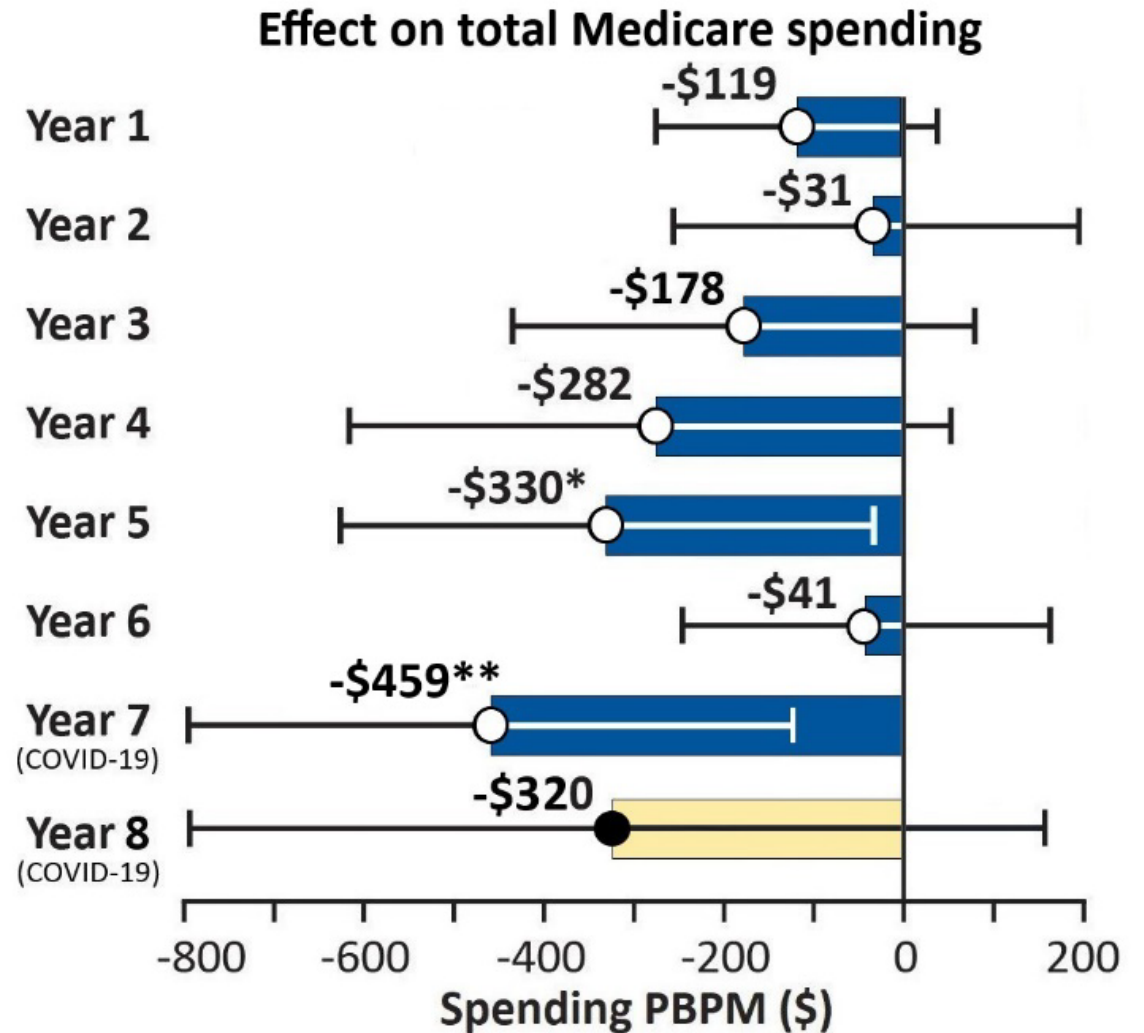
- Small numbers of patients per practice have less reliable spending measurements, so more uncertain for evaluation
- Small numbers of practices make the results less generalizable
- Attrition in practices exacerbates the challenges of small numbers

IAH PARTICIPATION, 2012-2022



TOTAL SPENDING PERFORMANCE OF IAH PRACTICES HAS BEEN INCONCLUSIVE

- Only 2 of 8 years have shown statistically significant total spending decreases
- If the same practices had remained after Year 5, results may be different
- The small number of participating practices is not generalizable to all providers delivering home-based primary care
- An estimated 4 percent* of fee-for-service Medicare patients are high-cost, frail older adults, which would be spread too thin for stable total spending measurements at the practice level



*Figuroa JF et al. Concentration of potentially preventable spending among high-cost Medicare subpopulations: an observational study. *Annals of Internal Medicine*. 2017.

QUALITY PERFORMANCE OF IAH PRACTICES HAS VARIED

- Most practices met the quality threshold for an incentive payment with claims-based rather than site-reported measures
- Practices may have decided that the effort for site-reported measures was not worthwhile

Quality measures tied to incentive payments:

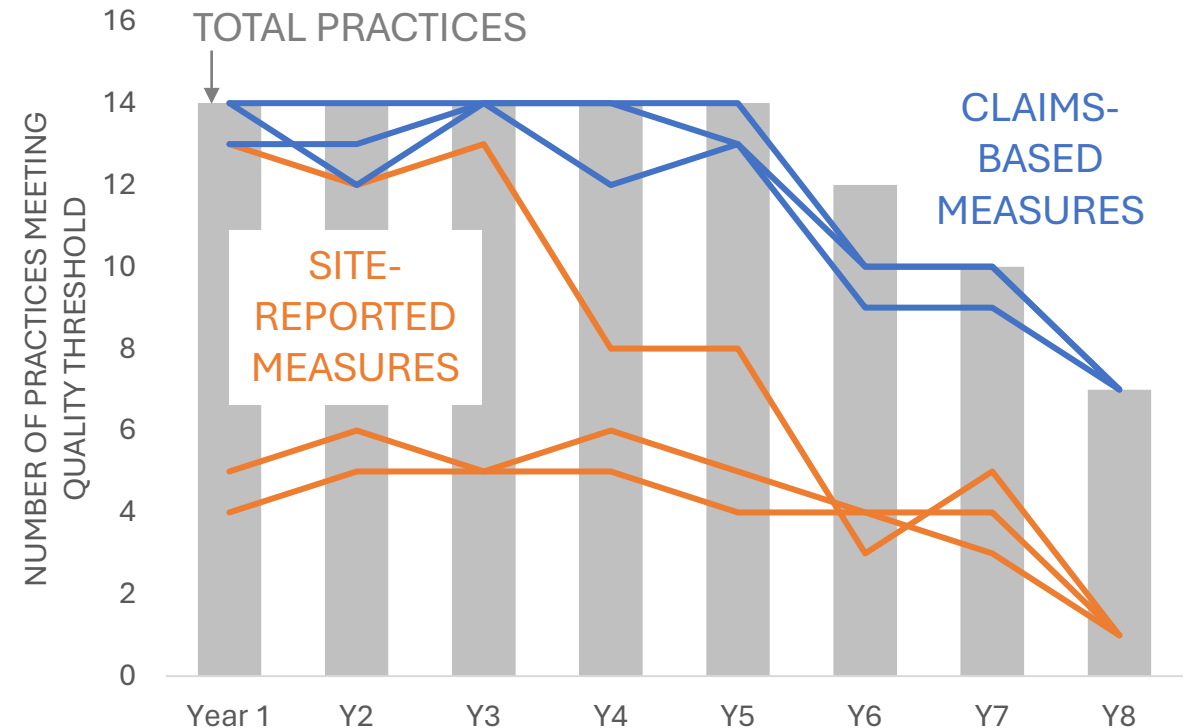
Claims-based measures

- Hospital admissions for ambulatory care-sensitive conditions
- ED visits for ambulatory care-sensitive conditions
- All-cause, 30-day hospital readmissions

Site-reported measures

- Patient preferences documented yearly
- Follow-up contact within 48 hours of hospital admissions, hospital discharges, or ED visits
- Medication reconciliation in the home within 48 hours of hospital discharge or ED visits

QUALITY MEASURE PERFORMANCE, 2012-2021



Practices must meet the quality performance threshold for 3 of 6 quality measures each year to qualify for an incentive payment, with higher payments for meeting the quality threshold of more measures. Most practices have met the quality threshold with claims-based measures alone.

KEY DEMONSTRATION DESIGN TAKEAWAYS FROM IAH

- **Event-based patient eligibility creates challenges.** Following a health event, spending tends to decrease, which makes it difficult to set spending targets and create comparison groups.
- **Consider the size of participating entities.** Small numbers of high-cost patients in an entity have volatile spending year-to-year, so it is harder to predict accurate spending targets and have reliable spending and utilization measurements.
- **Participants may not be responsive to site-reported measures if they are not required for incentive payments.** Rely on data already collected to keep participants accountable for quality of care.

Medicare Advantage Value Based Insurance Design (VBID) Model - Hospice Component

Julia Driessen, PhD

Economist, Research and Rapid Cycle Evaluation Group, and
Evaluation Lead, Medicare Advantage Value-Based Insurance Design Model, CMS/CMMI

VBID Hospice Background

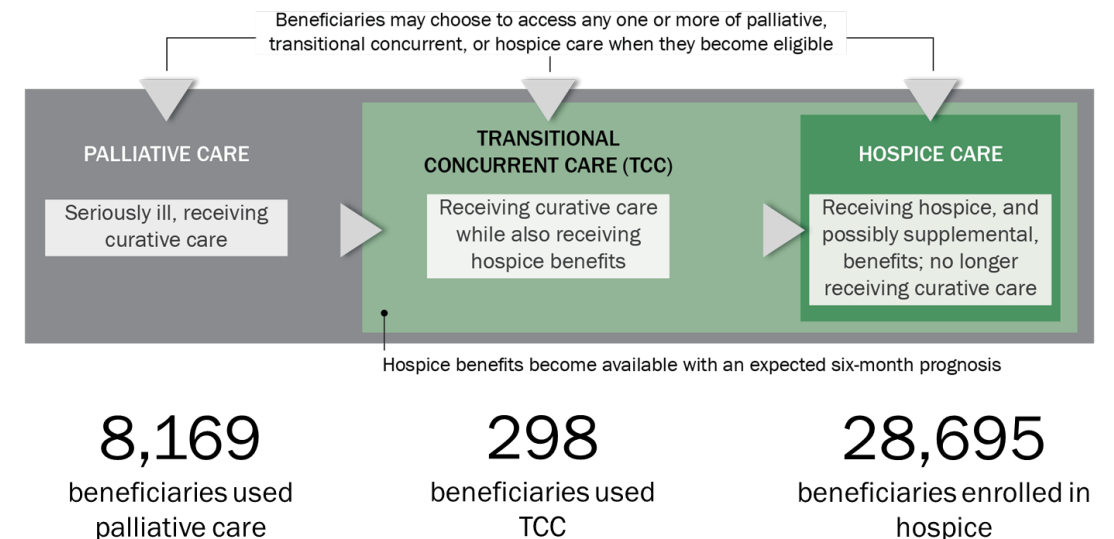
- Voluntary model in operation from 2021-2024 (will conclude on December 31, 2024)
- Allowed Medicare Advantage Organizations (MAOs) to include the hospice benefit as part of their benefit packages
 - Also required palliative care and transitional concurrent care offerings
 - Option to offer hospice supplemental benefits
 - Phase-in of network adequacy requirements for plans; beneficiaries maintained unrestricted choice of hospice
- In 2021, 9 MAOs entered 49 plans into the VBID Hospice model test. Currently, there are 13 MAOs and 78 plans participating.
- CMS has released four evaluation reports on the VBID model, two of which include evaluations of VBID Hospice.

VBID Hospice Implementation Findings

- Variation in how MAOs approached operationalizing the model, such as network formation, concurrent care criteria, and palliative care models.
- Hospices and new insurers reported substantial implementation challenges, but insurers with more than one year of experience with VBID Hospice reported fewer challenges.
- Persistent challenges included:
 - For MAOs, education of both providers and enrollees on services offered as part of the model test
 - For hospices, the effort associated with reporting requirements and administrative processes, and concerns about reimbursement.

VBID Hospice Utilization and Quality Findings

- Utilization of model services was lower than MAOs expected.
- No impact on hospice enrollment or care patterns.
- VBID Hospice was associated with a small increase in hospice care experience, as captured by the CAHPS Hospice Survey.
- In interviews, many palliative care recipients were unfamiliar with these services, but those who were aware reported positive experiences.



Utilization of VBID Hospice services, 2021-2022

Key Design Takeaways from VBID Hospice

- New collaborations may create opportunities for new care delivery models and improved coordination, but also take time to establish.
- New services offered as part of a model require significant education for payers, providers, and patients.
- There is an inherent tension between being prescriptive and providing flexibility to participants.
- Substantial administrative requirements for MAOs to offer the Medicare hospice benefit in some cases were a limiting factor for a care model that participants were enthusiastic to offer.

ACO Realizing Equity, Access, and Community Health (REACH) Model – High Needs Population ACOs

Meghan Elrington-Clayton, MPH

Director, Division of Financial Risk, CMS/CMMI

High Needs Population ACOs were envisioned for beneficiaries of severe health status in Traditional Medicare

Context

Options like Program of All-inclusive Care for the Elderly (PACE) and Medicare Advantage Special Need Plans (SNPs) have long existed for dual-eligible beneficiaries with **complex health needs that attain coverage through private plans**

In Traditional Medicare, **ACOs have mostly been population-agnostic** and focused more on experience and risk level

Certain pieces of historical ACO design – such as risk adjustment and population size – have been **less compatible with the dynamic and high-acuity profile** of sickest and costliest beneficiaries



Policy

In 2021, the Global and Professional Direct Contracting Model, later redesigned and renamed the ACO REACH Model, launched the **first ACO track specifically designed for the coordination of high-need patient care**, available for both dual-eligible and Medicare-only beneficiaries*

New ACO design choices related to **risk adjustment, benchmarking, and population size** are being tested to spur formation of new care models tailored to sickest and fastest-declining patients

Care delivery strategies are intended to mirror those in PACE / SNPs, with frequent, coordinated, and longitudinal touchpoints that occur across care settings, including home and long-term care facilities

**The Global and Professional Direct Contracting Model was redesigned and renamed the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model starting January 1, 2023.*

Design Features Optimized for High Needs Population ACOs

Alignment

High Needs eligibility criteria

- Beneficiaries must meet a minimum risk score threshold, post-acute utilization level, or mobility / frailty status
-

Population size

Lower beneficiary minimum requirement

- The minimum population size and year-over-year population growth required is relaxed relative to other ACOs
-

Benchmarking

Regional benchmark

- Promote stability for High Needs Population ACOs
 - Benchmarks based on regional expenditures (vs. blended with population historical experience) for first four years
-

Risk adjustment

Concurrent risk adjustment model

- Expected to better capture a changes in health status and enable more stable benchmarking
- Revised CMS-HCC prospective risk adjustment model where demographics and diagnoses from a given year predict same year expenditures
- Acute conditions weighted more heavily than both chronic conditions and demographics

Risk adjustment guardrails

- Constraints on risk score growth applied more gradually than other ACOs

High Needs ACOs have positively and broadly impacted patient care



Primary Care Capacity, Infrastructure, and Access

- Staffing capacity including **advanced practice providers**
- Enhanced services such as **behavioral health providers and home-based care**
- **Strengthened emphasis on palliative care via hospice use**
- Increased access to care through specialized networks, home visits, and extended hours



Reaching Diverse Populations

- Larger share of beneficiaries that are from **racial and ethnic** minority groups, are **dual-eligible**, and reside in **areas of greater socioeconomic disadvantage**



Specialized Care Provider Networks

- **Networks of individual practices** specifically focused on serving dual-eligible beneficiaries with complex health needs

CMS is learning about how to design models for High Needs Population ACOs

- **Eligibility:** Definition of “high needs” and resultant eligibility for specialized track continues to evolve.
- **Growth and scale:** High Needs ACOs may face difficulties achieving scale needed for a dedicated track.
- **Incentives:** CMS focused on payment stability to maintain participation incentive in the newly tested track.
- **Risk adjustment:** Concurrent risk adjustment model has been tested for 3 years with favorable reception.
- **Spending:** ACOs models have strongest savings potential with populations that have high costs and inefficiency at baseline – High Needs Population ACOs align with this profile. CMS looks forward to model evaluation results to understand impact on gross and net Medicare spending.

Kidney Care Choices (KCC) Model

Laura Missett, MPA

Model Lead, Kidney Care Choices Model,
Seamless Care Models Group, CMS/CMMI

Model Design Features

- Focused on CKD Stages 4 & 5, ESRD, and Transplant Beneficiaries
- Beneficiaries aligned through Nephrology Professionals
- Different Risk Options – both APM and Advanced APM Status
 - CMS Kidney Care First Option: For Nephrology Practices Only (Medicare Home Model similar to Primary Care First)
 - Comprehensive Kidney Care Contracting: For Nephrology Practices, Transplant Participants, and others who provide kidney care (Shared Savings Initiative, ACO-style option)
- Three Innovative Payments – CKD QCP, HDTU, and KTB
- 130 Model Participants

Halfway Point Observations

- Large RTA reduces final benchmarks in PY 1 & likely PY 2
 - Risk Corridors added for PY 3 and beyond
- More care coordination organizations entering the market
 - Signals interest in investing in value-based kidney care
 - Increased competition in a previously consolidated market
- Greater number of model participants in CKCC than expected
 - Comparatively, CEC, the predecessor model, had 37 ACOs participating from 7 organizations
 - CKCC has 100 participants from 10 organizations

Challenges to Kidney Models

- Difficulty in benchmarking and swings from a small population
- Small numbers of population and difficulty in meeting beneficiary minimums
- Carving out certain procedures, medications, and devices
- Overlapping beneficiaries and conflicts with other models/programs
- Accounting for quality of life/intangibles in evaluation results
- Entities having difficulty implementing Benefit Enhancements (BEs), such as the Concurrent Care BE or the Kidney Education BE.

Guiding an Improved Dementia Experience (GUIDE) Model

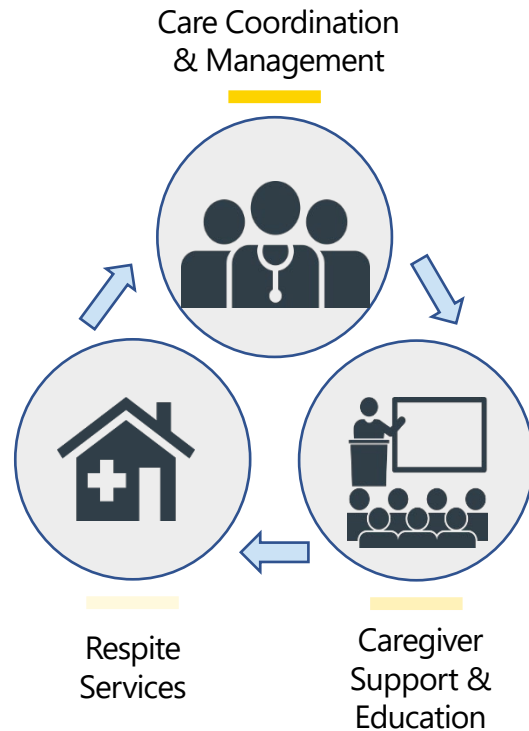
Announced Model

Tonya L. Saffer, MPH

Director, Division of Healthcare Payment Models,
Patient Care Models Group, CMS/CMMI

Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support**.

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **\$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

Eligible Beneficiaries

The GUIDE Model is designed for community-dwelling Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. Eligibility criteria for Model beneficiaries are outlined below:



GUIDE Beneficiary Eligibility Criteria



Dementia Attestation

Beneficiary has dementia confirmed by attestation from clinician practicing within a participating GUIDE dementia care program



Enrolled in Medicare Parts A & B

Beneficiary must have Medicare as their primary payer and not enrolled in Medicare Advantage, including Special Needs Plans (SNPs)



Not Residing in Long-Term Nursing Home



Has Not Elected the Medicare Hospice Benefit

Services overlap significantly with the services that will be provided under the GUIDE Model



Not Enrolled in PACE

Services overlap significantly with the services that will be provided under the GUIDE Model

Voluntary Alignment Process

The GUIDE Model will use a voluntary alignment process. Participants must document that a beneficiary (or their legal representative if applicable) consents to align to the Participant.

Participants may request a list of potential beneficiaries who may be eligible for voluntary alignment. Additionally, Participants may have beneficiaries self-referred to them based on letters sent by CMS, or by other provider referrals.

Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

COMPREHENSIVE ASSESSMENT

Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN

Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS

Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

ONGOING MONITORING & SUPPORT

Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.



REFERRAL & SUPPORT COORDINATION

Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

CAREGIVER SUPPORT

Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

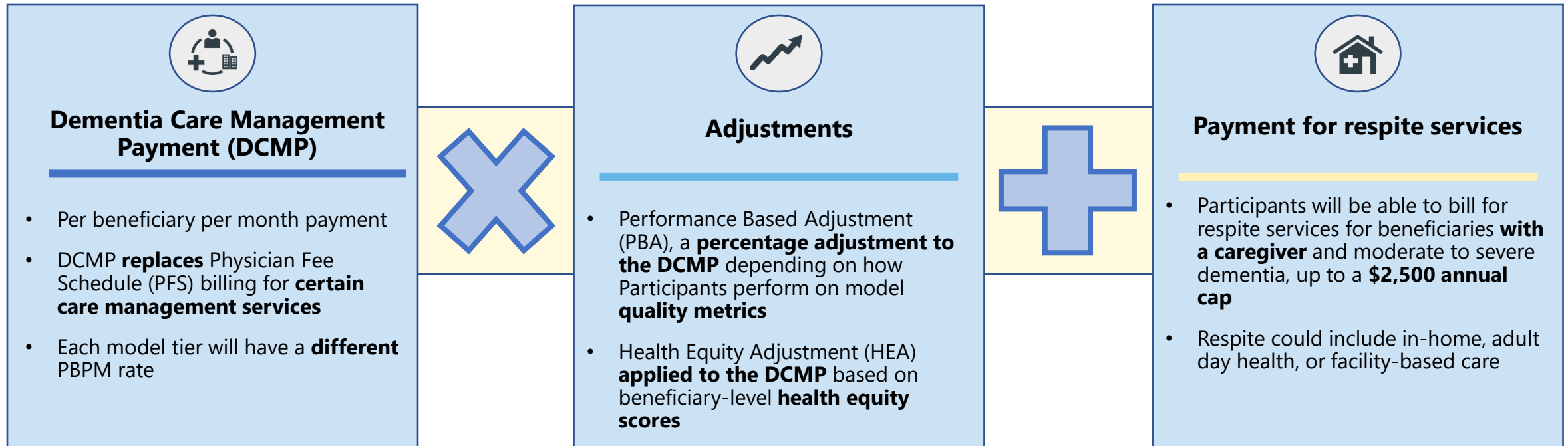
MEDICATION MANAGEMENT

Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

CARE COORDINATION & TRANSITION

Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate care with the specialist.

Payment Methodology



Participants in the new program track that are classified as safety net providers will also be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program. Safety net provider status will be defined based on the share of a provider's patient population that receives the Medicare Part D Low Income Subsidy or is dually eligible for Medicare and Medicaid.

Program Overlap

CMS will allow organizations to participate in both the GUIDE Model and any other current Innovation Center models, as well as the Medicare Shared Savings Program. Both beneficiaries and participants may overlap in any of the below models.

Shared Savings Program and Innovation Center ACO Model			Advanced and Comprehensive Care for Joint Replacement (CJR) Models		Innovation Center Models with Care Management Payment*			
ACO REACH	Shared Savings Program	Kidney Care Choices	BCPI Advanced	Comprehensive Care for Joint Replacement	Primary Care First	Making Care Primary	Maryland Primary Care Program	Enhancing Oncology Care Model

*CMS may recoup parts of the DCMP if deemed duplicative of the same payments for the same provider and beneficiary combination in a different Innovation Center model.

Thank you!