STRATEGIC HEALTH CARE

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CENTER FOR MEDICARE AND MEDICAID INNOVATION (PPACA SEC. 3021)

CMS officially launched its new Center for Medicare and Medicaid Innovation (CMI) on November 17, 2010. PPACA authorized $10 billion through FY 2019 to establish the CMI to test innovative payment and delivery models in Medicare, Medicaid and CHIP. Beginning in 2011, the Secretary will select models that improve coordination, efficiency and quality in health care.

The legislation outlines 20 models that the CMI will seek input on for possible pilots and demonstration programs; however, CMI has broad authority to select the programs best suited to its objectives.

How is the CMI different from the demonstration program that already exists in CMS?

The new center is part of Administrator Berwick's pledge: "I'm going to do everything I can to make rapid cycle improvement and very rapid spread a characteristic capability of the center itself and the partner organizations we'll be working with," Berwick added. "We can do a lot and we can do it fast."

The CMI will seek to partner with organizations that can develop and implement innovative payments systems much more quickly than the current demonstration and pilot program office. Also, the payment systems tested by CMI will not have to be budget neutral initially. This means that the CMI will have more latitude to test ideas that require higher payments in the short-run to achieve long-run savings and quality improvements.

The CMI will focus on innovations that achieve at least several of its key goals:

- Coordination of health care services across settings
- Reduction of preventable hospitalizations
- Prevention of hospital readmissions
- Reduction of ER visits
- Improvement in quality and health outcomes
- Improvement in the efficiency of care
- Reduction in the cost of health care services in Medicare and Medicaid
- Improvement in beneficiary and family-caregiver satisfaction

The CMI will focus on several types of innovations:

- Modifying the way Medicare, Medicaid, or CHIP pays for healthcare,
- Changing the way healthcare is delivered, or
- Using technology in new ways.

The twenty models set out in PPACA provide some concrete examples of the kinds of payment, delivery, and technologic changes that will interest the CMI.

Twenty models to be tested by the Innovation Center are set forth in the law

i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following: 1) An inability to perform 2 or more activities of daily living, 2) Cognitive impairment, including dementia,

iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

v) Supporting care coordination for chronically ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

vi) Varying payment to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

vii) Utilizing medication therapy management services.

viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools that improve applicable individual and caregiver understanding of medical treatment options.

x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

xii) Aligning nationally recognized, evidence based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals with cancer, including the identification of gaps in applicable quality measures.

xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for: 1)developing, documenting, and disseminating best practices and proven care methods; 2) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and 3)providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service, telehealth services: I) in treating behavioral health issues (such as post-traumatic stress disorder) and stroke; and II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project .