DRAFT

The Center for Medicare and Medicaid Innovation: Opportunities for Prevention and Health Promotion

Section 3021 of the Affordable Care Act (ACA) creates a new entity within CMS: the Center for Medicare and Medicaid Innovation ("Center"). The Center will test various innovative payment and service delivery models to determine how these models reduce program expenditures while preserving or enhancing the quality of care provided to individuals enrolled in Medicare, Medicaid, and CHIP.[i] The Secretary is given the authority to spread effective models, including through certain waiver authorities. The ACA appropriated $10 billion in direct funding for the Innovation Center, available now and to be spent during FY2011 through 2019.

The Center's work will fall into three major areas: Patient Care Models ("developing innovations that make care safer, more patient-centered, more efficient, more effective, more timely, and more equitable"); Seamless Coordinated Care Models ("models that make it easier for doctors and clinicians in different care settings to work together to care for a Medicare, Medicaid and CHIP beneficiaries"); and Community and Population Health Models ("steps to improve public health and make communities healthier and stronger").[ii] It will test models that result in better healthcare, better health outcomes, *and* reduced costs. Other portfolio criteria include:

- Have the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries, and the ability to improve how care is delivered nationally.
- Address the priority areas in the National Quality Strategy.
- Focus on health conditions that offer the greatest opportunity to improve care and reduce costs.
- Meet the needs of the most vulnerable and address disparities in care.
- Improve existing Medicare, Medicaid and CHIP payments to promote better outcomes and patient-centeredness.
- Are relevant across diverse geographic areas and states.
- Involve major provider types.
- Engage broad segments of the delivery system.
- Balance short-term and long-term investments.
- Are structured at a scale and scope consistent with the evidence.
- Is consistent with Innovation Center and CMS capacity.[iii]

Examples of Actions Called for in the National Prevention Strategy That May Fit Into the Work of the Innovation Center

State, tribal, local and territorial governments can use data to identify populations at greatest risk and work with communities to implement policies and programs that address highest priority needs.	Elimination of Health Disparities (p. 27)
The federal government will improve monitoring capacity for	Clinical and Community

quality and performance of recommended clinical preventive services.	Preventive Services (p. 20)
State, tribal, local and territorial governments can promote the use of interoperable systems to support data-driven prevention decisions and implement evidence-based prevention policies and programs, such as those listed in the Guide to Community Preventive Services.	Healthy and Safe Community Environments (p. 16)
State, tribal, local and territorial governments can create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services and other social services.	Clinical and Community Preventive Services (p. 20)
The federal government will support state, tribal, local, and territorial partners to enhance epidemiology and laboratory capacity, health information technology and performance improvement.	Healthy and Safe Community Environments (p. 16)
State, tribal, local and territorial governments can enhance data collection systems to better identify and address mental and emotional health needs.	Mental and Emotional Well-Being (p.49)
Health care systems, insurers and clinicians can enhance care coordination and quality of care (e.g., medical home models, integrated care teams).	Elimination of Health Disparities (p. 27)
The federal government will encourage HIV testing and treatment, align programs to better identify people living with HIV, and link those who test positive to care.	Reproductive and Sexual Health (p.46)
Health care systems, insurers and clinicians can adopt medical home or team-based care models.	Clinical and Community Preventive Services (p. 21)
Health care systems, insurers and clinicians can create linkages with and connect patients to community resources (i.e. tobacco quitlines), family support, and education programs.	Clinical and Community Preventive Services (p. 21)
State, tribal, local and territorial governments can pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas, such as rural communities.	Mental and Emotional Well-Being (p. 49)
The federal government will promote and expand research efforts to identify high-priority clinical and community preventive services and test innovative strategies to support delivery of these services.	Clinical and Community Preventive Services (p. 20)
Health care systems, insurers and clinicians can facilitate coordination among diverse care providers (e.g. clinical care, behavioral health, community health workers, complementary and alternative medicine).	Clinical and Community Preventive Services (p. 21)
The federal government will encourage adoption of certified electronic health record technology that meets Meaningful Use criteria, particularly those that use clinical decision	Clinical and Community Preventive Services (p. 20)

supports and registry functionality, send reminders to patients for preventive and follow-up care, provide patients with timely access to their health information (e.g., lab results, discharge instructions), identify resources available to patients, and incorporate privacy and security functions (e.g., encrypting health information to keep it secure, generating audit logs to record actions).	

[i] ACA details the types of models that will be eligible for testing:
''(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:
''(I) An inability to perform 2 or more activities of daily living.
''(II) 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 chronicallyill 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 (as defined in section 1834(e)(1)(B)) 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, such as those described in section 935 of the Public Health Service Act.
''(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, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, 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, evidencebased guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) 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— ''(I) developing, documenting, and disseminating best

practices and proven care methods; ‘‘(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and ‘‘(III) 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.

[ii] Center for Medicare and Medicaid Innovation, “Our Work,” (online at http://innovations.cms.gov/about-us/our-work/).

[iii] Center for Medicare and Medicaid Innovation, “Portfolio Criteria,” (online at http://innovations.cms.gov/about-us/portfolio-criteria/).