



## **CMMI Models Relevant for the Seriously Ill Population Fact Sheet**

The Center for Medicare & Medicaid Innovation (CMMI) is a division of the Centers for Medicare & Medicaid (CMS) focused on testing new healthcare payment and delivery models that aim to improve care, lower costs, and support patient-centered practices. Payment and delivery reform for advanced illness care is vital to ensuring that individuals and their families receive support that meets their unique needs, wishes, and values. C-TAC actively advocates for community-based care models that address a seriously-ill person's whole range of needs – physical, mental, emotional, social, and spiritual. A primary goal of our care model development and advocacy work is to reduce silos between providers of different types of care to foster a truly interdisciplinary team-based approach that blends medical, social, and functional support services.

There are currently a number of existing CMMI models that are particularly relevant for those living with serious or advanced illness. While not exhaustive, below are brief descriptions and links to a handful of these models:

### **[Primary Care First-Serious Illness Population Model](#)**

Primary Care First is a regionally-based, multi-payer model that aims to address the pervasive fragmentation of care experienced by many seriously-ill Medicare beneficiaries.

PCF-SIP gives practitioners freedom to innovate their primary care delivery approach based on the specific needs of their patient population. It is specifically designed to support practices caring for patients with chronic needs or advanced illness. The five key components of this model include *access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and population health*.

The PCF-SIP model was informed by the C-TAC *Advanced Care Model* proposal that was recommended to the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

### **[Direct Contracting Model](#)**

Direct Contracting (DC) payment model is Medicare's next iteration of accountable care organizations (ACOs), where groups of providers come together to coordinate care for an entire population and are held accountable for the total cost and quality of that care.

The DC payment model options aim to engage a wider variety of organizations that have experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations (ACOs), Medicare Advantage (MA) plans, and Medicaid managed care organizations (MCOs). There is financial incentive for providers to deliver



innovative, coordinated, and affordable care while maintaining access to the original Medicare benefits. The model structure places emphasis on patient empowerment, meaning that individuals have greater choice in health care providers with whom that want to have a care relationship.

In addition, the DC model includes a “High Needs” track which focuses on the unique care needs of patients with complex, chronic needs and the seriously ill population. High Needs Direct Contracting Entities (DCEs) must deliver care using an interdisciplinary team that coordinates all services, spanning primary care, behavioral health care, long-term services and supports, and other services.

### [Kidney Care Model](#)

The current Medicare payment system encourages in-center hemodialysis as the default treatment for patients beginning dialysis. There are more than 430,000 Medicare fee-for-service beneficiaries with End Stage Renal Disease (ESRD) who spend an average of 12 hours a week receiving in-center hemodialysis. Many beneficiaries with ESRD suffer from poorer health outcomes, such as higher hospitalization and mortality rates, often the result of underlying disease complications and multiple co-morbidities.

The Kidney Care Model builds on the existing structure of the Comprehensive ESRD Care Model. There is strong financial incentive for providers in the model to properly manage Medicare beneficiaries with chronic kidney disease stages 4 and 5 and ESRD by:

- Delaying start of dialysis
- Incentivizing kidney transplantation
- Including patients in the decision-making process

By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision making for their care.

### [Oncology Care Model](#)

There are 1.6 million people diagnosed with cancer each year in this country. The Oncology Care Model is one of a few CMMI models which focus on the efficiency and effectiveness of specialty care. It works to address three goals in the care of this medically complex population: better care, smarter spending, and healthier people.

Through episode-based provider payments, this model increases financial and performance accountability for chemotherapy treatment given to cancer patients. Practitioners in OCM are expected to rely on the most current medical evidence and shared decision making with beneficiaries to inform their recommendation about whether a beneficiary should receive treatment. In addition, there is strong incentive for providers to



address the complex needs of patients and help them access services which improve their patient experience or health outcomes.

### [Value-Based Insurance Design Hospice Carve-In](#)

MA plans offer Medicare beneficiaries an alternative to original Medicare, also referred to as “fee-for-service.” In addition to covering all Medicare services, some MA plans also offer Medicare beneficiaries extra coverage through supplemental benefits, such as vision, hearing, and dental services. Value-based insurance design generally refers to health insurers’ efforts to structure cost-sharing and other health plan design elements to encourage enrollees to use the services that can benefit them the most.

The Hospice Carve-In is a component of the VBID model which aims to increase quality of care for seriously ill Medicare Beneficiaries, with special attention to those with low incomes such as dual-eligibles. With the carve-in, MA organizations can include the Medicare hospice benefit in their part A benefits package. In addition, there is a requirement for plans to provide upstream palliative care. One key component of the carve-in is allowing curative (disease modifying) treatment to be given concurrently with hospice benefit coverage for the first month of hospice. Overall, the carve-in aims to increase MA beneficiaries’ access to quality end-of-life care.

### [Medicare Care Choices Model](#)

Recent reports indicate that fewer than half of eligible Medicare beneficiaries use hospice care and most only for a short period of time. Currently, Medicare beneficiaries are required to forgo Medicare payment disease-directed care in order to receive access to hospice services. The Medicare Care Choices Model provides Medicare beneficiaries who qualify for the Medicare hospice benefit and dually eligible beneficiaries who may qualify for the Medicaid hospice benefit in their state, the option *to receive supportive care services typically furnished under the Medicare hospice benefit, while continuing to receive care from other Medicare providers for their terminal condition.*