Advancing Equity through the CMS Innovation Center

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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's Range of Impact

28+ million

Beneficiaries touched*

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

528,000+

Providers participating*

Over 528,000 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
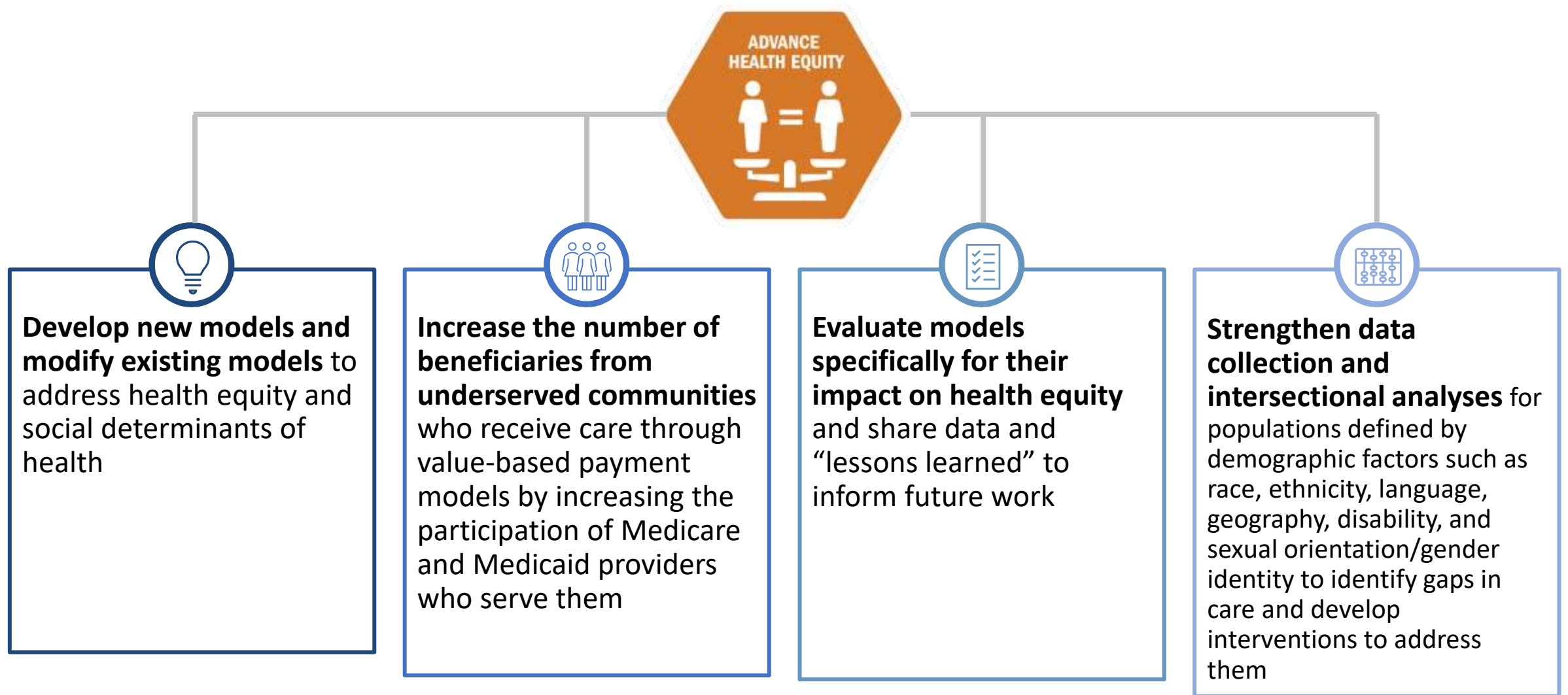[2] Figures as of December 2019
* Data represents only 2 years of CMMI impact not all affected beneficiaries and providers over the entire CMMI experience, to date
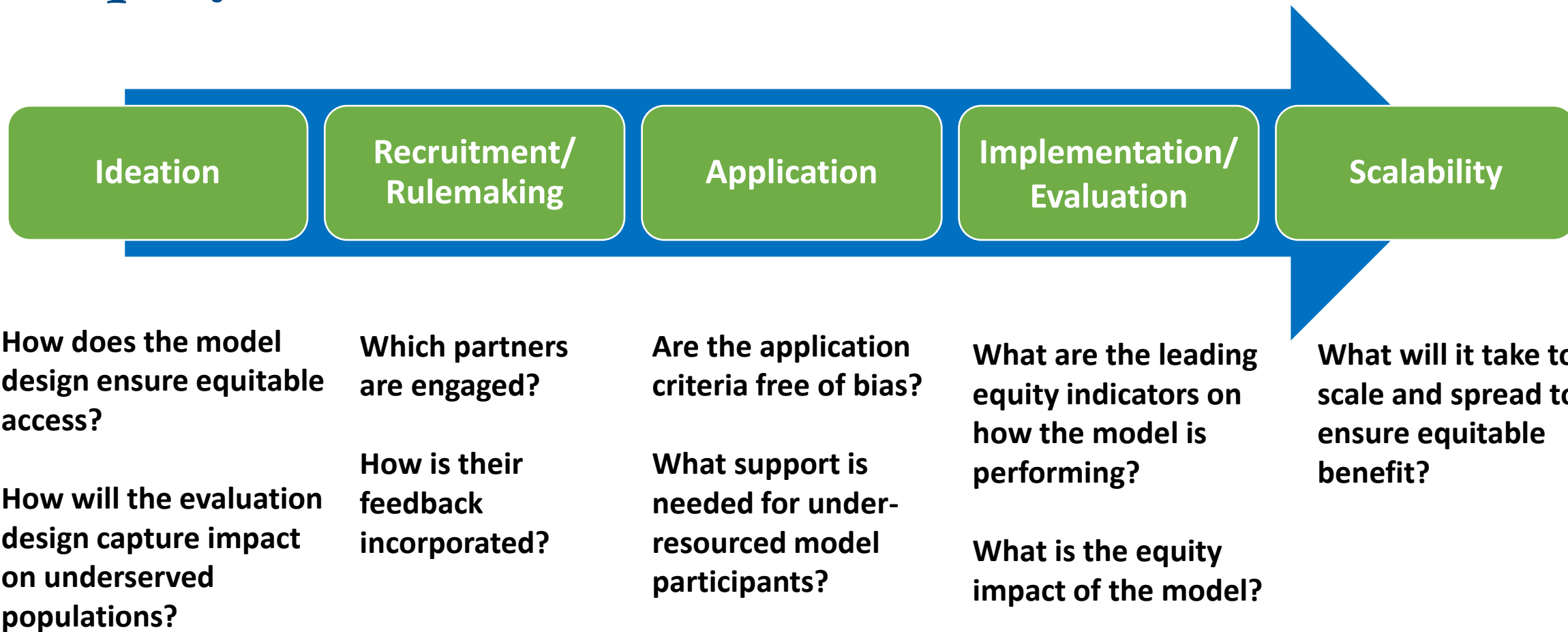
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Vision: What Is To Come Over the Next 10 Years

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

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

Life Cycle of Models: Opportunities to Embed Equity

Ideation	Recruitment/ Rulemaking	Application	Implementation/ Evaluation	Scalability

How does the model design ensure equitable access?

How will the evaluation design capture impact on underserved populations?

Which partners are engaged?

How is their feedback incorporated?

Are the application criteria free of bias?

What support is needed for under-resourced model participants?

What are the leading equity indicators on how the model is performing?

What is the equity impact of the model?

What will it take to scale and spread to ensure equitable benefit?

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Strategic Objective 2: Advance Health Equity

Health equity is integral to the Innovation Center's vision of improving health care quality. As it pursues a broad range of strategies to advance equity over the next decade, the Innovation Center has developed five health equity metrics that will allow it to track its progress (see Table 3).

Table 3. Health Equity Metrics

Aim: Embed health equity in every aspect of Innovation Center models and increase focus on underserved populations.

Impact on Beneficiaries: By embedding health equity into all Innovation Center models, underserved beneficiaries will have increased access to accountable, high-quality, and person-centered care. Model tests will then allow for robust evaluation and confidence in generalizing results to all populations served by CMS programs.

Metric 1: Percent of all models that will collect and report demographic and, where feasible, social needs data and health equity plans to CMS	• **2022 Baseline**	• 37%
	• **2025 Target**	• 85%
	• **2030 Target**	• 100%
Metric 2: Percent of facilities participating in Innovation Center models identified as safety net facilities***	• **2022 Baseline***	• 3.9%
	• **2025 Target**	• 7.0%
	• **2030 Target**	• 12.0%
Metric 3: Percent of primary care providers participating in Innovation Center models identified as safety net providers***	• **2022 Baseline***	• 23.9%
	• **2025 Target**	• 24.9%
	• **2030 Target**	• 26.5%
Metric 4: Rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by an Innovation Center model	• **2022 Baseline****	• 4,989
	• **2025 Target**	• 4,614
	• **2030 Target**	• 3,989
Metric 5: Disparity in the rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by Innovation Center models across race and ethnicity groups	• **2022 Baseline****	• 6,097
	• **2025 Target**	• 5,722
	• **2030 Target**	• 5,097

* Note this baseline is an average of 2017, 2018, and 2019 data (see supplemental document).
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***See supplemental document for definitions of safety net facilities and providers.

Model/Initiative Highlights

Accountable Health Communities

Key Innovations:

- **Systematic screening** to identify unmet health-related social needs

- Tests the **effectiveness of referrals and community services navigation**

- **Partner alignment** at the community level

Of the first 750,000 completed screenings:

- 63% were Medicaid beneficiaries

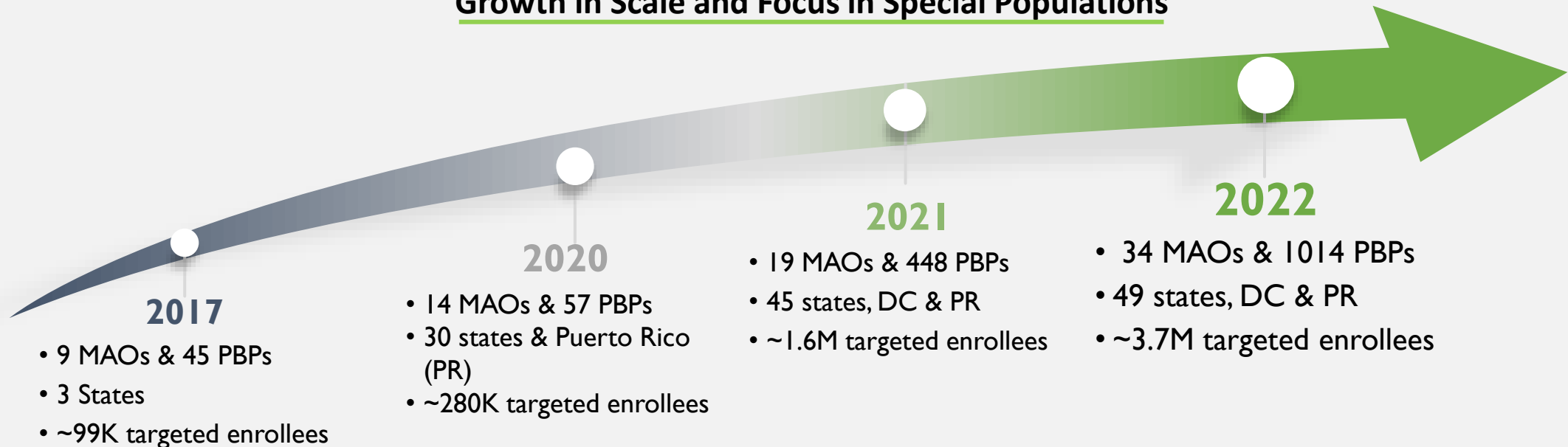- 33% reported at least one health-related social need

Medicare Advantage Value-Based Insurance Design Model

Tests Additional Flexibilities to Address Needs of Underserved Enrollees

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

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

- Builds upon **current ACO efforts** to advance health equity

- Emphasis on **person-centered, coordinated, team-based care** to improve health outcomes and beneficiary experience

- Includes **health equity benchmark adjustment**, requirement for **health equity plan**, and **sociodemographic data collection**

Bluerock Primary Care

Enhancing Oncology Model

**Health Equity Components**

- Sociodemographic data collection and reporting

- Risk-adjusted benchmark

- Increased per-beneficiary per-month payment for enhanced services for dual eligibles

- Screening for HRSNs

- Health Equity Plan

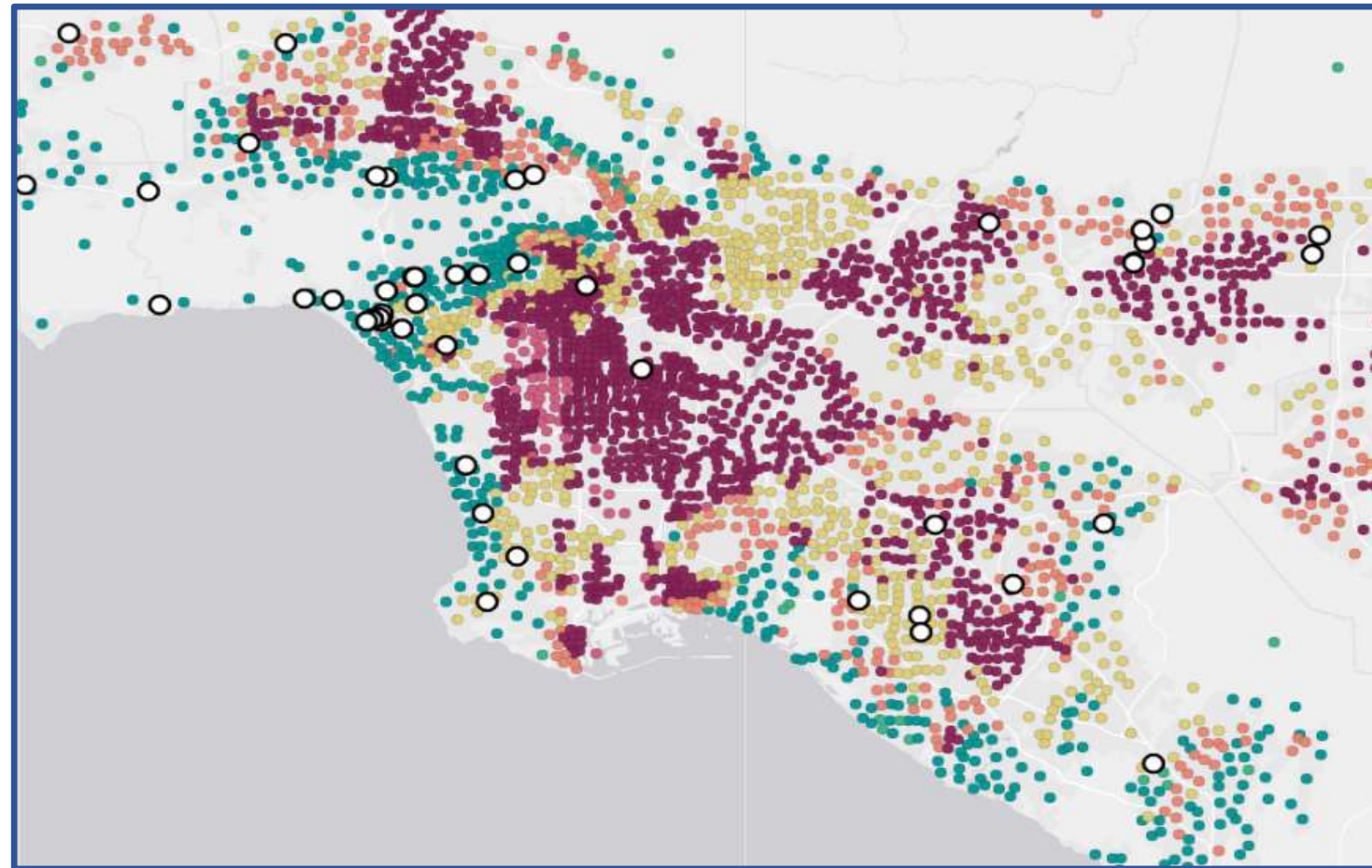# Primary Care First: 2,949 Practices in 26 Regions

Primary Care First Goals

- To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions.

- To **improve quality of care and access to care** for all patients, particularly those with complex chronic conditions.

Number of Practices

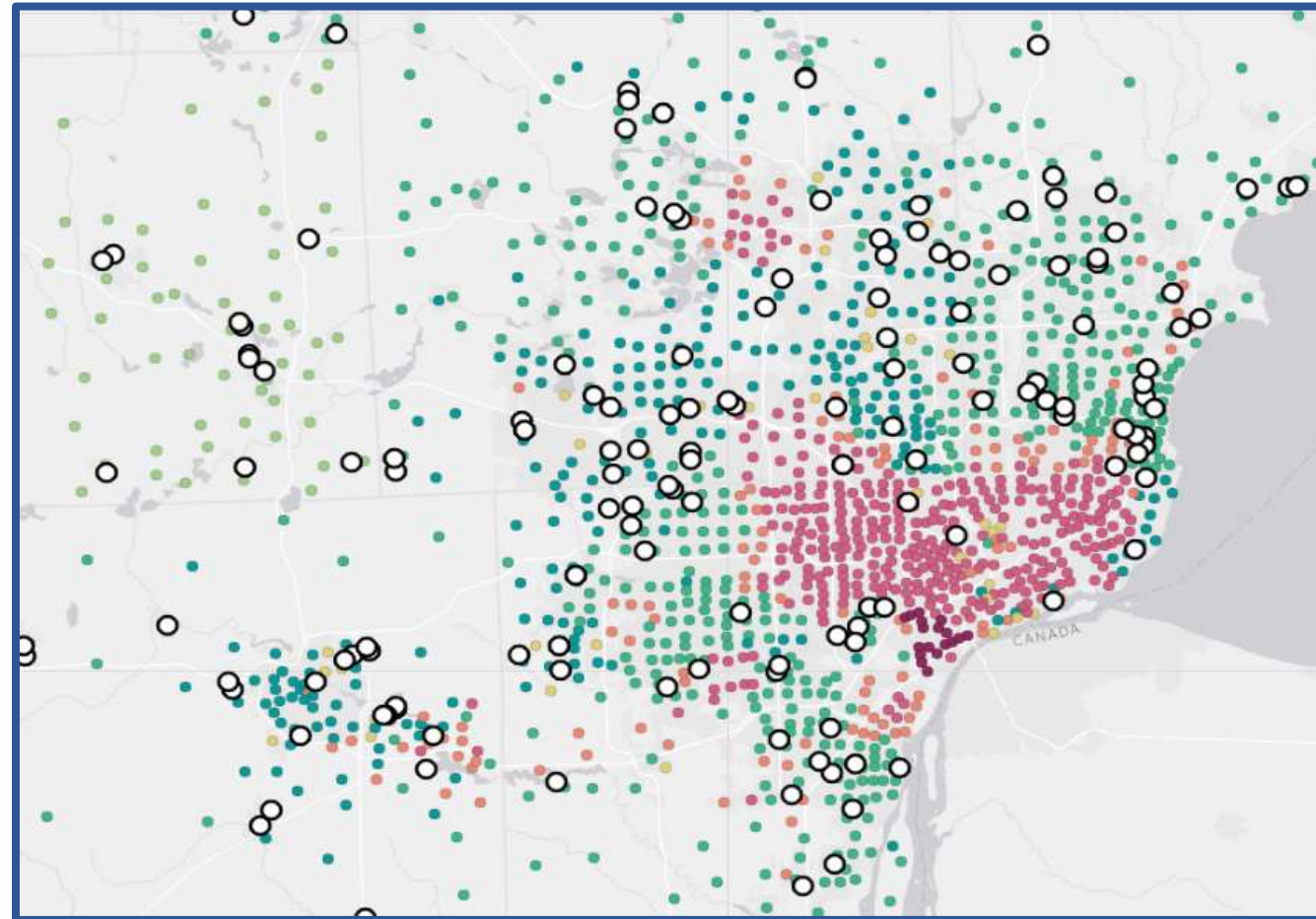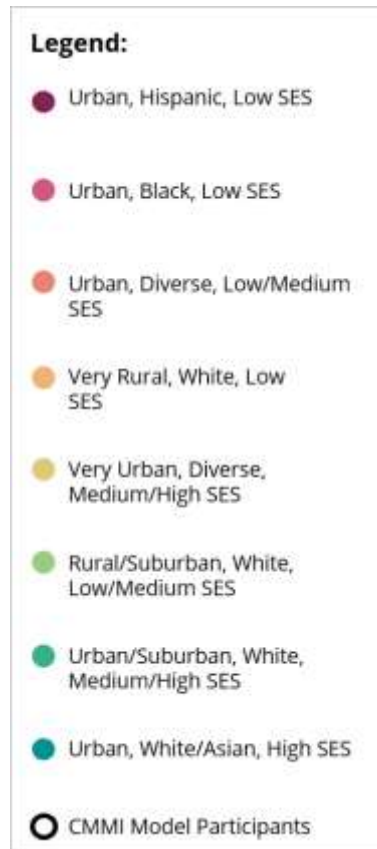|	
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	100-199
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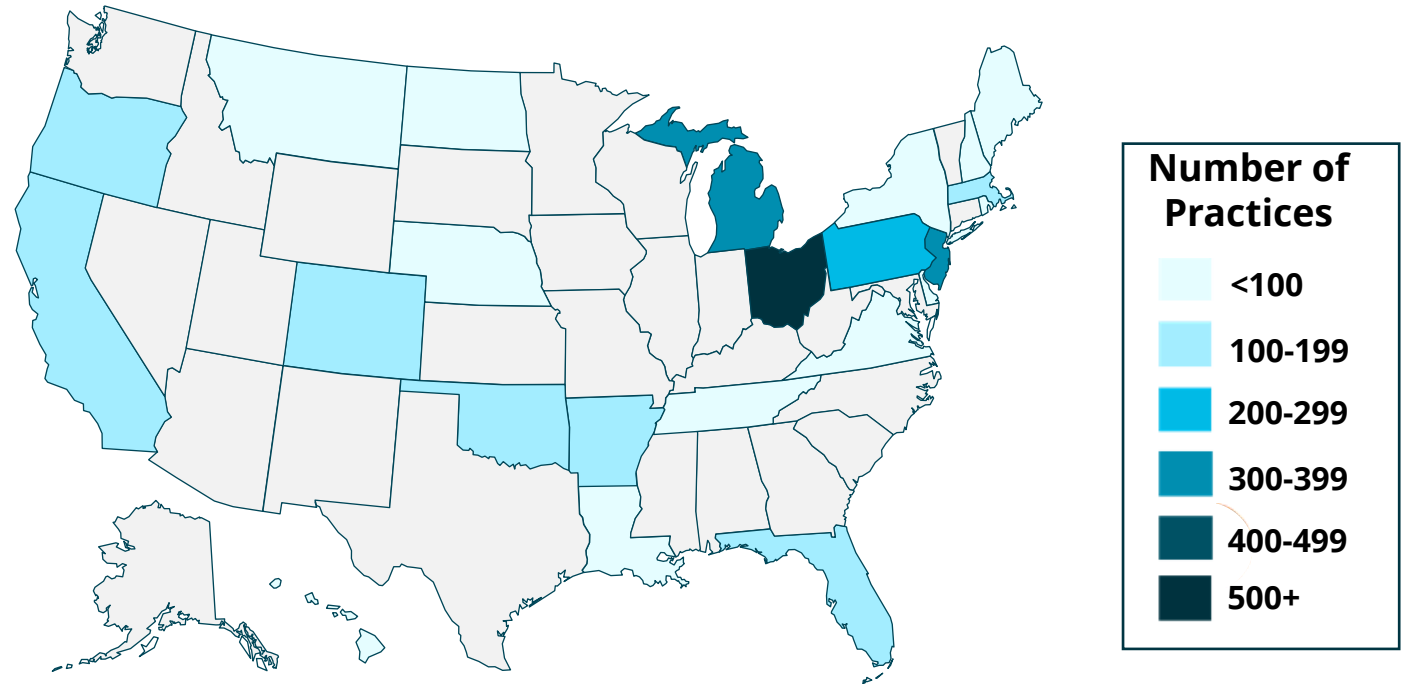
Primary Care First Model Participation in Los Angeles

Participants seem to be concentrated in the more affluent areas, with fewer beneficiaries in low SES, predominantly Hispanic census tracts.

Legend:
- Urban, Hispanic, Low SES
- Urban, Black, Low SES
- Urban, Diverse, Low/Medium SES
- Very Rural, White, Low SES
- Very Urban, Diverse, Medium/High SES
- Rural/Suburban, White, Low/Medium SES
- Urban/Suburban, White, Medium/High SES
- Urban, White/Asian, High SES
- CMMI Model Participants

Primary Care First Model Participation in Detroit

Participants seem to be concentrated in the more affluent areas, with fewer beneficiaries in low SES, predominantly Black census tracts.

Legend:
- Urban, Hispanic, Low SES
- Urban, Black, Low SES
- Urban, Diverse, Low/Medium SES
- Very Rural, White, Low SES
- Very Urban, Diverse, Medium/High SES
- Rural/Suburban, White, Low/Medium SES
- Urban/Suburban, White, Medium/High SES
- Urban, White/Asian, High SES
- CMMI Model Participants

Review of CMMI Algorithms Used for Eligibility Screening

- Implicit algorithmic bias pilot identified **potential for bias** in some models selected for review

- Bias may have contributed to **under-representation of low-income beneficiaries and racial minorities** in the models

HEALTH AFFAIRS FOREFRONT   HEALTH EQUITY

RELATED TOPICS:
MEDICARE SAVINGS PROGRAMS | BENEFICIARIES | HEALTH EQUITY | COSTS AND SPENDING | ACCESS TO CARE
| SOCIOECONOMIC STATUS | POPULATIONS | PAYMENT

CMS Innovation Center Tackles Implicit Bias

Melissa Majerol, Dora Lynn Hughes

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Administration Priorities

Thank You

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

- CMMI Resources:
  - https://innovation.cms.gov/