

## Transcript of the presentation of Synthesis of Evaluation Results across 21 Medicare Models

JENNIFER LLOYD: Hello, I'm here to review a high-level summary of the findings from the synthesis of evaluation results across 21 Medicare models created by the CMS Innovation Center.

The CMS Innovation Center has created this summary of evaluation results for 21 Innovation Center models and demonstrations focused on Medicare beneficiaries and healthcare providers.

We conducted this synthesis to capture a number of learnings from evaluating models over the past 10 years that could be useful to inform future model development.

First, we'll review results for total Medicare expenditures.

We looked at total Medicare expenditures for both gross and net spending.

Across the 21 Medicare models examined, 14 of the models, or more than half, demonstrated gross savings to Medicare.

While many models produced gross savings to Medicare, fewer models were able to demonstrate net savings due to the financial incentive payments provided to participants by CMS.

These payments ensure robust participation in the Innovation Center models.

Financial incentive payments typically include distributions of shared savings to successful model participants and/ or monthly payments to participants for enhanced care management or infrastructure investment.

For models that paid financial incentives to participants, of which there were 18 models in this analysis, six of those models had net savings, six models incurred net losses, and six models did not change net spending.

Changes in Medicare spending were driven by improvements in healthcare utilization, particularly within the inpatient and post-acute care settings, both of which are costly care settings. Ten models reduced inpatient admissions. Fourteen models resulted in more efficient post-acute care. Seven models reduced emergency department visits and or inpatient readmissions.

Some models had unfavorable increases in care in these settings although, in some cases, these increases could have been the result of increased access and engagement with the healthcare system that may dissipate over time. For example, two models identified and treated chronic conditions to prevent beneficiaries' conditions from worsening. When beneficiaries learn more about their health conditions and receive more care to treat those conditions, they may have more health care utilization, particularly in the short term. Both of these particular models focused on prevention, which should reduce utilization and expenditures in the long-term if beneficiaries' chronic conditions are better managed.

Next, we will review results for quality of care.

For the two measures that were available to examine across all of these models, we found that quality of care was mostly maintained. Based on beneficiaries' self-reported survey results, most of the models show that beneficiaries had similar care experiences as Medicare beneficiaries who are not in Innovation Center models.

Beneficiaries in most models are very satisfied with their care, and most model participants find it difficult to further improve on beneficiaries' care experience.

Two models in this analysis had notable improvements in patient or caregiver self-reported care experience.

One model had unfavorable findings. These findings were small in magnitude and were not accompanied by worse functional status outcomes among those beneficiaries.

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We also examined mortality, or a beneficiaries' risk of dying related to their provider's participation in a model. Four of the models showed that beneficiaries had a lower risk of mortality from their provider's participation in the model. Most other models found that there was no harm caused by the model as the risk of mortality did not increase.

A number of themes emerged across the 21 Medicare models that were examined. Themes fell within two broad categories: 1) models focused on acute or specialty care and targeted populations, and 2) primary care and population management models. The two groupings of models serve different purposes to effectively manage both the complex and healthier populations that make-up the Medicare beneficiary population.

Models that focus on reducing acute or specialty care or that target specific populations, such as beneficiaries with cancer or end-stage renal disease, were more likely to show gross savings and generally had larger, more favorable impacts on utilization.

It is possible that the higher baseline spending of sicker beneficiaries, the inclusion of institutional and specialty care providers, and the more narrowly focused target populations in these models provided more room to cut costs.

The primary care and population management models operating through primary care practices, accountable care organizations or ACOs, health homes, or health plan networks typically had smaller average declines in spending and other outcomes. These models generally serve large panels of relatively healthy, mostly low-cost Medicare beneficiaries and focus on preventing disease and improving care coordination. To observe any potential cost savings in such models, longer time windows may be needed.

Next, we will review the results for the acute or specialty care and targeted population models.

All of these models reduced gross spending for Medicare. Most of these models reduced inpatient admissions and or had more efficient post-acute care use. Fewer models reduced emergency department visits. Less than half of these models reduced inpatient readmissions. Quality of care was mostly maintained in these models where beneficiaries' experience of care and risk of mortality remained relatively unchanged. There were favorable improvements in one model for caregivers' experience of care. There were also unfavorable results for another model related to beneficiaries' experience of care. As I previously mentioned, these results were small in magnitude and not associated with worse functional status outcomes. Three models reduced beneficiaries' risk of mortality.

Next, we will review results for the primary care and population management models.

The primary care and population management models had less pronounced improvements in Medicare spending, utilization, and quality, relative to the prior models which served more targeted, higher-need patients. Only half of the models in this grouping reduced inpatient admissions and emergency department visits or both. Four models showed unfavorable increases in inpatient admissions, emergency department visits, or post-acute care. While seven of the twelve models had more efficient post-acute care, few reduced inpatient readmissions. Quality of care was mostly maintained in these models, though one model reduced beneficiaries' risk of mortality and another model improved beneficiaries' experience of care.

More information on these analyses is available on the CMS Innovation Center web site on the Data and Reports web page, where you can find the white paper, the slide deck, and a Findings at a Glance two-pager.

Thank you.