

CMS Innovation Center Overview for NCVHS

Value Based Care Models vs Fee-For-Service: Implications for HIPAA Standards

April 11, 2024

- **Purpose:** To describe how the Innovation Center manages models.

- **Personal Benefit:** You'll have information to help you develop the NCVHS Workplan

- **Agenda:**
 1. What is the Center for Medicare and Medicaid Innovation (CMMI)?
 2. Model Operations
 3. Model Data Exchanges

The Affordable Care Act created the Innovation Center.

- The Marketplace (healthcare.gov) and Medicaid expansion increased **access to care.**
- The Innovation Center improves the cost and quality of care.
The purpose of the Innovation Center is to “test innovative payment and service delivery models to reduce **program expenditures** while preserving or enhancing the **quality of care.**” – ACA Section 3021

We pursue our vision through model tests.

A CMMI “model” is not AI, a mathematical model, or a system.

A model . . .

- Pilots a policy change.
- Puts an intervention into Medicare or Medicaid that tests new ways to reward providers for novel approaches to delivering cost-efficient, high-quality care.
- Can be voluntary or mandatory. **Most are voluntary.**
- Impacts the actual payments and experience of a real subset of providers and beneficiaries.
- Is created through a unique model creation process.
- Has a limited duration (typically five years).

You will also see the term Alternative Payment Model (APM) in the Quality Payment Program, created from the MACRA (Medicare Access and CHIP Reauthorization Act).

A model test can expand to the permanent Medicare or Medicaid program.

Three scenarios for success from Statute:

1. Quality improves; cost neutral
2. Quality neutral; cost reduced
3. Quality improves; cost reduced (best case)

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking.

We have launched over 50 models in several categories.

Goal: All Traditional Medicare beneficiaries in an accountable care relationship by 2030.

Seamless Care Models Group

- Accountable Care Organization Models
- Special population models (e.g., Kidney Care Models)
- Medicare Advantage models (managed care)
- Prescription Drug Models.

Patient Care Models Group

- Primary Care Models
- Hospital Based Models
- Episode-Based Payment Models

State & Population Health Models Group

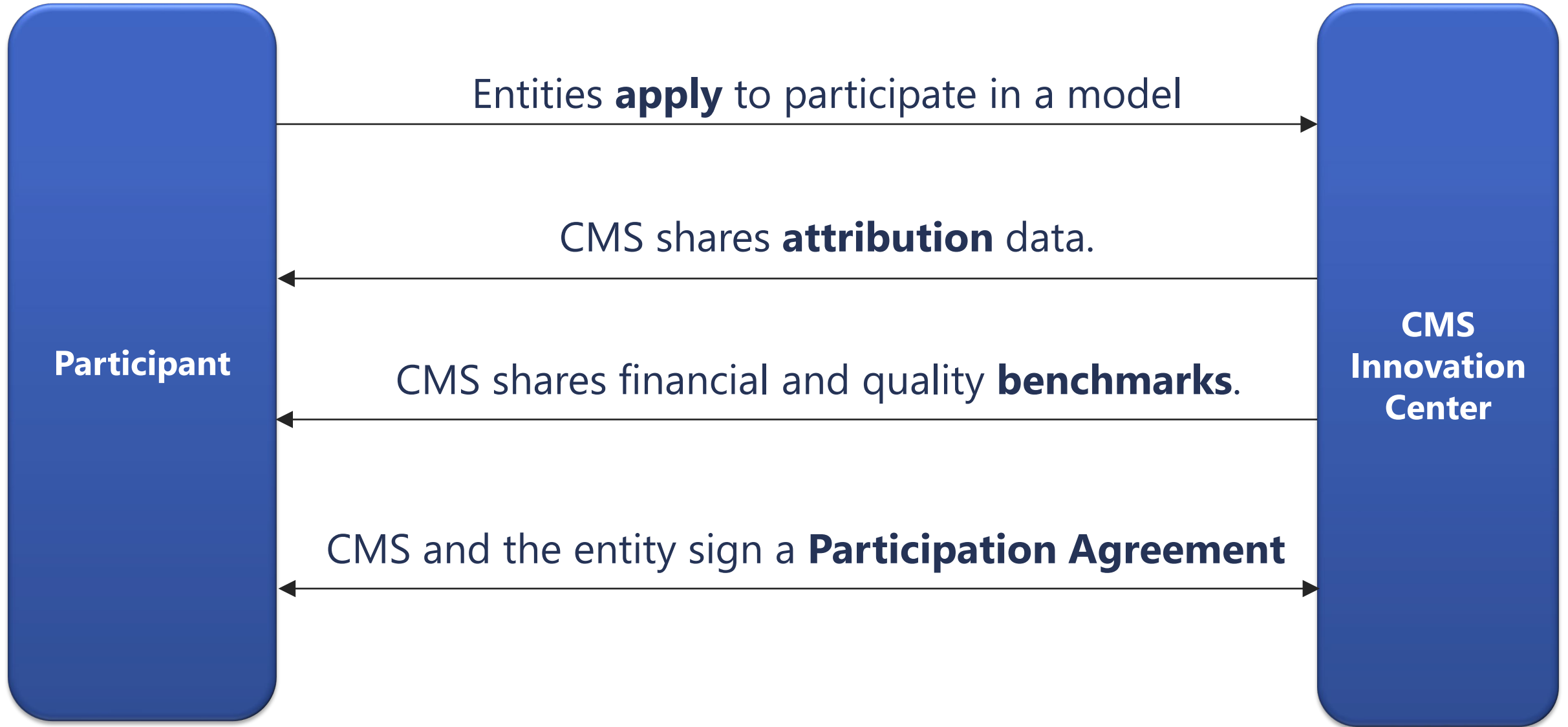
- Population Health Models
- State and Local Models
- Multi-Payer Models

There are several unique aspects of Innovation Center operations vs. the CMS Fee-For-Service program.

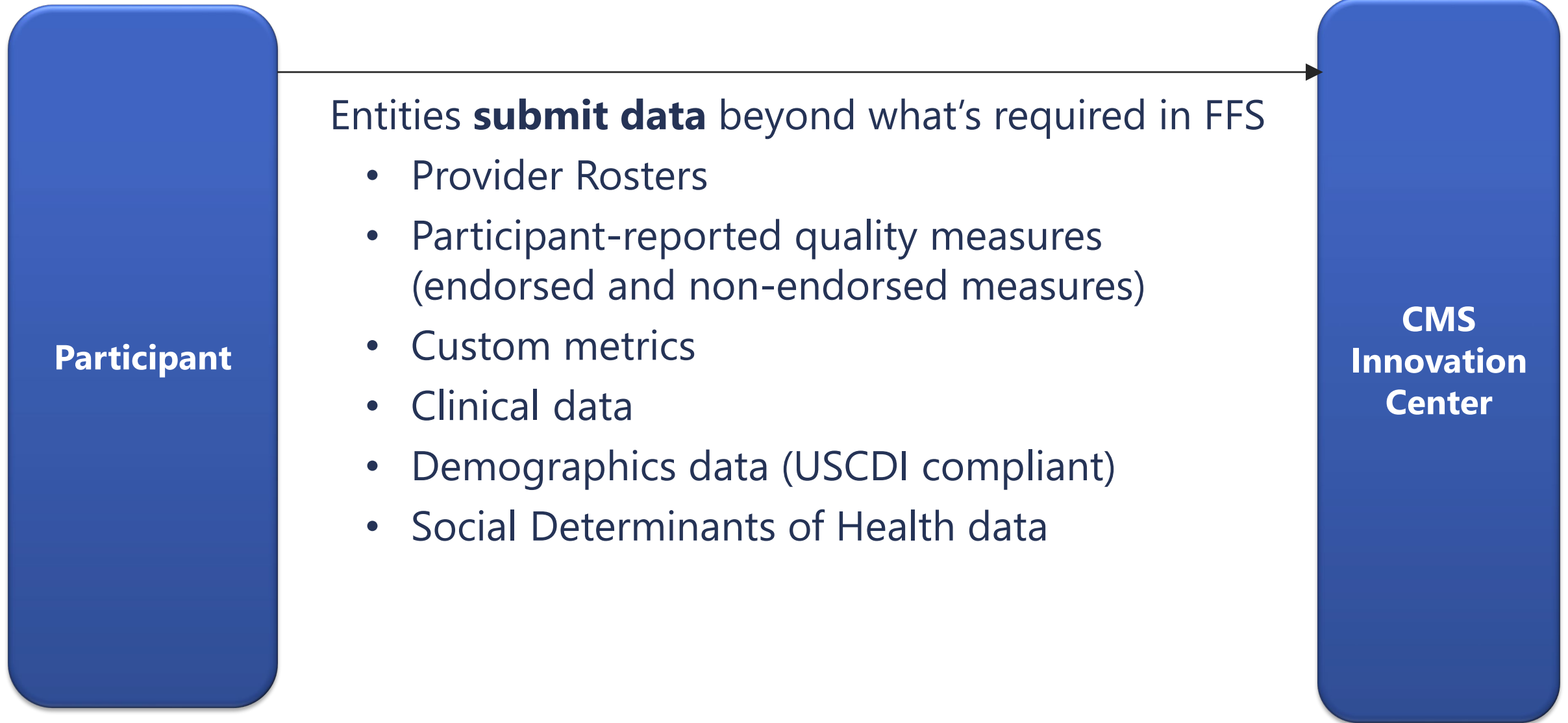
- We interact with entities **beyond** traditional providers and suppliers.
- Participants **apply** to join voluntary models (even existing Medicare providers).
- There is significant **participant heterogeneity**.
- We work with **data** beyond administrative data (quality measures, clinical, social determinants).
- We make **non-claims-based payments**. Many payments aren't based on diagnoses or procedures documented in a claim.

We have unique data exchanges for models vs. FFS.

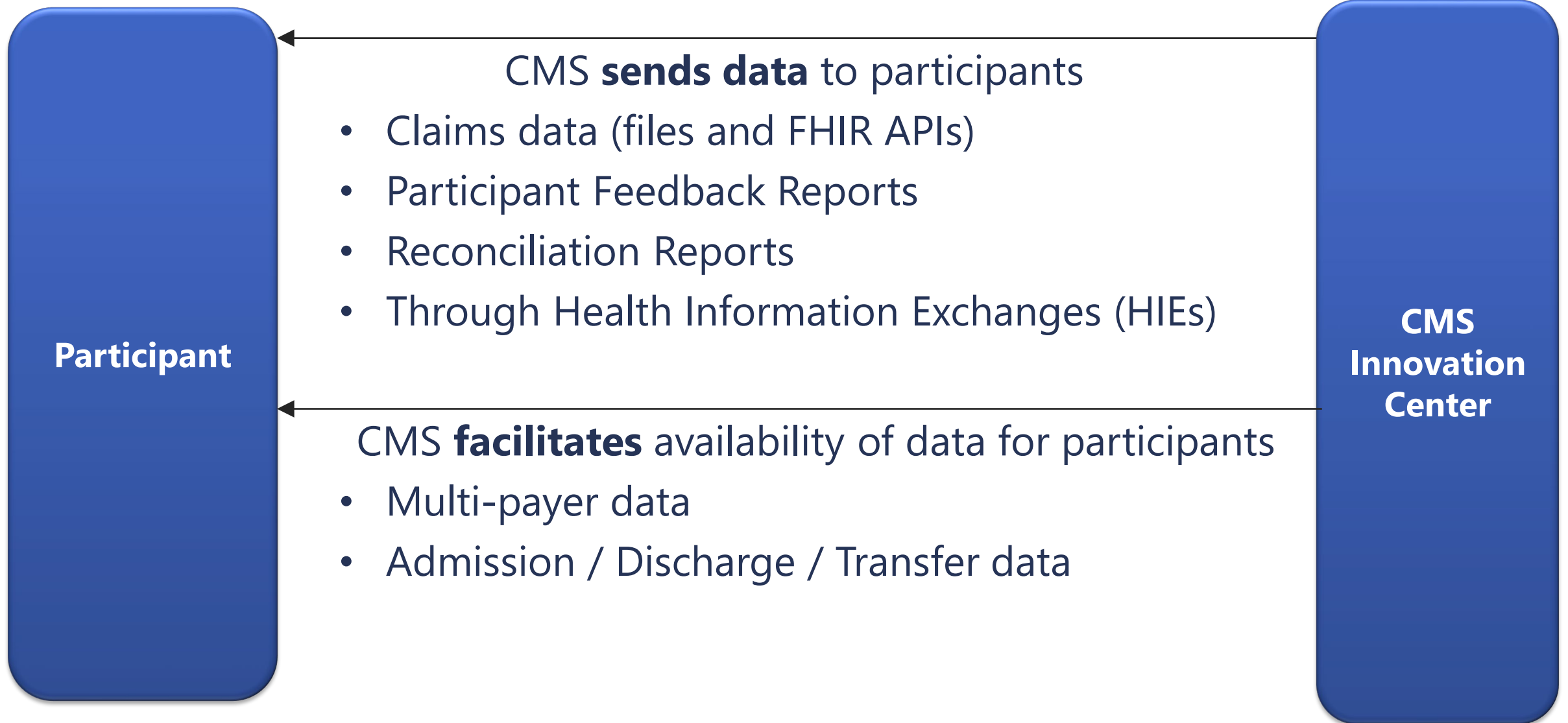
- We don't use X12 administrative standards in our unique data exchanges.
- We have recently introduced FHIR-based exchanges.
 - Beneficiary Claims Data Sharing (API) share claims data with ACOs via FHIR
 - We are developing
 - A FHIR-based API to collect HRSN data for models.
 - A FHIR-based data collection for our Enhanced Oncology Model (EOM). This data collection will interface with EHR vendors to collect Minimal Common Oncology Data Element compliant data (a FHIR Implementation Guide)
 - A FHIR Questionnaire capability for our GUIDE model. This will let providers supply data to us while working in their EHRs.
- However, most of our data exchanges with participants are custom.



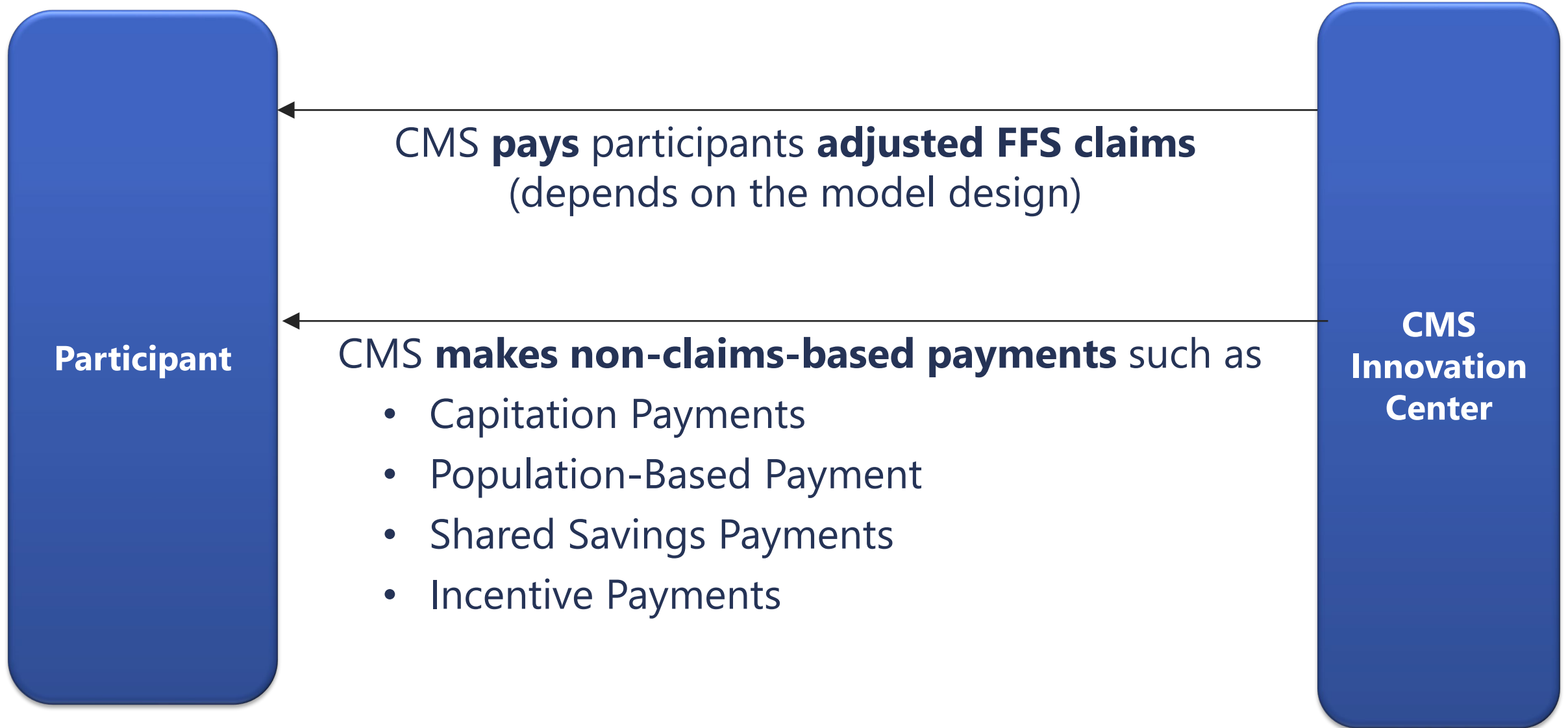
Other payers have similar data exchanges for their value-based care programs.



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- We want to reduce burden on our participants and to maximize the actionable data available to them.
 - Standards-based exchanges are important.
 - Multi-payer alignment is also critical.
- The CMS Innovation Center treats models as tests. New models may introduce new concepts and data exchanges.

Appendix

- [Innovation Center Strategy](#)
- [Health Care Learning & Action Framework](#)
 - [APM Framework](#)
- [Value Based Care from a patient perspective](#)
- [Evaluations of Innovation Center models](#)



**A HEALTH SYSTEM THAT ACHIEVES EQUITABLE OUTCOMES
THROUGH HIGH QUALITY, AFFORDABLE, PERSON-CENTERED CARE**



[Innovation Center Strategy Refresh \(2022\)](#)

We create each model uniquely through a Model Lifecycle

- **Concept:** Identify and describe the idea.
- **Planning and Design:** Create the policy design and produce an Innovation Center Investment Proposal (ICIP). OMB and HHS clear each ICIP.
- **Solicit and Build:** Participants sign Participation Agreements. We create the programmatic, operational, and IT elements of the model.
- **Run and Execute:** The model goes “live”
- **Evaluation:** determine if the model is effective.
- **Closing:** close the model or expand and transition to the CMS-owning component.

We have 9 to 12 months to launch a model after clearance.

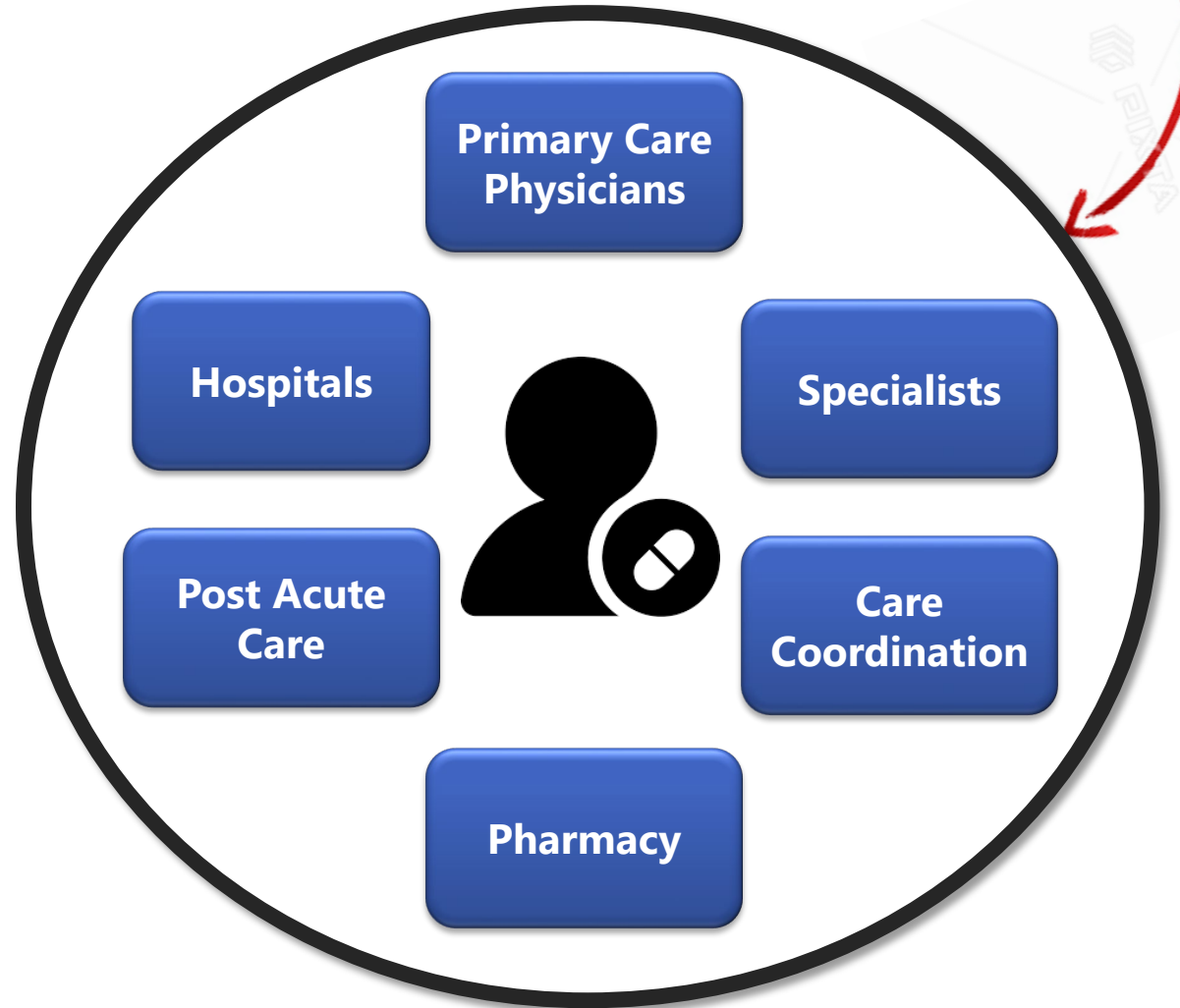
Many models are value-based care models.

Value-based care pays providers based on outcomes instead of a fee schedule or for number of services.

CMMI started Accountable Care Organizations (ACO).

ACO

- ACOs are groups of providers who come together to coordinate patient care.
- CMS establishes an agreement with the ACO, measures performance, and pays the ACO against outcomes (i.e., performance against cost and quality targets).
- The ACO maintains a provider network, coordinates care, and pays providers.



Example Models: Pioneer ACO, NextGen ACO, ACO REACH

**More than 41 million
beneficiaries touched***



CMS Innovation Center models impact more than 41 million beneficiaries **in all 50 states**

**More than 314,000
providers participating***



More than 314,000 health care providers and provider groups ² **across the nation** are participating in CMS Innovation Center programs

* Source: 2022 **Report to Congress: Center for Medicare and Medicaid Innovation**. Represents two years of data. 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. The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests.

The CMS Innovation Center has engaged the health care delivery system and invested in innovation across the country.



Health care facilities where Innovation Models are being tested

CMMI has launched over 50 models. Four model tests met requirements for expansion.

- Financial
 - 14 produced gross savings
 - 6 had net savings
 - 6 had net losses
 - 6 had no impact on net spending
- Mortality
 - Improved in 4 models
 - Unchanged for the rest

Source: <https://innovation.cms.gov/data-and-reports/2022/wp-eval-synthesis-21models>

Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020

Data is essential to our policy development and operations.



Participants

- Entities (ACOs, Conveners)
- Medicare providers
- Medicare suppliers
- Non-profits
- States (Medicaid, Health Departments, State DOT)
- MAPD Plans
- Commercial Health Plans



We are data consumers

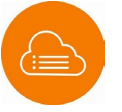


Medicare

- Administrative (provider, beneficiary, claims, encounters)
- Quality (e.g., surveys)

Medicaid (provider, beneficiary, claims)

We are data producers



Participants

- Applications/registration
- Agreements
- Participant & beneficiary lists from attribution

Unique data collections for models, such as:

- Provider rosters
- Performance measures
- Clinical Data
- Quality Measures
- Social Det. of Health

Model-specific computations

Evaluation data sets