# CMS Innovation Center Overview for NCVHS

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

April 11, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# Topics

- **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.

Public Law 111-148 [H.R. 3590], the Patient Protection and Affordable Care Act Section 3021 (March 23, 2010)

# 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

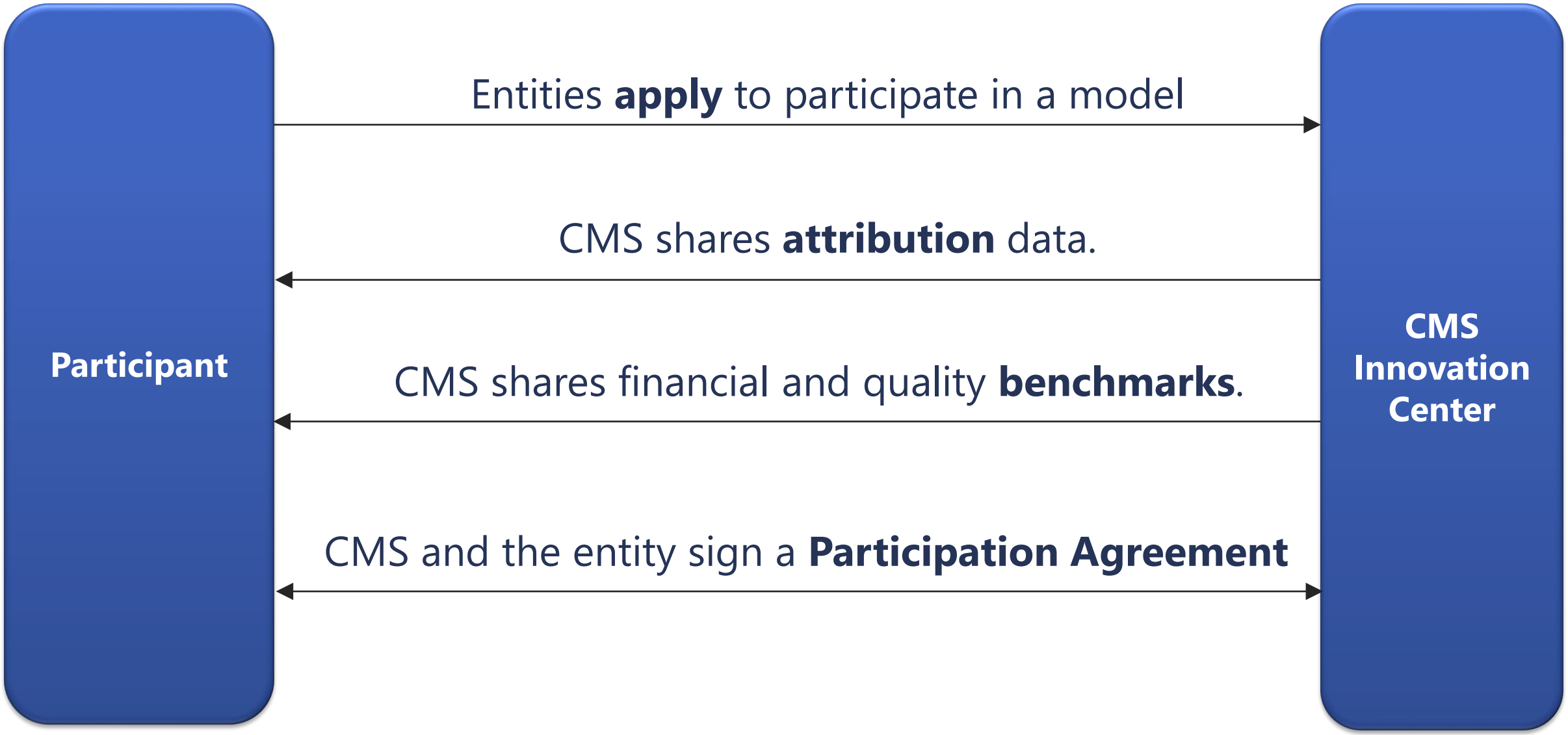
# There are several unique aspects of Innovation Center operations vs. the CMS Fee-For-Service program.

- 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.

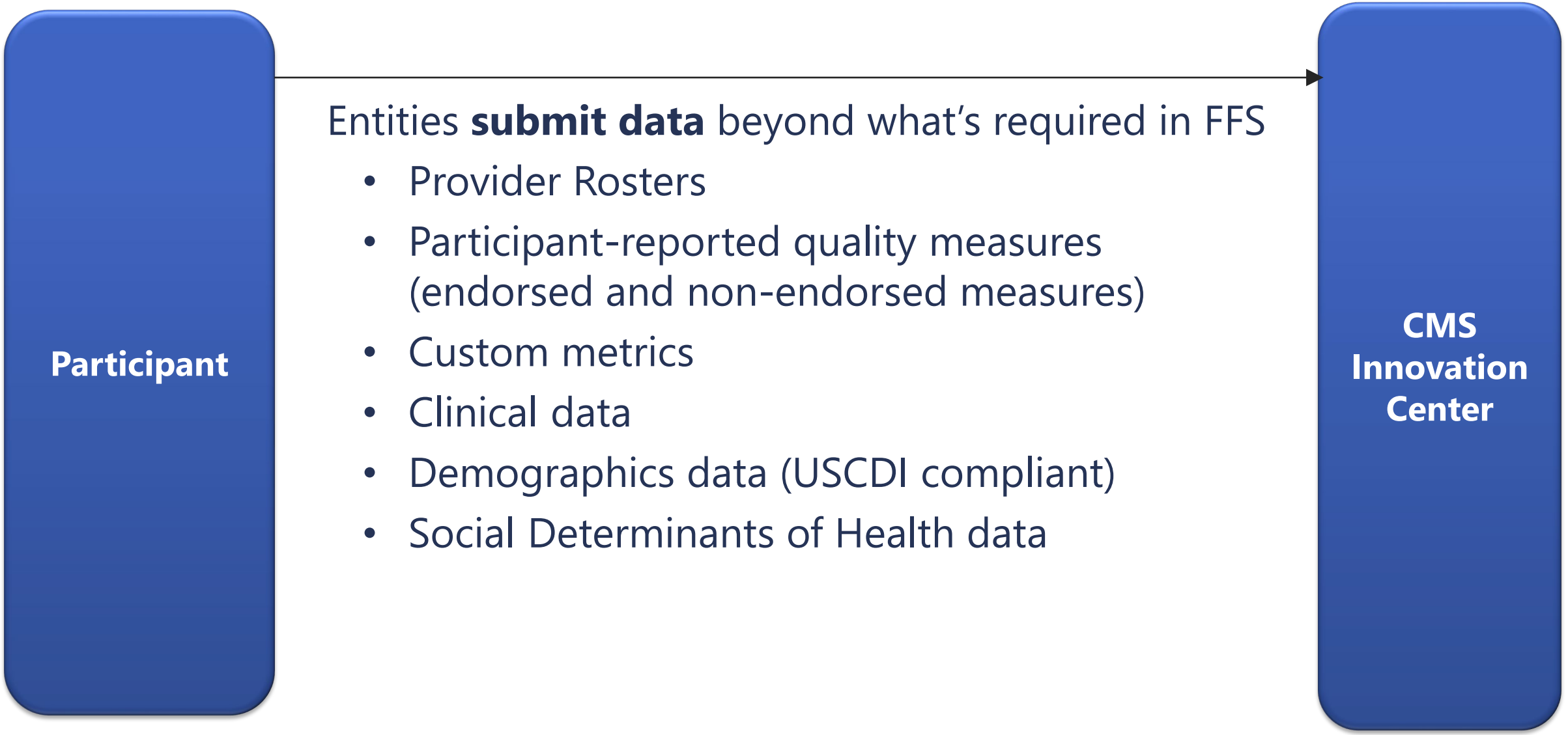
- We don't use X12 administrative standards in our unique data exchanges.
- We have recently introduced FHIR-based exchanges.
  - Beneficiary Claims Data Sharing (API) share claims data with ACOs via FHIR
  - We are developing
    - A FHIR-based API to collect HRSN data for models.
    - A FHIR-based 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.

# Data Exchanges (1 of 4)



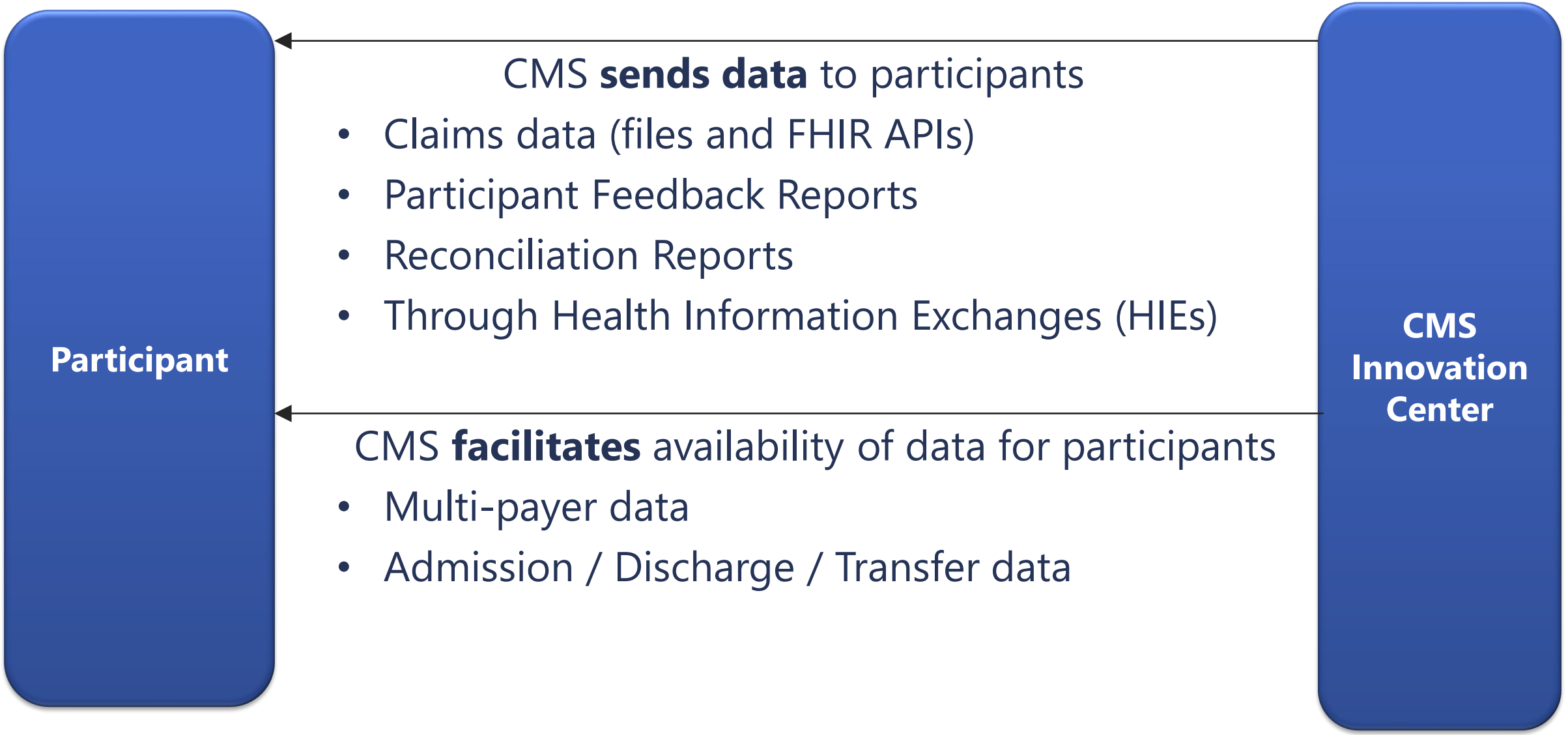

Other payers have similar data exchanges for their value-based care programs.

# Data Exchanges (2 of 4)



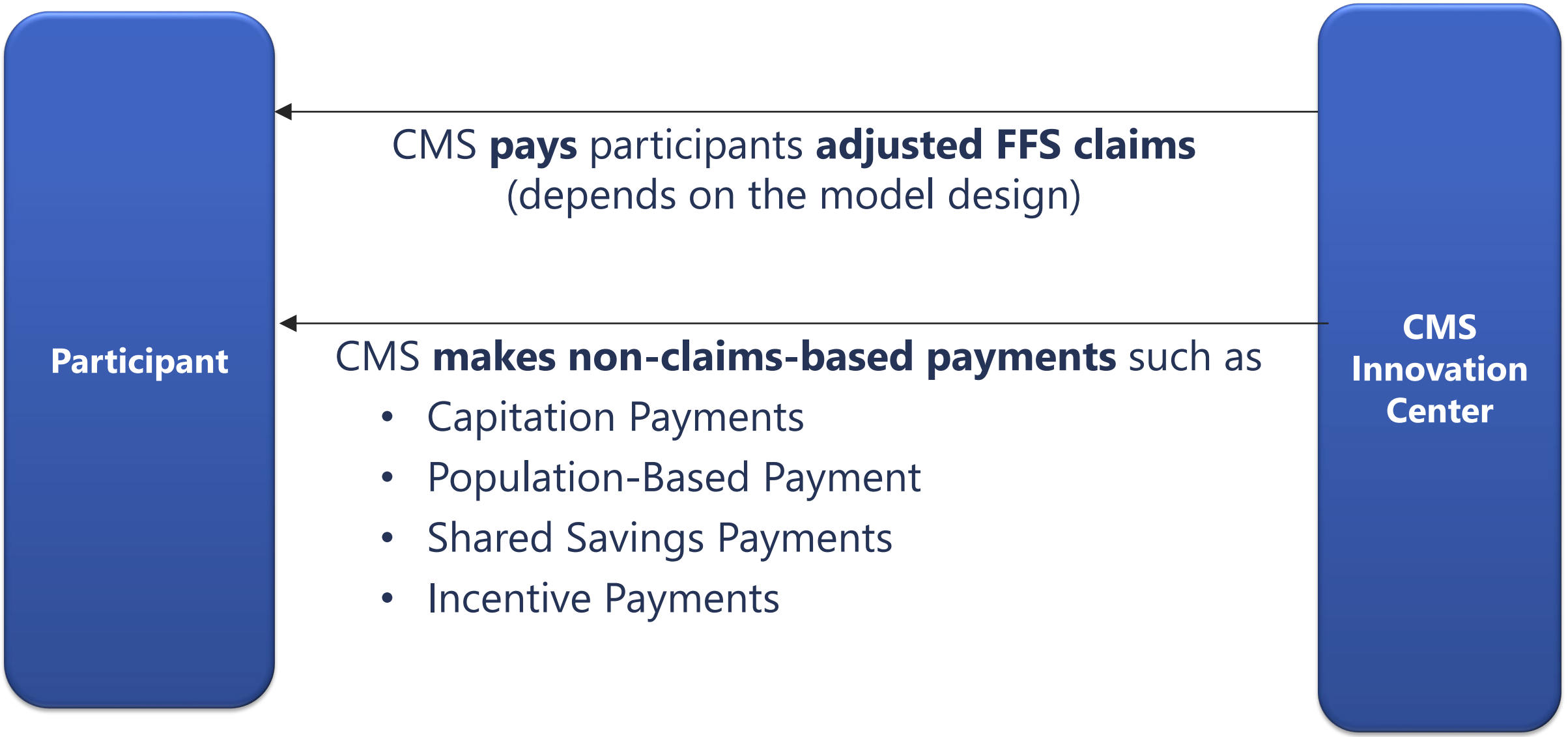

Other payers have similar data exchanges for their value-based care programs.

# Data Exchanges (3 of 4)




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

# Data Exchanges (4 of 4)




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

# Final Thoughts

- 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

# **Appendix** | References

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

# **Appendix** | Innovation Center Vision


[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.

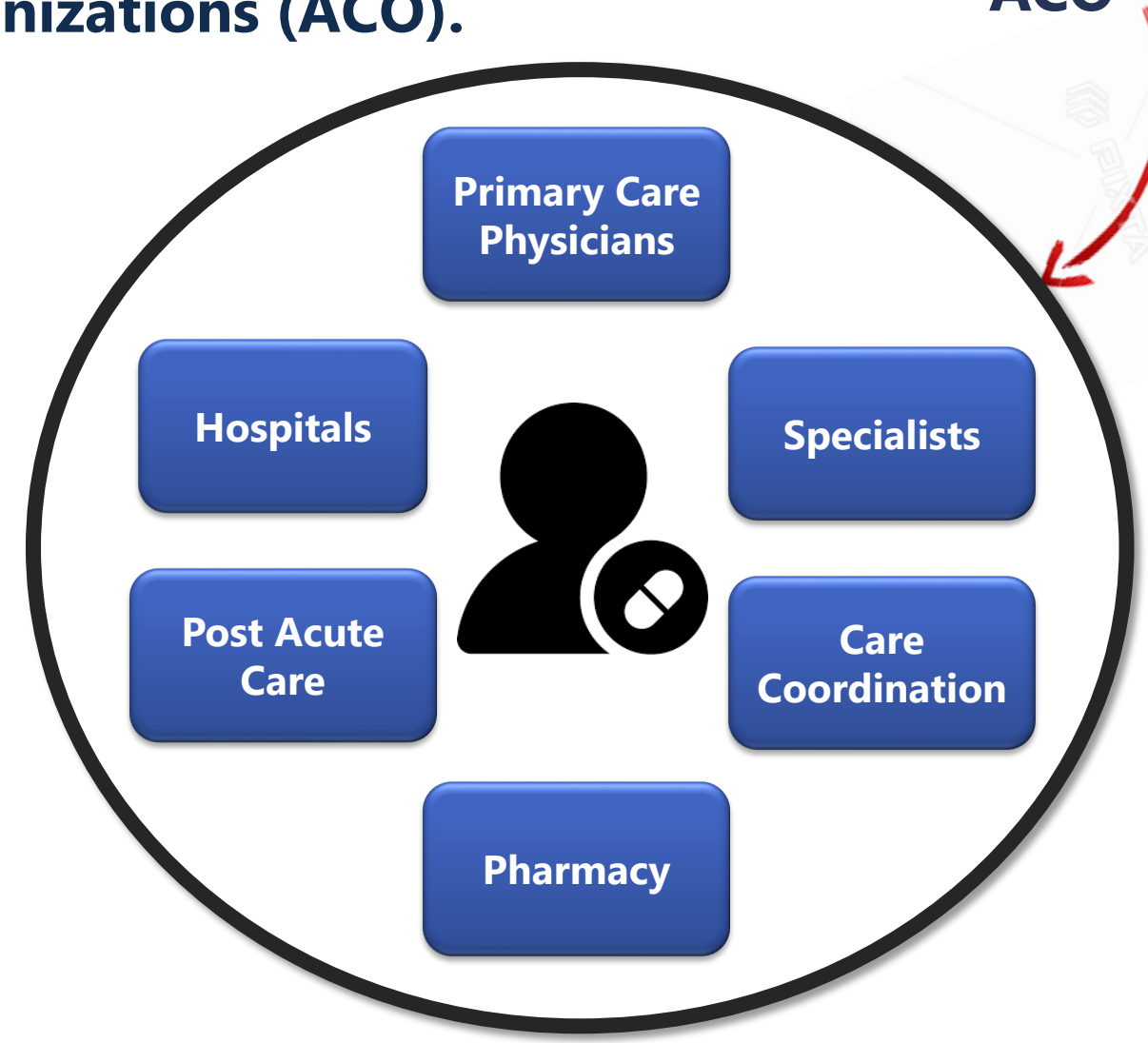
We have 9 to 12 months to launch a model after clearance.

# 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).

- 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

# **Appendix** | Scope

## 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**