CMS Innovation Center

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Overview | 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"

Three scenarios for success:

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

A model that meets one of these three criteria (and other statutory prerequisites), can be expanded in duration and scope through rulemaking

Overview | Lessons Learned from the Past 10 Years

- Not enough focus on health disparities or Medicaid
- Too many models, some of which overlap
- Voluntary models result in increased spending due to risk selection
- Too many providers reluctant or unable to accept downside risk
- Challenges in setting appropriate financial benchmarks have undermined models' effectiveness
- Statutory bar for success of models (certification) is high
- Appropriate focus on provider and health system input but lack of patient or beneficiary perspective

Current Priorities & Progress | Strategy Refresh

Five Strategic Objectives:

Example: *primary care models to improve patient navigation*

Examples: *ACO REACH benchmark adjustment; new incentives for safety net providers*

Examples: *practice-specific data, payment flexibilities, peer learning collaboratives*

Examples: *Part D Senior Savings model; proposed Medicare $2 drug list*

Example: *AHEAD state total-cost-of-care model*

Health Equity| 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 (race, ethnicity, geography, language, disability, and sexual orientation/gender identity) to identify gaps in care and develop interventions

CMS Innovation Center Strategy Roadmap| 2023 - 2030

External Engagement & Learning

Health Care Payment Learning and Action Network (LAN)
State Transformation Collaboratives, Health Equity Advisory Team, Accountable Care Action Collaborative, Person Perspectives Council, National Plan Workgroup

Listening Sessions and Webinars
Engaging beneficiary and provider perspectives across the model life cycle, informing new model development and cross-model priorities

2023

New Models Announced:
- Making Care Primary (MCP)
- Guiding an Improved Dementia Experience (GUIDE)
- States Advancing All-Payer Health Equity and Development (AHEAD)
- Transforming Maternal Health (TMaH)

2024

New Models Announced[1]: Innovation in Behavioral Health (IBH), Cell & Gene Therapy Access Model (CGT)

New Model Launches: MCP, GUIDE, AHEAD, IBH

Model Concepts Under Development:
- Population- and condition-specific models
- ACO model tests (e.g., primary care prepayment)
- Episode-based payment and specialty care models
- Models to lower prescription drug costs, including the Medicare $2 Drug List (M2DL)

2025-2029

New Model Launches: CGT, TMaH, M2DL

New Concepts Under Consideration:
- Additional ACO model tests and other policy initiatives to achieve 2030 accountable care goals
- Specialty integration models
- Health Plans and Prescription Drugs

Cross-Model Priorities

- Person-Centered Quality
- Health Equity
- Multi-payer Alignment
- Measuring Transformation Impacts
- Transparency, Interoperability, and Data Sharing

MCP Aim and Components

MCP will aim to achieve widely accessible high-quality care while testing a new payment and care delivery structure that builds on insights from previous models and has an intentional focus on advancing health equity and partnerships to increase alignment.

Integrated, Coordinated, Person-Centered Care

- Interprofessional Care Team
- Care Management and Coordination
- Specialty Care Integration
- Community Supports and Services
- Capabilities Built Over Time

Flexible, Enhanced Prospective Payment with Accountability

- Progression to Prospective Payment
- Progression in Accountability
- Payment for Specialty Integration
- Practice Definition and Attribution
- Regulatory Flexibilities

Achieve equitable health outcomes through widely accessible high quality, affordable, person-centered care with accountability for outcomes

Advance Health Equity

- Integrate Health-Related Social Needs into Care
- Enhanced Services Payments to Enable Improved Health Outcomes
- Quality Strategy Targeting Reduction in Disparities
- Model Reach in Underserved Communities

Partnerships

- State-Based Implementation
- Multi-Payer Directional Alignment
- Stakeholder and Beneficiary Engagement
- State-Based Learning System

Key Model Design Features

MCP includes the following design features, which incorporate insights, address lessons learned from previous CMS Innovation Center models, and integrate stakeholder feedback.

- Upfront infrastructure funding for eligible organizations
- Focus on equity, underserved populations, and social-risk adjustment in payment to participants
- Ten-year model with three progressive tracks as well as a 6-month implementation period
- Incorporation of high-quality specialty care partnerships
- Commitment and early engagement with state Medicaid agencies (SMAs)
- Support to reach patients outside of visits and beyond the walls of the clinic

CMMI Portfolio | Making Care Primary (MCP)

MCP provides a pathway from FFS payment to prospective, population-based payment. The model is designed to support comprehensive primary care while aiming to improve quality, patient experience, and population health outcomes.

Comprehensive Primary Care

Ensure patients receive primary care that is integrated, coordinated, person-centered and accountable

New Payment Pathway for Value-Based Care

Create a pathway for primary care organizations and practices – especially small, independent, rural, and safety net organizations – to enter into value-based care arrangements

Improved Quality and Outcomes

Improve the quality of care and health outcomes of patients

Quality Performance Measures

Mirroring CMS's broader quality measurement strategy, measures were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk "*"), Quality Payment Program (QPP), MIPS Value Pathways (MVP) and MIPS APM Performance Pathway (APP) measure sets, and the National Quality Forum (NQF)'s Core Quality Measures Collaborative (CQMC) Primary Care Core Measures.*

Focus	Measure	Type	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey Vendor or CQM	X	X	X
Behavioral Health	Screening for Depression with Follow Up*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*+	To be determined		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-health centers and Non-Indian Health Programs (IHPs))*	Claims		X	X
	EDU CI *(Health Centers and IHPs)*	Claims		X	X

+Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

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IBH Objectives and Intended Outcomes

The IBH Model aims to test a value-based payment (VBP) approach, aligned across Medicaid and Medicare, that enables behavioral health (BH) practices to integrate BH care with physical health (PH) care and health-related social needs (HRSNs).

OBJECTIVES

Improve care quality and health outcomes for people with moderate to severe BH conditions, including mental health (MH) conditions and/or substance use disorders (SUDs).

Support BH practices to provide integrated, person-centered care in a BH setting, working with other providers as part of an **interprofessional care management team** to address beneficiaries' BH and PH needs as well as HRSNs.

INTENDED OUTCOMES

- Enhanced quality and delivery of **whole person care**
- Increased **access to BH, PH, and HRSN services**
- Improved health and equity **outcomes**
- Fewer **avoidable emergency department** and inpatient visits
- Strengthened **health information technology (IT) systems capacity**

State Medicaid Agency Recipient Role

SMA recipients will lead IBH implementation via their responsibilities outlined below.

ROLE OVERVIEW

- Develop and enhance **statewide infrastructure to support BH practice** participants
- **Recruit and select BH practices**, working with managed care partners and/or state fiscal intermediaries as applicable
- **Partner with state MH agencies** to inform and carry out model pre-implementation and implementation activities
- Implement the **care delivery framework**
- **Develop and implement a Medicaid APM** that aligns with the IBH payment approach
- **Convene** relevant stakeholders in model development and implementation
- **Collect, analyze, and share model data** among practice participants and with CMS
- Contribute to **model learning and convening**

The model quality strategy will measure:

Health outcomes targeted by IBH

Care coordination

Physical health screenings

HRSNs

Beneficiary utilization of services

Patient-reported outcome measures

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BH Practice Participant Role

BH practice participants within awarded states will deliver the IBH care delivery framework for eligible beneficiaries.

ROLE OVERVIEW

- **Screen, assess, and refer beneficiaries,** as needed, for BH and PH conditions
- **Lead an interprofessional care team** to address the beneficiary's BH and PH conditions and HRSNs, adjusting the care plan as needed
- **Support equitable care** by implementing HRSN screenings, a population needs assessment, and a health equity plan

Examples of potential IBH practice participants:

- Outpatient Opioid Treatment Programs
- Community Mental Health Centers (CMHCs)
- Certified Community Behavioral Health Clinics (CCBHCs)
- Non-affiliated, Independent Providers
- Health Departments
- Tribal Health Organizations and Clinics
- Hospital- or University-Affiliated Outpatient BH Programs or Clinics
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

CMMI Portfolio | Innovation in Behavioral Health (IBH) Model

Model Participants

States

CMS will select up to 8 states through a Notice of Funding Opportunity (NOFO). States will lead IBH implementation.

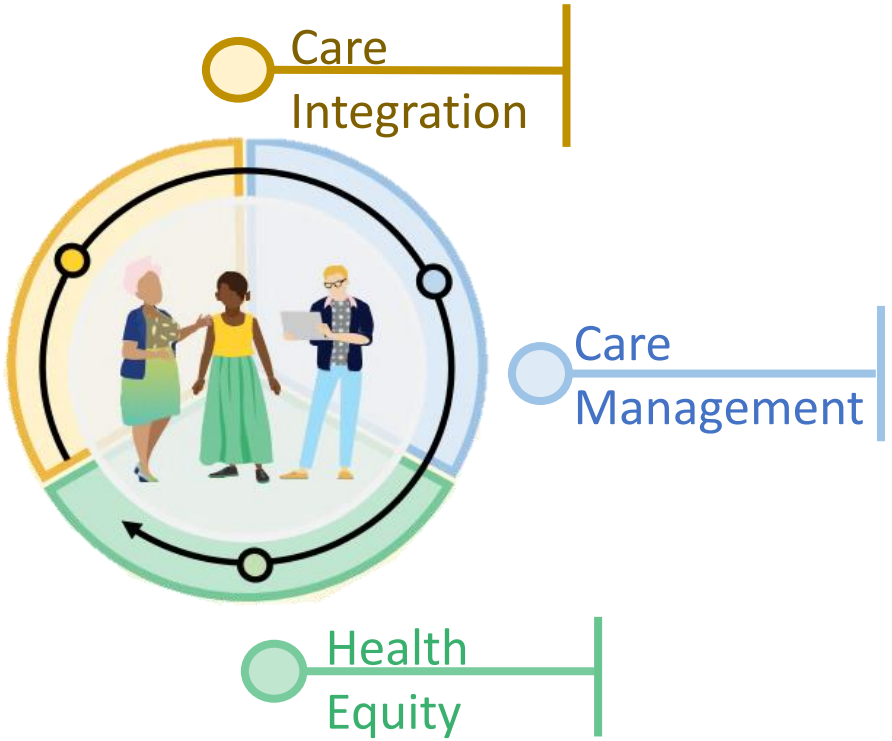
BH Practices

Practices must be licensed in the selected states and willing to provide IBH Model services.

Beneficiaries

Adult Medicaid and Medicare beneficiaries with moderate to severe MH conditions and/or SUDs.

Care Delivery Framework



Payment Approach

- **Aligned Medicare and Medicaid APMs** to support the care delivery framework and address funding gaps in the BH system while promoting accountable care
- **Cooperative Agreement funding** to states to support practice participants and develop a Medicaid APM
- **Infrastructure funding to practice participants** to support health IT investments and practice transformation

Additional Information

- Visit the CMS Innovation Strategic Direction webpage and read the white paper
- Email your questions and feedback to CMMIStrategy@cms.hhs.gov
- Sign up to receive regular email updates about the CMS Innovation Center, including opportunities to engage with, provide input on and potentially participate in model tests
- Follow us @CMSinnovates on Twitter