THE EVOLVING ROLE OF THE CENTER FOR MEDICARE AND MEDICAID INNOVATION IN ACHIEVING VALUE-BASED PAYMENT GOALS

The Affordable Care Act (ACA) established a new capacity within the Center for Medicare and Medicaid Services (CMS) for linking healthcare payment and delivery to quality and efficiency, by creating the Center for Medicare and Medicaid Innovation (CMMI) to advance new payment and delivery models. CMMI is charged with testing payment and delivery models which, if shown to be effective, can then be more broadly deployed across the Medicare and Medicaid programs.

In January 2015, the U.S. Department of Health and Human Services (HHS) further accelerated the movement towards value-based payments by setting a goal to shift 50 percent of Medicare fee-for-service payments to alternative payment models (APMs) by 2018.[1] Shortly following that announcement, Congress also passed the Medicare Access and CHIP Reauthorization Act (MACRA), which incentivizes participation in APMs, further elevating the importance of CMMI's work to develop and test APMs.

CMMI's Approach to APM Development and Testing

Since its inception, CMMI has launched APMs across a variety of chronic and acute conditions, and a diverse range of settings including hospitals, nursing homes, primary care, and post-acute care facilities. CMMI's models include a range of APMs, including patient centered medical homes (PCMHs), accountable care organizations (ACOs), and bundled or episode-based payments. Figure 1 outlines select examples of programs that CMMI has announced or proposed since 2001. Figure 2 provides a timeline of these models and outlines whether they are voluntary or mandatory.

CMMI can expand the scope and duration of its programs under section 3021 of the ACA within section 1115A of the Social Security Act (SSA).[2] Section 3021 stipulates that the Secretary has authority to expand the scope and duration of a CMMI model being tested and implement testing on a nationwide basis if the model meets the following criteria: reduces spending without reducing the quality of care, or improves the quality of care without increasing spending, and does not deny or limit the coverage or provision of any benefits.[3] CMMI's testing models are evaluated for qualification by CMS and spending is certified by CMS's Chief Actuary.[4] To date, two models – Pioneer ACOs and the Medicare Diabetes

[1] Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value [news release]. HHS Press Office. January 26, 2015. Available at: http://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html.
[2] About the CMS Innovation Center. CMS. October 21, 2015. Available at: https://innovation.cms.gov/about/index.html.
[3] CMMI Model Certifications. CMS. March 23, 2016. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/CMMI-Model-Certifications.html.
[4] About the CMS Innovation Center. CMS. October 21, 2015. Available at: https://innovation.cms.gov/about/index.html.

Prevention Program – have been certified as meeting the expansion criteria, but CMMI has not yet exercised its authority to expand the scope or duration of these demonstrations and pilots.[5,6]

Figure 1: Examples of CMMI Programs

Program Name	Year	Aim	Type of Participation	Eligible Participants	Scale
Bundled Payment for Care Improvement Initiative (BPCI)[7]	2011	Test episode-based payments	Voluntary	Hospitals, physician groups, post-acute care providers	1457 participants across 48 states, and the District of Columbia
Comprehensive Primary Care (CPC) Initiative[8]	2011	Test a multi-payer performance-based payment model for primary care practices	Voluntary	Primary care practices	2,188 participating providers, 445 practice sites, distributed across 7 CPC regions
Pioneer ACO Model[9]	2011	Test ACOs among providers experienced in care coordination	Voluntary	ACOs	9 Pioneer ACOs across 6 states
Health Care Innovation Awards (HCIA)[10]	2012	Test innovative payment and delivery models	Voluntary	Providers, payers, local government, public-private partnerships	Grants awarded to 146 individual organizations/ entities
State Innovation Model (SIM)[11]	2013	Test multi-payer models aiming to improve care/health and decrease costs	Voluntary	States	Grants awarded to 38 individual states/territories and the District of Columbia

[5] Certification of Medicare Diabetes Prevention Program. Office of the Actuary. March, 14 2016. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf

[6] Press Release: Affordable Care Act payment model saves more than $384 million in two years, meets criteria for first-ever expansion. HHS. May 4, 2015. Available at: http://www.hhs.gov/about/news/2015/05/04/affordable-care-act-payment-model-saves-more-than-384-million-in-two-years-meets-criteria-for-first-ever-expansion.html

[7] Bundled Payments for Care Improvement (BPCI) Initiative: General Information. CMS. April 29, 2016. Available at: https://innovation.cms.gov/initiatives/Bundled-Payments/.

[8] Comprehensive Primary Care Initiative. CMS. April 14, 2016. Available at: https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/.

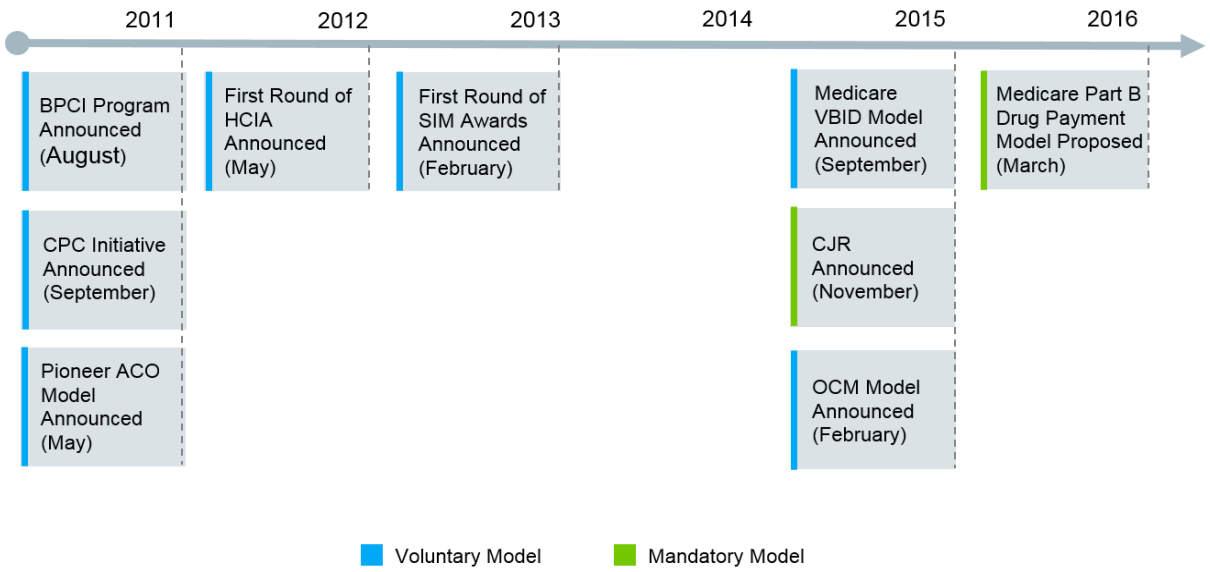
[9] Pioneer ACO Model. CMS. April 29, 2016. Available at: https://innovation.cms.gov/initiatives/Pioneer-aco-model/.

[10] Health Care Innovation Awards. CMS. April 29. 2016. Available at: https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/.

[11] State Innovation Models Initiative: General Information. CMS. October 5, 2015. Available at: https://innovation.cms.gov/initiatives/state-innovations/.

Comprehensive Care for Joint Replacement Model (CJR)[12]	2015	Test bundled payments for hip and knee replacements	Mandatory	Acute-care Hospitals	67 geographic areas, equaling about 20% of hospitals nation-wide
Medicare Advantage Value-Based Insurance Design (VBID) Model[13]	2015	Test the effect of additional plan benefits and reduced cost sharing on enrollees	Voluntary	Medicare Advantage plans	Medicare Advantage plans selected in 7 states
Oncology Care Model (OCM)[14]	2015	Test bundled payments for physician practices administering chemotherapy	Voluntary	Practices and Payers	At least 100 physician practices
Medicare Part B Drug Payment Model[15]	*Proposed in 2016*	Test an alternative drug payment design	Mandatory	Providers and suppliers furnishing Part B drugs	About 75% of providers nation-wide

Figure 2: Development of CMMI Innovation Initiatives



[12] Comprehensive Care for Joint Replacement Model. CMS May 6, 2016. Available at: https://innovation.cms.gov/initiatives/cjr.
[13] Medicare Advantage Value-Based Insurance Design Model. CMS. May 6, 2016. Available at: https://innovation.cms.gov/initiatives/vbid/.
[14] Oncology Care Model. CMS. March 3, 2016. Available at: https://innovation.cms.gov/initiatives/oncology-care/.
[15] Medicare Program; Part B Drug Payment Model. Federal Register. March 11, 2016. Available at: https://www.federalregister.gov/articles/2016/03/11/2016-05459/medicare-program-part-b-drug-payment-model.

Evolution of CMMI's Approach

Since its inception, CMMI's strategy has evolved from voluntary small scale model tests, to the inclusion of mandatory models, and some that are much larger in scope. CMMI has also signaled its desire to transition its quality measures toward those that focus on outcomes and, in some cases, has specifically introduced the use of patient-reported outcome measures (PROMs).

From Voluntary Participation to Mandatory Models

CMMI's early demonstrations were primarily voluntary for providers. To test a model, CMMI would typically issue a Request for Applications (RFA) to solicit eligible applicants and select model participants. Examples of early CMMI programs that followed this procedure include CPC, BPCI, and the Pioneer ACO program.

Over the past year, CMMI's approach has evolved to include the implementation of mandatory models, such as CJR and the proposed Medicare Part B Drug Payment Model. CJR represents CMMI's first mandatory model, as it *requires* participation across all hospitals in one of every five U.S. metropolitan areas – including the vast majority that chose not to participate and bear risk in previous voluntary models testing bundled payments (e.g., BPCI). The Part B model, intended to test new models to pay for prescription drugs, is the first time that CMMI is proposing a mandatory demonstration program without previous testing of the model. Given the requirement that CMS' Chief Actuary evaluate CMMI testing models before expansion, this proposed rule represents a new approach for CMMI.

From Small Scale to Large Scale Models

While a majority of CMMI's voluntary models have been open to applicants nationally, most have been small-scale model tests focused on evaluating specific APM approaches. For example, the Pioneer ACO program was set up to test advanced approaches to risk-bearing accountability for population health, and included 32 ACOs at initiation.[16] Similarly, the OCM tests an episode-based payment approach for medical oncologists, and is expected to include about 100 practices. Moreover, SIM and HCIA grants focus on implementing APMs within distinct geographical areas and organizations; and models such as the Comprehensive ESRD Care Model focus on improving care quality and efficiency for particular patient groups.

As CMMI transitions to testing mandatory models, it has also begun to issue formal rulemaking and test interventions on a larger scale. For example, the CJR model includes 67 metropolitan statistical areas, or about 20% of the approximate 4,600 acute care hospitals participating in Medicare.[17] The proposed Part B Drug Payment Model is the largest CMMI model to date and would test at least some level of payment changes in approximately 75% of regions nationwide.

Evolving Use of Quality Measures

The quality measures used in CMMI models suggest that CMS is promoting a shift toward the greater use of PROMs. For example, the Pioneer ACO model requires 34 quality measures, including eight measures

[16] Report to Congress. CMS Center for Medicare and Medicaid Innovation. December 2014. Available at: https://innovation.cms.gov/Files/reports/RTC-12-2014.pdf.

[17] June 2015 Data Book, Dection 6: Acute inpatient services. MedPAC. 2015. Available at: http://www.medpac.gov/documents/data-book/june-2015-data-book-section-6-acute-inpatient-services.pdf?sfvrsn=0

of patient/caregiver experience.[18] BPCI, on the other hand, does not require any specific quality measures.[19] More recent demonstrations explicitly include the use of PROMs for performance-based payments. For example, CJR incentivizes participating hospitals to voluntarily submit PROMs - beyond reporting the program's three required quality measures - by adjusting their episode payments for doing so.[20] It is not clear at this point whether the proposed Part B model will follow this trend. Unlike previous CMMI RFAs and Notice of Proposed Rule Making (NPRMs) - such as the CJR and OCM - the proposed rule for the Part B model does not include a detailed list of quality measures.[21,22,23] However, CMS indicates in the proposed rule that quality measures will be incorporated into later phases of the model.

Implications of CMMI's Shifting Approach

In the last year of the Obama Administration, CMMI may expand its use of mandatory models in areas where they encountered challenges achieving their objectives through voluntary programs. That is, whereas participants in voluntary models such as BPCI are likely to be the high-performing organizations that expect to achieve savings, mandatory models will engage those providers who previously elected not to participate in voluntary programs and who may be generally less prepared for implementing new payment models. For example, only 6 out of the approximately 800 hospitals currently participating in CJR were previously at risk for the costs of major joint replacement surgery in the voluntary BPCI program.[24] This broader sample of participants may impact CMMI's ability to achieve greater savings and improvements in care quality. Similarly, another potential approach for CMMI to broaden its impact could be to expand successful state and local programs - tested via SIM and HCIA grants - or to model mandatory programs from them.

In addition to its larger demonstrations, CMMI could also develop similar policies for its smaller, disease-specific programs. To fill in the gaps and ensure that models catering to the more targeted needs of specific patients are being tested, CMMI may also look to expand its smaller demonstrations such as the Comprehensive ESRD Care Model. For example, just recently, CMS announced the Comprehensive Primary Care Plus (CPC+) model, built off of the Comprehensive Primary Care Initiative (CPCI) implemented in 2012. Compared to the smaller-scale CPCI, CPC+ will span across 20 regions, about 5,000 practices, over 20,000 clinicians and 25 million beneficiaries.[25]

A central question for how future CMMI models will be designed and deployed is the mechanism through which the Secretary and CMS's Chief Actuary determine that a model will reduce spending (without decreasing the quality of care), or improve the quality of care (without increasing spending), as well as its overall impact on net program spending. Given that CMMI can use its authority to expand the duration and scope of models being tested, this evaluation and measurement of overall value will be critically

[18] Accountable Care Organization 2016 Program Quality Measure Narrative Specifications. RTI International. January 13, 2016. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2016-ACO-NarrativeMeasures-Specs.pdf
[19] Bundled Payments for Care Improvement (BPCI) Initiative: General Information. CMS. April 29, 2016. Available at: https://innovation.cms.gov/initiatives/bundled-payments/
[20] Medicare Program; Comprehensive Care for Joint Replacement Payment Model for Acute Care Hospitals Furnishing Lower Extremity Joint Replacement Services. Federal Register. November 24, 2015. Available at: https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals#h-85.
[21] Comprehensive Care for Joint Replacement Model. CMS. March 31, 2016. Available at: https://innovation.cms.gov/initiatives/cjr.
[22] Oncology Care Model (OCM) Request for Applications (RFA). CMS. June 3, 2015. Available at: https://innovation.cms.gov/Files/x/ocmrfa.pdf
[23] Medicare Program; Part B Drug Payment Model. Federal Register. March 11, 2016. Available at: https://www.federalregister.gov/articles/2016/03/11/2016-05459/medicare-program-part-b-drug-payment-model.
[24] Avalere analysis of CMS Bundled Payments for Care Episode Analytic file (link; last updated January 2016) and CMS CJR Hospital List (link; last updated February 2016).
[25] CMS launches largest-ever multi-payer initiative to improve primary care in America. CMS. April 11, 2016. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html.

important to the future of Medicare payment policy. Similarly, CMMI's approach to introducing changes to the Medicare and Medicaid programs using its unique regulatory authority rather than a legislative process represents a significant evolution in how HHS is executing its authority, which warrants close attention.