Person-Centered Innovation – An Update on the Implementation of the CMS Innovation Center's Strategy – Supplemental Document

November 7, 2022

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List of Exhibits

Abbreviations

AHRQ	Agency for Healthcare Research and Quality
AMS	Innovation Center Analysis and Management System
BRR	Balanced Repeated Replication method
CAH	Critical Access Hospitals
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCN	CMS Certification Number
CCW	Chronic Conditions Datawarehouse
CMHCs	Community Mental Health Centers
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHCs	Federally Qualified Health Centers
ICD-10 Codes	International Statistical Classification of Diseases and Related Health Problems (10th revision)
ICD-10-CM	International Statistical Classification of Diseases and Related Health Problems (10th revision), Clinical Modification
ICD-10-PCS	International Statistical Classification of Diseases and Related Health Problems (10th revision), Procedure Coding System
MA	Medicare Advantage
MA PDP	Medicare Advantage and Prescription Drug Plan
MCBS	Medicare Current Beneficiaries Survey
MDM POR	Master Data Management Provider-Organization Relationship
NPI	National Provider Identifier
Part D LIS	Part D Low-Income Subsidy
PCP	Primary Care Provider
PQI	Prevention Quality Indicator
RHCs	Rural Health Clinics
SAS QI	SAS Quality Indicators software
SE	Standard Error
SSMs	Summary Survey Measures

Introduction

In the fall of 2021, the Center for Medicare and Medicaid Innovation (Innovation Center) at the Centers for Medicare and Medicaid Services (CMS) launched a renewed vision focused on five objectives to support and help execute CMS' strategic plan and priorities. Subsequently in the fall of 2022, the Innovation Center released a 1-year Status Update Report that provides an update on the Innovation Center's progress implementing the new strategy, describes areas of focus for the coming year, and begins the process of measuring progress against the five objectives to drive accountable care, advance health equity, support care innovations, address affordability, and partner to achieve system transformation. This supplemental document provides technical documentation for the metrics that will be used to measure progress against the five strategic objectives outlined in the Innovation Center Strategy 1-year Status Report. Technical documentation for the metrics includes the definition, rationale, methods, limitations, and results.

Where noted, the Innovation Center engaged MITRE in the development of metrics to measure progress on strategic objectives 2, 3, and 4, as well as baselines and targets. As such, MITRE's work on these metrics is referenced throughout this document.

As the health care landscape continues to change, the Innovation Center will continue to assess whether new metrics are needed and the potential for these shifts to impact data sources as well as the methods used to calculate metric denominators, baselines, and targets by regularly monitoring and analyzing the metrics to identify any issues that may warrant revisiting baselines and targets in future years.

Strategic Objective 1 – Drive Accountable Care

Metric 1: Percent of Traditional Medicare beneficiaries with Parts A & B that will be in a care relationship with accountability for quality and total cost of care; and

Metric 2: Disparity in the percent of Traditional Medicare beneficiaries with Parts A & B in accountable care relationships within each race and ethnicity category

Definition

Medicare fee-for-service (FFS) beneficiaries with Parts A and B in an accountable care relationship, defined as a care relationship with accountability for quality and total cost of care. This is operationalized with the following criteria:

- A longitudinal (6 or more months), aligned care relationship between beneficiary and clinician/provider
- Provider (e.g., clinician, group practice, accountable care organization) performance measure that includes total cost of care
    - At a minimum this covers Parts A and B services, but need not be a capitated payment arrangement or full financial risk for total cost of care

This metric measures the percent of Medicare FFS beneficiaries that are in an accountable care relationship, as measured through alignment to a CMS program, model, or demonstration that satisfies the criteria. The Innovation Center will evaluate new models against the criteria and include the following CMS programs, models, and demonstrations in this analysis:

Exhibit 1. Models Included in Strategic Objective 1: Drive Accountable Care Metrics 1 and 2

Medicare Shared Savings Program	Next Generation ACO (NGACO)
Comprehensive Primary Care Plus (CPC+)	Global and Professional Direct Contracting (GPDC)
Primary Care First (PCF)	Vermont All Payer ACO Model (VTAPM)
Maryland Primary Care Program (Track 2) (MDPCP)	Maryland Total Cost of Care (MDTCOC)
Kidney Care Choices Model (both Kidney Care First and Comprehensive Kidney Care Contracting options) (KCC)	Oncology Care Model (OCM)
Comprehensive ESRD Care (CEC)	Independence at Home Demonstration (IAH)

$$\frac{\textit{Medicare FFS beneficiaries with Parts A and B in an accountable care relationship}}{\textit{All Medicare FFS beneficiaries with Parts A and B}}$$

Additionally, the metric determines this percent within categories of beneficiary race and ethnicity. A beneficiary's race/ethnicity is identified using data collected by the Social Security Administration (SSA) with adjustments to improve the race/ethnicity classification for Hispanic and Asian/Pacific Islander populations. Specifically, CMS engaged the Research Triangle Institute (RTI) to develop an algorithm that uses Census surname lists for likely Hispanic and Asian/Pacific Islander origin and simple geography (residence in Puerto Rico or Hawaii) to improve the SSA race/ethnicity data. The variable developed using this algorithm is often referred to as the RTI Race Code. The race/ethnicity classifications are: American Indian/Alaska Native, White, Black/African American, Asian/Pacific Islander, Hispanic, and Other. Note: Even with the application of the RTI algorithm, comparisons to self-reported data show that race/ethnicity is still misclassified for some people (self-reported data is only available through survey and assessment data for a small subset of the Medicare population). The RTI algorithm improves the accuracy of Medicare race/ethnicity data, but continues to undercount people with a race/ethnicity of Asian/Pacific Islander and American Indian/Alaska Native, and to a lesser extent Hispanic, in the Medicare population.[1]

Rationale

Accountable care has the potential to reduce fragmentation and provide high-quality, coordinated, team-based care that promotes positive health outcomes and person-centered care. Since the launch of the Innovation Center's strategic refresh, stakeholders across the health care system have been focused on bringing accountable care relationships to more people. This metric directly measures Medicare FFS beneficiaries in accountable care relationships.

Methods

The Innovation Center used Medicare beneficiary enrollment and demographic data, the Master Data Management (MDM) system data, and the Innovation Center Analysis and Management System (AMS) data to identify all Medicare FFS beneficiaries with Parts A and B and those in accountable care relationships from 2017 – 2022. The baseline for this metric is 44% using 2021 data. The Innovation Center then calculated the 2024 and 2025 targets (60% and 65%, respectively) based on historical trends, Medicare Trustees Reports, and the 2030 target of 100% of Medicare beneficiaries in an accountable care relationship.

Limitations

The numerator for this metric is subject to change based on the number and types of Innovation Center models that begin and end in certain years. The numerator and denominator are subject to change based on faster or slower growth in the Medicare Advantage program.

[1] https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf; beneficiary was used instead of person.

Strategic Objective 2 – Advance Health Equity

Metric 1: Percent of all models that will collect and report demographic and, where feasible, social needs data and health equity plans to CMS

Definition

This metric measures the percent of Innovation Center models that require model participants to develop health equity plans for beneficiaries served, require model participants to collect demographic and where feasible social needs data, and require model participants to report demographic and where feasible social needs to CMS. Models are defined as those that have launched in 2022 and those with active performance periods in 2022. Health equity plans could include model requirements for statements indicating areas of focus with regards to health disparities or health equity (e.g., Health Equity Plans, Disparities Impact Statements)). Collection of demographic data would include the data elements itemized under the United States Core Data for Interoperability (USCDI) V2 patient demographic class.[2] Reporting of demographic data to CMS would include the same data elements as those that are collected. Collection of social needs data where feasible would include models with requirements, incentives, or options for social needs screening for all or part of a model population. Reporting of social needs data to CMS where feasible would include beneficiary-level, aggregate, or quality measures related to social needs screening, including participants who report such data to CMS.

Rationale

Measuring Innovation Center model participant health equity planning and demographic and where feasible social needs data collection and reporting to CMS will support the Innovations Center's ability to embed health equity in Innovation Center models and increase focus on underserved populations.

Methods

To develop the baseline, the Innovation Center measured all models in 2022 that require model participants to develop health equity plans for beneficiaries served, require model participants to collect demographic and where feasible social needs data, and require model participants to report demographic and where feasible social needs to CMS. In 2022, there are 11 of 30 models that have these requirements. As such, the 2022 baseline is set as 37%.

Exhibit 2. Models Included in Strategic Objective 2: Advance Health Equity Metric 1

Metric Component	Models
Models that require statements indicating areas of focus with regards to health disparities or health equity	▪ Medicare Advantage Value-Based Insurance Design—Hospice ▪ Integrated Care for Kids ▪ Accountable Health Communities
Models that require participants collect demographic data	No models have this metric component in 2022.

[2] https://www.healthit.gov/isa/sites/isa/files/2021-07/USCDI-Version-2-July-2021-Final.pdf

Metric Component	Models
Models that require participants submit demographic data to CMS	▪ Accountable Health Communities (AHC) ▪ Integrated Care for Kids (InCK) ▪ Maternal Opioid Misuse (MOM)
Models that require incentives, or options for social needs screening for all or part of a model population	▪ Accountable Health Communities (AHC) ▪ Global Professional Direct Contracting (GPDC) ▪ Integrated Care for Kids (InCK) ▪ Maryland Total Cost of Care (MDTCOC) ▪ Maternal Opioid Misuse (MOM) ▪ Pennsylvania Rural Health Model (PARHM) ▪ Primary Care First (PCF) ▪ Medicare Advantage Value-Based Insurance Design Model (MAVBID) ▪ Medicare Advantage Value-Based Insurance Design—Hospice (MAVBID-Hospice) ▪ Vermont All-Payer Model (VAPM) ▪ Financial Alignment Initiative (FAI)
Models that report social needs data to CMS (including beneficiary-level, aggregate, or quality measures related to social needs screening)	▪ Accountable Health Communities (AHC) ▪ Integrated Care for Kids (InCK)

To develop the 2025 and 2030 targets, the Innovation Center trended the 2022 baseline forward accounting for models launching between 2022 and 2030. The Innovation Center projects that by 2025, 85% of Innovation Center models will require model participants to develop health equity plans for beneficiaries served, require model participants to collect demographic and where feasible social needs data, and require model participants to report demographic and where feasible social needs to CMS. By 2030, the Innovation Center projects that 100% of Innovation Center models will require model participants to develop health equity plans for beneficiaries served, require model participants to collect demographic and where feasible social needs data, and require model participants to report demographic and where feasible social needs to CMS.

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of Innovation Center models that begin and end in certain years.

Metric 2: Percent of facilities participating in Innovation Center models identified as safety net facilities

Definition

This metric determines the percent of facilities that participate in Innovation Center models that are identified as safety net facilities.

For this metric, safety net facilities include:

- Hospitals (short-term hospitals and critical access hospitals (CAHs)) that serve above a baseline threshold of beneficiaries with dual eligibility or Part D Low-Income Subsidy (LIS)
- Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and Community Mental Health Centers (CMHCs)

Facilities are identified as safety net facilities when their patient-mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all congruent facilities who bill Medicare. The threshold is constructed by determining the weighted average of the highest quartiles among each beneficiary subgroup (dual eligibility or Part D LIS) for all congruent facilities who bill Medicare during the baseline years (see Methods for more detail).

$$\frac{\textit{The count of safety net facilities that participate in Innovation Center models}}{\textit{The count of facilities that participate in Innovation Center models}}$$

Rationale

Beneficiaries with dual eligibility or Part D LIS represent populations that may face barriers to receiving or accessing care. Patients who are eligible to receive Part D LIS report incomes at or below 135% of the Federal Poverty Level (FPL). Beneficiaries become dually eligible for Medicare and Medicaid based on a combination of poverty, age, and long-term disability. Those with dual eligibility are considered a vulnerable group for several reasons including the nature of dual eligibility requirements, a higher proclivity for experiencing chronic conditions,[3] and an increased likelihood of mental health diagnosis.[4] They are nearly three times as likely to be of minority race or ethnicity than the full Medicare population.[5,6]

FQHCs and RHCs both provide primary care services to underserved areas. RHCs specifically provide such services to communities in rural areas. CMHCs are community-based facilities that provide patients with mental health services. These facility types are included due to the nature of the population demographics they serve, and/or the areas in which they operate.

Methods

The approach to constructing the safety net provider facility metric draws from MITRE's initial literature scan and scoping analysis from the summer of 2021, which determined a patient-mix variable that defines safety net facilities by whether a provider serves a certain threshold of beneficiaries with dual eligibility. In the updated approach, MITRE included recipients of Part D

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf
[4] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NationalProfile_2012.pdf
[5] https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf
[6] https://www.healthaffairs.org/do/10.1377/forefront.20190423.701475/

LIS in the consideration of the patient-mix, as a proxy for low-income status. MITRE used Medicare claims data to construct this metric.

Threshold. The threshold was based on the distribution of the two subgroups' proportions (beneficiaries with dual eligibility or Part D LIS) for all hospitals who bill Medicare. The threshold was determined based on inclusion within the weighted baseline average of the highest quartile among each subgroup's distribution for the baseline years (2017- 2019). For patients with Part D LIS, the threshold is set at 36.5%. For beneficiaries with dual eligibility, the threshold is set at 35.4%. This means that to be considered a safety net facility, the facility's patient-mix must be at least 36.5% beneficiaries with Part D LIS or at least 35.4% beneficiaries with dual eligibility.

Performance Monitoring. For monitoring the Innovation Center's performance against the thresholds, claims data were pulled for the baseline period, limited to short-term hospitals and CAHs only. After identifying the list of hospitals during the baseline period, the analysis retained claims associated with the hospitals and determined the number of beneficiaries with dual eligibility and the number of beneficiaries with Part D LIS for each hospital. Hospitals whose proportion of beneficiaries with dual eligibility or Part D LIS fall above one of the baseline thresholds were considered safety net facilities.

The analysis separately pulled the list of active FQHCs, RHCs, and CMHCs using the CMS Certification Number (CCN) during the baseline period. Once all facilities were identified, they were linked by CCN to Innovation Center model participation data (for detailed technical specifications see Appendix B, Exhibit B.1).

Exhibit 3. Strategic Objective 2: Advance Health Equity Metric 2 Data Sources

Variable	Variable Description	Data Source
Innovation Center Model Participation	Individual facilities who participate in Innovation Center models	Innovation Center Analysis and Management System (AMS) and MDM Provider-Organization Relationship (MDM POR) tables
Patients with low-income	Beneficiaries who receive Part D Low-Income Subsidy (LIS)	Medicare Claims Data
Beneficiaries with dual eligibility	Beneficiaries who are enrolled in both Medicare and Medicaid	Medicare Claims Data
Facility Type	Short-term hospitals • Last four digits of CCN: 0001-0879 Critical Access Hospitals (CAHs) • Last four digits of CCN: 1300-1399 Federally Qualified Health Centers (FQHCs) • Last four digits of CCN: 1000-1199; 1800-1989 Rural Health Clinics (RHCs)	Medicare Claims Data

Variable	Variable Description	Data Source
	• Last four digits of CCN: 3400-3499; 3800-3999; 8500-8999 Community Mental Health Centers (CMHCs) • Last four digits of CCN: 1400-1499; 4600-4799; 4900-4999	

Exhibit 4. Models Included in Strategic Objective 2: Advance Health Equity Metric 2

2017	2018	2019
Comprehensive ESRD Care (CEC)	Accountable Health Communities (AHC)	Accountable Health Communities (AHC)
Comprehensive Primary Care Plus (CPC+)	Bundled Payment for Care Improvement Advanced (BPCI-A)	Bundled Payment for Care Improvement Advanced (BPCI-A)
Home Health Value-Based Purchasing (HHVBP)	Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)	Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)
Medicare Care Choices Model (MCCM)	Home Health Value-Based Purchasing (HHVBP)	ESRD Treatment Choices (ETC)
Next Generation ACO (NGACO)	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)	Home Health Value-Based Purchasing (HHVBP)
Rural Community Hospital Demo (RCH)	Medicare Care Choices Model (MCCM)	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)
	Next Generation ACO (NGACO)	Maryland Total Cost of Care (MDTCOC)
	Rural Community Hospital Demo (RCH)	Medicare Care Choices Model (MCCM)
		Next Generation ACO (NGACO)
		Pennsylvania Rural Health Model (PARHM)
		Rural Community Hospital Demo (RCH)
		Vermont All-Payer ACO Model (VAPM)

Limitations

The broad categorization of certain facility types as safety net facilities may mask differences in facility service patterns among dual eligibility or Part D LIS beneficiary subgroups. For instance, while the majority of RHCs may provide services to a high volume of beneficiaries with dual eligibility, some facilities that are classified as RHCs may not. MITRE's analysis accounted for

these disparities in short-term hospitals and CAHs; however, unique differences in patterns of beneficiary subgroups may exist within FQHCs, RHCs, and CMHCs. A more exhaustive approach may examine the distribution or counts of subgroup beneficiaries for each facility type and determine appropriate thresholds for inclusion based on the distribution.

The numerator and denominator for this metric are subject to change based on the number and types of models that are beginning and ending in certain years, and the types of facilities for which the models are designed. Targets may be misleading if not adjusted for large shifts in overall model participation, and the Innovation Center will monitor for this in the future.

In addition, as this metric used Medicare claims data only, the Innovation Center will revisit this metric in future years to include Medicaid claims data for the purposes of including Medicaid safety net facilities.

Results

Baseline. 3.9% of facilities currently participating in active Innovation Center models are identified as safety net facilities.

Targets. By 2030, 12% of facilities participating in active Innovation Center models would be identified as safety net facilities.

Exhibit 5. Strategic Objective 2: Advance Health Equity Metric 2 Baseline and Targets

% of Facilities Identified as Safety Net Facilities					
Group	**Subgroup**	**Baseline (Weighted Avg. 2017-2019)**		**Targets**	
		Denominator	**% (N)**	**2025**	**2030**
Model Participants	Any Active Innovation Center Model Participant	6,746.6	3.9% (264.1)	7.0%	12.0%
Reference Values					
Medicare	Overall	59,433.3	19.3% (11,500.2)		

NOTE: The baseline was established by taking a weighted average of the denominator, proportion, and numerator (N) of facilities identified as safety net facilities weighted by the number of facilities identified in the denominator within each baseline year.

Metric 3: Percent of primary care providers participating in Innovation Center models identified as safety net providers

Definition

The individual-level safety net provider metric measures the percent of primary care providers (PCPs) that participate in Innovation Center models who are identified as safety net providers.

For this metric, safety net provider is defined by:

- Primary care providers that serve beneficiaries with dual eligibility or Part D LIS above a baseline threshold

Providers are identified as safety net providers when their patient-mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all PCPs who bill Medicare. The threshold is constructed by determining the weighted average of the highest quartile among each patient subgroup for all PCPs who bill Medicare during the baseline years (see Methods for more detail).

$$\frac{\textit{The count of primary care providers that participate in Innovation Center models who are identified as safety net providers}}{\textit{The count of primary care providers that participate in Innovation Center models}}$$

Rationale

See the rationale for Safety Net Provider – Facility Level for the rationale of the incorporation of beneficiaries with dual eligibility or Part D LIS as a proxy for determining the status of a provider as a safety net provider.

Methods

MITRE constructed the individual-level safety net provider metric using Medicare claims data, limited to claims rendered by PCPs. Drawing from the CMS Claims Processing Manual, PCPs consist of (1) physicians practicing in family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) certified clinical nurse specialists, nurse practitioners, or physician assistants, all for whom primary care services must account for at least 60% of billed services[7] (see Appendix A, Figure A.1 for method diagram).

Threshold. MITRE set the threshold for inclusion in the same way as the Safety Net Provider – Facility Level metric. For all PCPs who bill Medicare and have seen more than 50 Medicare beneficiaries within the baseline year, counts of beneficiaries with dual eligibility or Part D LIS were computed. Based on the weighted average of the highest quartile of the distributions during the baseline years (2017, 2018, and 2019), the threshold for the proportion of beneficiaries with Part D LIS is set to 36.0% and the threshold for the proportion for beneficiaries with dual eligibility is set at 33.7%.

Performance Monitoring. After identifying the list of PCPs during the baseline period, MITRE retained claims associated with the identified PCPs and determined the number of beneficiaries with dual eligibility or Part D LIS for each PCP. Safety net providers are those whose proportion of beneficiaries with dual eligibility or Part D LIS fell above the threshold.

[7] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Once identified, MITRE linked PCPs to Innovation Center model participation data by National Provider Identifier (NPI) (for detailed technical specifications see Appendix B, Exhibit B.2).

Targets for this metric were informed by examining the trends of both Innovation Center model participants and the general Medicare population. This metric is conditional on annual changes within the broader Medicare population, including the rate of entry/exit of PCPs billing Medicare each year and the annual change in beneficiaries who receive Part D LIS or are dually eligible for Medicare and Medicaid. As the Innovation Center draws providers from this larger pool, performance on the metric is implicitly tied to trends that exceed the scope of the Innovation Center's influence. As a result, this metric examines Innovation Center's performance in relation to trends that are occurring within the broader Medicare context.

Exhibit 6. Strategic Objective 2: Advance Health Equity Metric 3 Data Sources

Variable	Variable Description	Data Source
Innovation Center Model Participation	Individual providers who participate in Innovation Center models	Innovation Center Analysis and Management System (AMS) and MDM Provider-Organization Relationship (MDM POR) tables
Patients with low-income	Beneficiaries who receive Part D Low-Income Subsidy (LIS)	Medicare Claims Data
Beneficiaries with dual eligibility	Beneficiaries who are enrolled in both Medicare and Medicaid	Medicare Claims Data
Primary care providers	Consisting of (1) physicians practicing in family medicine, internal medicine, geriatric medicine, or pediatric medicine; or (2) certified clinical nurse specialists, nurse practitioners, or physician assistants, all for whom primary care services must account for at least 60 percent of billed services.	Medicare Claims Data

Exhibit 7. Models Included in Strategic Objective 2: Advance Health Equity Metric 3

2017	2018	2019
Accountable Health Communities (AHC)	Accountable Health Communities (AHC)	Accountable Health Communities (AHC)
Bundled Payment for Care Improvement (BPCI)	Bundled Payment for Care Improvement Advanced (BPCI-A)	Bundled Payment for Care Improvement Advanced (BPCI-A)
Comprehensive Care for Joint Replacement Payment (CJR)	Bundled Payment for Care Improvement (BPCI)	Comprehensive Care for Joint Replacement Payment (CJR)
Comprehensive ESRD Care (CEC)	Comprehensive Care for Joint Replacement Payment (CJR)	Comprehensive ESRD Care (CEC)
Comprehensive Primary Care Plus (CPC+)	Comprehensive ESRD Care (CEC)	Comprehensive Primary Care Plus (CPC+)

2017	2018	2019
Frontier Community Health Integration Project Demonstration (FCHIP)	Comprehensive Primary Care Plus (CPC+)	ESRD Treatment Choices (ETC)
Independence at Home Demonstration (IAH)	Frontier Community Health Integration Project Demonstration (FCHIP)	Frontier Community Health Integration Project Demonstration (FCHIP)
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)	Independence at Home Demonstration (IAH)	Independence at Home Demonstration (IAH)
Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (NFI)
Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)	Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)	Maryland Total Cost of Care Model (MDTCOC)
Next Generation ACO (NGACO)	Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)	Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)
Oncology Care Model (OCM)	Next Generation ACO (NGACO)	Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)
Transforming Clinical Practice Initiative (TCPI)	Oncology Care Model (OCM)	Next Generation ACO (NGACO)
	Transforming Clinical Practice Initiative (TCPI)	Oncology Care Model (OCM)
		Transforming Clinical Practice Initiative (TCPI)
		Vermont All-Payer ACO Model (VAPM)

Limitations

The numerator and denominator for this metric are dependent on the number and types of models that the Innovation Center initiates or discontinues, similar to the Safety Net Provider – Facility Level metric. Some of these models may be more appropriate for PCPs versus other types of models and could impact the results.

The AMS data does not include individual NPIs for Shared Savings Program model participating providers for years prior to 2019. For this reason, Shared Savings Program participants were excluded from the analysis.

In addition, as this metric used Medicare claims data only, the Innovation Center will revisit this metric in future years to include Medicaid claims data for the purposes of including Medicaid safety net providers.

Results

Baseline. 23.9% of individual providers currently participating in active Innovation Center models are identified as safety net providers, compared to 26.5% of providers in Medicare.

Targets. By 2030, the percent of individual providers identified as safety net in Innovation Center models will be at or above the percent of safety net providers in Medicare, which would be 26.5%.

Exhibit 8. Strategic Objective 2: Advance Health Equity Metric 3 Baseline and Targets

		% of Primary Care Providers Identified as Safety Net Providers			
Group		**Wgt. Baseline Avg. (2017-2019)**		**Targets**	
		Denominator	**% (N)**	**2025**	**2030**
Model Participants	Active Innovation Center Model Participants	43,183.52	23.9% (10,309.4)	24.9%	26.5%
Reference Trends					
Medicare	Overall	189,273.7	26.5% (50,134.1)		

NOTE: The baseline was established by taking a weighted average of the denominator, proportion, and numerator (N) of PCPs identified as safety net providers weighted by the number of PCPs identified in the denominator within each baseline year. Appendix A, Exhibit A.1 contains historical trends on the proportion of PCPs who bill Medicare and are identified as safety net providers that participate in Innovation Center Models.

Metric 4: Rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by an Innovation Center model; and

Metric 5: Disparity in the rate of potentially preventable admissions for overall conditions per 100,000 Medicare beneficiaries served by Innovation Center models across race and ethnicity groups

Definition

This metric is based on the Prevention Quality Indicator #90 (PQI#90) measure.[8] PQI#90 is a composite measure that captures the rate of potentially preventable admissions per 100,000 population, ages 18 years and older. The measure includes hospital admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes *without* complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure without a cardiac procedure, community-acquired pneumonia, or urinary tract infection. The definition for PQI #90 rate applied to Innovation Center model beneficiaries is as follows:

[8]PQI 90. https://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2022/TechSpecs/PQI_90_Prevention_Quality_Overall_Composite.pdf; Quality Indicator User Guide: Prevention Quality Indicators (PQI) Composite Measures

$$\frac{\textit{Number of potentially preventable admissions for specified conditions among Medicare beneficiaries served by an Innovation Center model}}{\textit{Medicare Beneficiaries served by an Innovation Center model}} * 100{,}000$$

Rationale

Evaluating the rate of preventable admissions with race and ethnicity stratifications enables the Innovation Center to monitor progress toward reducing disparities in health outcomes for beneficiaries in Innovation Center models. PQIs have been validated for quality improvement, comparative reporting, and pay for performance programs.[9] The Agency for Healthcare Research and Quality (AHRQ) developed composites from individual condition indicators to provide national summary-level estimates while enabling tracking and comparisons over time.[10] PQI #90 was previously used as a measure to evaluate the Maryland Total Cost of Care Model[11], the Vermont All-Payer ACO Model[12], as well as across multiple state health agencies[13,14] to monitor and evaluate health system performance.

Methods

To establish baselines and to observe trends in historic data on PQI #90 amongst beneficiaries in Innovation Center models, MITRE used software developed by AHRQ to generate numerators and calculate observed rates for PQIs. AHRQ Quality Indicators (QI) software is available in two different platforms: a SAS application and a Microsoft Windows application. AHRQ maintains and updates the SAS QI software to reflect changes in the AHRQ QI technical specifications and is intended for use with claims coded with ICD-10-CM/PCS data. The software processes data from discharge data abstracts that contain information about hospital stays. The specific data elements required are located in the input data file and can be found in Appendix F of the Quality Indicators Software Instructions and Data Dictionary.

A discharge data abstract was created using the Medicare claims and encounter data from the Integrated Data Repository (IDR). Medicare inpatient claims (type of bill code: 011X and 012X) were limited to adult Medicare Part A enrollees for the selected year. The software processed the discharge data and marked inpatient records to indicate whether they met the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes Short-Term Complications Admission Rate
- PQI #3 Diabetes Long-Term Complications Admission Rate

[9] Expanding Use of the AHRQ Prevention Quality Indicators
[10] Quality Indicator User Guide: Prevention Quality Indicators (PQI) Composite Measures (ahrq.gov)
[11] Independent Evaluation of the Maryland Total Cost of Care Model: Implementation Report (cms.gov)
[12] Vermont All-Payer ACO Model Evaluation (vermont.gov)
[13] New Jersey Health Care Quality Assessment Prevention Quality Indicators 2020 (nj.gov)
[14] Hospital-Level AHRQ Quality Indicators for California (hcai.ca.gov)

- PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI #7 Hypertension Admission Rate
- PQI #8 Heart Failure Admission Rate
- PQI #11 Community-Acquired Pneumonia Admission Rate
- PQI #12 Urinary Tract Infection Admission Rate
- PQI #14 Uncontrolled Diabetes Admission Rate
- PQI #15 Asthma in Younger Adults Admission Rate
- PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

Discharges that met the inclusion and exclusion rules for the numerator in more than one of the above PQIs were counted only once in the composite numerator.

The preventable hospitalization rate was calculated using the PQIs from AHRQ. PQIs are population-based and adjusted for age and sex. They are adapted for Medicare beneficiaries by using the Medicare population instead of the entire population. The analysis population includes 100% of Medicare beneficiaries ages 18 years and older, enrolled in Medicare Part A for the selected year (i.e., 2017, 2018, 2019, 2020, or 2021).

To calculate the PQI rates for the Innovation Center model participants, the adult population enrolled in Medicare Part A was narrowed to only active model participants with non-missing and non-unknown RTI race codes[15] during the selected year using the AMS and MDM beneficiary tables. (Note: PQI rates computed in this report for Medicare Overall, Medicare Fee for Service (FFS), Medicare Advantage (MA), and the Shared Savings Program do not exclude beneficiaries with missing or unknown RTI race codes since these rates are intended only for use as aggregate reference trends.)

Baselines were determined using a weighted average from 2017-2019. PQI data, derived from claims, are available on an ongoing basis, which enabled MITRE to examine trends up until 2021. Data from 2020 and 2021 showed an unprecedented decrease in PQI #90 rates that likely reflected access issues brought on by the COVID-19 pandemic across the broader Medicare population (as shown in the historic data for PQI #90 in Appendix A). The baseline was constructed by weighting the annual rates by beneficiary counts from the three years prior to the pandemic to stabilize variations across changes in the Innovation Center's model portfolio, and 2030 targets were constructed based on trend data from 2017-2019. MITRE examined the absolute decreases and relative reductions annually in PQI #90 between 2017-2019. The results from using both methods to extrapolate out the existing desired trend to 2030 suggest an expected overall reduction of about 1,000 potentially preventable admissions per 100,000 Innovation Center beneficiaries, which informed the targets. As noted above regarding baseline development, the 2025 target was developed with the understanding that the variation in PQI #90 rates likely brought on by the COVID-19 pandemic across the Medicare population would normalize in future years and, that there could be a return in future years to PQI #90 rates that

[15] ResDAC. Research Triangle Institute (RTI) Race Code (Available at: https://resdac.org/cms-data/variables/research-triangle-institute-rti-race-code)

were observed prior to the COVID-19 pandemic. PQI #90 composite results are expected to increase towards pre-pandemic levels or potentially reflect the impact of delayed care during the pandemic before reducing over time with new initiatives.

Exhibit 9. Strategic Objective 2: Advance Health Equity Metric 4 and 5 Data Sources

Variable	Variable Description	Data Source
Innovation Center Model Participants	Individual Medicare providers who participate in Innovation Center models during the selected year	Innovation Center Analysis and Management System (AMS) and MDM Provider-Organization Relationship (MDM POR) tables
Population	Individual beneficiaries enrolled in Medicare Part A during the selected year	Medicare Beneficiary Data
Hospital Discharges	Hospital discharges for adult Medicare Part A enrollees during the selected year	Medicare Claims and Encounter Data
PQI #90 Number of cases	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #11 Community-Acquired Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.	Medicare Claims and Encounter Data flagged by the AHRQ PQI software

Exhibit 10. Models Included in Strategic Objective 2: Advance Health Equity Metric 4 and 5

2017	2018	2019
Community-Based Care Transitions Program (CCTP)	Accountable Health Communities Model	Accountable Health Communities (AHC)
Comprehensive Care for Joint Replacement Payment (CJR)	Comprehensive Care for Joint Replacement (CJR)	Comprehensive Care for Joint Replacement Payment (CJR)
Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)
Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)
Independence at Home Demonstration (IAH)	Independence at Home Demonstration (IAH)	Independence at Home Demonstration (IAH)
Medicare Prior Authorization Models: Repetitive Schedule Non-Emergent Ambulance Transport (RSNAT)	Medicare Prior Authorization Models: Repetitive Schedule Non-Emergent Ambulance Transport (RSNAT)	Maryland Primary Care Program (MDPCP)
Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)	Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)	Medicare Prior Authorization Models: Repetitive Schedule Non-Emergent Ambulance Transport (RSNAT)
Next Generation ACO (NGACO)	Next Generation ACO (NGACO)	Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)
Oncology Care Model (OCM)	Oncology Care Model (OCM)	Next Generation ACO (NGACO)
Financial Alignment Initiative (FAI)	Financial Alignment Initiative (FAI)	Oncology Care Model (OCM)
		Financial Alignment Initiative (FAI)
		Vermont All-Payer Model (VAPM)

Limitations

PQI #90 is a composite of 10 individual PQI measures examining discharges for potentially preventable admissions for selected acute and chronic conditions. A general limitation of composite measures is that they may obscure variations of the measures which comprise the composite, and changes in the composite's overall value may not clearly reflect the impact of specific strategic interventions. To address this limitation, the Innovation Center will examine individual PQI rates along with the overall composite rate to identify potential programmatic changes and to evaluate performance more comprehensively across models to drive improvement.

The proposed targets for PQI #90 aim to monitor both an absolute and relative reduction in potentially preventable admissions, with a two-part goal: 1) reduce the overall rate of potentially preventable admissions and 2) close the gap in potentially preventable admissions across racial and ethnic subgroups. However, race and ethnicity only represent one dimension along which

disparities may occur. The Innovation Center may monitor PQI #90 in additional subpopulations in which disparities may occur.

Differences in PQI #90 rates among Innovation Center model beneficiaries by race and ethnicity are likely driven by structural barriers embedded within the larger health delivery system, many of which the Innovation Center alone may not be able to sufficiently address. Broader social and environmental factors can also impact PQI #90 rates, as the COVID-19 pandemic demonstrated. Results from 2020 show a sharp decline in potentially preventable admissions across all race and ethnicity groups; however, the steep drop likely reflects confounding effects of health care access and utilization during the pandemic.

Additionally, the introduction of new Innovation Center models or closing out of existing ones may result in shifts in the Innovation Center population composition over time. PQI rates are sensitive to changes in patient mix, particularly by age and chronic conditions. As the Innovation Center rolls out new models, especially models that may focus on patients with higher prevalence of the conditions monitored within PQI #90, the Innovation Center will consider adjusting results and/or revisiting the baseline and targets.

Results

Baseline. The PQI #90 Overall Composite average rate between 2017-2019 is 4,989 potentially preventable admissions per 100,000 Innovation Center model beneficiaries, and the range in the average rates is 6,097 potentially preventable admissions per 100,000 beneficiaries across race and ethnicity groups with the greatest and least potentially preventable admissions.

Targets. By 2030, the range of potentially preventable admissions across race and ethnicity groups with the greatest and least potentially preventable admissions will be reduced by 1,000 per 100,000 beneficiaries among active Innovation Center model participants, and the overall rate of potentially preventable admissions for acute and chronic conditions will be reduced by 1,000 per 100,000 beneficiaries.

Exhibit 11. Strategic Objective 2: Advance Health Equity Metric 4 and 5 Baselines and Targets

Rate of Potentially Preventable Admissions per 100,000 Innovation Center Model Beneficiaries						
Group	**Subgroup**	**Baseline (Weighted Avg. 2017-2019)**			**Targets**	
		Numerator	**Denominator**	**Observed Rate per 100,000 population**	**2025**	**2030**
Active Innovation Center Model Participants	Overall	235,166	4,068,972	4,989	4,614	3,989
	White	177,308	3,932,320	4,509	Range = 5,722	Range = 5,097
	Black	36,917	387,138	9,536		
	Hispanic	13,082	190,969	6,850		

Rate of Potentially Preventable Admissions per 100,000 Innovation Center Model Beneficiaries						
Group	Subgroup	Baseline (Weighted Avg. 2017-2019)			Targets	
		Numerator	Denominator	Observed Rate per 100,000 population	2025	2030
	Asian or Pacific	4,831	140,472	3,439		
	Native American	1,523	22,413	6,797		
	Other	1,505	45,020	3,766		
Reference Trends						
Medicare	Overall	2,296,381	62,634,206	3,666		
	FFS	1,512,935	41,514,949	3,644		
	MA	783,446	22,842,383	3,430		
	Shared Savings Program	578,730	12,157,675	4,762		

Strategic Objective 3 – Support Innovation

Metric 1: Percent of Medicare beneficiaries in Innovation Center models that responded with best possible response options "always" or "yes, definitely" on Medicare FFS CAHPS care coordination measures

Definition

Care Coordination Summary Survey Measures (SSMs) from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) emphasize interactions between patients and clinicians that deliberately organize patient care activities to achieve safer and more effective care.

$$\frac{\textit{Number of Medicare beneficiaries in Innovation Center Models that responded with best possible response options "always" or "yes, definitely" on CAHPS Care Coordination Questions}}{\textit{Number of Medicare beneficiaries in Innovation Center Models responding to Medicare FFS CAHPS questionaires}}$$

Rationale

Person-centered care is an approach that puts patients first, focusing on their individual needs and taking into consideration their preferences, values, and goals. It is entrenched as a crucial component of health care quality. This metric will support the Innovation Center's aim to improve person-centered care by setting targets based on patient-reported ratings of their experiences of care related to care coordination using the CAHPS survey.

Patients are the best and often the only source of meaningful information regarding their experiences with health care delivery,[16] and CAHPS surveys are well-established and have a history of being used along with other quality measures by CMS to help determine payment incentives that reward high-performing providers. AHRQ launched the CAHPS program in 1995 in response to concerns about the lack of information about the quality of health plans from the enrollees' perspective[17], and it has expanded to include surveys that can be administered across the health care system to allow for a better understanding of the overall patient experience.

CAHPS surveys are developed through a process that emphasizes scientific rigor and incorporates input from patients, health care professionals and other stakeholders to ensure the surveys will generate valid and reliable data that are suitable for comparisons across populations. As such, the CAHPS surveys are used not just by CMS and other agencies, but by physicians, hospitals, and other health care providers to help identify strengths and areas to improve upon the patient experience delivered within their offices or institutions, making these surveys strong candidates for obtaining information about Innovation Center model participants' performance on providing person-centered care.[18]

Methods

All data used in the metric was sourced and analyzed in the Chronic Conditions Data Warehouse (CCW) and included respondent-level data from Medicare Fee-for-Service (FFS CAHPS).

MITRE selected survey records for inclusion if any questions falling within the care coordination SSM were either fully or partially completed by the respondent.

Exhibit 12. Strategic Objective 3: Support Innovation Metric 1 Data Sources

Variable	Variable Description	Data Source(s)
MD_MEDRECS	Last 6 months, how often MD office have medical records	MCAHPS_LINKED_FFS
MD_TALKMEDS	Last 6 months, how often personal MD talk about all Rx medicines	MCAHPS_LINKED_FFS
SP_MDINFORMD	Last 6 months, how often personal MD up-to-date on care from specialists	MCAHPS_LINKED_FFS

[16] https://doi.org/10.1377/hlthaff.2010.0238
[17] https://www.ahrq.gov/cahps/about-cahps/cahps-program/index.html
[18] https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/about-cahps/cahps-program-brief.pdf

Variable	Variable Description	Data Source(s)
MD_GETMNGCA	Last 6 months, got help from personal MD to manage care	MCAHPS_LINKED_FFS
MD_TESTFUP	Last 6 months, how often MD office follow up with test results	MCAHPS_LINKED_FFS
MD_TESTASAN	Last 6 months, how often got test results as soon as needed	MCAHPS_LINKED_FFS
BENE_ALGNMT_EFF_DT	Effective start date a beneficiary was an Innovation Center model participant during a year	MDD_BENE_EXTRACT_LINKED_220708
BENE_ALGNMT_END_DT	End date a beneficiary was an Innovation Center model participant during a year	MDD_BENE_EXTRACT_LINKED_220708

Exhibit 13. Models Included in Strategic Objective 3: Support Innovation Metric 1

2017	2018	2019
Community-based Care Transition Program (CCTP)	Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)
Comprehensive ESRD Care (CEC)	Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)
Comprehensive Primary Care Plus (CPC+)	Financial Alignment Initiative (FAI)	Financial Alignment Initiative (FAI)
Financial Alignment Initiative (FAI)	Next Generation ACO (NGACO)	Independence at Home (IAH)
Independence at Home (IAH)		Maryland Primary Care Program
Next Generation ACO (NGACO)		Next Generation ACO (NGACO)
		Vermont All-Payer Model

Limitations

Only the FFS CAHPS was included in the examinations of the Care Coordination SSM. Initially several CAHPS surveys were considered but several limitations were identified. These limitations are primarily related to the availability of the CAHPS survey data, the incongruence in the SSMs evaluated across surveys, and the challenges they bring in evaluating and comparing rating results across surveys.

CAHPS surveys are designed for specific project goals rather than long-term evaluation. The level of reporting across CAHPS survey sources is also a challenge, with some survey data only available at the organization-level, whereas other survey data are reported at the respondent-level. This issue extends to the SSMs as well, with some survey results only available at the SSM composite-level, making it difficult to determine ratings of best possible response options "always" or "yes, definitely" for individual questions within an SSM.

In addition to the challenges stemming from the availability of the CAHPS data, there are also challenges associated with measuring SSMs across surveys. Not every CAHPS survey examines the same SSMs, or even include the same questions across SSMs. Some, like the CAHPS survey for Clinicians and Groups (CG-CAHPS), only measure select SSMs like Health and Functional Status through supplemental surveys such as the Primary Care First (PCF).

To address these limitations, the Innovation Center focused on the Care Coordination SSM as it is the only SSM being considered for the purpose of improving the patient experience that is consistently available across CAHPS survey data sources. A concentration on Care Coordination would also allow for a specialized focus on the individual components that make up the SSM, enabling a more defined view of areas that have more room and opportunity for improvement. As such, ratings of best possible response options "always" or "yes, definitely" will be calculated for the individual survey questions within the Care Coordination domain, and baseline and target scores provided at both the Care Coordination composite and individual item level. In the future, the Innovation Center may consider the inclusion of additional SSMs, and potentially other surveys if the availability of the CAHPS data improves.

Results

Baseline. 72.9% of beneficiaries in Innovation Center models reported ratings of best possible response options "always" or "yes, definitely" averaged across 6 questions within the Care Coordination SSM.

Targets. By 2030, 75% of beneficiaries in Innovation Center models will report ratings of best possible response options "always" or "yes, definitely" averaged across 6 questions within the Care Coordination SSM.

Additionally, the Innovation Center will monitor progress on the following individual question items:

- 66% of beneficiaries in Innovation Center models would respond *always* to "Last 6 months, how often personal MD talk about all prescription (Rx) medicines"
- 60% of beneficiaries in Innovation Center models would respond *always* to "Last 6 months, how often personal MD up-to-date on care from specialists"
- 76% of beneficiaries in Innovation Center models would respond *always* to "Last 6 months, how often MD office follow up with test results"
- 80% of beneficiaries in Innovation Center models would respond *always* to "Last 6 months, how often got test results as soon as needed"

Exhibit 14. Strategic Objective 3: Support Innovation Metric 1 Baseline and Targets

Best Possible Response Options "Always" Or "Yes, Definitely" Ratings for CAHPS Care Coordination SSM						
Group	**Subgroup**	**Question(s)**	**Baseline (2019)**		**Targets**	
			Denom.	**% Rating**	**2025**	**2030**
Model Participants	Any Active Innovation	**Care Coordination Composite**	10,515	72.9	73.8%	75.0% (+2.06)

Best Possible Response Options "Always" Or "Yes, Definitely" Ratings for CAHPS Care Coordination SSM						
Group	**Subgroup**	**Question(s)**	**Baseline (2019)**		**Targets**	
			Denom.	**% Rating**	**2025**	**2030**
	Center Model Participants	Office has medical records		89.5%		
		MD talks about all Rx medicines		62.8%	64.0%	66.0% (+3.2)
		MD up-to-date on care from specialists		56.6%	58.0%	60.0% (+3.4)
		Help from personal MD to manage care		80.2%		
		Office follows up with test results		73.5%	74.1%	76.0% (+2.5)
		Got test results as soon as needed		77.9%	78.75%	80.0% (+2.00)
Reference Baselines						
Medicare FFS	Overall	Care Coordination Composite	72,660	72.0%		
	Duals	Care Coordination Composite	6,215	68.5%		
	Shared Savings Program	Care Coordination Composite	25,223	72.6%		

Metric 2: Percent of models using at least two patient-reported measures

Definition

This metric measures the percent of Innovation Center models with a performance start date on or after January 1, 2021 reporting at least two patient-reported measures in different Meaningful Measures 2.0 domains. These domains identify high priority areas for quality measurement and improvement and include person-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health.

Patient-reported measures are those measures where data comes directly from the patient. Broadly, patient-reported data includes patient-reported outcomes (PROs) and ePROs, which is the electronic capture of this data; patient-reported outcome measures (PROMs), which is the structure of how the PRO data is reported (e.g., a survey instrument); and patient-reported outcome-based performance measures (PRO-PMs), which are reliable and valid quality measures of aggregated PRO data reported through a PROM and potentially used for performance assessment. For example, the Hospital CAHPS® survey is the PROM, a patient response to the survey is the PRO, and the Hospital CAHPS quality measure, whereby survey responses from

multiple patients are aggregated to produce an overall patient experience score for a hospital, is the PRO-PM.

Exhibit 15. Strategic Objective 3: Support Innovation Metric 2 - Examples of PROs, PROMs, and PRO-PMs

Type	Depression Example	Experience of Care Example
PRO	Patient-reported answers on depression survey	Patient reported answers on survey
PROM	Patient Health Questionnaire (PHQ)-9	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
PRO-PM	Percent of patients with diagnosis of major depression or dysthymia and initial PHQ-9 score >9 with a follow-up PHQ-9 score <5 at 6 months (NQF #0711)	Average response to each of 29 survey items grouped into 10 sub-measures among eligible hospital inpatients 18 years or older discharged from an acute care hospital (NQF # 0166)

Note: Examples adapted from NQF report.

Rationale

The Innovation Center established a set of principles for expanding use of PROs, PROMs and PRO-PMs within models to further the goals of increasing person- centeredness. This metric will help achieve the larger goal in the supporting innovation strategic objective in which all Innovation Center models will consider or include patient-reported outcomes as part of the measurement strategy.

Methods

To develop the baseline, the Innovation Center reviewed all recent models, which are defined as those as having a performance start date on or after January 1, 2021. As of 2022, two of seven models are currently reporting using at least two patient reported measures in different Meaningful Measures 2.0 domains. As such, the 2022 baseline for this metric is 29.0%.

Exhibit 16. Models Included in Strategic Objective 3: Support Innovation Metric 2

Enhancing Oncology Model (EOM)	Kidney Care Choices (KCC)

To develop 2025 and 2030 targets, the Innovation Center defines new models as those that have launched on or after January 1, 2023 and projected those that will use at least two patient reported measures in different Meaningful Measures 2.0 domains. By 2025, the Innovation Center projects that 50.0% of Innovation Center models will use at least two patient reported measures in different Meaningful Measures 2.0 domains and by 2030 that 75.0% of Innovation Center models will use at least two patient reported measures in different Meaningful Measures 2.0 domains.

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Metric 3: Percent of models that provide CMS-developed participant data dashboards

Definition

This metric measures the percent of Innovation Center models that provide CMS-developed participant data dashboards to model participants. Models included in this metric are those that have launch dates within the year we are reporting this metric and those models that have active performance periods in the year we are reporting this metric. CMS-developed participant data dashboards are secure web-hosted applications that display metrics and data designed to assist participants succeed in the model and design care innovations.

Rationale

The Innovation Center can leverage a range of supports that enable integrated, person-centered care - such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities. This metric will measure the Innovation Center's ability to support care innovation by sharing data in a useful and transparent manner with participants.

Methods

To develop the baseline, the Innovation Center reviewed all models. As of 2022, 3 of 30 models are currently using CMS-developed participant data dashboards. As such, the 2022 baseline for this metric is 10.0%.

Exhibit 17. Models Included in Strategic Objective 3: Support Innovation Metric 3 and Types of Dashboards Currently Offered to Participants in Each Model

Model	Type of Dashboard Offered
Primary Care First	Electronic Data Feedback Report is available to PCF participants through the Innovation Center landing page secure Model site
Integrated Care for Kids Model	Participants can access Awardee Dashboards through the Innovation Center landing page secure model site.
Community Health Access and Rural Transformation Model	Data Analytic Dashboard for CHART is also available to participants through a secure web hosted application.

To develop 2025 and 2030 targets, the Innovation Center trended the 2022 baseline forward accounting for new models launching between 2022 and 2030. By 2025, the Innovation Center

projects that 25% of Innovation Center models will use CMS-developed participant data dashboards. By 2030, the Innovation Center projects that 70% of Innovation Center models will use CMS-developed participant data dashboards.

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Metric 4: Percent of models offering interoperable, standards-based data exchange (i.e., via an API) to participants

Definition

This metric measures the percent of Innovation Center models that offer an interoperable data exchange option to model participants. Included models are those that have launch dates or those that have active performance periods within the year the Innovation Center is reporting this metric an. An interoperable data exchange uses Health IT application programming interface (API) standards to send or receive data from participants.

Rationale

The Innovation Center can leverage a range of supports that enable integrated, person-centered care - such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities. This metric aims to impact the Innovation Center's ability to reduce the administrative burden for participants to engage in models. The metric will also measure the Innovation Center's ability to encourage care innovation through data transparency.

Methods

To develop the baseline, the Innovation Center reviewed all models. As of 2022, there are 3 of 30 models that are offering an interoperable data exchange with participants. As such, the 2022 baseline for this metric is 10%.

Exhibit 18. Models Included in Strategic Objective 3: Support Innovation Metric 4 and Types of Interoperable Data Exchange Options Currently Offered by Each Model

Model	Type of Interoperable Data Exchange Offered
Kidney Care Choices (KCC)	May elect to receive claim data through the Beneficiary Claim Data API
ACO Realizing Equity, Access, and Community Health (ACOREACH)	May elect to receive claim data through the Beneficiary Claim data API
Emergency Triage, Treat, and Transport (ET3)	Uses the National Emergency Medical Services Information System (NEMSIS) API data exchange for EMS data

To develop 2025 and 2030 targets, the Innovation Center trended the 2022 baseline forward accounting for new models launching between 2022 and 2030. By 2025, the Innovation Center projects that 50% of Innovation Center models will offer an interoperable data exchange with participants. By 2030, the Innovation Center projects that 100% of Innovation Center models will offer an interoperable data exchange with participants.

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Metric 5: Percent of models, where applicable, that offer technical assistance and learning supports

Definition

This metric measures the percent of Innovation Center models that provide technical assistance and learning supports to model participants. Included models are those that have launch dates or those that have active performance periods within the year the Innovation Center is reporting this metric. Technical assistance is the information that can support participants understanding of model operations and payment, and to meet participation requirements. Learning supports are the tools that model participants can use to effectively implement changes in care delivery and to impact health outcomes. This can include:

1. Access to comprehensive, timely and actionable data that guides priority setting, systems improvement, and patient care;
2. Learning communities that connect model participants together to test strategies and tactics to deliver high quality, integrated care and to improve patient outcomes;
3. Dissemination of best practices on effective implementation associated with success in changing outcomes and patient experience; and
4. Targeted facilitation and coaching to help build change management capacity.

Rationale

The Innovation Center can leverage a range of supports that enable integrated, person-centered care, such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities. This metric will measure the Innovation Center's ability to provide support and tools for model participants to implement care delivery changes and impact health outcomes.

Methods

To develop the baseline, the Innovation Center reviewed all models that that have launch dates and those that have active performance periods within the year the Innovation Center is reporting this metric. As of 2022, 11 of 30 models provide technical assistance and learning supports to model participants. As such, the 2022 baseline for this metric is 37%.

Exhibit 19. Models Included in Strategic Objective 3: Support Innovation Metric 5

Bundled Payment for Care Improvement Advanced (BPCI-A)	Maternal Opioid Misuse Model (MOM)
Community Health Access and Rural Transformation (CHART)	Oncology Care Model (OCM)
Emergency Triage, Treat and Transport (ET3)	Primary Care First (PCF)
Global and Professional Direct Contracting (GPDC)	Shared Savings Program
Integrated Care for Kids (InCK)	Vermont All-Payer ACO Model (VAPM
Kidney Care Choices (KCC)	

To develop the 2025 target, the Innovation Center trended the 2022 baseline forward accounting for new models launching between 2022 and 2025. By 2025, the Innovation Center projects that 60% of Innovation Center models will provide technical assistance and learning supports to model participants. By 2030, the Innovation Center projects that 100% of Innovation Center models will provide technical assistance and learning supports to model participants.

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Strategic Objective 4 – Address Affordability

Metric 1: Percent of Innovation Center model beneficiaries who indicated "yes" that they delayed medical care due to cost in last 12 months; and

Metric 2: Percent of Innovation Center model beneficiaries who indicated they "often" or "sometimes" delayed filling prescription drugs due to costs in last 12 months

Definition

The Medicare Current Beneficiary Survey (MCBS) is a survey of a nationally representative sample of the Medicare population. There are two survey questions used to determine the percent of Medicare beneficiaries who delay medical care or filling prescription drugs due to cost.

Metric 1:

$$\frac{\textit{Number of Innovation Center model beneficiaries who reported delayed medical care due to cost in a given year}}{\textit{Number of Innovation Center model beneficiaries asked the survey question}}$$

Metric 2:

$$\frac{\textit{Number of Innovation Center model beneficiaries who delayed filling presciptions due to cost in a given year}}{\textit{Number of Innovation Center model beneficiaries asked the survey question}}$$

Rationale for Metric 1 and 2

As the Innovation Center works to align payment strategies across CMS and the broader health care delivery system, incorporating a metric that examines affordability from the beneficiary perspective can help identify strategies that address health care prices and affordability, and reduce unnecessary or duplicative care. High out-of-pocket costs, which can lead to delay of care for beneficiaries, can have cascading effects and lead to worse health outcomes over time. The delay in care due to cost metric is a self-reported measure of cost as a barrier to patient care. The metric can serve as a proxy to assess the prevalence of unaffordability of medical and prescription drugs in the Medicare population.

Methods for Metric 1 and 2

MITRE examined the most recent available data at the time of the analysis from the Medicare Current Beneficiary Survey (2017-2019), restricting the sample population to ever-enrolled Medicare beneficiaries who had at least one recorded response in each of the survey segments used in the cross-sectional analysis. MITRE generated weighted estimates for both parts of the metric by means of the Balanced Repeated Replication (BRR) method. In this method, a series of replicate weights are included in the variance estimation and does not require special subgroup considerations. The ever-enrolled survey weights and the corresponding 100 replicate weights were used for the delayed medical care due to cost metric, and the topical ever-enrolled weights specific to the Prescription Questionnaire (RXQ) survey file were used for the delayed prescription drugs due to cost metric.

For the delay in medical care due to cost question, MITRE preserved the original coding scheme such that any beneficiary who indicated “yes” to the delayed care due to cost question counted towards the numerator. For the second metric, delay in prescription drugs due to cost, MITRE recoded beneficiaries who indicated “often” or “sometimes” as “yes”.

The five subgroups used to stratify the results are defined in Exhibit 20.

Exhibit 20. Strategic Objective 4: Address Affordability Metric 1 and 2 Subgroups

Subgroup	Construction
Shared Savings Program Model Participant	Individual Medicare enrollees who participate in the Medicare Shared Savings Program model during the selected year

Subgroup	Construction
Any Active Innovation Center Model Participant	Individual Medicare enrollees who participate in active Innovation Center models during the selected year
FFS (enrolled at any point in the year)	Individual Medicare enrollees who enrolled in fee-for-service for at least one month during the selected year
MA/Other Medicare Capitated Payment Plan (enrolled at any point in the year)	Individual Medicare enrollees who enrolled in Medicare Advantage or any other capitated payment plan for at least one month during the selected year
Duals	Individual Medicare enrollees who enrolled in full, partial or Qualified Medicare Beneficiary (QMB) Medicaid benefits for at least one month during the selected year

Exhibit 21. Strategic Objective 4: Address Affordability Metric 1 and 2 Data Sources

Variable	Variable Description	Data Source
H_PRGID	Various CMS Program payment model types	MCBS Health Insurance survey
H_OPMDCD	Medicare-Medicaid dual eligibility indicator	MCBS Health Insurance survey
H_MAFF01 – H_MAFF12	Enrollment flag on a monthly basis for MA, FSS or no enrollment	MCBS Health Insurance survey
HCDELAY	Last year ever delay in care due to cost	MCBS Access to Care survey
DELYRX	Frequency of delaying prescription drugs due to cost	MCBS Prescription Drug survey

Exhibit 22. Models Included in Strategic Objective 4: Address Affordability Metrics 1 and 2

2017	2018	2019
Community-Based Care Transitions Program (CCTP)	Community-Based Care Transitions Program (CCTP)	Community-Based Care Transitions Program (CCTP)
Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)	Comprehensive ESRD Care (CEC)
Comprehensive Primary Care Initiative (CPC)	Comprehensive Primary Care Initiative (CPC)	Comprehensive Primary Care Initiative (CPC)
Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)	Comprehensive Primary Care Plus (CPC+)
Independence at Home Demonstration (IAH)	Independence at Home Demonstration (IAH)	Independence at Home Demonstration (IAH)
Medicare Health Care Quality Demonstration - IHIE	Medicare Health Care Quality Demonstration - IHIE	Maryland Primary Care Program (MDPCP)
Medicare Health Care Quality Demonstration - NC-CCN	Medicare Health Care Quality Demonstration - NC-CCN	Medicare Health Care Quality Demonstration - IHIE

2017	2018	2019
Multi-Payer Advanced Primary Care Practice Demonstrations (MAPCP)	Multi-Payer Advanced Primary Care Practice Demonstrations (MAPCP)	Medicare Health Care Quality Demonstration - NC-CCN
Next Generation ACO (NGACO)	Next Generation ACO (NGACO)	Multi-Payer Advanced Primary Care Practice Demonstrations (MAPCP)
Physician Group Practice Transition Demonstration (PGP)	Physician Group Practice Transition Demonstration (PGP)	Next Generation ACO (NGACO)
Pioneer ACO	Pioneer ACO	Physician Group Practice Transition Demonstration (PGP)
Financial Alignment Initiative (FAI)	Financial Alignment Initiative (FAI)	Pioneer ACO
	Vermont All-Payer Model (VAPM)	Financial Alignment Initiative (FAI)
		Vermont All-Payer Model (VAPM)

Limitations

Affordability of medical care and prescription drugs may hold different meanings across diverse beneficiaries. The MCBS, as a survey instrument, is based on self-reported data and thus subject to recall bias. This metric is limited in its ability to capture multiple dimensions on the impact of affordability, as it only assesses beneficiaries who delay care due to cost. However, in 2019, the MCBS introduced questions to the survey sections pertaining to beneficiaries forgoing care due to cost or lack of coverage, but these questions are only asked of a subset of the beneficiaries, which limits data representativeness and the ability to trend historically. The Innovation Center will continue to monitor both delaying and forgoing forgo care with the potential for updates and revisions based on future data availability.

Starting in 2020, the MCBS introduced questions regarding the inability to access health care services due to COVID-19 pandemic. Survey responses revealed that as high as 1 in 5 Medicare beneficiaries were affected during the summer of 2020, with a decline to 7.5% during the fall.[19] The Innovation Center will continue to monitor the impact of alternative responses to questions around delayed and forgone care within the MCBS to account for other potential issues that may supersede or coincide with affordability as a reason for delay of care or filling prescription drugs.

Results

Baseline. Across Innovation Center models, 8.3% of beneficiaries delay medical care due to cost, and 7.2% of beneficiaries delay prescription drugs due to cost.

Targets. By 2030, 5.0% of beneficiaries in Innovation Center models will be identified as delaying medical care due to cost, and 5.0% of beneficiaries will be identified as delaying prescription drugs due to cost.

[19] Inability to Access Health Care Due to COVID-19 Among Medicare Beneficiaries, https://www.ajmc.com/view/inability-to-access-health-care-due-to-covid-19-among-medicare-beneficiaries

Exhibit 23. Strategic Objective 4: Address Affordability Metric 1 and 2 Baselines and Targets

% Delay Medical Care / Prescription Drugs Due to Cost						
Group	**Subgroup**	**Question(s)**	**Baseline (2019)**		**Targets**	
			Denom.	**% (SE)**	**2025**	**2030**
Model Participants	Any Active Innovation Center Model Participant	Medical Care	4,074	8.3% (0.59)	7.1%	5.0%
		Prescription Drugs	2,545	7.2% (0.64)	6.4%	5.0%
Reference Trends						
Medicare	Overall	Medical Care	14,148	10.1% (0.36)		
		Prescription Drugs	8,926	7.3% (0.38)		
	FFS	Medical Care	8,475	10.0% (0.44)		
		Prescription Drugs	5,341	7.0% (0.50)		
	MA	Medical Care	6,057	10.7% (0.55)		
		Prescription Drugs	3,827	7.9% (0.54)		
	Duals	Medical Care	3,102	12.7% (0.85)		
		Prescription Drugs	1,874	9.3% (0.83)		
	Shared Savings Program	Medical Care	3,072	8.4% (0.69)		
		Prescription Drugs	1,916	6.3% (1.32)		

Strategic Objective 5 – Partner to Achieve System Transformation

Metric 1: Percent of new models, where applicable, that make multi-payer alignment available

Definition

This metric measures the percent of new Innovation Center models that make multi-payer alignment available on key design features. New Innovation Center models are those that are launched on or after January 1, 2023. Multi-payer alignment is being defined as directional alignment across payers that enable providers to move away from fee-for-service payments and more fully commit to taking on accountability for their patients cost and quality outcomes. Key

design features of alignment include, quality measurement, data and data aggregation, care delivery, and learning supports.

Rationale

The Innovation Center is aligning priorities and policies across CMS and aggressively engaging payers, providers, states, and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs. This metric will measure the Innovation Center's ability to support directional alignment across payers on key design features that can reduce variability and administrative burden and help providers to pursue the same goals for all patients, regardless of which payer or program insures them.

Methods

To develop the baseline, the Innovation Center reviewed all new models announced as of 2022. One of two new models make multi-payer alignment available. As such, the 2022 baseline for this metric is 50%.

To develop 2025 and 2030 targets, the Innovation Center trended the 2022 baseline forward accounting for new models launching between 2023 and 2030. By 2025, the Innovation Center projects that 75% of Innovation Center models will make multi-payer alignment available. By 2030, the Innovation Center projects that 100% of Innovation Center models will make multi-payer alignment available where possible.

Exhibit 24. Models Included in Strategic Objective 5: Partner to Achieve System Transformation Metric 1

Enhancing Oncology Model (EOM)

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Metric 2: Percent of models that engaged patients/beneficiaries, caregivers, and patient groups throughout the model lifecycle

Definition

This metric determines the percent of Innovation Center models that engaged patients/ beneficiaries, caregivers, and patient groups throughout the model lifecycle. This includes model ideation, implementation, and evaluation. Included models are those that have launch dates and those that have active performance periods within the year the Innovation Center is reporting this metric. The model ideation phase, considered the model idea pipeline, is dedicated to the solicitation of ideas, identification of specific concepts for models, research and evidence gathering to develop business processes and model requirements, and the solicitation and selection of model participants. The model implementation and evaluation phases involve the

necessary steps to test, monitor, and evaluate the impacts of a model to inform the potential for scaling and expanding the model, as appropriate.

Rationale

The Innovation Center is promoting beneficiary-centered decision-making through a new beneficiary engagement strategy that will collect and operationalize beneficiary feedback. This metric will measure the Innovation Center's ability to incorporate beneficiary and caregiver perspectives into model designs and throughout the model lifecycle and better identify and meet beneficiary and caregiver needs. The Innovation Center seeks to improve care quality for beneficiaries, improve experience for beneficiaries, and drive better health care outcomes for beneficiaries.

Methods

To develop the 2022 baseline, the Innovation Center reviewed models that have launch dates and those that have active performance periods within the year the Innovation Center is reporting this metric. As of 2022, all 30 active models are engaging patients/beneficiaries, caregivers, and/or patient groups at some point during the model lifecycle. Based on this review, the 2022 baseline for this metric is 100%.

By 2025 and 2030, the Innovation Center will maintain that 100% of Innovation Center models will engage patients/beneficiaries, caregivers, and/or patient groups in the model development process. Given that all models are all currently meeting this metric, the Innovation Center will revisit this metric and other opportunities to measure engagement in the model lifecycle in future years.

Exhibit 25. Models Included in Strategic Objective 5: Partner to Achieve System Transformation Metric 2

Accountable Health Communities (AHC)	Medicare Diabetes Prevention Program - Expanded (MDPP)
Global and Professional Direct Contracting (GPDC)	Medicare Intravenous Immunoglobulin Access Demonstration Project
Bundled Payment for Care Improvement Advanced (BPCI-A)	Shared Savings Program
Comprehensive Care for Joint Replacement Payment (CJR)	Medicare-Medicaid Financial Alignment Initiative
Comprehensive Primary Care Plus (CPC+)	Million Hearts: Cardiovascular Disease Risk Reduction Model (CRRM)
Emergency Triage, Treat and Transport (ET3)	Community Health Access and Rural Transformation (CHART)
ESRD Treatment Choices (ETC)	Oncology Care Model (OCM)
Home Health Value-Based Purchasing (HHVBP)	Part D Enhanced Medication Therapy Management (Part D-MTM)
Independence at Home Demonstration (IAH)	Part D Payment Modernization (PDPM)
Integrated Care for Kids Model (InCK)	Part D Senior Savings Model (PDSSM)
Kidney Care Choices (KCC)	Pennsylvania Rural Health Model (PARHM)

Maryland Total Cost of Care (MDTCOC)	Primary Care First (PCF)
Maternal Opioid Misuse (MOM)	Rural Community Hospital Demo (RCH)
Medicare Advantage Value-Based Insurance Design (MAVBID)	Value in Opioid Use Disorder Treatment Demonstration Program
Medicare Care Choices Model (MCCM)	Vermont All-Payer ACO Model (VAPM)

Limitations

The numerator and denominator for this metric are subject to change based on the number and types of models that begin and end in certain years.

Appendix A. Supporting Documentation

Figure A.1. Strategic Objective 2: Advance Health Equity Metric 3 Method for Identifying Primary Care Safety Net Providers

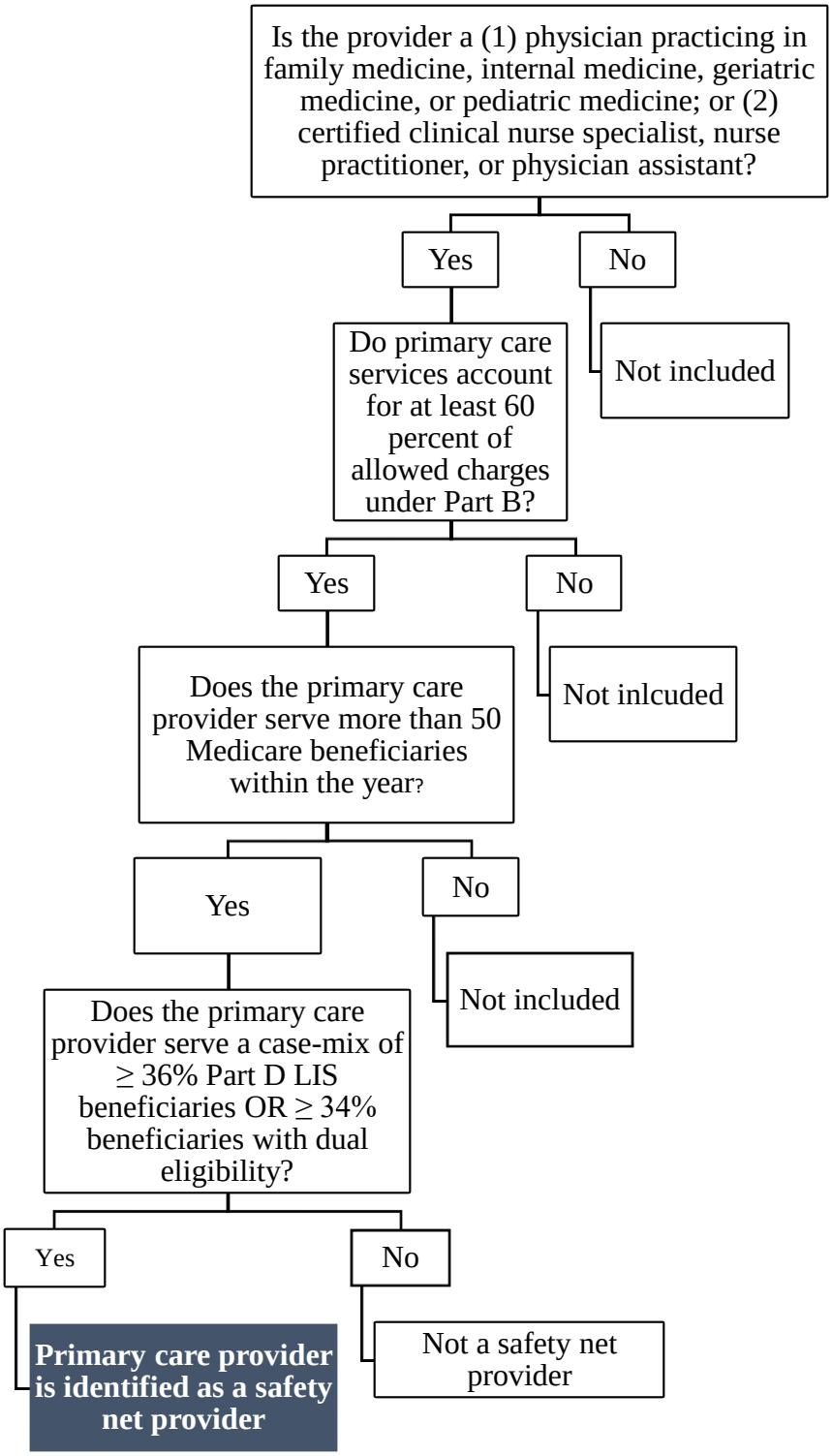


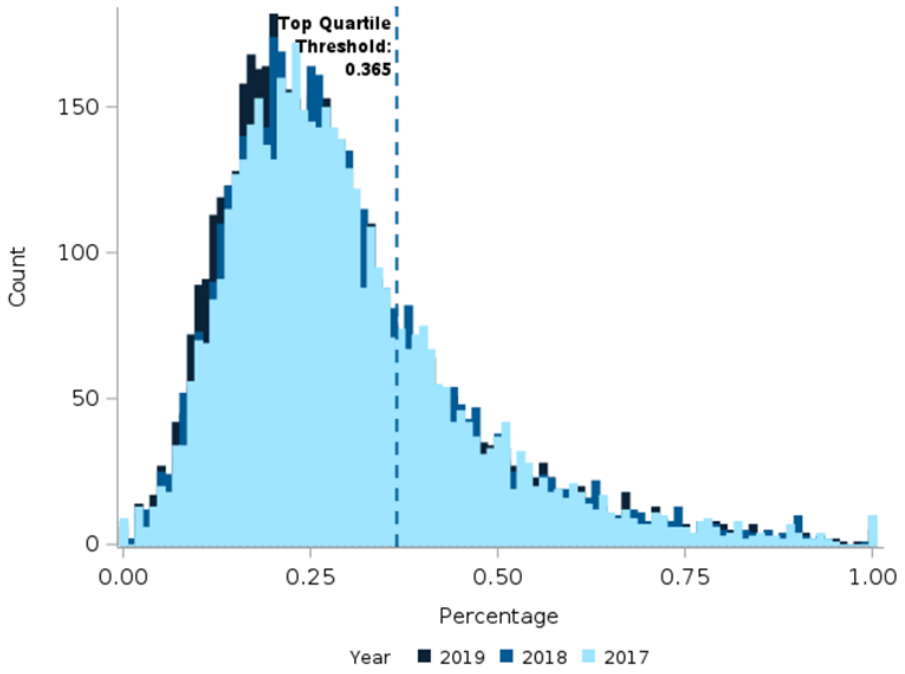
Exhibit A.1. Strategic Objective 2: Advance Health Equity Metric 3 - Supplemental Table: Percent of Primary Care Providers who bill Medicare and are Identified as Safety Net Providers that Participate in Innovation Center Models

% of Primary Care Provider Safety Net Providers Participating in Innovation Center Models						
Group	**2017**		**2018**		**2019**	
	Denominator	**% (N)**	**Denominator**	**% (N)**	**Denominator**	**% (N)**
Model Participants	50,608	**20.7%** (10,496)	50,630	**21.9%** (11,072)	49,223	**27.2%** (9,409)

Exhibit A.2. Strategic Objective 2: Advance Health Equity Metric 2 - Supplemental Table: Percent of Facilities who bill Medicare and are Identified as Safety Net Providers that Participate in Innovation Center Models

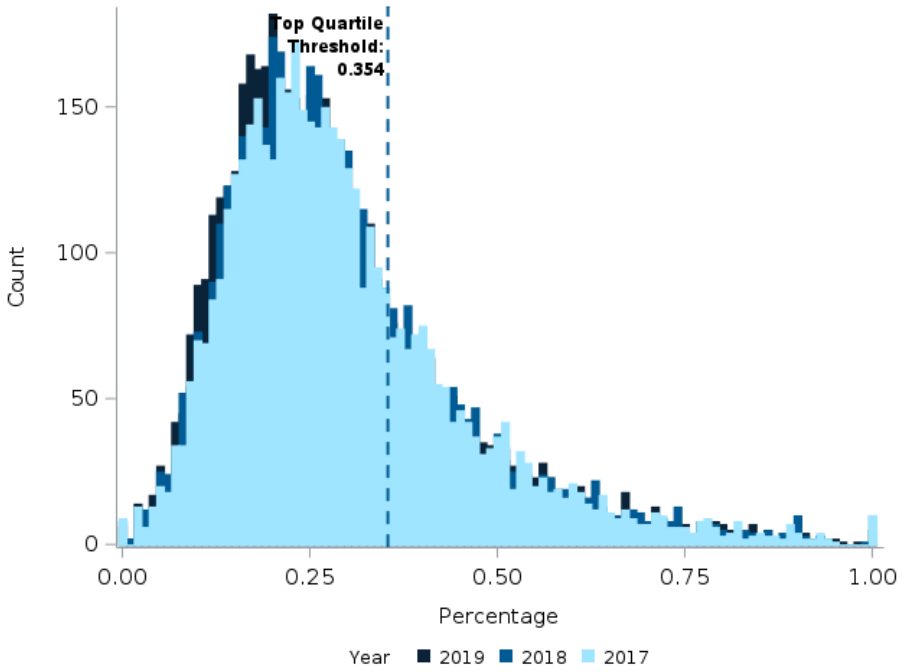
% of Safety Net Facilities Participating in Innovation Center Models						
Group	**2017**		**2018**		**2019**	
	Denominator	**% (N)**	**Denominator**	**% (N)**	**Denominator**	**% (N)**
Model Participants	9,018	**1.8%** (161)	8,960	**2.4%** (217)	8,219	**5.1%** (418)

Figure A.2. Strategic Objective 2: Advance Health Equity Metric 2 - Facility-Level Distribution of LS Recipients Among Hospitals in 2017, 2018, and 2019 and Calculated Threshold for Inclusion



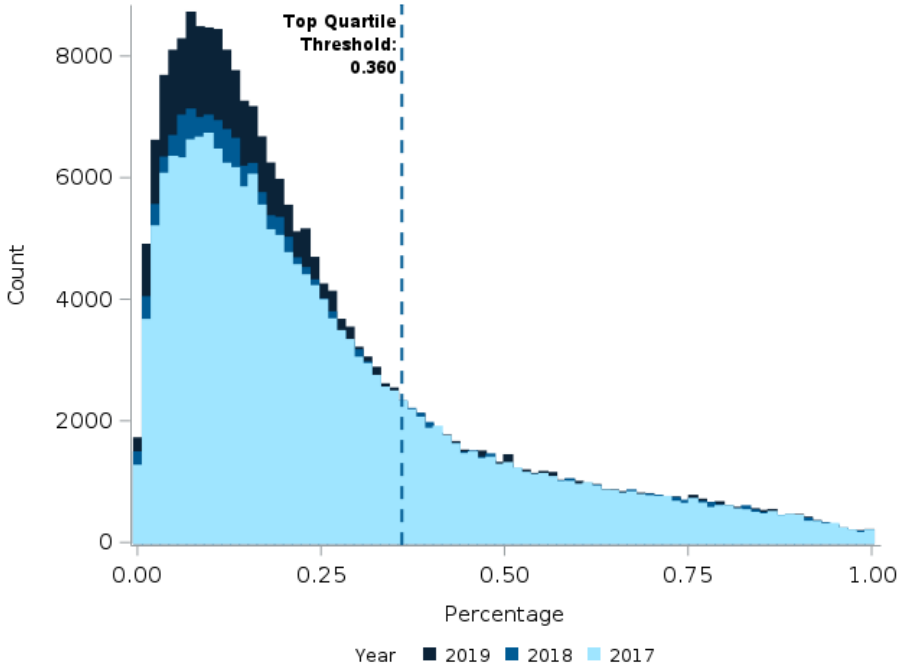
Note: The top quartile threshold, or 'threshold of inclusion' was determined by taking the weighted average of the 3rd quartile for each baseline year. The calculation was weighted based on the number of Medicare beneficiaries within the baseline year.

Figure A.3. Strategic Objective 2: Advance Health Equity Metric 2 - Facility-Level Distribution of Dually Eligible Beneficiaries Among Hospitals in 2017, 2018, and 2019 and Calculated Threshold for Inclusion



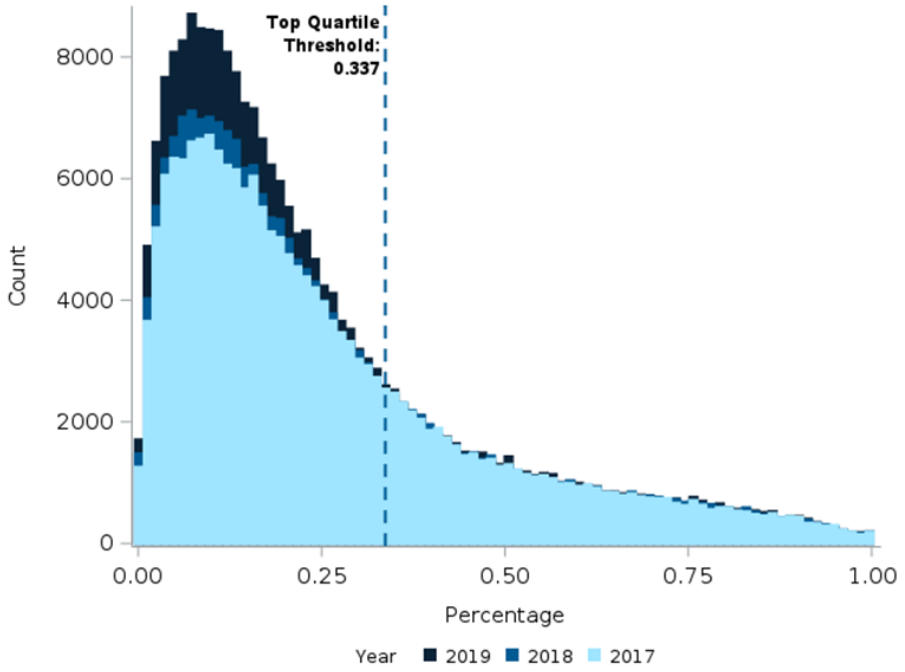
Note: The top quartile threshold, or 'threshold of inclusion' was determined by taking the weighted average of the 3rd quartile for each baseline year. The calculation was weighted based on the number of Medicare beneficiaries within the baseline year.

Figure A.4. Strategic Objective 2: Advance Health Equity Metric 3 - Distribution of LIS Recipients Among PCPs in 2017, 2018, and 2019 and Calculated Threshold for Inclusion



Note: The top quartile threshold, or 'threshold of inclusion' was determined by taking the weighted average of the 3rd quartile for each baseline year. The calculation was weighted based on the number of Medicare beneficiaries within the baseline year.

Figure A.5. Strategic Objective 2: Advance Health Equity Metric 3 - Distribution of Dually Eligible Beneficiaries Among PCPs in 2017, 2018, and 2019 and Calculated Threshold for Inclusion



Note: The top quartile threshold, or 'threshold of inclusion' was determined by taking the weighted average of the 3rd quartile for each baseline year. The calculation was weighted based on the number of Medicare beneficiaries within the baseline year.

Figure A.5. Strategic Objective 2: Advance Health Equity Metric 2 - Percent of Safety Net Facilities in Medicare and Innovation Center Models in 2017, 2018, and 2019)

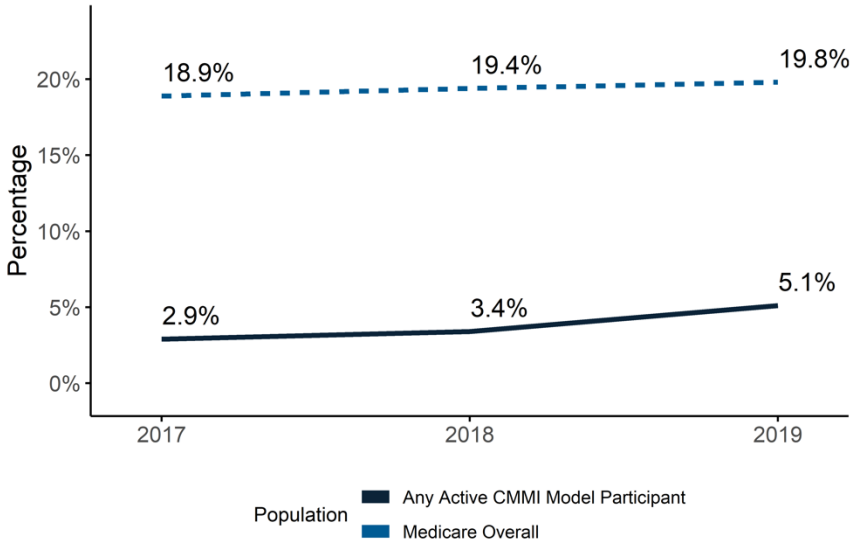


Figure A.6. Strategic Objective 2: Advance Health Equity Metric 3 - Percent of Individual Safety Net Providers in Medicare and Innovation Center Model in 2017, 2018, and 2019

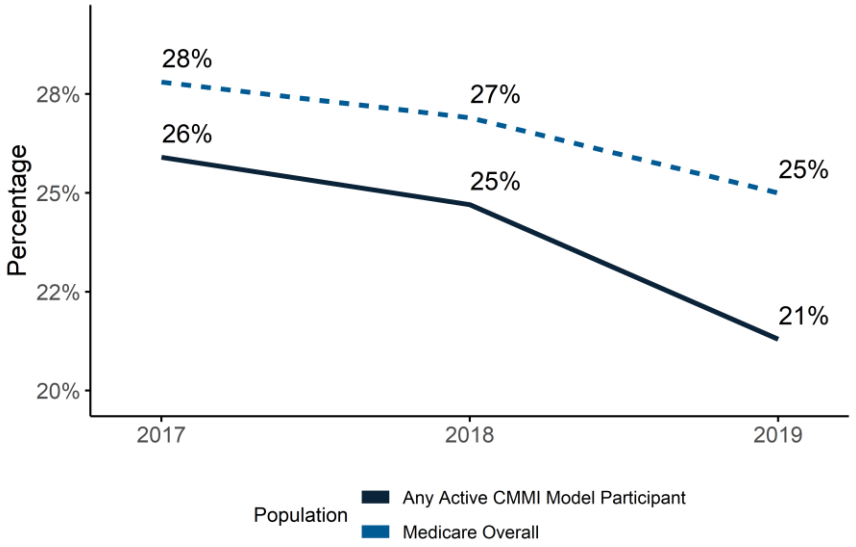


Figure A.7. Strategic Objective 2: Advance Health Equity Metric 4 - Rate of Potentially Preventable Admissions per 100,000 population for Medicare Beneficiaries, Innovation Center Model Beneficiaries, and Shared Savings Program Beneficiaries 2017 through 2021 (PQI #90 Overall Composite)

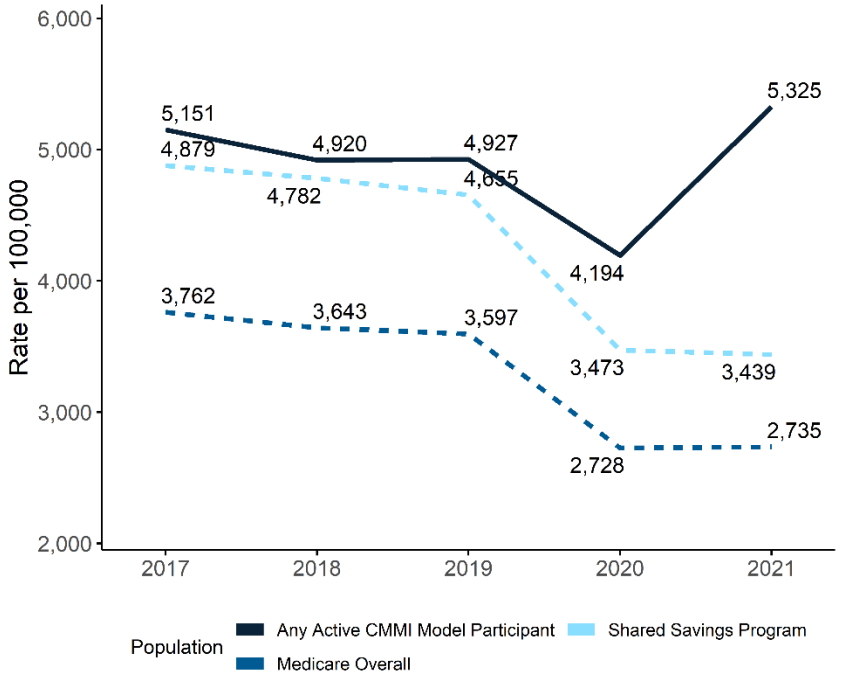


Figure A.8 Strategic Objective 2: Advance Health Equity Metrics 4 and 5 - Rate of Potentially Preventable Admissions per 100,000 population for Innovation Center Model Beneficiaries by Race/Ethnicity 2017 through 2021 (PQI #90 Overall Composite)

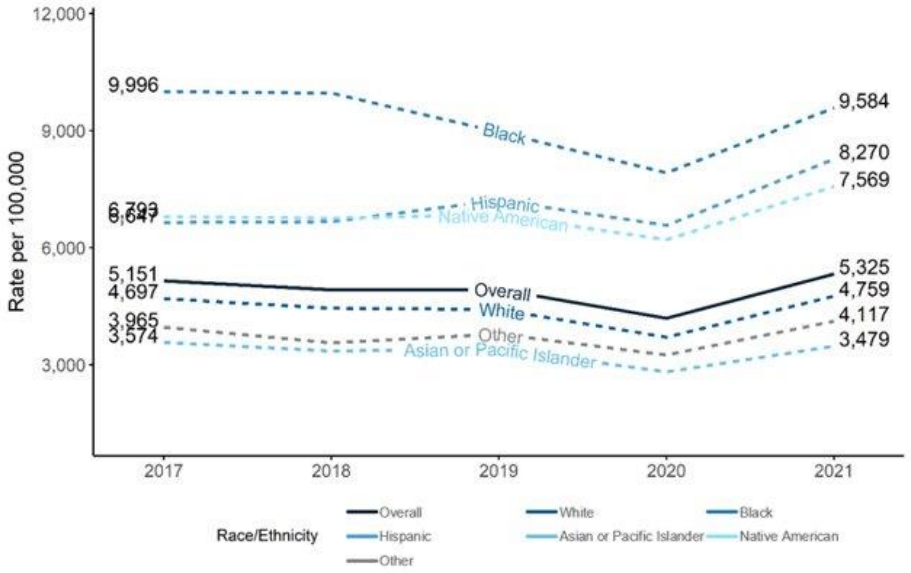


Figure A.9. Strategic Objective 3: Support Innovation Metric 1 - Percent of Beneficiaries in Medicare, Innovation Center Models, and Shared Savings Program who Reported Ratings of Best Possible Response Options "Always" or "Yes, Definitely" Averaged Across 6 Questions within the Care Coordination SSM in 2017, 2018 and 2019

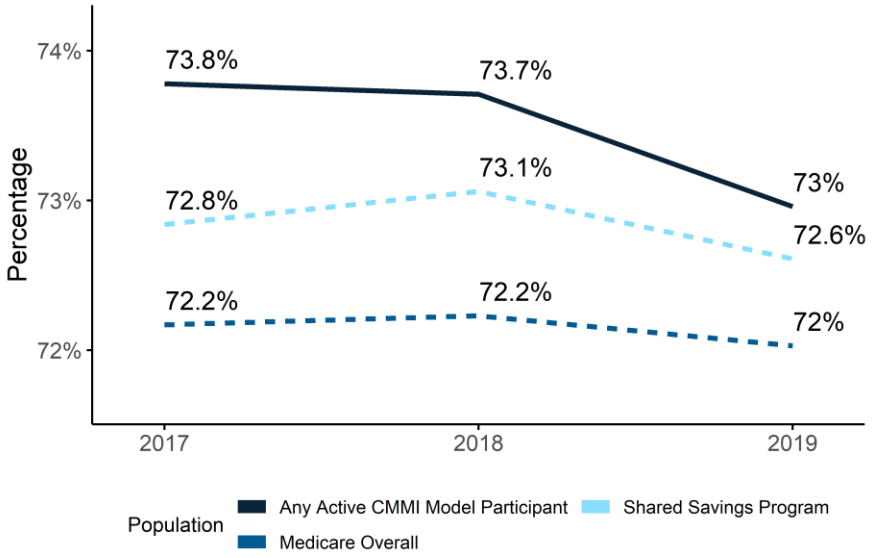
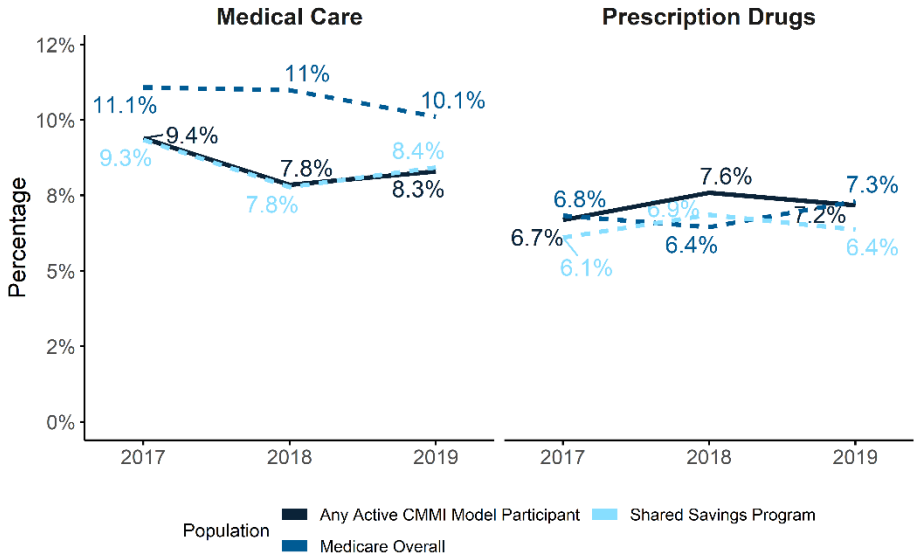


Figure A.10. Strategic Objective 4: Address Affordability Metrics 1 and 2 - Percent of Beneficiaries in Medicare, Innovation Center Models, and Shared Savings Program who Delay Medical Care and Prescription Drugs Due to Cost in 2017, 2018 and 2019



Appendix B. Additional Technical Specifications

Exhibit B.1. Strategic Objective 2: Advance Health Equity Metric 2 Technical Specifications

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td>Description</td><td>The percent of facilities that participate in Innovation Center models that are identified as safety net facilities.</td></tr>
<tr><td>Measurement Period</td><td>A one-year period beginning January 1st of the measurement year and ending December 31st of the measurement year.</td></tr>
<tr><td>Numerator</td><td>The count of safety net facilities that participate in Innovation Center models.

Where safety net facilities are defined by inclusion in:
• Hospitals (short-term hospitals and critical access hospitals (CAHs)) that serve above a baseline threshold of beneficiaries with dual eligibility or Part D LIS
  ○ Part D LIS threshold: 0.3653
  ○ Dual eligible threshold: 0.3541
• Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and Community Mental Health Centers (CMHCs)

<u>Step 1a.</u> Using Medicare claims data found in the CMS Integrated Data Repository (IDR) retain claims rendered by hospitals using the following CCN categories:

<table>
<tr><th>Category</th><th>Last four digits of CCN Range</th></tr>
<tr><td>Short-term Hospitals</td><td>0001-0879</td></tr>
<tr><td>Critical Access Hospitals</td><td>1300-1399</td></tr>
</table>

<u>Step 2.</u> Limited to only beneficiaries enrolled in Medicare Parts A &B, determine a count of beneficiaries receiving Part D Low Income Subsidy (LIS) and a count of beneficiaries with dual eligibility for each facility identified.

<u>Step 3.</u> Flag the facilities whose count of patients receiving LIS or beneficiaries with dual eligibility is greater than or equal to the set threshold.

<u>Step 4a.</u> Using Medicare claims data, determine the list of active FQHCs, RHCs, and CMHCs during the measurement period using the following CCN categories.

<table>
<tr><th>Category</th><th>Last four digits of CCN Range</th></tr>
<tr><td>FQHCs</td><td>1000-1199; 1800-1989</td></tr>
<tr><td>Rural Health Clinics</td><td>3400-3499; 3800-3999; 8500-8999</td></tr>
<tr><td>Community Mental Health Centers</td><td>1400-1499;</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>4600-4799;
4900-4999</td></tr>
</table>

Step 4b. Combine the datasets created in Step 3 and Step 4a.

<u>Step 5.</u> Join the dataset created in Step 4b with the Innovation Center model participation data and determine the unique number of facilities identified as Innovation Center model participants (TABLE: V2_APM_PRVDR) (Denominator)

<u>Step 6.</u> Retain only providers who can be found in the Innovation Center model participation data (TABLE: V2_APM_PRVDR, V2_MDCR_POR_ORG_PRVDR_DTL) (Numerator)</td></tr>
<tr><td>Denominator</td><td>The count of facilities that participate in Innovation Center models.</td></tr>
<tr><td>Exclusions</td><td>Facilities that do not meet the criteria of being a safety net facility.</td></tr>
<tr><td>Stratifications</td><td>None</td></tr>
<tr><td>Data source</td><td>○ Medicare Claims: V2_MDCR_CLM
○ Beneficiary Fact Transactional Tracking: V2_MDCR_BENE_FCT_TRANS_HSTRY
○ POR MDM Data: V2_MDCR_POR_ORG_PRVDR_DTL
○ AMS Data: V2_APM_PRVDR
○ MDM Data: V2_MDCR_POR_ORG_PRVDR_DTL</td></tr>
</table>

Exhibit B.2. Strategic Objective 2: Advance Health Equity Metric 3 Technical Specifications

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td>Description</td><td>The percent of primary care providers that participate in Innovation Center models who are identified as safety net providers.</td></tr>
<tr><td>Measurement Period</td><td>A one-year period beginning January 1st of the measurement year and ending December 31st of the measurement year.</td></tr>
<tr><td>Numerator</td><td>The count of primary care providers that participate in Innovation Center models who are identified as safety net providers

Safety net provider is defined by:
• Providers that serve above a baseline threshold of beneficiaries with dual eligibility or Part D LIS
○ Where receiving Part D LIS is a proxy for low income
○ Part D LIS threshold: 0.3602
○ Dual eligible threshold: 0.3369

<u>Step 1a.</u> Using the primary care practitioner definition found in the Medicare claims processing manual[20] and Medicare Part B Professional claims data found in the CMS Integrated Data Repository (IDR) retain claims rendered by providers with the following specialties:
<table>
<tr><td>Specialty</td><td>Specialty Code</td></tr>
<tr><td>Family Medicine</td><td>08</td></tr>
<tr><td>Internal Medicine</td><td>11</td></tr>
</table></td></tr>
</table>

[20] Medicare Claims Processing Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td></td><td>
<table>
<tr><td>Geriatric Medicine</td><td>38</td></tr>
<tr><td>Certified Clinical Nurse Specialist</td><td>89</td></tr>
<tr><td>Nurse Practitioner</td><td>50</td></tr>
<tr><td>Physician Assistant</td><td>97</td></tr>
<tr><td>Pediatrics</td><td>37</td></tr>
</table>

Step 1b. For each provider NPI, count the number of claims that were rendered for primary care serves using its inclusion in the following HCPCS codes:
• 99201 to 99215
• 99304 to 99340
• 99341 to 99350

Step 2. Retain only providers whose count of primary care claims account for at least 60 percent of all claims rendered.

Step 3. Determine a count of patients receiving Part D Low Income Subsidy (LIS) and a count of beneficiaries with dual eligibility for each provider identified as a primary care provider.

Step 4. Create a flag for providers whose proportion of patients receiving LIS or beneficiaries with dual eligibility is greater than or equal to the set baseline threshold for LIS or dually eligibility:
• LIS: 0.3602
• Dual: 0.3369

Step 5. Determine the unique number of providers that can be linked to the Innovation Center model participation data (TABLE: V2_APM_PRVDR) (Denominator)

Step 6. Retain only providers who can be linked to the Innovation Center model participation data (TABLE: V2_APM_PRVDR, V2_MDCR_POR_ORG_PRVDR_DTL) (Numerator)
</td></tr>
<tr><td>Denominator</td><td>The count of primary care providers that participate in Innovation Center models.</td></tr>
<tr><td>Exclusions</td><td>Providers who do not meet the requirement for categorization as primary care.
Providers who serve less than or equal to 50 Medicare Beneficiaries in a given year.</td></tr>
<tr><td>Stratifications</td><td>None</td></tr>
<tr><td>Data source</td><td>
○ Medicare Claims: V2_MDCR_CLM
○ Medicare Claim Line: V2_MDCR_CLM_LINE
○ Beneficiary Fact Transactional Tracking: V2_MDCR_BENE_FCT_TRANS_HSTRY
○ POR MDM Data: V2_MDCR_POR_ORG_PRVDR_DTL
○ AMS Data: V2_APM_PRVDR
○ MDM Data: V2_MDCR_POR_ORG_PRVDR_DTL
</td></tr>
</table>

Exhibit B.3. Strategic Objective 2: Advance Health Equity Metrics 4 and 5 Technical Specifications

Metric: Prevention Quality Indicator 90 (PQI 90) Prevention Quality Overall Composite	
Metric element	Description
Description	Prevention Quality Indicators (PQI) composite of overall conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.
Numerator	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate • PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI#11 Community-Acquired Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.
Denominator	The analysis population includes 100 % of adult Medicare beneficiaries enrolled in Medicare Part A for the selected year
Exclusions	-Excluded from the analysis are: Beneficiaries who were younger than 18 at the beginning of the selected year. -Discharges where the sex is missing -Discharges with missing Diagnosis codes -Discharges with missing Claim From dates -Discharges with a DRG code = 999 -Discharges with an MDC = 14 – which indicates Pregnancy, Childbirth & the Puerperium - Beneficiaries with missing or "Unknown" RTI race category
Stratifications	Model Participants Medicare Benefit (FFS or MA) Race and Ethnicity
Data source	Integrated Data Repository (IDR) - Claims Table (include Medicare claims and Encounter claims): MDCR_CLM, MDCR_CLM_INSTNL, MDCR_CLM_PROD_MTRLZD, MDCR_DGNS_DRG_CD - MDM model data: MDCR_POR_ORG_BENE_DTL - AMS model data: APM_BENE - Beneficiary tables: MDCR_BENE_FCT_TRANS_CRNT, MDCR_BENE_ST_CNTY_HSTY AHRQ PQI Software v2021 - Software package includes diagnosis codes to identify the medical conditions in question - SAS QI Software (ahrq.gov)

Exhibit B.4. Strategic Objective 3: Support Innovation Metric 1 Technical Specifications

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td>Description</td><td>This goal calculates the score for ratings of best possible response options “always” or “yes, definitely” for the care coordination composite from the FFS CAHPS survey.</td></tr>
<tr><td>Best Possible Response Options “Always” or “Yes, Definitely” Scoring</td><td>Scores for ratings of best possible response options “always” or “yes, definitely” were calculated as the percent of respondents who chose the most positive option on the given response scale.
<table>
<tr><td>Response Scale Type</td><td>Best possible response options</td></tr>
<tr><td>3-point response scale</td><td>Yes, definitely</td></tr>
<tr><td>4-point response scale</td><td>Always or Yes, definitely</td></tr>
</table></td></tr>
<tr><td>Care Coordination Composite Scoring</td><td>The Care Coordination Composite measure is comprised of 6 survey items.
<table>
<tr><td>Question</td><td>Response Options</td></tr>
<tr><td>Item 1: Personal MD had medical records or other info about care</td><td>Never (1)
Sometimes (2)
Usually (3)
Always (4)</td></tr>
<tr><td>Item 2: How often talk about Rx medications</td><td>Never (1)
Sometimes (2)
Usually (3)
Always (4)</td></tr>
<tr><td>Item 3: MD informed about care from specialists</td><td>Never (1)
Sometimes (2)
Usually (3)
Always (4)</td></tr>
<tr><td>Item 4: Get needed help to manage care</td><td>No (2)
Yes, somewhat (3)
Yes, definitely (4)</td></tr>
<tr><td>Item 5: MD office follow-up to give test results*</td><td>Never (1)
Sometimes (2)
Usually (3)
Always (4)</td></tr>
<tr><td>Item 6: Got test results as soon as needed**</td><td>Never (1)
Sometimes (2)
Usually (3)
Always (4)</td></tr>
</table>
*Note that those answering item 5 as Never (1) are asked to skip item 6
**If item 5 is answered as Never (1), then item 6 assumes a value of Never (1) regardless of whether item 6 was skipped or how it was answered. Items 5 and 6 are averaged to generate a single item score.
To score the composite, the weighted average of 6 best possible response options of “always” or “yes, definitely” scores was calculated:

The score for items 1-4, each with a weight of 1, and
The score for item 5, with a weight of ½, and
The score for item 6, recoded if applicable, with a weight of ½
</td></tr>
<tr><td>Exclusions</td><td>Surveys records if all of questions falling within the care coordination SSM were not completed by the respondent.</td></tr>
<tr><td>Stratifications</td><td>Model Participants
Dual Eligibility
Race and Ethnicity</td></tr>
<tr><td>Data source</td><td>Chronic Conditions Data Warehouse (CCW) Virtual Research Data Center (VDRC)
- FFS CAHPS survey: MCAHPS_LINKED_FFS_YYYY
- The most recent MDM model data: MDD_BENE_EXTRACT_LINKED_YYMMDD</td></tr>
</table>

Exhibit B.5. Strategic Objective 4: Address Affordability Metrics 1 and 2 Technical Specifications

<table>
<tr><th>Metric Element</th><th>Description</th></tr>
<tr><td>Description</td><td>The Medicare Current Beneficiary Survey (MCBS) is a survey of a nationally representative sample of the Medicare population. There are two survey questions used to determine the proportion of Medicare beneficiaries who delay medical or pharmaceutical care due to cost.</td></tr>
<tr><td>Numerator</td><td>Delay in medical care due to cost:
Number of beneficiaries who indicated “yes” that they delayed or did not receive medical care due to cost in last 12 months.

Q1: Since (HF MONTH YEAR), have you (SP) delayed seeking medical care because you were worried about the cost?

Delay in prescription drugs due to cost:
Percent of beneficiaries who indicated “often” or “sometimes” that they delayed prescription drug due to cost in last 12 months.

Q2: Please tell me how often during (CURRENT YEAR) (you have/survey participant) done any of the following things (often, sometimes, or never): delayed getting a prescription filled because the medicine cost too much

NOTE- this variable has been recoded as binary. “Often” or “sometimes” is “yes” and “never” is “no.”</td></tr>
<tr><td>Denominator</td><td>The analysis population includes 100 percent of adult Medicare beneficiaries enrolled in Medicare Part A for the selected year</td></tr>
<tr><td>Exclusions</td><td>Excluded from the analysis are beneficiaries who were not asked the survey question aka has a null value for the survey question.</td></tr>
<tr><td>Stratifications</td><td>For the stratifications, the following inclusions apply:
<table>
<tr><th>Subgroup</th><th>Inclusion</th></tr>
<tr><td>Medicare SSP Model Participant</td><td>Any beneficiary who has a value of “08” in the H_PRGID variable in the HISUMRY survey topic. It should be noted H_PRGID is one of three payment model participation flags and H_PRGID2 and H_PRGID3 are only populated if the beneficiary has multiple program IDs. We have selected H_PRGID as the payment model enrollment designation flag to avoid duplication of counts so the sum constitutes the total beneficiaries in the sample.</td></tr>
<tr><td>Any Active Innovation Center Model Participant</td><td>Any beneficiary who has a value of 01,08,11,18,21,22,23,53,56 in the H_PRGID variable in the HISUMRY survey topic. We have selected H_PRGID as the payment model enrollment designation flag to avoid duplication of counts so the sum constitutes the total beneficiaries in the sample.</td></tr>
<tr><td>FFS (enrolled at any point in the year)</td><td>Any beneficiary who has a value of “FF” in at least one of the variables H_MAFF01 – H_MAFF12 in the HISUMRY survey topic</td></tr>
</table></td></tr>
</table>

Metric Element	Description	
	MA/Other Medicare Capitated Payment Plan (enrolled at any point in the year)	Any beneficiary who has a value of "MA" in at least one of the variables H_MAFF01 – H_MAFF12 in the HISUMRY survey topic
	Duals	Any beneficiary who has a value of 1,3,4 in the H_OPMDCD variable in the HISUMRY survey topic
Data source	Medicare Current Beneficiary Survey (MCBS) accessible through the Chronic Conditions Data Warehouse (CCW)	