

INNOVATION
CENTER
STRATEGY
REFRESH

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Figure 1. CMS Innovation Center Vision and 5 Strategic Objectives for Advancing System Transformation.

Driving Health System Transformation - A Strategy for the CMS Innovation Center’s Second Decade

The Center for Medicare and Medicaid Innovation (CMS Innovation Center or “Innovation Center”) is launching a bold new strategy with the goal of achieving equitable outcomes through high-quality, affordable, person-centered care. To achieve this vision, the Innovation Center is launching a strategic refresh organized around five objectives [see Figure 1]. These strategic objectives will guide the Innovation Center’s models and priorities, and progress on achieving goals for each will be to assess the CMS Innovation Center’s work and impact.

The last ten years of testing and learning have laid a strong foundation for the CMS Innovation Center to lead the way towards broad and equitable health system transformation. This white paper describes the Innovation Center’s refreshed vision and strategy and provides examples of approaches and efforts under consideration to achieve the goals of each strategic objective. The Innovation Center’s overarching goal will continue to be expansion of successful models that reduce program costs and improve quality and outcomes for Medicare and Medicaid beneficiaries. In addition, the paper emphasizes how measuring progress toward broader health system transformation is also critical to achieving these goals and vision.

Lessons from the CMS Innovation Center's First Decade – Foundation for a Strategy Refresh

The CMS Innovation Center was established in 2010 as part of the Affordable Care Act with the goal of transitioning the health system to value-based care by developing, testing, and evaluating new payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).¹ In establishing the CMS Innovation Center, Congress recognized the need for innovations in payment and care delivery that addressed the two most pressing problems facing the U.S. health system at the time — lower than acceptable quality of care and ever increasing spending that was (and continues to be) a growing burden on households, states, and the federal government.

In the last decade, the CMS Innovation Center has launched over 50 model tests. From 2018-2020, Innovation Center models have reached nearly 28 million patients and over 528,000 health care providers and plans.² These models have generated important lessons about how to transition the U.S. health system to value-based care. Models have been launched in advanced primary care, episode-based care, accountable care, state-based transformation efforts, and for specific populations, such as Medicare

beneficiaries with end-stage renal disease (ESRD), diabetes, heart disease, and in Medicaid for maternal opioid-use disorders, and populations that experience higher risk for premature births. Each model has yielded important policy and operational insights that will drive the next decade of health system transformation, helping to address not only continued challenges with health costs and quality of care, but also the impacts of inequity and health disparities that have become starkly apparent, particularly during the COVID-19 pandemic.

The CMS Innovation Center has undertaken an internal review of its portfolio of models and consulted external research and experts to inform this strategy refresh and chart its course for the next decade. Leading health policy experts and advisory bodies—including the Medicare Payment and Advisory Commission (MedPAC) in its June 2020 Report to Congress and the National Academy of Medicine^{3,4} — have recommended that the Innovation Center reexamine its portfolio in light of the need to accelerate the movement to value-based care and drive broader system transformation.

The CMS Innovation Center's Statutory Authority and Expansion Potential

The CMS Innovation Center was created in Section 3021 of the Affordable Care Act (ACA) to test payment and delivery models expected to reduce program costs and improve or maintain the quality of care for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. Congress gave the Innovation Center unique authorities to test and expand models. Namely, the CMS Innovation Center can waive requirements in Medicare and, to a more limited extent, Medicaid. This waiver authority allows the Center to test promising payment and service delivery changes.

If models are deemed successful in that they reduce or do not increase federal health expenditures while maintaining or improving quality for beneficiaries, and certain other requirements are met, the ACA gave the Secretary of HHS the authority to expand the duration and scope of the model test.

- 1 The Patient Protection and Affordable Care Act of 2010, Public Law 111-148, Section 1115A of the Social Security Act (the "Act") (42 U.S.C. 1315a).
- 2 CMS Innovation Center. (2021).2020 [Report to Congress: Center for Medicare and Medicaid Innovation](#).
- 3 Medicare Payment Advisory Commission (MedPAC). (2021) [Report to the Congress: Medicare and the Health Care Delivery System](#).
- 4 National Academy of Medicine. (2021). [Priorities in Advancing High-Quality Value-based Health and Health Care: CMMI catalyzing innovative health system transformation](#).

Over the last ten years, only six out of more than 50 models launched generated statistically significant savings to Medicare and to taxpayers⁵ and four of these met the requirements to be expanded in duration and scope.⁶ CMS Innovation Center staff also: examined policy and operational lessons from other model tests and used these to directly inform

development of subsequent models; performed an extensive literature review; conducted interviews with experts and other stakeholders; and convened focus groups with agency leaders. Based on this internal and external review, the Innovation Center identified key lessons learned, as well as next steps for addressing issues and challenges (see Table 1).

Table 1. Informing the CMS Innovation Center’s Future Direction - Key Learnings

Lesson Learned	Issues and Challenges	Next Steps
<p>Ensure health equity is embedded in every model.</p>	<ul style="list-style-type: none"> The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many models to date. Medicare-focused models have limited reach to Medicaid beneficiaries and safety net providers. Models have not been systematically evaluated impacts across beneficiaries with different demographic characteristics. 	<ul style="list-style-type: none"> Better understand facilitators and barriers to participation in value-based payment models so that future models are designed to target and increase participation among providers that care for underserved populations. Ensure all beneficiaries have access to providers engaged in care transformation to deliver high-quality care by addressing issues such as implicit bias in model design, implementation and evaluation. Launch more Medicaid-focused models and/or modify existing models to include additional Medicaid beneficiaries. Require a more deliberate and consistent approach within the Innovation Center, as well as across CMS, in quality measurement and evaluations to assess the impact of models on underserved populations and to close disparities in care and outcomes.

⁵ As of September 2021, the models that showed statistically significant savings include the Maryland All-Payer Model (MDAPM); Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model; the Home Health Value-Based Purchasing (HHVBP) Model; the ACO Investment Model (AIM); the Pioneer ACO Model; and the Medicare Care Choices Model (MCCM).

⁶ As of September 2021, the Pioneer ACO, Medicare Diabetes Prevention Program (MDPP), RSNAT, and HHVBP model met the requirements under Section 1115A(c) of the Social Security Act (the Act) to be expanded in duration and scope.

Lesson Learned	Issues and Challenges	Next Steps
<p>Streamline the model portfolio and reduce complexity and overlap to help scale what works.</p>	<ul style="list-style-type: none"> • Complex payment policies and model overlap rules in CMS Innovation Center models can sometimes result in conflicting or opposing incentives for health care providers (e.g., multiple shared savings models operating in the same health system). • Participants face difficulty in joining or continuing in models due to investments required for care transformation, complexity of model payment and/or participation parameters, administrative burden, and lack of clarity on long-term strategy for models. • Complexity of model design impedes scalable transformation. 	<ul style="list-style-type: none"> • Create a cohesive strategy that drives model development and evolution. • Ensure the hierarchy of models in the case of overlap is rational and incentives distribution of financial incentives to achieve model objectives and is also clear on elements such as beneficiary attribution and allocation of savings. • Build on successful integration of CMS Innovation Center model policies and efforts in Medicare programs—such as the Medicare Shared Savings Program—to more systematically align with the overall direction of CMS programs. • Make model parameters, requirements, and other critical details as transparent and easily understandable as possible for participants and to make scaling and integration into broader CMS operations easier. • Assess current participation requirements with an aim to reduce administrative burden.
<p>Tools to support transformation in care delivery can assist providers in assuming financial risk.</p>	<ul style="list-style-type: none"> • Accepting downside risk⁷ is challenging if providers lack: care management tools, sufficient protection against the financial impact of beneficiaries with unpredictably high-costs, and appropriate payment and regulatory flexibilities. • Significant infrastructure investments are often needed to participate in models, including electronic health record (EHR) enhancements, new staff, and data analytic support especially for safety net providers and those serving Medicaid beneficiaries. 	<ul style="list-style-type: none"> • Make available and increase uptake of actionable data, learning collaboratives, and payment and regulatory flexibilities to participants, especially those caring for the underserved, to enable them to transform delivery at the point of care, assume greater levels of financial risk, and use model evaluation to drive dissemination of best practices. • Send strong and consistent signals and expectations about Medicare and Medicaid's commitment to value-based care so that participants can more predictably make the necessary investments. • Improve sharing of more timely and actionable data with providers to support decision-making at point of care and to identify successful care delivery practices for dissemination. • Encourage and support use of interoperability standards for the exchange of health data.

⁷ Note that downside risk is the term for the financial risk model participants bear when actual spending exceeds financial targets or capitation rates.

Lesson Learned	Issues and Challenges	Next Steps
<p>Design of models may not consistently ensure broad provider participation.</p>	<ul style="list-style-type: none"> Certain model design features, including in some cases voluntary participation, can limit potential savings and impede evaluation due to selection bias, as participants may opt in if they project that the financial incentives in the model (e.g., benchmarking) are in their favor and drop out when potential losses are projected. Multi-payer models designed for Medicare providers have not consistently led to high levels of participation from Medicaid and commercial payers. 	<ul style="list-style-type: none"> Reduce selection bias by improving model design (e.g., benchmarking, risk adjustment, and care transformation supports) to ensure participation from a diverse group of providers—including those that care for underserved communities—in order to stabilize participation across the life cycle of model tests, and to help meet the requirements for model expansion and potential scaling by other providers and payers. To avoid risk selection associated with voluntary models, examine whether mandatory models can increase quality and access for beneficiaries, as well as increase provider participation, without negatively impacting those who care for underserved populations. Consider multi-payer alignment opportunities earlier in model design process.
<p>Complexity of financial benchmarks have undermined model effectiveness.</p>	<ul style="list-style-type: none"> Many financial benchmarks and risk adjustment methodologies have created opportunities for potential gaming and upcoding among participants — and reduced savings for Medicare. 	<ul style="list-style-type: none"> Set benchmarks to balance achieving the following goals: maximizing provider participation, while sustainably generating savings, limiting spending growth, and motivating continuous improvement. Improve testing and analysis of benchmarks and risk adjustment methodologies prior to model launch. Test risk adjustment methodologies that incent appropriate coding of patient conditions and needs. Continue to refine benchmark methodologies that leverage lessons learned from models and incorporate input from and consideration of the future needs of CMS programs. Share lessons learned with Medicaid and other payers to inform

Lesson Learned	Issues and Challenges	Next Steps
<p>Models should encourage lasting care delivery transformation.</p>	<ul style="list-style-type: none"> • Model testing has been focused on meeting the statutory standards for certification and expansion. • Transformation can be limited to the duration of model test. 	<ul style="list-style-type: none"> • In addition to statutory criteria for model expansion, consider a model's impact on dimensions of system transformation, such as equity, care delivery transformation, patient outcomes, and/or market characteristics. • Align models and lessons learned across CMS, including Medicare FFS, Medicare Advantage, and Medicaid. • Facilitate multi-payer alignment with Medicaid, states, and private payers on service delivery and operational model elements to accelerate system transformation.

The CMS Innovation Center will continue to develop and test models that can meet the statutory criteria for expansion to reduce federal health expenditures and improve care delivery for beneficiaries. However, the renewed vision also calls for a more streamlined portfolio of models that can deliver high-quality, person-centered care, and drive health system transformation. Broad transformation of health systems and

markets should support the delivery of care that is consistent with people's goals and values, is culturally and linguistically responsive, and focuses on what matters to them, such as their health outcomes and functional status. The CMS Innovation Center believes meaningful partnership with providers, health plans, employers, and states, among others, will be critical to achieve this vision for all people.

A Roadmap for Achieving the Vision – Strategic Objectives, Measuring Progress, and Next Steps

As part of its strategy refresh, the CMS Innovation Center set out to articulate a vision of the health system of the future for Medicare and Medicaid beneficiaries — and to reinvigorate the national push toward value with a clear path and strategy for the Innovation Center’s role in achieving these goals. The new strategy lays out how the vision will be advanced in partnership with other components within CMS, including the Center for Medicare (CM), the Center for Medicaid and CHIP Services (CMCS), the Center for Clinical Standards and Quality (CCSQ), the Medicare-Medicaid Coordination Office (MMCO), the Office of Minority Health (OMH), and other Department of Health and Human Services (HHS) partners, such as the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), and the Administration for Community Living (ACL), among others. It will be just as critical, however, for the CMS Innovation Center to work more synergistically with external stakeholders — especially beneficiaries, caregivers, and providers that are most directly impacted by our models as well as other payers, both public and private. The implementation of the strategic refresh is described in greater detail below, starting with how the CMS Innovation Center will more closely collaborate with beneficiaries and providers in particular. This is followed by sections on the strategic objectives, which includes an aim for each and long-term approaches to measuring progress. The CMS Innovation Center will also be setting interim targets to regularly assess progress and to inform changes to the implementation of the new strategy as needed.

CMS Innovation Center Vision

A health system that achieves equitable outcomes through high-quality, affordable, and person-centered care.

CMS Innovation Center’s Strategic Refresh: Beneficiary and Provider Goals

The health system must recognize and meet people’s medical needs by considering their preferences, values, and circumstances, should strive to keep people healthy and independent, and help providers coordinate care seamlessly and holistically across settings in a manner that puts people at the center of their own care. This must include a more intentional focus on addressing health disparities and on ensuring equitable access, quality, and outcomes. For models to drive system transformation in this way, the CMS Innovation Center must work more closely with external stakeholders, especially beneficiaries and caregivers, primary care, specialty, and other providers that are most directly affected by models. This includes collaborating across the life cycle of models – from design to evaluation and potentially expansion – and in the implementation of each of the five objectives of the strategic refresh. In particular, beneficiaries, patient groups, and providers will see a deeper partnership with the CMS Innovation Center in which their needs and perspectives inform model development, evaluation, and the definition of success, and in which beneficiaries see improvements in quality of care and providers receive clear signals and a more transparent movement to value-based care (see Table 2).



Table 2. CMS Innovation Center Strategy Refresh - Beneficiary and Provider Impact Goals

Accountable Care	
Beneficiary Goals	<ul style="list-style-type: none"> • Medicare FFS beneficiaries will be in an accountable care relationship with providers and will have the opportunity to select who will be responsible for assessing and coordinating their care needs and the cost and quality of their care. • Medicare FFS beneficiaries will continue to have the choice to seek care from any FFS provider. • Medicaid beneficiaries in FFS and managed care organizations (MCOs) will be in accountable care relationships that drive improved quality and outcomes for beneficiaries. • Dual eligible beneficiaries will be in accountable care relationships that help manage the quality and cost of their care and improve their care across the Medicare and Medicaid programs.
Provider Goals	<ul style="list-style-type: none"> • Transformation supports, such as data-sharing, learning opportunities, and regulatory flexibilities, as well as varying levels of options to assume risk will be available for primary care practices to transition to population-based payments and to sustain accountable care relationships. • Increase the capability of primary care providers, as well as specialists and other providers, to engage in accountable care relationships with beneficiaries through incentives and flexibilities to manage quality and total cost of care.
Health Equity	
Beneficiary Goals	<ul style="list-style-type: none"> • Underserved beneficiaries will have increased access to accountable, value-based care as the CMS Innovation Center focuses on increasing participation among safety net providers in its models. • Underserved beneficiaries will experience improved quality and outcomes due to CMS Innovation Center efforts to design models that are simpler and responsive to the needs of these beneficiaries and communities.
Provider Goals	<ul style="list-style-type: none"> • The CMS Innovation Center will address barriers to participation for providers that serve a high proportion of underserved and rural beneficiaries, such as those in Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs), and designated provider types such as Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), and other safety net providers and create more opportunities for them to join models with supports needed to be successful. • The CMS Innovation Center will offer targeted learning opportunities for model participants to advance health equity, including collaborating with community partners to address social needs. • The CMS Innovation Center will require and consider incentives and supports for model participants to collect data on race, ethnicity, geography, disability, and other demographics and results will be reported to the Innovation Center to help providers address health disparities (in a manner that protected health information (PHI) complies with HIPAA-and other applicable laws).

Care Innovations

Beneficiary Goals	<ul style="list-style-type: none"> • Drawing on more diverse beneficiary, caregiver, and patient perspectives will systematically inform development of models that test care delivery changes and innovations that are meaningful and understandable to them. • Beneficiaries in accountable care relationships will receive more person-centered, integrated care, which could include support with social determinants of health (SDoH) and greater access to care in the home and community. • Beneficiaries in accountable care relationships and their caregivers may have access to benefit enhancements and beneficiary engagement incentives that support engagement and care management.
Provider Goals	<ul style="list-style-type: none"> • Providers will receive support to leverage actionable, practice-specific data, detailed case studies, and other data to implement practice changes that deliver integrated, person-centered, and community-based care. • Providers participating in models, particularly total cost of care models, will have access to more payment flexibilities that support accountable care, such as telehealth, remote patient monitoring, and home-based care.

Address Affordability

Beneficiary Goals	<ul style="list-style-type: none"> • Beneficiaries in CMS Innovation Center models may have lower out-of-pocket costs through changes in cost-sharing or through reductions in avoidable utilization of duplicative or wasteful services. • Beneficiaries may experience reduced out-of-pocket costs on drugs by lowering program spending, and by increasing biosimilar and generic drug utilization. • Beneficiaries may experience reduced barriers to accessing high-value care using tools such as value-based insurance design that can help improve outcomes and lower overall costs.
Provider Goals	<ul style="list-style-type: none"> • Better align provider and beneficiary incentives to increase use of high-value services that efficiently deliver and coordinate care, achieve the best outcomes for patients, and reduce utilization of duplicative or wasteful services – especially in total cost of care models. • Create payment and performance incentives in models, especially in total cost of care models, for specialty and primary care providers to coordinate delivery of high-value care and to reduce duplicative or wasteful care.

Partner to Achieve Health System Transformation

Beneficiary Goals	<ul style="list-style-type: none">• Beneficiaries in accountable care relationships will experience more person-centered, seamless care that supports their health and independence.• The perspectives of all Medicare and Medicaid beneficiaries, including underserved populations, caregivers, and patient groups will help shape models from conceptualization and design to evaluation and potential expansion.
Provider Goals	<ul style="list-style-type: none">• Providers will be able to deliver more integrated care across settings and engage in more comprehensive and longitudinal care as a result of accountable care relationships and participation in total cost of care models.• Providers will benefit from burden reduction as a result of alignment across payers on value-based care initiatives.• Aligning and partnering with other payers on key design features such as clinical tools and outcome measures will enable improved evaluation and scaling of transformation.

Innovation Center Strategic Objective 1: Drive Accountable Care



Aim:

Increase the number of people in a care relationship with accountability for quality and total cost of care.

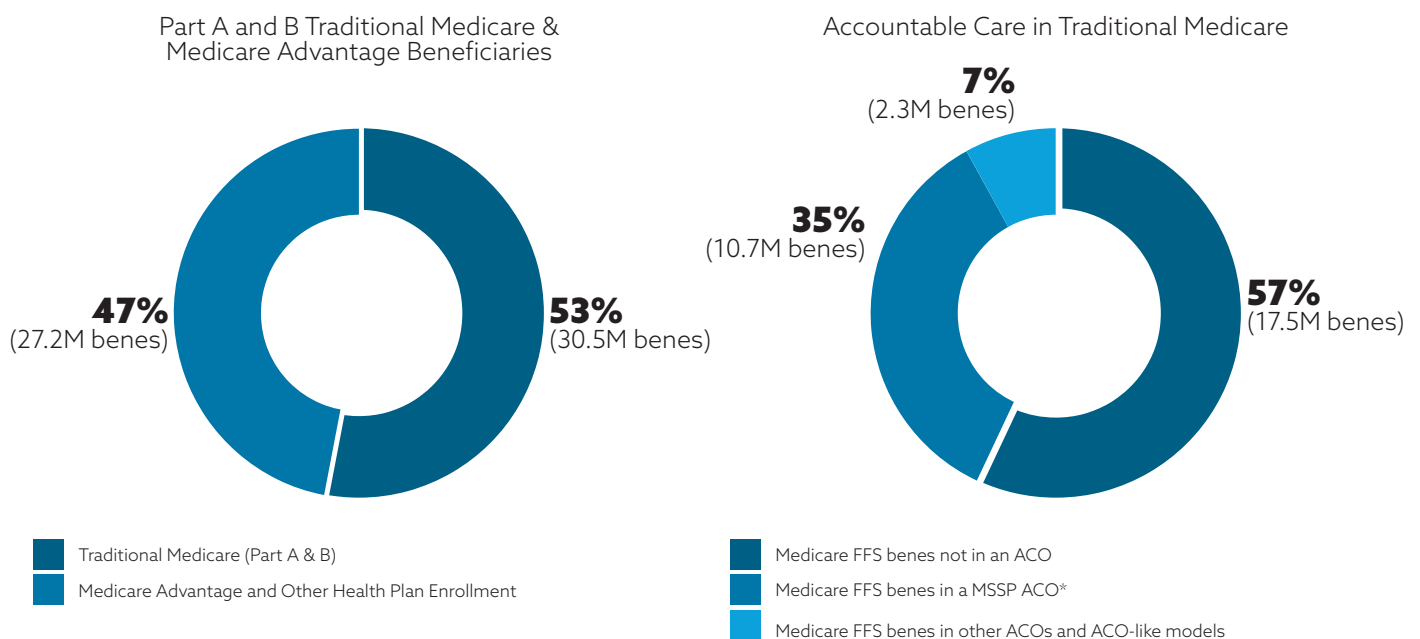
Measuring Progress:

- All Medicare beneficiaries with Parts A and B will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

The key feature of accountable care is to give all participating providers the incentives and tools to deliver high-quality, coordinated, team-based care that promotes health, thereby reducing fragmentation and costs for people and the health system. Depending on the model or program and their respective requirements, accountable entities could include physician group practices,

hospitals, and other health care providers, Medicare Advantage (MA) plans, Programs of All-Inclusive Care for the Elderly (PACE), or even Medicaid managed care plans. In 2020, 67% of Medicare beneficiaries enrolled in Part A and Part B were in MA plans or were attributed to an accountable care organization (ACO) through either a CMS Innovation Center model or the Shared Savings Program (See Figure 2).^{8,9}

Figure 2. Medicare Beneficiaries in Accountable Care Relationships (2021).



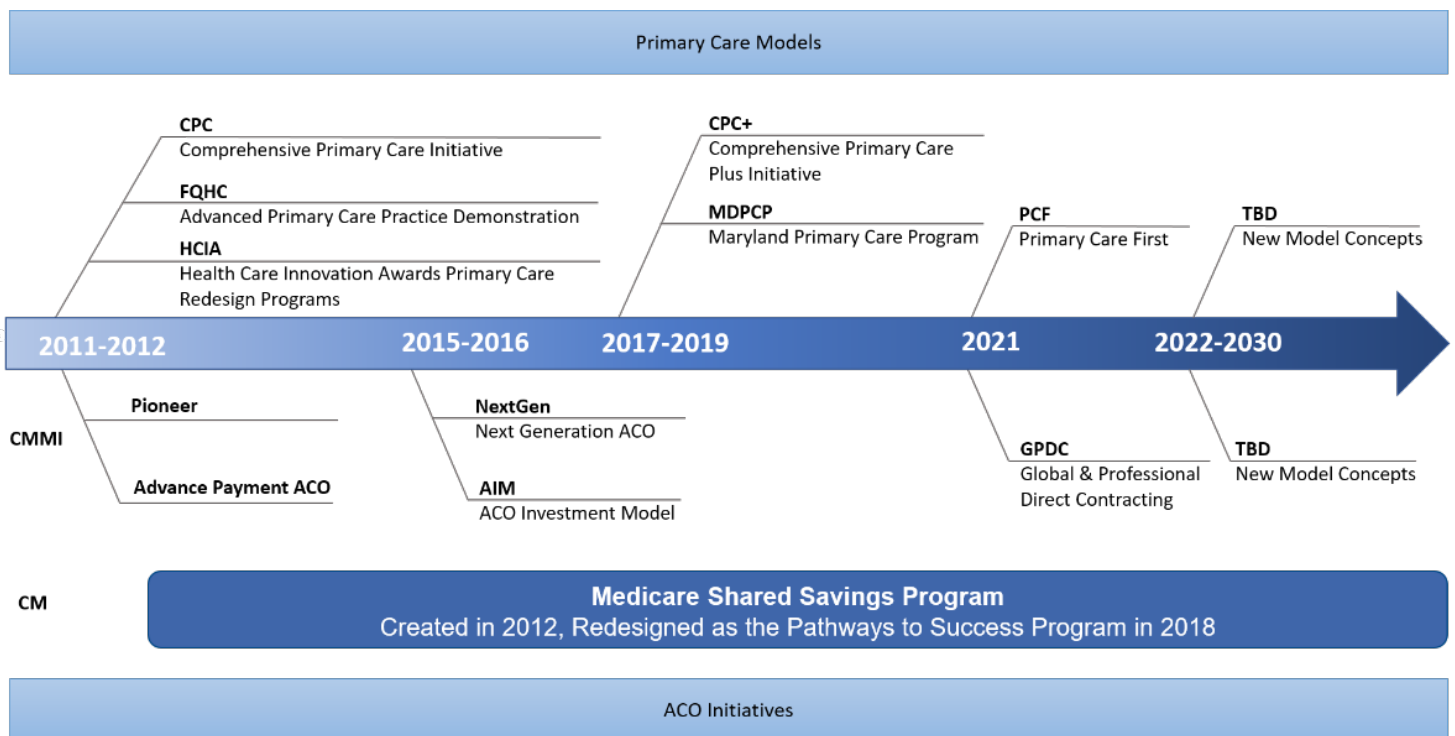
⁸ Medicare Payment Advisory Commission (MedPAC). (2020). [“A Data Book: Health Care Spending and the Medicare Program.”](#)

⁹ Medicare Payment Advisory Commission (MedPAC). (2020). [“A Data Book: Health Care Spending and the Medicare Program.”](#)

Advanced primary care and accountable care models are central to driving growth in the number of beneficiaries in accountable care relationships. The CMS Innovation Center has set the goal of having every Medicare FFS beneficiary in an accountable care relationship by 2030 and will set interim targets to measure progress towards that goal. This goal would not only aim to have all beneficiaries in value-based care arrangements, but for them to be in care arrangements where their needs are holistically assessed and their care is coordinated within a broader total cost of care system. CMS anticipates that this could lead to an additional 30

million beneficiaries (adjusted for growth in the Medicare population) attributed to organizations such as an advanced primary care practice, an ACO, or similar entity that is responsible for the cost and quality of care. The CMS Innovation Center is also committed to working with CMCS to define accountable care that achieves equitable, high-quality, person-centered care for Medicaid and dually eligible beneficiaries. Lessons learned and the considerations for future work in these two areas, which will include coordinating with the Medicare and Medicaid programs, are outlined below (see Figure 3).

Figure 3. Primary Care and ACO Model Evolution



Note 1: ACO and DC models (Pioneer, NGACO, GPDC) are also designed on a primary care foundation with accountability for populations.
 Note 2: In 2021, CMMI put CHART ACO Transformation Track on hold as it is exploring AIM expansion.

Advanced Primary Care – Lessons Learned and Model Considerations

The National Academy of Medicine recently published a report on rebuilding primary care, which noted that high-quality primary care forms the foundation of a high-functioning health system and is key to improving the experience of patients and care teams, as well as population health, and reducing costs.¹⁰ Given the foundational

role of primary care in transforming the health system, the CMS Innovation Center has devoted significant time and resources to develop and test primary care models. Models have tested advanced primary care across the country to improve and enhance how practices deliver care. The Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) multi-payer models, for example, gave practices

10 National Academy of Medicine, [Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care](#) (2021).



the opportunity to deepen their capabilities to deliver comprehensive and coordinated primary care. In CPC+, participating practices were able to gain experience in assuming limited risk for performance. In turn, these models gave the Innovation Center a chance to build an infrastructure to deliver more timely data to participants, to provide learning resources to engage practices in continuous improvement, and to gain experience in working with other payers to align care goals. The CPC and CPC+ models directly informed the design of the Primary Care First (PCF) model, which was launched earlier this year.

Previous primary care models illustrated that practices can be effectively incentivized to broaden their care delivery capabilities, including making medical record and facilities more accessible after hours for patients in need. Practices have also effectively increased usage of care managers, integrated behavioral health, and incorporated screening for social service needs at rates much higher than non-participating practices. These results have begun translating into favorable outcomes – the latest CPC+ evaluation report indicates there have been slight decreases in emergency department and hospital utilization among beneficiaries attributed to participating

CPC+ practices. These models have also offered lessons for future model testing: there was limited participation among independent practices; beneficiaries in advanced primary care models were more likely to be white and less likely to be dually eligible; and further, these primary care models have not generated net savings for the Medicare program. In the context of the strategy refresh, the CMS Innovation Center can make improvements to broaden participation among practices, to include a broader population of beneficiaries, and to consider primary care’s role in generating savings.

CMS Innovation Center models have also tested bundled payment models to drive improved quality and lower costs for episodic care. Future models must test incentives for advanced primary and specialty, episodic care to generate greater value under total cost of care approaches. Such models may need to include tracks that differ by readiness to take on risk, targeted populations, and payment schedules.

Accountable Care Organizations (ACOs) – Lessons Learned and Model Considerations

CMS has learned significant lessons from its portfolio of ACO initiatives as it has grown and evolved over the last ten years. The CMS Innovation Center designed and led first-generation models including the Pioneer ACO Model and Advanced Payment ACO Model, and second-generation models including the Next Generation ACO Model (NGACO) and the ACO Investment Model (AIM). While only the Pioneer ACO Model, as tested in the first two years of the model, was certified for expansion the Innovation Center has learned much from the other ACO models, both in terms of successes and challenges, which are informing future ACO model development. For instance, the CMS Innovation Center is examining its benchmarking and risk adjustment approaches to provide incentives to encourage participation, especially among providers caring for underserved beneficiaries. It is important to ensure that benchmarks and risk adjusters are appropriate for ACOs at varying levels of experience and that models are not resulting in inaccurate payments and potential upcoding among participants, both of which can reduce savings for Medicare.

The Innovation Center is also examining how beneficiaries can be better engaged in accountable care relationships through benefit enhancements and beneficiary engagement incentives, as well as voluntary alignment, which supports beneficiaries actively choosing a provider either on Medicare.gov or via paper forms. The experience of the ACO Investment Model (AIM), which demonstrated the value of advancing payments to support new ACOs in rural and underserved areas, is informing current and future ACO model design concepts. Last, ACOs must manage high-cost episodic and specialty care more effectively. Future ACO efforts will incorporate lessons learned from other models, including bundled payment models, to drive coordinated and efficient care.

These first two generations of ACO models have informed the development of new ACO models, such as the Global and Professional Direct Contracting (GPDC) Model. ACO models are a

critical component of the CMS Innovation Center's strategic refresh and its goal of engaging all beneficiaries in an accountable care relationship.

Next Steps to Advance Accountable Care

- Educate and engage beneficiaries on what an accountable care relationship is and the potential value and benefits associated with these arrangements for them.
- Test voluntary beneficiary alignment and attribution methodologies, benefit enhancements, and beneficiary engagement incentives to facilitate accountable care relationships between beneficiaries and care teams.
- Include outcome measures that are meaningful to people, such as functional status, out-of-pocket costs, and patient-reported outcomes measures (PROMs) to ensure meaningful accountability for quality improvement.
- Create and test combinations of risk levels, per beneficiary per month payments, and population-based and advanced payment options to increase the number of health care providers and organizations—including primary care practices and safety net providers—that can participate in accountable and total cost of care models.
- Test incentives to drive coordination between providers responsible for accountable care relationships and specialty providers accountable for delivering high-cost episodic and/or complex care.
- Test approaches that enable ACOs to manage more high-cost specialty and episodic care using lessons learned from bundled payments and other models.
- Provide time-limited upfront funds to smaller primary care practices or those with more limited experience in value-based payment models to help them prepare for the transition to population-based payments and total cost of care approaches.

- Pursue changes to risk adjustment and benchmarking methodologies to drive accountability and improve accuracy of payments in CMS programs and Innovation Center models.
- Work with the Medicare and Medicaid programs, including the Medicare Shared Savings Program and the Quality Payment Programs, to better incentivize the transition towards value-based care and encourage alternative payment model (APM) participation.
- Ensure that Medicaid beneficiaries – in managed care and FFS programs – are not only attributed to a provider but also in arrangements that drive accountability for quality, outcomes, and costs

Innovation Center Strategic Objective 2: Advance Health Equity

Aim:

Embed health equity in every aspect of CMS Innovation Center models and increase focus on underserved populations.

Measuring Progress:

- All new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health.*
- All new models will include patients from historically underserved populations and safety net providers, such as community health centers and disproportionate share hospitals.
- Identify areas for reducing inequities at the population level, such as avoidable admissions, and set targets for reducing those inequities.



*Data would be collected in a manner in which PHI complies with HIPAA and other applicable laws.

The CMS Innovation Center is committed to developing a health system that advances health equity, a goal that is integral to its mission to improve health care quality. Healthy People 2030 defined health equity as “the attainment of the highest level of health for all people.”¹¹ Achieving this goal requires considering equity¹² in all stages of model development, including ideation, development, recruitment, implementation, and evaluation, and harmonizing this approach across model tests.

The CMS Innovation Center will build on early efforts to address health equity, which have laid the groundwork for increasing and accelerating efforts to ensure equity is embedded in the design, testing, and evaluation of all models. The Community Health Access and Rural Transformation (CHART) and Pennsylvania

Rural Health Models, for example, focus on rural health access and outcomes, the Maternal Opioid Misuse (MOM) model connects current and expecting mothers enrolled in Medicaid to substance use disorder treatment and wrap-around services, and the Integrated Care for Kids (InCK) model aims to improve prevention, early identification, and treatment of children’s behavioral and physical health needs. In addition, the Accountable Health Communities (AHC) Model is examining whether identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries improves health outcomes and reduces costs.

Recent evaluation results from the Next Generation ACO model showed that aligned Medicare beneficiaries were more likely to

¹¹ U.S. Department of Health and Human Services. (2021). [Healthy People 2030 Questions & Answers](#).

¹² As defined in the [Racial Equity and Support for Underserved Communities Through the Federal Government Executive Order 13985](#), the term “equity” means “The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. The term “underserved communities” refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life, as exemplified by [the aforementioned list.]”

be white and less likely to be either dually eligible or to live in rural areas relative to other FFS beneficiaries in the same market areas.¹³ Internal Innovation Center analysis of Medicare beneficiaries aligned to participants in other models, including CPC+, PCF, and Global and Professional Direct Contracting yielded similar findings. Recognizing this, the CMS Innovation Center is committed to broadening the reach of all models to underserved populations.

The CMS Innovation Center’s focused efforts to advance equity encompass actions across the following domains:

1. Develop new models and modify existing models to address health equity and social determinants of health (SDoH);
2. Increase the number of beneficiaries from underserved communities that receive care through value-based payment models by increasing the participation of Medicare and Medicaid providers who serve them;
3. Evaluate models specifically for their impact on health equity and share data and “lessons learned” to inform future work; and
4. Strengthen data collection and intersectional analyses for populations defined by demographic factors such as race, ethnicity, language, geography, and disability—in order to identify gaps in care and develop interventions to address them (in a manner that PHI complies with HIPAA and other applicable laws).

Success will require partnerships with stakeholders with deep expertise and experience in providing equitable care for underserved populations, including organizations that may not have historically engaged with the Innovation Center.

Developing new models and modifying existing models to address equity

The CMS Innovation Center has tested several models that have had the potential to advance equity – especially through advanced primary care and ACO models; however, equity has not been systematically addressed across the Innovation Center’s portfolio of interventions. Efforts will now include identification of opportunities to embed equity across the life cycle of models, including design, testing, and evaluation.

The Innovation Center has also supported model tests that tackle beneficiaries’ social needs and will broaden its efforts to incorporate screening tools and/or facilitate coordination with social service providers, as in the AHC and MOM models. In addition, the CMS Innovation Center will also consider model tests that address issues of specific concern to underserved populations, which could include certain diseases, health conditions, or care settings, as well as models that seek to remedy upstream, community-level SDoH.

Increasing participation of underserved beneficiaries and safety net providers

Health care providers participating in models such as ACOs continue to have fewer Medicare beneficiaries from underserved populations and generally include beneficiaries who are less likely to live in rural areas. To broaden the reach of model tests to underserved beneficiaries, the Innovation Center will emphasize engagement with local communities and public health leaders in order to reach providers who may not have previously participated in value-based care, including those that disproportionately care for uninsured, Medicaid, rural, and other underserved populations. Examples of these providers include community health centers, rural health clinics, community-based providers, and public and critical access hospitals.

Beyond outreach, the CMS Innovation Center is reviewing its application and selection processes to ensure such providers are not disadvantaged

13 NORC. (2020). Next Generation Accountable Care Organization Model Evaluation. [See Exhibit 2.10.](#)

or disincentivized from participating. Examining the barriers and challenges safety net and rural providers have faced in participating in previous models can inform changes. Once in models, safety net providers need dedicated—and sometimes greater—financial and technical assistance to provide equitable care, given that upfront infrastructure investments may be needed for them to succeed in value-based care arrangements. The Innovation Center is considering a variety of incentives to encourage and sustain participation, such as upfront payments, social risk adjustment, benchmark considerations, and payment incentives for reducing disparities or screening for SDoH and coordinating with community-based organizations to address social needs. Technical assistance may include application support, sharing of best practices for caring for underserved populations, and assistance with screening tools and data collection workflows.

Evaluating health equity impact

A critical component of the Innovation Center's health equity strategy is assessing the individual and collective impact of models on underserved populations, and efforts to do so will be aligned with efforts across CMS. Standardized, hypothesis-driven evaluation requirements and measures for health impact assessment will be developed early during the model design process. In addition, the CMS Innovation Center will consider how to measure health equity impact across its portfolio of models, which will include retrospective review as feasible. Finally, the Innovation Center will determine how to share site-specific data and evaluation findings with participants and partners during and at completion of models as feasible.

Increasing collection and analysis of demographic data

Across model design, testing, and evaluation, the availability of demographic data is fundamental to the success of the Innovation Center's strategic objective focused on equity. The CMS Innovation

Center will require participants in all new models to collect and report data to identify and monitor impacts on health and the reduction of disparities. For existing models, requirements, incentives, or other mechanisms to collect data from participants will be considered, and CMS will potentially examine the use of other federal data sources such as T-MSIS to gain a greater understanding of those being served. In addition, the Innovation Center will continue to review and curate its data repositories and will work with federal partners to obtain additional demographic data when appropriate and feasible. Common and validated area-level indices, such as the Social Vulnerability Index (SVI) and the Area Deprivation Index (ADI), might be used to augment patient and provider data.^{14, 15} Data will be used to support participants, including through the use of data dashboards or other mechanisms for sharing.

Next Steps to Advance Equity

- Conduct and release analyses of characteristics of participating providers and Medicare and Medicaid beneficiaries attributed to model participants to help ensure equitable reach of models.
- Develop approaches to model design and the model application process to improve participation of applicants that provide care for underserved communities.
- Require and consider incentives or supports for the collection of beneficiary-level demographic data (in a manner that PHI complies with HIPAA and other applicable laws) to identify and monitor impacts on underserved beneficiaries in CMS Innovation Center models.
- Incorporate screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats.

¹⁴ [CDC/ATSDR Social Vulnerability Index](#). (2021)

¹⁵ University of Wisconsin, School of Medicine and Public Health, Department of Medicine. [Neighborhood Atlas®](#).

- Incorporate equity in model quality strategies, including quality measurement and monitoring performance to incentivize the reduction of health disparities.
- Provide learning supports to model participants on equity (e.g., support for participants caring for underserved populations and best practices for partnering with community-based organizations) and data and model design support to states seeking to align with Innovation Center models.

Innovation Center Strategic Objective 3: Support Care Innovations



Aim:

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.

Measuring Progress:

- Set targets to improve performance of models on patient experience measures, such as health and functional status, or a subset of Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* measures that assess health promotion and education, shared decision-making, and care coordination.
- All models will consider or include patient-reported outcomes as part of the performance measurement strategy.

* CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Accountable care models, especially those that include total cost of care approaches, will need payment incentives to support the delivery of integrated, equitable person-centered care. This could include testing supports for providers to deliver care that is more accessible and convenient for beneficiaries and to integrate care across providers and settings. Driving care innovations that facilitate person-centered care should increase the proportion of people who receive care that is aligned to their goals, values, and preferences – and increase provider and participant success in Innovation Center models.

Integrating Whole-Person Care

Person-centered care integrates individuals' clinical needs across providers and settings, as well as addressing their social needs. For instance, areas that can be explored for greater integration with primary care include behavioral health, palliative care, and care for beneficiaries with complex needs and serious illness, where there is significant opportunity to improve care and outcomes while reducing overall costs.

The CMS Innovation Center is examining how to enhance addressing SDoH in models.¹⁶ This includes cross-model efforts to support providers' ability to address SDoH, including improving the collection and precision of SDoH data, addressing evidence gaps on what works, understanding beneficiary needs and the costs of services, improving coordination between community-based organizations and health care entities, better coordinating federal funding, and identifying incentives to address SDoH in health care settings.

Providing Payment and Regulatory Flexibilities

The Innovation Center has also tested a number of payment and regulatory waivers and flexibilities in models to support the delivery of more person-centered care including waivers of conditions of payment for post-acute care rules, such as requirement that the beneficiary be determined as homebound to receive home health care, beneficiary engagement incentives, such as offering transportation, and other provider payment arrangements that are otherwise not allowed in Medicare FFS. For instance, a number of models use telehealth waivers of originating site requirements in

¹⁶ HHS, Assistant Secretary for Planning and Evaluation. (2021). [Overview of Social Determinants of Health \(SDoH\) and Equity in the Context of Alternative Payment Models \(APMs\) and Physician-Focused Payment Models \(PFPMs\)](#).

order to furnish care in new settings that are more person-centric, such as home or community centers. Moving forward, payment and regulatory flexibilities for model participants will be examined that can support the provision of home or community-based care, especially in models that are moving towards or that encompass total cost of care. Last, it will be critical to coordinate within CMS to identify opportunities for program alignment and to share learnings.

Sharing Actionable Practice-Specific Data

Access to more actionable, close to real-time data are needed to support providers in value-based care arrangements. The CMS Innovation Center is committed to making practice-specific data on performance available and is considering options for a more interactive value-based care management system. As part of the PCF Model, the Innovation Center is currently piloting a tool that would provide model participants with an interactive platform to assist in managing patient-care. Such platforms are intended to help providers better understand and forecast their performance through interactive data visualizations and dashboards that highlight factors driving quality performance and can be important tools to help facilitate person-centered care at the practice level.

These efforts will also aim to simplify CMS Innovation Center operations by helping to automate beneficiary attribution, risk adjustment, and model payment calculations and tracking quality measure performance. In addition, CMS is exploring efforts to accelerate data sharing, including the use of Fast Healthcare Interoperability Resources-based (FHIR) application program interfaces (APIs) such as the Beneficiary Claims Data (BCD) API for sharing claims data with participants. This BCD API option is currently offered in the Global and Professional Direct Contracting Model, a Medicare payment model, with other models to follow. Further, the Innovation Center is continuing to build and share actionable dashboards such as in the CHART Model in which participants will receive a dashboard of their community's baseline performance on access to care, quality, and other

financial measures. The goal is to help guide participant decision making at the beginning of the model, rather than providing this information later in the performance period. These tools are key to giving providers access to more user-friendly information that also reduces their administrative burden of participation. Finally, the CMS Innovation Center will continue to work across CMS and HHS to support adoption and implementation of interoperability standards that allow for the exchange of health data that will enhance care delivery, support patient engagement, and improve research on and evaluation of models.

Next Steps to Provide Tools to Drive Care Innovations

- Deepen and sustain outreach and solicitation of input from beneficiary and caregiver groups, and providers on gaps in care and their impact, preferences for home- and community-based treatment choices, and supports to facilitate provider-patient communication.
- Develop and test models or care delivery innovations across models that address gaps in care, such as behavioral health, SDoH, and palliative care.
- Test payment waivers and regulatory flexibilities as participants move to total cost of care models that can support home- and community-based care that meets patient and caregiver needs and preferences.
- Support providers in the delivery of person-centered care through actionable, practice-specific data, technology, dissemination of best practices, and peer-to-peer learning collaboratives to make more timely, actionable data available to model participants in order to both facilitate care that is responsive to changing patient needs and that reduces administrative burden.
- Accelerate sharing of best practices and tools across participants to facilitate successful model implementation and participation.

Innovation Center Strategic Objective 4: Improve Access by Addressing Affordability



Aim:

Pursue strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

Measuring Progress:

- Set targets to reduce the percentage of beneficiaries that forgo care due to cost by 2030.
- All models will consider and include opportunities to improve affordability of high-value care by beneficiaries.

The statutory provisions establishing the CMS Innovation Center called for the testing of models that are expected to reduce costs while maintaining or improving the quality of care for beneficiaries of the Medicare, Medicaid, and CHIP programs. Although national health spending growth slowed between 2010-2019 compared to the previous decade, costs are continuing to rise at unsustainable rates, not just for the federal and state governments, but also for households.¹⁷ As a result, affordability is an important consideration in achieving the Innovation Center's vision of driving broad system transformation.

Reducing Program Expenditures to Lower Out-of-pocket Costs for Beneficiaries

As cost pressures mount on individuals and families, CMS Innovation Center models will focus not only on reducing federal health expenditures, but also how they can help lower out-of-pocket costs for Medicare and Medicaid beneficiaries and maintain access to quality care. An example of this focus is the Part D Senior Savings Model, which the CMS Innovation Center launched to test the impact of offering beneficiaries Part D prescription drug plan options that offer lower out-of-pocket costs and maintain access to insulin. The Innovation Center will prioritize models that test ways to lower beneficiary and program spending on drugs and incentivize the use

of biosimilar and generic drug utilization to improve quality and beneficiary health. This could include models that test innovative payment approaches for Medicare Part B drugs, such as shared savings and bundled payment models for episodes of care, models that build on the Part D Senior Savings Model or lower cost-sharing for Low-income Subsidy (LIS) beneficiaries utilizing biosimilar and generic drugs, or future total cost of care models that could include both Part B and Part D drugs. While Medicaid beneficiaries' exposure to out-of-pocket costs is more limited, they can still face co-pays and other indirect financial barriers to access care, such as lack of access to transportation, child care, or taking time from work to attend to medical issues.

Medicare beneficiaries can also be subject to differential out-of-pocket costs for the same services depending on where they are delivered (e.g., in a hospital outpatient department or a physician's office). The Radiation Oncology Model is one example of Medicare testing an innovative payment where the amount paid does not vary by care setting or how much care is delivered over time. Given the potential to reduce Medicare spending and beneficiary out-of-pocket costs, the CMS Innovation Center could consider models that include site-neutral payments for services offered in different settings.

¹⁷ Center for Medicare and Medicaid Services (2020). [National Health Expenditure Data](#).

Increasing Utilization of High-Value Care – Regulatory, Beneficiary, and Plan Flexibilities

Duplicative or wasteful care is defined as services that are not needed, increase costs, and may cause harm. These can be harmful to and inefficient for patients and ultimately cause significant waste of valuable health care resources and dollars, including out-of-pocket costs. The Innovation Center has also used and is exploring the use of other model design features and incentives to increase the delivery of higher value care. For instance, accountable care models with total cost of care approaches could be used to reduce waste and encourage high-value care.

Payment Waiver and Other Flexibilities.

Payment waivers and other flexibilities can enable providers and suppliers to encourage beneficiaries to use more high-value services. For instance, the Innovation Center has tested a number of payment waivers to support the delivery of high-value care in different models, including waivers of physician supervision requirements to

enable model participants to provide home visits following a hospital discharge or for beneficiaries at high risk of hospitalization. In designing new models and modifying existing models, payment waivers such as these can be tested to enable model participants to provide enhanced Medicare services under the model.

Innovation Center models have also involved additional flexibilities, including beneficiary engagement incentives, many of which involve incentivizing choices to use high-value services. For instance, in certain FFS models, the Innovation Center has permitted participating providers to reduce or eliminate beneficiary co-pays for high-value care such as primary care services and certain other Part B services. Other beneficiary incentives include preventive care items and services that advance a clinical goal, such as vouchers for over-the-counter medications recommended by their providers. In designing new and modifying existing models, the Innovation Center may explore the use of these and other flexibilities.



Value-based Insurance Design (VBID). Under VBID, health plans modify the incentives that they offer to enrollees to encourage high-value care. The Innovation Center is testing VBID in the Medicare Advantage program, allowing plans flexibility to provide supplemental benefits for beneficiaries based on health conditions and/or socioeconomic factors. These benefits include reduced cost-sharing for high value care, access to new and existing technologies and FDA-approved medical devices, vouchers for transportation to health care visits and for over-the-counter medications recommended by their providers, as well as items and services that have a reasonable expectation of improving or maintaining the health or overall function of an enrollee with regard to the chronic condition or socioeconomic status, which may include food and housing supports. The model also requires plans to engage with their enrollees in wellness and advance care planning, and some plans are also testing access to concurrent hospice care. Lessons learned from these efforts could be tested more broadly to increase utilization of high-value care in future CMS Innovation Center efforts.

Increasing Utilization of High-Value Care – Provider efforts

The strategic refresh includes a focus on creating financial incentives and support for providers to deliver high-value care while eliminating duplicative or wasteful services. Model strategies may include testing payment targets and implementing payment structures that foster greater accountability by reducing the delivery of duplicative or wasteful services and for overall spending and outcomes. Through episodic payments for all care furnished during an episode of intense treatment, the CMS Innovation Center tests ways to foster greater appropriateness in the choice of high-value care, as well as ways of generating efficiency in operations and administration. For example, skilled nursing facility use after an acute care hospitalization has declined significantly under BPCI Advanced episodes without compromising quality and outcomes for beneficiaries.

In addition, the Innovation Center establishes quality metrics for each model that frequently affect payment. For example, many models are structured such that participating providers may share in savings with CMS, but these savings may be adjusted or contingent based on achieving specific quality performance thresholds. The CMS Innovation Center is exploring how quality metrics may also be used in models to promote greater beneficiary use of high-value services.

Next Steps to Provide Tools to Improve Access by Addressing Affordability

- Identify ways to align or integrate episode payment models with accountable care and other total cost of care models to ensure delivery of accountable and affordable specialty care in addition to robust advanced primary care.
- Identify areas where Innovation Center models can test efforts to reduce program expenditures, which may also lower out-of-pocket costs for beneficiaries.
- Explore model tests that make changes to payment structures for specialty care that results in the delivery of high-value person-centered care.
- Include payment waivers and other flexibilities in total cost of care models to incentivize use of high-value services across Innovation Center models and benefit designs.

Innovation Center Strategic Objective 5: Partner to Achieve System Transformation

Aim:

Align priorities and policies across CMS and aggressively engage payers, purchasers, providers, states and beneficiaries to improve quality, to achieve equitable outcomes, and to reduce health care costs.

Measuring Progress:

- Where applicable, all new models will make multi-payer alignment available by 2030.
- All new models will collect and integrate patient perspectives across the life cycle.



The CMS Innovation Center's vision for broad health system transformation is ambitious and requires collaboration with and actions by a wide range of stakeholders. In particular, alignment with private payers, purchasers, and states is needed to increase the number of providers participating in value-based payment models and to make their participation sustainable across payers. Achieving this vision requires working across CMS and beyond, taking a whole-of-government approach – and collaborating with employers, health plans, and states, as well as with patients, caregivers, providers, and community organizations.

CMS Health Care Payment Learning and Action Network (LAN) and Private Purchasers and Payers

The CMS Innovation Center has historically engaged with external partners in different ways. The Health Care Payment Learning and Action Network (LAN), a public-private collaboration funded by HHS through the Innovation Center, is the most public, structured, and significant mechanism for engagement and partnerships centered on shared goals with external stakeholders. The LAN and its participants will be critical partners in ensuring

successful implementation of the refreshed strategy, particularly in achieving the goals of multi-payer alignment by increasing the number of providers that are sustainably participating in value-based payment models and to advance system transformation nationally.

State and Medicaid partners

In a number of CMS Innovation Center models, such as the State Innovation Model (SIM), CPC+, the Maryland Total Cost of Care Model, the Vermont All Payer ACO Model, CHART, OCM, the Pennsylvania Rural Health Model, and PCF, CMS is partnering with other payers and/or states to amplify the model's impact across Medicare and Medicaid, as well as commercial payers, in some cases. Providers have found that multi-payer alignment can make it easier to transition to value-based care. Recognizing that payers are in different stages of the value-based care journey with their own operational considerations, the Innovation Center will build on lessons learned from these efforts to work more closely with CMCS to drive alignment on critical payment and operational design components such as clinical tools, outcome measures, and payment.

Beneficiary collaborations

Closer collaborations with beneficiaries, caregivers, and patient groups across the lifecycle of models from conceptualization to evaluation and potential model expansion will help ensure that existing and new models are meeting people's needs – and not just the needs of providers. Public input is also critical to developing and testing tools that support person-centered care. However, patient and caregiver perspectives are not often brought to the process early enough to influence the development of care management tools and programs, payment incentives for providers, and payment waivers and other flexibilities. Across all of the strategic objectives in the CMS Innovation Center's refreshed vision, beneficiary and patient engagement and collaboration is a key mechanism for driving broad system transformation.

Health equity partnerships

Working with groups with deep expertise and experience in providing equitable care for underserved populations, including community-based organizations and other entities that have historically not engaged with the Innovation Center, will be critical to increasing the reach of value-based models to underrepresented and underserved populations. Such collaborations will benefit model design, implementation, and evaluations.

CMS, HHS, and other federal partnerships

Achieving broad health system transformation requires working across CMS, HHS, and the federal government. Every part of the Innovation Center's strategy and work moving forward could be strengthened by successfully engaging federal partners for their insights and support in testing new approaches to payment and care delivery and incorporating lessons learned from other programs into CMS Innovation Center models. These enhanced federal partnerships will assist in facilitating the adoption of the CMS Innovation Center's lessons learned into the Medicare and Medicaid programs, improving care and reducing costs and improving and automating the collection and analysis of data that can support decision making on models, program changes, and new

initiatives. Federal collaboration can also help examine ways that federal investments to address social needs can be used more effectively with Medicare and Medicaid payments to achieve improved and more sustainable outcomes. To start, partnerships will be formed in areas of shared interest, such as health equity, accountable care, SDoH, state-based transformation, measure alignment, and health information technology and interoperability.

Next Steps to Partner to Achieve Health System Transformation

- Focus on opportunities to drive multi-payer alignment, especially with Medicaid programs, during development of new models.
- Strengthen partnerships with beneficiary, caregiver, and patient groups, as well as providers, and solicit input and feedback to understand care needs and challenges that can be addressed across the life cycle of models.
- Make model data more easily available to stakeholders to advance transparency on model performance and to support external research and learnings.
- Focus the collaboration with the LAN and its members on achieving the vision of the Innovation Center's strategic refresh, especially in terms of advancing health equity and advancing multi-payer alignment.

CMS Innovation Center Commitment to Transparency and Communication

In order for implementation of the strategy outlined here to be successful, the Innovation Center must improve the transparency of its work and communication with key stakeholders. As part of the strategy refresh, the following issues have been identified as critical to implementation of each of the five objectives:

1. **Stakeholder Outreach.** The CMS Innovation Center is committed to strengthening communication with stakeholders. This work starts with beneficiaries and patient advocates to help ensure that their perspectives and needs are a key driver to designing and deploying care innovations that facilitate integrated, high-value, and affordable care. New and more consistent mechanisms for outreach will include regular listening sessions with existing and new partners, private purchasers and payers, providers, and other model participants, and broad Innovation Center participation in stakeholder events. It will also be critical to speak with non-participants to understand barriers to participating in prior or current models – and how future models can be designed for them to participate.
2. **Data Transparency.** Transforming the health system will require generating insights and learnings from models with leaders and experts outside of the CMS Innovation Center, making sharing data on models an imperative. As a first step, the Innovation Center is piloting efforts to share research identifiable files via the CMS Virtual Research Data Center (VRDC) so that researchers may link claims data with model participant lists (in a manner that safeguards PHI and is consistent with HIPAA and other applicable laws) to identify model claims data sets for analysis. Lessons are also being examined from the Medicare Shared Savings Program, which provides research identifiable files on beneficiaries assigned to and providers participating in ACOs and that are updated on a regular basis and available to researchers.

We anticipate this will assist researchers in generating valuable insights on the impacts of models and design features on quality, outcomes, and costs. We also note that many models engage in data collection for clinical information not submitted on claims and through various surveys. The CMS Innovation Center is also actively working to identify and prepare additional data files from these model specific data collections in order to further supplement and enrich the data available for analysis in the VRDC. Making additional supplemental summary-level, de-identified data on model performance available on the website would allow those stakeholders who do not work in the VRDC additional insights into the models.

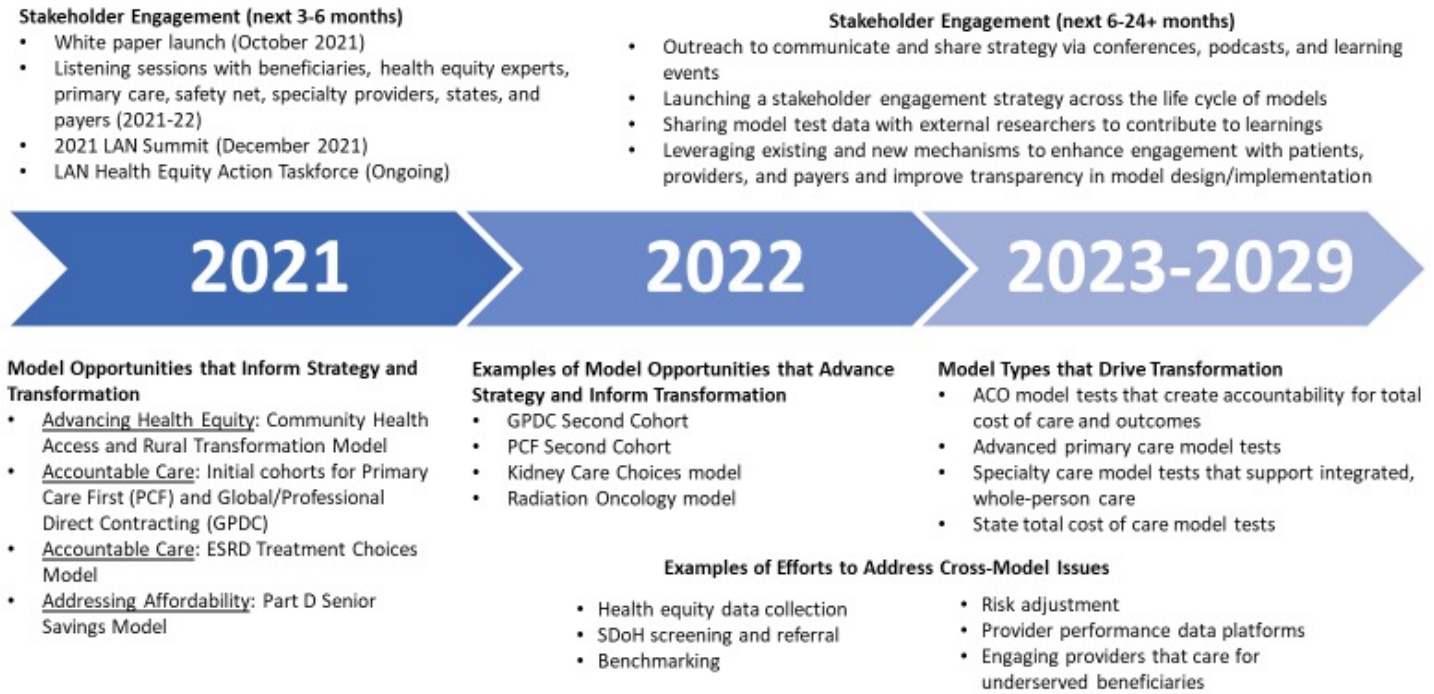
3. **Defining Success.** The CMS Innovation Center's overarching goal will continue to be expansion of successful models that reduce program costs and improve quality and outcomes for Medicare and Medicaid beneficiaries. The statutory language creating the Innovation Center stipulated that a model that reduces costs or improves quality can be expanded in duration and scope only if the CMS Chief Actuary certifies that it would not increase net program spending in addition to meeting certain other requirements outlined in the ACA. However, only a handful of models have met the certification standard. In addition to reducing costs or improving quality, model success will also be considered for impacts on health equity, person-centered care, and health system transformation—efforts which are aligned with CMS-wide goals.

This would entail efforts such as tracking progress on the metrics offered in this white paper for each of the strategic objectives, using qualitative research findings to understand model impacts on beneficiaries, providers, and health care markets (see Table 3). A more systematic and structured approach to understanding model impacts on these broader factors could help inform not only the CMS Innovation Center's future models, but also other payers and providers in their move to value-based payment and care.

Table 3. Approaches to Assessing CMS Innovation Center Impact.

Categories for Assessing CMS Innovation Center Model Impact	Examples of Metrics
Beneficiary Impacts	<ul style="list-style-type: none"> • Patient experience • Functional status improvements • Population level metrics, such as avoidable admissions • Quality of care transitions across settings • Access to follow-up care • Coordination across providers • Access to home- and community-based care • Access to telehealth services and other forms of virtual care • Disparities in outcomes by demographic characteristics • Beneficiary costs
Provider Impacts	<ul style="list-style-type: none"> • Care transformation • Impact on administrative burden • Level of alignment on models across payers • Sustainability of participation in models • Access to actionable, more real-time data to inform care management
Market Impacts	<ul style="list-style-type: none"> • Level of consolidation • New linkages or relationships between providers • Spread of model elements to other payers • Scalability of model to other regions or payers • Generalizability of impacts to other populations

Figure 4. CMS Innovation Center Strategy – Moving to Implementation.



A commitment to transparency and improved and regular communication with stakeholders and the research community, including providing more information about forthcoming models, will accelerate the Innovation Center’s mission to drive value-based payment across the health system – and ability to achieve its renewed vision.

Looking Forward

The CMS Innovation Center enters its second decade with a solid foundation of models, results, and lessons learned that can be leveraged to achieve a bold, renewed vision by 2030. A commitment to the five strategic objectives and to measuring progress against defined metrics will guide revisions to existing models and the development of a more streamlined portfolio that can drive broad system transformation. Cross-cutting issues identified in this white paper will be critical to success, including engaging in deeper collaborations with beneficiaries and patient advocates, advancing access to value-based

care for underserved populations, and sharing data with external researchers and experts to accelerate learning. As part of achieving the Innovation Center’s renewed vision, its contribution to building a health system of the future that achieves equitable outcomes through high-quality, affordable, person-centered care will need to be assessed. Beyond reducing costs and improving quality, success must also be measured by how its models impact CMS programs, patients and families, providers, payers, states, and the broader health care system to ensure all benefit from and participate in this vision.

Streamlining and Harmonizing CMS Innovation Center Models

To build a more harmonized and streamlined portfolio of models, the CMS Innovation Center will consider a number of issues to guide model development and refinement moving forward.

- **How would a model support or advance one or more of the five strategic objectives?**
- **What are the potential impacts of a model on health system transformation for beneficiaries and patients, providers, payers, states, and the Medicare and Medicaid programs?**
- **What is the likelihood of successful execution of a model?**
- **What is the potential for adoption and scaling by other payers and providers?**
- **What is the potential for a model to support innovation in the Medicare and Medicaid programs more broadly?**

