



## THE CENTER FOR MEDICARE AND MEDICAID INNOVATION: PAVING THE WAY FOR VALUE-BASED PAYMENT REFORM

### New payment and care delivery models

Since its inception, the CMS Innovation Center has designed, implemented, and tested over 40 innovative payment and service delivery models.

The models can be generally categorized based on the delivery and payment approaches and beneficiaries covered:

- **Accountable Care:** Models built around accountable care organizations (ACOs) which hold groups of providers responsible for cost and quality of care for a population of patients.
- **Episode-based payment initiatives:** Providers are held accountable for costs and quality for certain conditions or “episodes of care” during a specified period of time.
- **Primary Care Transformation:** Models built around the medical home structure and improved investments in primary care.
- **Initiatives to Speed the Adoption of Best Practices:** Models include cross-sector collaboration focused on preventing disease and addressing upstream factors that impact health.
- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models:** State-based and locally developed models address care for Medicare, Medicaid, and dually-eligible beneficiaries and Children’s Health Insurance Program beneficiaries.

*CMS Innovation Center: Model Implementation and Center Performance* (GAO)

The Center for Medicare and Medicaid Innovation (CMMI or CMS Innovation Center) was established in 2010 by the Patient Protection and Affordable Care Act to test innovative health care payment and care delivery models that reduce federal health care expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) beneficiaries.

**Over the last decade, CMMI has spurred positive reforms in health care delivery by playing a key role in the proliferation of value-based payment and alternative payment models (APMs) that tie reimbursement to the quality and efficiency of care rather than the volume of services provided.**

The importance of CMMI to health care transformation efforts was further bolstered with the bipartisan passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA created financial incentives for providers to participate in Advanced APMs in the form of higher annual payment adjustments and a time-limited opportunity for a bonus payment as a percentage of overall Medicare revenue. CMMI is the cornerstone entity responsible for generating new Advanced APM opportunities for providers and encouraging a multi-payer transition away from fee-for-service health care.

## CMMI models are experiments to determine what payment methodologies and concepts should be incorporated into permanent programs

The CMS Innovation Center's authorizing statute gives the Secretary of Health and Human Services authority to expand successful models through rulemaking without further Congressional action. The model expansion criteria established in statute serve as the framework for CMMI model design considerations. To qualify for expansion, a model must: 1) be expected to reduce spending without reducing the quality of care, or improve quality without increasing spending, 2) be certified by the Chief Actuary of CMS (OACT) to either reduce or not result in an increase in net spending upon expansion, and 3) be determined that an expansion of the model would not deny or limit the coverage or provision of benefits to applicable program beneficiaries.

Each CMMI payment and delivery model is rigorously monitored and evaluated to determine what successful elements can be brought to scale. As mandated by statute, the formal evaluation must include an assessment of the quality of care and changes in spending for each model; the evaluations also collect information on best practices and other lessons learned during model testing that can inform future model development and health system improvements. These comprehensive model-specific evaluation reports are made available to the public on an annual basis and once the demonstration concludes. In addition, CMMI prepares a biennial report to Congress on its activities.

### Model Certification and Expansion

The Secretary of Health and Human Services has utilized its authority to expand the duration and scope of three CMMI models through rulemaking. The Pioneer ACO was the first CMMI model to be [certified](#) by OACT in 2015 as expected to reduce net program spending to Medicare based on combined evidence from the formal evaluation as well as independent actuarial analysis of financial impacts compared to the current cost baseline. OACT [certified](#) in 2016 that expansion of the Diabetes Prevention Program as a covered Medicare benefit would not result in an increase in spending. And in 2020, CMS expanded the Medicare Scheduled Non-Emergent Ambulance Transport model, which OACT certified would reduce net Medicare spending based on the model's evaluation reports that found a total decrease of Medicare fee-for-service expenditures of 2 percent over the first four years of the program.

**To date, CMMI has expanded three models. The CMS Office of the Actuary is not asked to opine publicly on every model CMMI tests.**

The CMS Innovation Center remains an important driver in the ongoing transition to a more resilient, value-based health care system. The lessons derived from the models tested in the Medicare, Medicaid, and CHIP population and shared transparently via regular model evaluations serve to inform and spur alternative payment model development in the public and private sector.



Established in 2014, the Health Care Transformation Task Force brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for its members, the Task Force is also a leading national voice on value-based payment and care delivery transformation.