HEALTH MANAGEMENT ASSOCIATES

ISSUE BRIEF #2

Center for Medicare and Medicaid Innovation: Recommendations for Future Direction

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throughout the project. We also express our appreciation to Jonathan Blum for his contributions to this issue brief; to Samantha Di Paola, Amanda Glickman, Elaine Henry, and Cami McIntire for their assistance with summarizing information about Innovation Center models for the companion catalog; to Matt Hudson for graphic design support; and Karen Brodsky for comments on a draft of this issue brief.

Overall, the results from the Innovation Centers' first decade show minimal success in fulfilling its statutorily defined objectives. Despite spending more than $10 billion overall and testing hundreds of models, only four models have met the statutory criteria of lower spending or improved quality and been expanded—or introduced—to the Medicare program nationwide:

Home Health Value-Based Purchasing (HHVBP) model
Medicare Diabetes Prevention Program (MDPP)
Pioneer Accountable Care Organizations (ACOs)
Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization model

With a new Administration and Innovation Center Director—who have announced they are reviewing demonstrations and plan to share details about future direction soon—combined with the start of the next decade of $10 billion in funding, now is an opportune time to look ahead and consider how to ad

> Secretary must determine that the expansion would not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP.[3]

The statute also requires that the Secretary terminate or modify CMMI models before testing is completed if the Secretary determines that the model is not expected to fulfill these spending and quality goals (and CMS's Chief Actuary agrees with the spending expectations).[4] In other words, if initial testing results indicate that a model is **not** expected to improve the quality of care without increasing spending or **not** reduce spending without reducing the quality of care, then CMMI has a responsibility to make changes to the model to improve the likelihood of a successful outcome or cease operating the model.

The statute dedicated funds to CMMI for:

> $5 million for fiscal year 2010,
> $10 billion in total for fiscal years 2011 through 2019, and
> $10 billion for each subsequent 10-year period beginning with fiscal year 2020.[5]

The statute also requires that the Secretary evaluate each CMMI model and "make the results of each evaluation … available to the public in a timely fashion."[6] Additionally, the Secretary must issue a report to Congress every other year that describes CMMI's models including:

> The number of Medicare and Medicaid beneficiaries participating in the respective models
> Payments made by Medicare and Medicaid for services for these participating beneficiaries
> Models chosen for expansion
> Results from model evaluations.[7,8]

The bi-annual report to Congress must also include recommendations that the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.[9] CMMI released the fifth report in August 2021.[10]

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[3] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[4] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[5] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[6] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[7] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[8] To date, CMMI has issued reports to Congress for 2012, 2014, 2016, 2018, and 2020.
[9] "Compilation of the Social Security Laws: Center for Medicare and Medicaid Innovation." Social Security Administration, accessed May 28, 2021, https://www.ssa.gov/OP_Home/ssact/title11/1115A.htm
[10] https://innovation.cms.gov/data-and-reports/2021/rtc-2020

This issue brief is the second of two that examine Innovation Center models to date and make recommendations for the future direction of models. In the first issue brief, Health Management Associates (HMA) reviewed information about Innovation Center models that was made publicly available by CMMI through May 11, 2021. We inventoried this information in a model catalog available here. A unique characteristic of our review is the description of the 110 individual Medicare models included under the umbrella of the Round One and Two Health Care Innovation Awards and State Innovation Models, which are typically reported in the aggregate in other studies.

In the first issue brief, along with describing characteristics of Innovation Center models to date, we noted questions raised by our various findings that policy makers may consider as they plan for the next phase of CMMI's work. These questions were included in 12 call-out boxes.[11] In this issue brief, we include each of the 12 call-out boxes and discuss these questions in more depth to lay out the competing goals and tensions that the Innovation Center will have to weigh going forward and offer recommendations on the outlook for new models.

The Innovation Center's first decade of experience has illustrated several competing goals that the Director will need to maintain in ongoing balance in the next decade. New CMS leadership has released a brief description of plans for CMMI's next decade in advance of forthcoming detailed information that addresses balancing some of these goals.[12] For example, CMMI plans to reduce the total number of models going forward. We review seven pairs of competing goals below and discuss ideas for refining CMMI's future direction to promote an optimal balance between each pair.

- Reduce the number of models versus maintain a broad portfolio
- Employ a bottom-up versus a top-down approach
- Focus on scalable versus targeted models
- Collaborate with other payers versus focus on Medicare-only models

The most common Medicare model category by far is "New Payment and Service Delivery" (76%).

Is this the right portfolio mix for CMMI models?

As we and other observers have noted, the Innovation Center has tested and continues to test more than 170 models that include Medicare across seven categories.[13,14,15] (Others count more than 50 models. Our total counts the Health Care Innovation Awards (HCIA) and State Innovation Models (SIM) individually.) This year, MedPAC voted to recommend that the Innovation Center reduce the total number of models. The Commission posited that "a smaller set of [models]—with better aligned incentives to reduce volume and costs—could increase the degree to which providers change their behavior in response to the models and could lead to reductions in spending over a time frame of longer than five years."[16] In addition, the new CMMI Director has indicated agreement with testing fewer models.[17] This could address several concerns, such as confusion, diluted incentives, and challenges in study design and evaluation caused by overlapping models, and spending significant resources on ideas that do not result in successful reduction of spending or improved quality. Ideally, there would be several promising models for the Innovation Center to focus resources on and several models that are clearly under-performing to be culled.

One idea to consider, if the Innovation Center were to reduce the number of models, is to review the different categories of models and number of models in each category. CMMI currently organizes models into seven categories:

Accountable Care
Episode-based Payment Initiatives
Primary Care Transformation
Initiatives Focused on the Medicaid and Children's Health Insurance Program (CHIP) Population

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[13] Jennifer Podulka and Yamini Narayan. "Issue Brief #1: Center for Medicare and Medicaid Innovation: Findings from Medicare Models To-Date." , June 2021. https://www.healthmanagement.com/wp-content/uploads/HMA-AV-Issue-Brief-1-CMMI-findings.pdf.

[14] . Washington, District of Columbia, 2021. http://www.medpac.gov/docs/default-source/default-document-library/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0

[15] Donald Berwick and Rick Gilfillan. "Reinventing the center for Medicare and Medicaid innovation." 325, no. 13 (2021): 1247-1248.

[16] Report to the Congress: Medicare and the Health Care Delivery System. Washington, District of Columbia, 2021. http://www.medpac.gov/docs/default-source/default-document-library/jun21_medpac_report_to_congress_sec.pdf?sfvrsn=0

[17] Chiquita Brooks-LaSure, Elizabeth Folwer, Meena Seshamani, and Daniel Tsai. "Innovation at the Centers for Medicare and Medicaid Services: A Vision for the Next 10 Years." August 2021. https://www.healthaffairs.org/do/10.1377/hblog20210812.211558/full/

Initiatives Focused on the Medicare-Medicaid Enrollees
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
Initiatives to Speed the Adoption of Best Practices

To date, three-quarters of models have been implemented under the category "New Payment and Service Delivery." Much of this skew is explained by the numerous HCIA and SIM models that were included in this category. Currently, the Innovation Center is operating 28 models.[18] Nearly half of these (12) fall into the "Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models" category.[19] The Innovation Center may wish to reduce the share of models in this category.

Reducing the number of models may prove to be easier said than done. The numerous Innovation Center models are intended to test various hypotheses about how care can be improved, and a decade of experience has shown that we do not yet have a clear, narrow path to guide us to which models that are currently being tested or that spring from new ideas in the future will succeed. Only four models have met the statutory criteria of lower spending or improved quality and were expanded to the Medicare program nationwide. These models cross provider type and category. All seven categories currently include select models that are testing exciting new approaches for improving healthcare delivery

2020.[20] About three thousand “clinicians, entrepreneurs, health centers, hospitals, and community-based organizations” submitted applications

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Exhibit 1. Current Innovation Center models that include Medicare and their earlier iterations

The Rural Community Hospital demonstration is scheduled to have 18 performance years.

None of these long-running models have yet been found to be successful enough in reducing spending or improving quality to be expanded into the Medicare program nationwide.

The Innovation Center has introduced several models that embrace calls for participants to focus broadly on maintaining and improving the overall health of a population, such as Comprehensive Primary Care Plus (CPC+), Global and Professional Direct Contracting (GPDC), Maryland Total Cost of Care (TCOC) model, and the currently under review Geographic Direct Contracting model. These models are designed to foster collaboration among participant providers and organizations in improving how care is delivered to beneficiaries. They include regulatory relief and additional flexibilities that, if the models prove to be successful, could transform how some aspects of the Medicare program operate.

However, in encouraging greater collaboration among participants for the goal of improved patient care, these models may be inadvertently, if incrementally, further increasing market consolidation pressures. Hospitals and physician groups have increasingly consolidated, in part to gain leverage in negotiating higher payment rates with private insurers (which, themselves, have become more concentrated).[34] Most studies indicate that increased market consolidation increases prices and does not improve quality. The Innovation Center may wish to seek ways to balance model design that encourages greater collaboration while seeking to mitigate or avoid model characteristics that drive providers towards increased market consolidation.

offer an appropriate glidepath in these situations. Since 2017, mixed-risk models are slightly more common (29% of models) than those that exclusively require two-sided risk.[38]

New CMS leadership has recently offered their reflections on lessons learned from the Innovation Center's first decade, laid out their vision for the next decade, and indicated that additional information about that outlook will soon be forthcoming.[39] We anticipate that the competing goals we have described here will touch on themes that will be included in that information and that the Innovation Center will be called upon throughout the next decade to continually balance each of the goals when designing and refining models. We offer four recommendations designed increase the transparency of Innovation Center efforts and improve the likelihood that more models prove to be successful in decreasing spending and/or improving quality. Adopting these recommendations may, to some degree, aid the 1.0257 1 1 re1U77(he)7(1.0

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In 2015, Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) through the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.[57] PTAC is charged with issuing comments and recommendations to the Secretary of HHS on proposals for physician-focused payment models submitted to it