Centers for Medicare & Medicaid Services: Innovation Center New Direction

I. Background

One of the most important goals at CMS is fostering an affordable, accessible healthcare system that puts patients first. Through this informal Request for Information (RFI) the CMS Innovation Center (Innovation Center) is seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The Innovation Center welcomes stakeholder input on the ideas included here, on additional ideas and concepts, and on the future direction of the Innovation Center.

II. Provisions of this RFI

A. Guiding Principles

While existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons, CMS is setting a new direction for the Innovation Center. We will carefully evaluate how models developed consistent with the new directions can complement what we are learning from the existing initiatives. The Innovation Center will approach new model design through the following guiding principles:

1) Choice and competition in the market – Promote competition based on quality, outcomes, and costs.
2) Provider Choice and Incentives – Focus on voluntary models, with defined and reasonable control groups or comparison populations, to the extent possible, and reduce burdensome requirements and unnecessary regulations to allow physicians and other providers to focus on providing high-quality healthcare to their patients. Give beneficiaries and healthcare providers the tools and information they need to make decisions that work best for them.

3) Patient-centered care – Empower beneficiaries, their families, and caregivers to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care across the care continuum.

4) Benefit design and price transparency – Use data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes.

5) Transparent model design and evaluation – Draw on partnerships and collaborations with public stakeholders and harness ideas from a broad range of organizations and individuals across the country.

6) Small Scale Testing – Test smaller scale models that may be scaled if they meet the requirements for expansion under 1115 A(c) of the Affordable Care Act (the Act). Focus on key payment interventions rather than on specific devices or equipment.

The Innovation Center is interested in testing models in the following eight focus areas: (1) Increased participation in Advanced Alternative Payment Models (APMs); (2) Consumer-Directed Care & Market-Based Innovation Models; (3) Physician Specialty Models; (4) Prescription Drug Models; (5) Medicare Advantage (MA) Innovation Models; (6) State-Based and Local Innovation, including Medicaid-focused Models; (7) Mental and Behavioral Health Models; and (8) Program Integrity. However, the Innovation Center may also test models in other areas.

B. Potential Models

1. Expanded Opportunities for Participation in Advanced APMs

In April 2015, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that repealed the Sustainable Growth Rate formula for updating the Medicare physician fee schedule, and replaced it with a series of fixed statutory updates and a Quality Payment Program that includes the Merit-Based Incentive Payment System (MIPS) and Advanced APMs. CMS administers the Quality Payment Program, and the Innovation Center bears primary

responsibility for development of policies and operations relating to Advanced APMs. Eligible clinicians who are Qualifying APM Participants (QPs) for a year from 2019 through 2024 receive a lump sum APM incentive payment and, beginning for 2026, a differentially higher update under the Medicare physician fee schedule. Eligible clinicians who are QPs for a year are also not subject to the MIPS reporting requirements and payment adjustment.

CMS expects that the number of eligible clinicians choosing to participate in Advanced APMs will grow over time. To facilitate this growth, CMS seeks comment on ways to increase opportunities for eligible clinicians to participate in Advanced APMs and achieve threshold levels of participation to become QPs. CMS has received feedback from the healthcare provider community on the extensive and lengthy process that is required for a model to qualify as an Advanced APM. CMS seeks feedback from stakeholders on ways the Administration can be more responsive to eligible clinicians and their patients, and potentially expedite the process for providers that want to participate in an Advanced APM. CMS also seeks guidance from the stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

2. Consumer-Directed Care & Market-Based Innovation Models

CMS believes beneficiaries should be empowered as consumers to drive change in the health system through their choices. Consumer-directed care models could empower Medicare, Medicaid, and CHIP beneficiaries to make choices from among competitors in a market-driven healthcare system. To better inform consumers about the cost and quality implications of different choices, CMS may develop models to facilitate and encourage price and quality transparency, including the compilation, analysis, and release of cost data and quality metrics that inform beneficiaries about their choices. CMS will consider new options for beneficiaries to promote consumerism and transparency. For example, beneficiaries could choose to participate in

arrangements that would allow them to keep some of the savings when they choose a lower-cost option, or that incentivize them to achieve better health. Models that we are considering testing include allowing Medicare beneficiaries to contract directly with healthcare providers, having providers propose prices to inform beneficiary choices and transparency, offering bundled payments for full episodes of care with groups of providers bidding on the payment amount, and launching preferred provider networks. CMS solicits feedback from patient and consumer advocacy groups, the healthcare provider community, as well as experts in the technology industry, and other stakeholders that can provide creative ideas on how to operationalize these principles in models that best serve patients in terms of cost, quality, and access to care.

3. Physician Specialty Models

a. Physician Specialty Models

The Innovation Center is interested in increasing the availability of specialty physician models to improve quality and lower costs and engage specialty physicians in alternative payment models, especially for independent physician practices. One potential option may be to include specialty physician management of a defined population of beneficiaries with complex or chronic medical conditions, including multiple chronic conditions. This may include the specialist serving as the primary source of care and providing care coordination for medically complex beneficiaries. Another option may be paying healthcare providers for limited episodes of care based on quality measure performance and competitive pricing. For cancer care in particular, a model could test full prepayment for Medicare and Medicaid beneficiaries, with care provided in collaborative networks, possibly incorporating elements from the existing Oncology Care Model. CMS solicits feedback from the provider community, patient and consumer advocacy groups, and other stakeholders regarding their best ideas for new physician specialty models and appropriate quality measures.

b. Physician-Focused Payment Model Technical Advisory Committee (PTAC) Recommended

Models

In addition to creating MIPS and Advanced APMs, MACRA also creates incentives for physicians to participate in Alternative Payment Models (APMs), including the development of physician-focused payment models (PFPMs). Section 101(e)(1) of MACRA creates the Physician-Focused Payment Model Technical Advisory Committee (PTAC). PTAC makes comments and recommendations to the Secretary on proposals for physician-focused payment models submitted by individuals and stakeholder entities. The Secretary may choose to recommend Innovation Center testing of models recommended by PTAC.

4. Prescription Drug Models

CMS wants to test new models for prescription drug payment, in both Medicare Part B and Part D and State Medicaid programs that incentivize better health outcomes for beneficiaries at lower costs and align payments with value. Models that better align incentives and engage beneficiaries as consumers of their care can continue to improve patient outcomes while controlling drug costs. Models that contemplate novel arrangements between plans, manufacturers, and stakeholders across the supply chain, including, but not limited to innovative value based purchasing arrangements, and models that would increase drug pricing competition while protecting beneficiaries' access to drugs are of particular interest.

5. Medicare Advantage (MA) Innovation Models

CMS wants to work with Medicare Advantage (MA) plans to drive innovation, better quality and outcomes, and lower costs. CMS seeks to provide MA plans the flexibility to innovate and achieve better outcomes. CMS is currently implementing an MA plan model, the Medicare Advantage Value-Based Insurance Design (VBID) model, that provides benefit design flexibility to incentivize beneficiaries to choose high-value services; but this model could be modified to provide more flexibility to MA plans and potentially add additional states. More generally, CMS is

interested in more models in the MA plan space and regulatory flexibility as necessary for purposes of testing such models. CMS is potentially interested in a demonstration in Medicare Advantage that incentivizes MA plans to compete for beneficiaries, including those beneficiaries currently in Medicare fee-for-service (FFS), based on quality and cost in a transparent manner. CMS is also interested in what additional flexibilities are needed regarding supplemental benefits that could be included to increase choice, improve care quality, and reduce cost. Additionally, CMS seeks comments on what options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as alternatives to FFS and MA.

6. State-Based and Local Innovation, including Medicaid-focused Models

States play a critical role in innovation and delivery of high quality care. CMS wants to partner with states to drive better outcomes for people based on local needs. CMS and the Innovation Center have worked with states on a variety of initiatives including the State Innovation Models, Innovation Accelerator Program, Strong Start and Medicaid Incentives for the Prevention of Chronic Diseases Model. These efforts and a variety of successful State-led models provide lessons learned for advancing innovation. Through this model focus area, States could drive reform and innovation. Healthcare providers and states would work with CMS to develop state-based plans and local innovation initiatives to test new models. Models would vary based on the needs and goals of each state for improving care and lowering costs, but could include providing states with more flexibility for multi-payer reforms as well as increasing opportunities for physicians serving Medicaid and CHIP populations to participate in value-based payment models. Models specific to Medicaid populations would also be considered. CMS would rely on authority under sections 1115 and 1115A of the Act in developing and implementing such models.

7. Mental and Behavioral Health Models

CMS is actively exploring potential models focused on behavioral health, including focus areas such as opioids, substance use disorder, dementia, and improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or utilize episode payment. CMS is interested in stakeholders' views of the best payment models and state and local interventions to improve care in these areas.

8. Program Integrity

CMS is seeking comment on ways that CMS may reduce fraud, waste, and abuse and improve program integrity. The costs and effectiveness of different approaches to program integrity could be tested to help CMS find the ideal balance between burdens on patients and additional workload created for the physician and effectiveness of the review. Such an approach could be tested as part of a new model and/or be layered on top of other models.

C. Questions

1. Do you have comments on the guiding principles or focus areas?
2. What model designs should the Innovation Center consider that are consistent with the guiding principles?
3. Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.
4. What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?
5. How can CMS further engage beneficiaries in development of these models and/or participate in new models?

6. Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?
7. Are there any other comments or suggestions related to the future direction of the Innovation Center?

Resources to submit comments can be found on https://innovation.cms.gov/initiatives/direction/. Comments will be received through November 20, 2017.

Special Note To Commenters:

Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement or program, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this RFI are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur costs for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publicly post the comments received, or a summary thereof.