LETTER FROM THE DIRECTOR

The Critical Role of the CMS Innovation Center in the American Health Care System

The Centers for Medicare & Medicaid Services (CMS) is the nation's largest payer for health care and plays a key role in transforming the health care system toward one that provides higher value, more equitable, and affordable care that reflects individual preferences. Congress established the Innovation Center within CMS in 2010 to enable CMS to test ways to improve the quality of care and reduce Federal spending on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Over the past 10 years, the CMS Innovation Center has tested more than 50 payment and care delivery models, which have contributed to shifting how we pay for care in the United States to focus more on quality, clinical outcomes, and patient experience.

When I joined the CMS Innovation Center in 2021, we undertook a Strategy Refresh, with the goal of understanding the lessons learned from our first decade and using those to inform our strategy for the future. The strategy laid out a path to a new vision: a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. In developing our strategy and conducting our ongoing work, we consult regularly with front-line health providers, beneficiaries, health plans, states, organizations, and committees comprised of stakeholders, like the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which are essential for our ability to successfully identify and test models.

A comprehensive review and analysis of our model tests yielded important insights on the models' impacts that have broadened our perspective for ways to build on successful models. Our statute, Section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act), lays out a path for expansion of a model's scope or duration: the independent Office of the Actuary certifies that the model would reduce or maintain spending and the Secretary determines that model expansion would improve or maintain quality of care. Each model is tested for a limited duration. We then conduct an extensive analysis and evaluation to identify factors that may have led to improved quality or reduced spending, which can then be incorporated into other model tests or CMS programs.

In addition to expansion of a model that meets the statutory requirements, in many cases we apply learnings from our models by integrating successful elements of the tests into the Medicare and Medicaid programs, which brings innovations in care to more beneficiaries. This approach to scaling a model test outside of the expansion pathway includes the following:

- *Model innovations incorporated permanently into Medicare*, such as the advance payment option of the ACO Investment Model, which was incorporated into the Medicare Shared Savings Program (SSP);
- *Model features adopted through legislation*, for example, the inclusion of the Medicare $2 Drug List Model Concept in the FY 2025 President's Budget as well as the expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) model test nationwide through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA);

- *Successor models building on lessons from previous models*, such as the mandatory Transforming Episode Accountability (TEAM)[1] and Increasing Organ Transplant Access (IOTA)[2] models, that further innovate and advance on our earlier bundled payment and kidney models, respectively; and
- *Broader adoption of a model's innovative features*, such as the screening tool for health-related social needs developed by CMS in the Accountable Health Communities Model.[3]

Furthermore, evidence from the literature and anecdotally from interviews with nearly 150 providers, payers, management services organizations, and industry and academic experts indicate that the broader adoption of our models' innovative features has "spillover effects" resulting in a wider impact on the health system beyond the boundaries of individual model tests.[4] For example, providers participating in CMS Innovation Center models often implement model-associated care delivery changes (such as access to a 24/7 nursing phone line) for all patients, regardless of payer and alignment to a model, leading to positive spillover effects on patients' health outcomes and expenditures.[5] Interviewees reported that this has subsequently contributed to greater adoption and acceleration of value-based care across the industry—including through increased creation of and participation in private payer "lookalike" models similar to CMS Innovation Center models—and changes in attitudes toward value-based care and how care is delivered.

Incorporating mechanisms to detect spillover effects when setting up model evaluations' comparison groups may allow us to more comprehensively evaluate changes in care quality and spending. We are committed to incorporating insights regarding spillover effects into both current and future model designs with the goals of broadening our models' impact and better measuring the overall effect of the CMS Innovation Center models.

[1] Final Rule available on the Federal Register at: https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.

[2] Final Rule available on the Federal Register at: https://www.federalregister.gov/public-inspection/2024-27841/medicare-program-alternative-payment-model-updates-and-the-increasing-organ-transplant-access-model.

[3] Cancer Support Community, "A New Screening Tool Identifies Unmet Health-Related Social Needs (HRSN)," Available at: https://www.cancersupportcommunity.org/blog/new-screening-tool-identifies-unmet-health-related-social-needs-hrsn.

[4] JAMA, "Alternative Payment Models — Victims of Their Own Success?" Available at: https://jamanetwork.com/journals/jama/fullarticle/2767680; JAMA, "Association of Participation in the Oncology Care Model With Medicare Payments, Utilization, Care Delivery, and Quality Outcomes." Available at: https://jamanetwork.com/journals/jama/fullarticle/2785949; PNAS, "Randomized trial shows healthcare payment reform has equal-sized spillover effects on patients not targeted by reform." Available at: https://www.pnas.org/doi/epdf/10.1073/pnas.2004759117.

[5] Health Affairs, "Market Momentum, Spillover Effects, And Evidence-Based Decision Making On Payment Reform." Available at: https://www.healthaffairs.org/content/forefront/market-momentum-spillover-effects-and-evidence-based-decision-making-payment-reform.

Recent Progress and Plans for the Future

Since our last biennial Report to Congress in 2022, the CMS Innovation Center has made substantial progress executing on our strategy.

This progress includes announcing nine new models: Making Care Primary (MCP), Guiding an Improved Dementia Experience (GUIDE), States Advancing Health Equity and Development (AHEAD), Transforming Maternal Health (TMaH), Innovation in Behavioral Health (IBH), Cell and Gene Therapy Access Model (CGT Access), ACO Primary Care Flex (ACO PC Flex), Transforming Episode Accountability Model (TEAM), and Increasing Organ Transplant Access (IOTA). Each model includes specific features and requirements to deliver on our five strategic objectives—driving accountable care, advancing health equity, supporting innovation, addressing affordability, and partnering to achieve system transformation. For example, the GUIDE Model is designed to improve the quality of life for people living with dementia and their caregivers by keeping them in their communities through greater support, including respite services for certain beneficiaries and their unpaid caregivers. The ACO PC Flex Model is an important part of the progress toward our goal to have all people with Medicare in a care relationship with accountability for quality and total cost of care by 2030 by promoting the development of new physician-led accountable care organizations in the Shared Savings Program. The IOTA and TEAM models reflect our commitment to health equity and improving care for beneficiaries through testing models with mandatory participation.

The CMS Innovation Center has addressed the strategic goal of advancing health equity in both new and existing models by including policies focused on reducing health disparities and increasing our impact on care for underserved populations. We have implemented payment adjustments in models to bridge the gap between historic spending levels and actual costs of caring for underserved beneficiaries, as well as to support participants who serve a higher proportion of underserved populations. A key measure of the success of these policies is that we have significantly expanded the number of safety net providers, such as Federally Qualified Health Centers, participating in Medicare models.

We also have made significant strides encouraging other payers to align their payment approaches with the work of the CMS Innovation Center. Most of the newly introduced models described above demonstrate our concerted effort to work more closely with state governments and to build a greater CMS Innovation Center focus on working with Medicaid, including the MCP, AHEAD, TMaH, IBH, and CGT Access models. The core principles of the AHEAD and MCP models include collaboration to achieve alignment between commercial payers, Medicaid, and Medicare in transformative new payment models.

The CMS Innovation Center also has focused on creating pathways for model participants who are new to value-based care. The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, for example, has a specific track to support providers that are new to ACOs. Additionally, through a progressive pathway to value-based payment including three tracks that increase in care delivery and payment advancement over time, MCP provides resources that are aimed at smaller, independent practices.

The CMS Innovation Center is continuing to build on lessons learned to implement these new models and to inform future ones. Equipped with the experience of the first 10 years of testing models, the CMS Innovation Center continues to prioritize model tests that fill critical gaps in care delivery; are feasible; are aligned with broader CMS efforts; have the potential to improve the quality of care and care experience for people with Medicare, Medicaid, and CHIP; and reduce spending in these programs. Beyond reducing costs and improving quality, a model's success must also be measured by how it impacts existing CMS programs, beneficiaries and families, providers, payers, states, and the broader health care system to ensure they all benefit from and participate in this vision.

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