



Center for Medicare and Medicaid Innovation “Strategy Refresh” White Paper

Background:

The Center for Medicare and Medicaid Innovation (CMMI) was established in 2010 through Section 3021 of the Affordable Care Act to test payment and delivery models in Medicare, Medicaid, and CHIP. These models aim to reduce program costs while improving or maintaining quality of care. Notably, of the over 50 models that CMMI has tested since its inception, only six generated statistically significant savings to the Medicare program and only four of these met statutory requirements for model expansion. [CMMI recently released a white paper](#) evaluating “lessons learned” over their first 10 years, and a “strategy refresh” for their work moving forward. Although CMMI has historically focused on Medicare-related models, the new strategic plan places an increased emphasis on Medicaid and multi-payor models.

Lessons Learned:

Through an internal review and consultations with external experts, CMMI identified a number of challenges facing their current models, including:

- Many Medicare-focused models have limited reach to Medicaid members and providers
- Complex model designs, payment policies, overlap rules, and administrative requirements have prevented provider participation, impeded scalability, and sometimes led to conflicting incentives for providers
- Many providers need significant infrastructure investments (including in electronic health records, staffing, and data analysis) to participate in models, and accepting downside risk can be challenging if these providers lack appropriate care management tools and financial protections
- Model design features (including current benchmarking and risk adjustment methodologies, and a lack of alignment across multiple payors) have prevented broader provider participation

New Strategic Direction:

To address these challenges, CMMI developed a new strategic direction based on five key objectives:

Objective 1: Drive accountable care

- Aim to have the vast majority of Medicaid members (in both managed care and FFS programs) in accountable care relationships by 2030
- Work with Medicaid programs to incentivize the transition towards value-based care and encourage alternative payment model participation
- Test combinations of risk levels, per member per month payments, and population-based or advanced-payment options to maximize provider participation
- Test voluntary member alignment and attribution methodologies and member engagement incentives to facilitate strong relationships between members and their care teams

- Include meaningful outcome measures (like functional status and patient-reported outcomes measures) in quality improvement metrics
- Provide short-term upfront funds to smaller primary care practices or other providers to help them transition to value-based payment models
- Test approaches to enable ACOs to manage high-cost specialty and episodic care

Objective 2: Advance health equity

- Analyze demographics of model participants (including providers and members) to identify disparities
- Review and modify model design and application processes to increase the number of providers who practice in underserved communities
- Incorporate screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data into models
- Monitor performance of models on equity-related metrics to incentivize the reduction of health disparities

Objective 3: Support care innovation

- Develop and test models that address gaps in care, such as behavioral health, social determinants of health, and palliative care
- Test payment waivers and regulatory flexibilities to support total cost of care models for home- and community-based services
- Increase outreach to members, caregivers, and providers to assess gaps in care, preferences for home- and community-based treatment choices, and supports to facilitate provider-patient communication

Objective 4: Improve access by addressing affordability

- Align episode payment models with accountable care and other total cost of care models to ensure affordable specialty care in addition to primary care
- Include payment waivers and other flexibilities in total cost of care models to incentivize use of high-value services

Objective 5: Partner to achieve system transformation

- Focus on opportunities to drive multi-payer alignment, especially with Medicaid programs, during development of new models
- Make model data more easily available to stakeholders to increase transparency and support external research

Implementation and Next Steps:

Over the next 3 to 24 months, CMMI plans to hold listening sessions and other stakeholder engagement opportunities to further inform their strategic approach. In the longer-term, CMMI intends to launch new models and modify existing models to better meet these objectives.