Model Design Factors

The Centers for Medicare & Medicaid Services through the Center for Medicare and Medicaid Innovation (Innovation Center) routinely reviews new ideas for models. Many factors are used in the selection of models to be tested.

Factors address a variety of details in a model's design and include:

1. Alignment with the Department's goals for delivery system reform and other key CMS goals, such as the quality strategy and implementation of the Medicare and CHIP Reauthorization Act of 2015

2. Extent of clinical transformation in model design – Do we expect the magnitude and types of changes in care delivery in the model to be significant improvements over current practice?

3. Strength of evidence base – What data or prior experience (of CMS or other payers) supports the intervention proposed in the model?

4. Number and/or percentage of beneficiaries and practitioners included in the model – what is the scale of the model?

5. Demographic, clinical and geographic diversity – Does the model target key diverse patient and practitioner populations that CMS has yet to engage in other models, or geographic regions with previously low participation in CMS models?

6. Alignment with other payers and CMS programs – To what extent can the model leverage investments:
    *   Other health care payers are making in payment and delivery system reform
    *   CMS has made in its other programs

7. Potential for quality improvement – To what extent do we expect the model to result in improved clinical quality or patient experience of care, including but not limited to:
    *   Making the care experience reflect patients' goals and preferences?
    *   Better coordinated?
    *   Producing better health?
    *   Reducing disparities in health care quality experienced by vulnerable populations?

8. Potential for cost savings –What amount of savings will the model generate for Medicare, Medicaid, and CHIP?

9. Size of investment required – What are the likely costs to CMS to implement the model?

10. Probability of model success – What are the nature and magnitude of risks/barriers to model success?

11. Economic impact – What is the likely yield that CMS will see for its time and resource investments in the model?

12. Overlap with current and anticipated models – To what degree is the intervention in the proposed model unique in design from that in other models?

13. Evaluative feasibility– Will CMS be able to design an appropriate study, collect data, and analyze results to make reasonable conclusions about the model's performance?

14. Stakeholder interest and acceptance – Will there be enough stakeholder interest to get to the desired/necessary levels of participation?

15. Operational feasibility – How feasible will it be for model participants to prepare and build the infrastructure they need to do what is expected? How feasible will it be for CMS to prepare and build the systems, processes, and other infrastructure necessary to test the model within existing time and resource constraints? Will CMS be able to appropriately monitor the model and the activities of its participants to ensure program integrity?

16. Effects on coverage and benefits – Does the model raise concerns about limits on coverage or provision of benefits for beneficiaries?

17. Waiver authority–Could the model be implemented under existing law, and if not, is CMS authorized to waive any laws or regulations for purposes of testing the model?

18. Ability of other payers to test the model – Are there other government or private entities that could test the model as effectively as CMS?

19. Scalability – Will CMS have appropriate legal authority to scale the model if it proves successful? Are there concrete policies and/or processes that CMS could change or create to scale the model if successful?