# 2020 Report to Congress

## CENTER FOR MEDICARE AND MEDICAID INNOVATION


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

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# The Center for Medicare and Medicaid Innovation 2020 REPORT TO CONGRESS

## 1. Executive Summary

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (the CMS Innovation Center) was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) for the purpose of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" provided to individuals who receive benefits from Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). The CMS Innovation Center operates under this statutory mandate in support of CMS' goal of fostering an affordable, accessible health care system that puts patients first.

Section 1115A(g) of the Social Security Act requires the Secretary of Health and Human Services (HHS) to submit to Congress a report on the CMS Innovation Center's activities under section 1115A at least once every other year beginning in 2012. This is the fifth Report to Congress submitted by the CMS Innovation Center; it focuses on activities conducted between October 1, 2018 and September 30, 2020. It also highlights certain important activities announced between September 30, 2020 and December 31, 2020 that had not yet started during the period of report.

Between October 1, 2018 and September 30, 2020, the CMS Innovation Center tested, announced, or issued Notices of Proposed Rulemaking for a total of 38 payment and service delivery models and initiatives under section 1115A authority (see list in Appendix I[1]). In addition, it conducted six congressionally mandated or authorized demonstration projects. The CMS Innovation Center also played a central role in the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) during the period of this report.

CMS estimates that during the period of this report more than 27,850,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 528,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.[2] The CMS Innovation Center is integral to CMS' efforts to accelerate the move from a health care system that pays for volume

[1] As noted in Appendix I and in Section 3: Review of CMS Innovation Center Activities, the implementation of a number of model tests has been delayed by the Coronavirus Disease 2019 Public Health Emergency.

[2] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these "overlaps," see Section 2, Part A of this report, "Accounting for Model Test and Alternative Payment Model Overlaps."

to one that pays for value and encourages health care provider innovation. Paying for value is a central premise of the Alternative Payment Models (APMs) tested by the CMS Innovation Center. APMs tested by the CMS Innovation Center include Accountable Care Organization (ACO) models, episode payment models (also known as bundled payment models), population health-focused payment models, and models that test integrated care for Medicare and Medicaid beneficiaries.

Model tests are designed to assess the impact of the models on both expenditures and the quality of care over multi-year periods of performance. Independent evaluations based on quantitative and qualitative data are conducted both annually and cumulatively. Evaluation reports are posted online. These reports provide public information on the impact of each model test on health care expenditures and utilization, beneficiary and health care provider experiences with care, and where feasible, health outcomes.

Since the inception of the CMS Innovation Center, five model tests have delivered statistically significant savings, namely: the ACO Investment (AIM) Model; the Home Health Value-Based Purchasing (HHVBP) Model; the Maryland All-Payer (MDAPM) Model; the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT); and the Pioneer ACO Model. Other models, such as the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model and Comprehensive Care for Joint Replacement (CJR) Model, did not show savings but demonstrated significant improvements in quality.

Evaluation reports for the CEC, HHVBP, and CJR model tests showed significant improvements in quality. For example, the CEC Model showed a decrease in emergency dialysis sessions, overall hospitalizations, readmissions, and hospitalization for ESRD-related complications.[3] The HHVBP Model showed an average 4.6 percent improvement in home health agencies' quality score over the first three performance years. The CJR Model achieved significant reductions in the rates of unplanned readmissions and surgical complications.[4]

More specifically, over the past two years, CMS Innovation Center model tests have reported the following results in cost savings and quality improvement:

- The CMS Chief Actuary certified in 2018 that a nationwide expansion of the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)[5] would reduce net program spending. The Chief Actuary's certification was based on an analysis that confirmed continued significant reductions in total ambulance spending for beneficiaries with ESRD in the model states, with total program savings

[3] An evaluation report covering the first three years of the model was released after the period of report, in November 2020.

[4] These findings come from the third evaluation report from the Comprehensive Care for Joint Replacement Model, which was released after the period of report, in November 2020.

[5] Hereafter in the text of this Report to Congress (except in alphabetical lists of model tests), the RSNAT Model will be referred to as the Repetitive Scheduled Non-Emergent Ambulance Transport Medicare Prior Authorization Model or the RSNAT Medicare Prior Authorization Model (the RSNAT Model).

of $136 million in 2017. The Chief Actuary also estimated a range of annual gross savings for the RSNAT Medicare Prior Authorization Model expansion of $57 million to $253 million. The analysis found that even using the most conservative assumptions, the projected savings from expansion would significantly exceed the cost of program administration.

The RSNAT Medicare Prior Authorization Model achieved $1 billion in total Medicare savings among Medicare beneficiaries with ESRD and/or pressure ulcers over its first 2020 quarters (beginning December 2014) relative to the comparison group, an average of $381 per-beneficiary-per-quarter.[6] The Secretary of Health and Human Services (the Secretary) determined that the model meets the statutory requirements for expansion.

- The Maryland All-Payer Model evaluation showed $975 million in total cost of care Medicare savings over the first four and a half years of the model (January 2014–June 2018), a 2.8 percent decline in total Medicare expenditures relative to a comparison group of non-Maryland hospitals with similar characteristics. There was no decline in quality of care as measured by the Consumer Assessment of Healthcare Providers and Services® (CAHPS) Hospital Survey.[7]

- The ACO Investment Model (AIM) evaluation showed $526 million in gross Medicare spending reductions in the first three years of the model (2016–2018). After accounting for all up-front payments—both recouped and unrecouped from shared savings—as well as any additional shared savings payments to participating ACOs, the net savings to Medicare were $382 million.

- Evaluation data for the Home Health Value-Based Purchasing (HHVBP) Model showed cumulative gross savings of $423 million in the first three years of the model (2016–2018). The evaluation has shown that this value-based purchasing model has led to higher quality care in home health agencies within model states compared to home health agencies in non-model states, and to a reduction in unplanned hospitalizations and use of skilled nursing facilities in model states compared to non-model states.

- The Comprehensive Care for Joint Replacement (CJR) Model evaluation showed a reduction in gross Medicare spending of $146 million through the first two years of the model test (2016–2017).[8] After deducting shared savings payments, the net Medicare savings were $17 million, but were not statistically significant. The CJR Model achieved significant reductions in the rates of unplanned readmissions and surgical

[6] The final evaluation report from the RSNAT Model was released after the period of report, in May 2021.
[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[8] An evaluation report covering the first three years of the CJR Model was released after the period of report, in November 2020.

complications. There was no decline in quality of care as measured by the unplanned readmission rate, emergency department visits, and mortality rate.

Some CMS Innovation Center models have not generated net savings to Medicare, but have provided valuable insights to inform the design and development of subsequent models or other models with common approaches. These models include but are not limited to the following:

- The Bundled Payments for Care Improvement (BPCI) Model evaluation to date has found that Medicare payments declined by $824 million ($827 per episode) under Model 2, but after reconciliation payments, there were $197 million in net Medicare losses.[9] Model 3 showed $139 million ($1,138 per episode) in gross Medicare savings, but after reconciliation payments, there was an estimated Medicare loss of $100 million during the first four years of the model test (October 2013–September 2017). Technical implementation issues, including the specification of appropriate target prices, may have contributed to these net losses. When BPCI ended, CMS began a new episode-based Advanced APM—the BPCI Advanced Model—which addresses some of the challenges of the original BPCI Model.

- The Next Generation ACO (NGACO) Model evaluation showed $349 million in reduced Medicare Part A and B spending across the first three performance years (2016–2018).[10] However, after deducting shared savings and Coordinated Care Reward payments, there was a $118 million increase in net Medicare spending. The model test was associated with reduced post-acute care and professional services spending but saw no appreciable declines in hospital utilization and spending. The NGACO Model, along with Medicare Advantage and other private sector risk-sharing arrangements, informed the design of the Global and Professional Direct Contracting (GPDC) Model. The GPDC Model includes two participation options under which participants will enter into risk-sharing arrangements with CMS. CMS also announced a Geographic Direct Contracting Model for organizations seeking to target beneficiaries within a specific geographic region.[11,12] The Global and Professional Direct Contracting Model will allow organizations without significant experience in serving Medicare Fee-for-Service (FFS) beneficiaries to enter into value-based care arrangements that CMS expects will help reduce program expenditures and improve the quality of care for beneficiaries while reducing provider burden.

[9] An evaluation report covering the entire performance period of the model test (through September 2018) was released after the period of report, in April 2021.

[10] An evaluation report covering the first three years of the NGACO Model was released in September 2020.

[11] On December 3, 2020, the CMS Innovation Center requested Letters of Intent for the Geographic Direct Contracting Model. This announcement occurred after the period of report.

[12] Status update: as this Report to Congress was being prepared for release, the Geographic Direct Contracting Model was under review by CMS.

- The Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model evaluation showed a $68 million reduction in Medicare spending in the first two years of the model test (2016–2017).[13] After taking into account shared savings payments made to the ESRD Seamless Care Organizations, the net Medicare losses were $46 million, but were not statistically significant. Results from the first two performance years show specialty-oriented ACOs for beneficiaries with ESRD can reduce spending while improving key quality outcomes; these ACOs decreased both overall hospitalizations and hospitalizations for ESRD-related complications. The lessons learned from the CEC Model are being incorporated into subsequent kidney care models. This includes the Kidney Care Choices (KCC) Model, which features stronger incentives for health care providers to manage care for beneficiaries with chronic kidney disease (CKD) stages 4 and 5 and ESRD to delay the onset of dialysis and guide beneficiaries through the kidney transplant process.

- The Comprehensive Primary Care Plus (CPC+) Model evaluation did not show any savings to Medicare in the first two years of the model test (2017–2018).[14] After taking into account care management fees and performance-based incentive payments, CPC+ increased net expenditures by 2 to 3 percent ($17 and $30 per-beneficiary-per- month for Tracks 1 and 2, respectively). However, lessons learned from CPC+ have informed the design of the Primary Care First (PCF) Model, an important investment in primary care and a stepping stone towards managing downside risk. PCF includes higher population-based payments for the care management of high-need, seriously ill beneficiaries. In 2021, PCF launched in all 18 of the current CPC+ markets, as well as eight additional regions.

Some CMS Innovation Center models have only recently been implemented, and therefore have not yet generated any results. This includes model tests for which implementation has been delayed by CMS in response to the Coronavirus Disease 2019 Public Health Emergency (PHE), as noted in the model test entries in Section Three of this report, Review of CMS Innovation Center Activities, and in Appendix I: Models, Initiatives, and Demonstrations Active During Period of Report.

The Secretary has the authority under section 1115A(c) of the Social Security Act to expand through rulemaking the duration and scope of a model being tested, including implementation on a nationwide basis if the model meets certain statutory criteria. The criteria for expansion are as follows: in order for the Secretary to exercise this expansion authority, the Secretary must determine that an expansion would either reduce spending without reducing quality of care or improve quality of care without increasing spending. In addition, the CMS Chief Actuary must certify that expansion of the model would reduce or not increase net program spending; and the Secretary must determine that the expansion would not deny or limit the

[13] The third and fourth evaluation reports from the CEC Model were released after the period of report, in November 2020 and March 2021, respectively.
[14] The third evaluation report from CPC+ was released after the period of report, in January 2021.

coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary's expansion determinations are made taking into account evaluations performed by CMS under section 1115A(b)(4).

To date, three CMS Innovation Center model tests have met the criteria to be eligible for expansion in paragraphs (1) through (3) of section 1115A(c), namely: the Pioneer ACO Model (as tested in its first two years), the Health Care Innovation Award's Y-USA Diabetes Prevention Program (DPP) model test, and the RSNAT Medicare Prior Authorization Model.[15, 16]

Congress has acted in two instances to require CMS to include additional states in models. First, the Bipartisan Budget Act of 2018 required the Medicare Advantage Value-Based Insurance Design (VBID) Model to include all states beginning in 2020. In addition, section 515(a) of MACRA required implementing the RSNAT Model in additional states, and section 515(b) of MACRA required the expansion of the RSNAT Model to all states if the criteria for expansion as defined in paragraphs (1) through (3) of section 1115A(c) of the Social Security Act are met. The criteria include: a determination by the Secretary that the expansion is expected to either reduce spending without reducing quality of care or improve the quality of care without increasing spending, an actuarial certification by the CMS Chief Actuary that such expansion would reduce (or would not result in any increase in) net program spending, and a formal determination by the Secretary that such expansion would not deny or limit the coverage or provision of benefits. The Chief Actuary of CMS has since certified that a nationwide expansion of the RSNAT Model would meet the requirements of section 1115A(c)(2), and the Secretary has determined that the model meets the requirements for expansion described in section 1115A (c)(1) and (c)(3).

In some cases, the CMS Innovation Center has created new models that build on existing models to take advantage of evaluation findings and new ideas about care delivery and payment learned from physicians and other innovators in the health care community. Examples include the Primary Care First Model, which was developed based on insights from the previous CPC+ and CPC Models; the Maryland Total Cost of Care (TCOC) Model, which built upon the positive results from the previous Maryland All-Payer Model; and the BPCI Advanced Model, which was designed using lessons from the BPCI Model. Existing models are also continually being refined, as in the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents Phase Two, which incorporated evaluation findings from Phase One.

The CMS Innovation Center also has a statutory obligation to modify or terminate models after testing has begun unless the model is expected to improve quality without increasing spending, reduce spending without reducing quality, or improve quality and reduce spending. The

[15] The RSNAT Medicare Prior Authorization Model is being expanded in accordance with section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

[16] The certification of the HHVBP Model for nationwide expansion of the HHVBP Model through rulemaking was announced on January 8, 2021. This falls outside the period of report.

ongoing BPCI Advanced Model was recently modified to better achieve these objectives. Such continuous and iterative efforts are an integral part of CMS Innovation Center model testing.

# 2. Introduction

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by statute in 2010 for the purpose of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" provided to individuals who receive benefits from Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).[17] The results of this model testing help guide decisions about improvements in health care payment at CMS, supporting its goal of fostering an affordable, accessible health care system that puts patients first.

Section 1115A(g) of the Social Security Act requires the Secretary of Health and Human Services (HHS) to submit to Congress a report on the CMS Innovation Center's activities under section 1115A at least once every other year beginning in 2012. This is the fifth Report to Congress submitted by the CMS Innovation Center; it focuses on activities conducted between October 1, 2018 and September 30, 2020. It also highlights certain important activities announced between September 30, 2020 and December 31, 2020 that had not yet started during the period of report.

Between October 1, 2018 and September 30, 2020, the CMS Innovation Center tested, announced, or issued Notices of Proposed Rulemaking for 38 payment and service delivery models and initiatives under section 1115A authority (see Appendix I for a list[18]). These model tests and initiatives now serve more than 27,850,000 Americans and involve more than 528,000 health care providers.[19] The CMS Innovation Center also conducted six congressionally mandated or authorized demonstration projects. In addition, it shared with the CMS Center for Clinical Standards and Quality a leading role in the implementation and monitoring of the Quality Payment Program, as created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[20] And it continues to support and participate in the Health Care Payment Learning and Action Network (LAN), through which public and private health care leaders and

[17] Section 1115A appropriated $5 million for fiscal year 2010 and provided a total of $10 billion for fiscal years 2011–2019, in addition to $10 billion for each 10-year fiscal period thereafter.

[18] As noted in Appendix I and in Section 3: Review of CMS Innovation Center Activities, implementation of a number of model tests has been delayed by CMS in response to the Coronavirus Disease 2019 Public Health Emergency.

[19] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these "overlaps," see Section 2, Part A: Accounting for Model Test and Alternative Payment Model Overlaps of this report.

[20] Also playing key roles in the implementation and monitoring of the Quality Payment Program are the CMS Center for Program Integrity (CPI) and the CMS Federal Coordinated Health Care Office (FCHCO).

other participants seek to accelerate the health care system's adoption of alternative payment models (APMs).

Model testing at the CMS Innovation Center informs and supports CMS efforts to foster value-based care, improving the quality of care delivered to beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while maintaining or reducing costs.

## *CMS Review of Innovation Center Model Testing*

Over the last 10 years, CMS Innovation Center model tests and initiatives have generated increasing interest and participation in APMs, provided training and support for practice transformation, and improved readiness for value-based care, including newer models that give providers more opportunity to share risk with CMS. Early model testing at the CMS Innovation Center supported enhanced and integrated care with minimal risk. Some of the CMS Innovation Center's newer models include higher standards in quality reporting, greater opportunity to share in the model's financial performance, and integration of clinical treatment and social services.

Internal review of model test performance shows that only five model tests have demonstrated statistically significant savings to the Medicare Trust Funds.[21] Though model tests have maintained the quality of care (one of the requirements of statute), only a few of the early model tests showed statistically significant improvements on quality metrics. Three model tests have satisfied the statutory requirements for expansion under paragraphs (1) through (3) of section 1115A(c). Based on findings from the internal review, the CMS Innovation Center is adjusting current models in an attempt to improve the model tests' performance and rebalance the portfolio.

The internal review found four major issues contributed to lower-than-expected performance: 1) selection bias created by voluntary models; 2) benchmark inaccuracy; 3) quality measure misalignment; and 4) the need for greater data transparency.

First, CMS Innovation Center voluntary model tests that offer financial incentives for participation can generate losses because they create opportunities for selection bias. When model tests are voluntary and risk is one-sided, they may create an incentive for disproportionate participation by providers whose performance falls below the models' national or regional benchmarks. Though many of these participants actually succeed in controlling costs, as a consequence of selection bias the federal government nevertheless loses money on the overall model test.

With this in mind, model tests are now being developed and redesigned to incorporate greater risk for participants; eliminate options or features that promote selection bias; and create incentives to participate through performance-based payment and increased regulatory

[21] Brad Smith, "CMS Innovation Center at 10 Years – Progress and Lessons Learned," *New England Journal of Medicine*, January 13, 2021.

flexibility within the model tests being developed. Mandatory model tests are being considered when selection bias is a substantial risk.

Second, the internal review revealed problems with the methodology and financial benchmarks in model tests. Many CMS Innovation Center models allow participants that reduce spending relative to a target (or benchmark) to receive a share of the savings to Medicare from CMS. But this payment structure only works if the targets and benchmarks are accurate. Since that has not been the case in certain model tests, CMS has consequently in such cases paid out too much to participants in performance-based payments. While many CMS Innovation Center model evaluations have shown statistically significant decreases in gross Medicare payments, they have shown net losses after taking into account the enhanced payments to providers, including those payments due to imprecise benchmarks.

For example, evaluation of the Next Generation ACO (NGACO) model test showed $349 million of gross Medicare savings over the first three performance years (2016–2018). However, after deducting shared savings payments and Coordinated Care Reward payments, there were $118 million in net Medicare losses.[22] Anticipating this issue, the CMS Innovation Center made several changes to elements of the NGACO Model's methodology in its fourth performance year (2019) that were designed to shift the focus of the model test from an emphasis that rewards ACOs for improvement to one that rewards ACOs for attained efficiency in their expenditures, while still maintaining or improving the quality of care. This strategy is expected to create a sustainable long-term business case for both the participating ACOs and CMS, and better aligns the model test with the aims of the CMS Innovation Center under the statute.

Another example of the actions CMS has taken is the Comprehensive Care for Joint Replacement (CJR) model test. Because of benchmarking issues that failed to accurately project spending, the CJR model test is on pace to lose millions of dollars in its final performance years. CMS has proposed to rectify this by making adjustments to the CJR model test through rulemaking. These adjustments are reflected in the proposed rule, Three-Year Extension and Modification of the Comprehensive Care for Joint Replacement (CJR) Model, as described in the CJR model test entry in this Report to Congress.[23]

Third, while CMS has recorded quality improvements in a number of model tests, there is room for improvement, both in outcomes and measurement. One of the main challenges in measuring quality has come from the difficulty of comparing quality metrics between participant organizations and comparison groups. While the CMS Innovation Center can collect a variety of data from model participants, we must rely on only claims-based measures from non-participants. There is also poor alignment between quality measures being evaluated and

[22] An evaluation report covering the first three years of the NGACO model was released in September 2020.

[23] The proposed rule can be accessed at "Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Medicare and Medicaid Programs; Policies and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." *86 Federal Register* (May 2, 2021), p. 23496-23576.

measures that influence performance-based payments. As a result, the CMS Innovation Center is working to align quality measurement with the CMS Meaningful Measure initiative and trends in the industry. Harmonizing quality measures and developing a thoughtful and comprehensive quality strategy has the potential to make models more impactful and to allow the CMS Innovation Center to better detect quality improvements.

Fourth, model test participants would benefit from better access to data. In response to that need, CMS is working to increase its support for participants by providing improved access to meaningful data and analytics. This access will be provided in a manner consistent with the Health Insurance Portability and Accountability Act (HIPAA) and other data privacy laws, including 42 CFR Part 2. The availability of such data will increase operational transparency, improving feedback about performance and enabling participants to use data to make informed decisions and drive results. Sharing data with participants will not only improve performance, it will also provide opportunities for earlier, data-informed interventions. CMS has already tested this approach in its Data at the Point of Care pilot program, which supplied claims data directly to providers in their electronic health records (EHR).[24]

Other improvements in model testing and operations are being introduced to make CMS Innovation Center model testing more effective and efficient in order to better serve beneficiaries and taxpayers and to accelerate the adoption of value-based care.

One of these improvements is reflected in the Global and Professional Options Model, part of the CMS Primary Cares Initiative. Since Direct Contracting features a flexible model design that depends on accurate benchmarks, the CMS Innovation Center carefully data-tested benchmarks against historical spending to ensure that if participants perform well the model will save money and be successful.

More recently, CMS announced changes to the existing Bundled Payments for Care Improvement Advanced Model for Model Year 4, which began on January 1, 2021, after the internal review revealed that the model was on pace to lose close to $2 billion over the model's 10 performance periods. After soliciting comments from participants about how to adjust the model, the CMS Innovation Center made several revisions, most of which were recommended by at least one—and in some cases multiple—model participants.[25] These announced changes are designed to improve target price accuracy for both CMS and model participants. CMS is also considering implementation of mandatory bundled payment programs that build on the best components of the redesigned Bundled Payments for Care Improvement Advanced Model test and address selection effects and other factors that have kept the model from achieving meaningful savings.

[24] Information about the Data at the Point of Care pilot program can be accessed at: Data at the Point of Care pilot program and news release.

[25] For details, see the FAQ about the new pricing methodology for BPCI Advanced participants.

To improve efficiency, in 2020 the CMS Innovation Center launched a comprehensive review of all model test budgets and Center-wide operations. Through this initiative, the CMS Innovation Center found more than $350 million of potential cost savings that could be realized through streamlining contracts, centralizing common functions, and reducing duplication across core data systems. These new efficiencies should enable the CMS Innovation Center to invest more wisely in model testing, broaden its model testing capacity, and further advance value-based care transformation.

This Report to Congress describes all new and continuing model tests in detail, discusses their status, and indicates where improvements are being made. It also reviews model test expansion determinations; model test development and implementation processes; the number of beneficiaries and individuals served by specific model tests; payments made; model test evaluation; and the cost savings and quality impact of model tests. The two appendices list all active model tests and demonstrations and all ended model tests and demonstrations (dating back to 2010), respectively.

## A. CMS Innovation Center Methods and Practices

To support its mission to test payment and service delivery models that show promise of reducing expenditures while preserving or enhancing the quality of care, the CMS Innovation Center seeks and reviews ideas from physicians, researchers, beneficiaries, and other stakeholders in the health care community. Each potential opportunity for improvement is analyzed to assess whether the evidence justifies testing, whether testing would duplicate previous work, whether prior research has or has not disproven the concept, and whether a model test would likely meet the statutory requirements.

### *Developing and Testing New Payment and Service Delivery Models*

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A of the Social Security Act. During the development of models, the CMS Innovation Center builds on ideas received from stakeholders and consults with clinical and analytical experts with expertise in medicine and health care management, as well as with representatives of relevant Federal and state agencies. In addition, when appropriate or necessary, the CMS Innovation Center seeks input through Requests for Information (RFIs) or Notice and Comment Rulemaking.

During the period between October 1, 2018 and September 30, 2020, the CMS Innovation Center announced, tested, or issued Notices of Proposed Rulemaking for a total of 38 models and initiatives authorized under section 1115A authority. It also managed six demonstrations mandated by other statutes.

In previous CMS Innovation Center Reports to Congress, different options, tracks, or phases of some model tests were counted as separate model tests if they each had distinctly different

approaches to care delivery and payment. To improve consistency, the CMS Innovation Center now counts each new model test with multiple options as a single model test.

A number of models listed in this report have names similar to precursor models that are no longer active.[26] These models are counted separately from their predecessors, as they have refined designs and substantially different requirements. Examples include the State Innovation Models, Round Two; the Next Generation ACO Model; Bundled Payments for Care Improvement Advanced; and the Comprehensive Primary Care Plus Model.

Between October 1, 2018 and September 30, 2020, the CMS Innovation Center announced or implemented the following models and initiatives (described in detail in Section 3):

1. Accountable Health Communities Model (AHC)
2. ACO Investment Model (AIM)
3. Artificial Intelligence Health Outcomes Challenge (AI)
4. Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
5. Community Health Access and Rural Transformation Model (CHART)
6. Comprehensive Care for Joint Replacement Model (CJR)
7. Comprehensive End-Stage Renal Disease Care Model (CEC)
8. Comprehensive Primary Care Plus Model (CPC+)
9. Emergency Triage, Treat, and Transport Model (ET3)
10. End-Stage Renal Disease Treatment Choices Model (ETC)
11. Global and Professional Direct Contracting Model (GPDC)
12. Health Care Payment Learning and Action Network (LAN)
13. Home Health Value-Based Purchasing Model (HHVBP)
14. Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, Phase Two (NFI)
15. Integrated Care for Kids Model (InCK)

[26] Model Tests, Initiatives, and Demonstrations that have ended are listed in Appendix II at the end of this Report to Congress.

16. Kidney Care Choices Model (KCC), including the Kidney Care First (KCF) Option; the Comprehensive Kidney Care Contracting (CKCC) Graduated Option; the CKCC Professional Option; and the CKCC Global Options

17. Maryland All-Payer Model (MDAPM)

18. Maryland Total Cost of Care Model (Maryland TCOC)

19. Maternal Opioid Misuse Model (MOM)

20. Medicaid Innovation Accelerator Program (IAP)

21. Medicare ACO Track 1+ Model (Track 1+ Model)

22. Medicare Advantage Value-Based Insurance Design Model (VBID)

23. Medicare Care Choices Model (MCCM)

24. Medicare Diabetes Prevention Program Expanded Model (MDPP)

25. Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)

26. Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals (FAI)

27. Million Hearts®: Cardiovascular Disease Risk Reduction Model (MH Model)

28. Next Generation ACO Model (NGACO)

29. Oncology Care Model (OCM)

30. Part D Enhanced Medication Therapy Management Model (MTM)

31. Part D Payment Modernization Model (PDM)[27]

32. Part D Senior Savings Model (PDSS)

33. Pennsylvania Rural Health Model (PARHM)

34. Primary Care First Model Options (PCF), including the general Primary Care First Model Option and the pending Seriously Ill Population (SIP) Option, which is currently under review

[27] Status update: As this Report to Congress was being prepared for release, CMS announced that the Part D Payment Modernization Model will be discontinued.

35. Radiation Oncology Model (RO)

36. State Innovation Models Initiative, Round Two (SIM)

37. Transforming Clinical Practice Initiative (TCPI)

38. Vermont All-Payer ACO Model (VT APM)[28,29]

## *Selecting Innovative Payment and Service Delivery Models for Testing*

The CMS Innovation Center is charged by statute with testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" provided to individuals who receive benefits from Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). Some testing is congressionally mandated. Other model tests are based on ideas suggested by research, stakeholders, strategic priorities, and need. The number of worthy proposals considered by the CMS Innovation Center exceeds its model testing capacity. Innovative models are selected for testing based on relative performance in regard to the following criteria:

- Alignment with CMS objectives;
- Responsiveness to need;
- The potential for improving value in health care, as reflected in:
    - The prospect of significant improvement in the quality of health care and
    - The likelihood of substantial savings in total cost of care;
- The quality of existing evidence for the innovation;
- Whether the innovation overlaps with, duplicates, or has been disproven by prior model testing;
- The quality of the proposed theory of action as a research hypothesis;
- Whether a viable research methodology can be designed;
- Whether a valid comparison group can be constructed;

[28] After the period of report, the CMS Innovation Center announced the Most Favored Nation Model test. The Most Favored Nation Model has not been implemented. It is currently the subject of a nationwide preliminary injunction.

[29] After the period of report, the CMS Innovation Center announced the Geographic Direct Contracting Model test. Status update: as this Report to Congress was being prepared for release, the Geographic Direct Contracting Model was under review by CMS.

- The quality and availability of data;
- The likelihood of sufficient return on investment (for implementation costs); and
- Whether it seems likely that results from prior studies can be replicated at other sites and in other regions.

Model test proposals are also vetted on programmatic considerations, such as how well they fit the CMS Innovation Center's model test portfolio, possible implementation challenges, risk assessment, availability of staff, market readiness, and other related concerns.

All CMS Innovation Center models test hypotheses about potential improvements in care delivery and payment. All model testing is performance-based. The model tests set performance goals, but as long as participants meet requirements established in the model design, the CMS Innovation Center generally does not prescribe the process through which participants achieve these goals. The CMS Innovation Center does not develop models based on specific or proprietary technologies, infrastructure, software, or products. It does not support clinical trials.

## *Soliciting and Selecting Participants for Model Tests*

**Model Test Solicitations and Selection Processes:** The CMS Innovation Center seeks applicants for voluntary model tests through open, competitive or selective solicitations. These are either Notices of Funding Opportunities (NOFOs) for cooperative agreements or Requests for Applications (RFAs) for participation agreements. NOFOs are published online as part of the Assistance Listings (formerly *The Catalog of Federal Domestic Assistance*) at https://sam.gov, and are announced on the CMS Innovation Center website. RFAs appear on the CMS Innovation Center website and, in some cases, in *The Federal Register*. Both NOFOs and RFAs are also announced through the CMS Innovation Center's listserv in order to assure wide dissemination of the announcements.

Model test solicitations and governing documentation are constructed to:

1. Facilitate the model's research methodology, hypothesis, and theory of action;
2. Support implementation of the model; and
3. Be fair and transparent.

To facilitate successful implementation and testing, solicitations and governing documentation are constructed to:

- Set performance-based goals that will confirm or disconfirm the hypothesis;
- Provide sufficient but not excessive incentives for participation;

- Set reasonable benchmarks or other mechanisms for determining payment;
- Assess risks and provide appropriate risk adjustments;
- Attribute an adequate number of beneficiaries to model participants;
- Attract the array of providers, suppliers, and other participants called for in the research design;
- Target specific geographic areas, if relevant; and
- Provide a valid basis for evaluation, including, in appropriate cases, the solicitation of a comparison group.

To support implementation of the model test, solicitations and governing documentation incorporate processes for the monitoring of progress, quality metrics, patient satisfaction, and value; payment; data collection; and evaluation. Model tests often incorporate a learning system, as well, which captures and disseminates best practices among model test participants.

Solicitations are carefully constructed to be fair and transparent. They describe the criteria that will be used to assess and vet applicants, and—in order to increase the scope and validity of the research—are designed to be inclusive of and open to all providers, suppliers, and other individuals and entities who meet the established eligibility criteria. Solicitations avoid conferring an advantage on any specific product, proprietary process, precursor site, or innovator.

Once a model is announced, the CMS Innovation Center provides publicly available information about the nature of the model test, and how to apply. This information is conveyed through webinars, listening sessions, answers to Frequently Asked Questions (FAQs), and listserv messages, as well as through website postings and notices issued through the Medicare Learning Network and other media. To ensure that all applicants receive the same information, the CMS Innovation Center does not meet with individual organizations or providers who are prospective applicants during the period between application and award.

The selection of model participants follows established protocols. Applications are reviewed and scored by Technical Expert Panels. Applicants whose scores meet or exceed a defined threshold are further assessed by the CMS Innovation Center model team and leadership to consider more general questions about fit for model participation, geographic variation, appropriate variety in the types of individuals and entities selected for participation in the model, variety in the approaches to implementation being proposed, and potential redundancies among participants. Applicants are chosen in rank order for competitive solicitations. Any deviations in rank order—based on the model-specific questions noted above—are internally reviewed by CMS Innovation Center leadership and either approved or rejected. Prospective participants may be further vetted through the CMS Center for Program

Integrity and the CMS Office of Acquisition and Grants Management before selections are announced.

**Notices of Proposed Rulemaking and the Issuance of Final Rules**: Mandatory model tests—which oblige certain providers to participate—are developed through notice and comment rulemaking.[30] When proposing a mandatory model test, CMS first publishes a Notice of Proposed Rulemaking (NPRM) in *The Federal Register* to propose its design for the model and solicit public comments on its proposals. CMS reviews all comments received during the specified comment period and considers those comments when and if a Final Rule is issued. Like the initial NPRMs, Final Rules are published in *The Federal Register*. Once a Final Rule is released, the CMS Innovation Center can formally announce a model. These finalized model-specific regulations are effective only for the duration of the model test.

Expansions of model tests are required by statute to be established through rulemaking, and therefore follow this same rulemaking process—although participation is not necessarily required.

Model tests that require participation are advantageous when addressing questions of site neutrality and payment disparities. They ensure the type of care being studied will be uniformly delivered and paid for at different sites within the same geographic area. In turn, mandatory models may ensure more valid comparisons and limit risk-adjustment issues that occur when sites are either burdened with higher-risk care; serve only lower-risk beneficiaries; or, through the effects of pricing and location, avoid beneficiaries from under-served populations. In addition to ensuring data is gathered from a broad cross-section of providers and suppliers, requiring participation mitigates the risk of selection bias. When model tests are voluntary and risk is one-sided, they may create an incentive for disproportionate participation by providers whose performance falls below the models' national or regional benchmarks. If not averted, this bias skews results and has the potential to reduce the amount of savings a model can generate.

During the current period of report, the CMS Innovation Center finalized regulations to implement two new models, namely: the Radiation Oncology Model and the End-Stage Renal Disease Treatment Choices Model.[31]

[30] Though CMS typically issues rules after notice and an opportunity to comment, an agency may forgo advance notice and comment "when the agency for good cause finds. . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to public interest." 5 U.S.C. § 553(b)(B); 42 U.S.C. § 1395hh(b)(2)(C) (incorporating this exception into the Social Security Act's rulemaking requirement for the Medicare program).

[31] Final Rule: Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures. (September 29, 2020). This final rule implements two new mandatory Medicare payment models under section 1115A of the Social Security Act. Available at: https://www.federalregister.gov/documents/2020/09/29/2020-20907/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures.

## *Accounting for Model Test and Alternative Payment Model Overlaps*

As the number of Alternative Payment Models (APMs) has increased, so too has the likelihood that individual beneficiaries will be aligned to, and thus receive care through, more than one CMS or CMS Innovation Center APM during overlapping performance periods. This circumstance is commonly referred to as "overlap."

Such overlaps have the potential to affect beneficiary attribution, payment, and evaluation findings. They can result in double counting of beneficiaries (when beneficiaries are attributed to two APM participants) and in duplicative payment for value-based care. In terms of model evaluation, it can be difficult to disaggregate the impact and assign such impact to one model versus the other.

To avoid such issues, the CMS Innovation Center has, since its inception: incorporated overlap policies into model design, including certain prohibitions against overlaps; tracked allowed overlaps; and adjusted beneficiary attribution, payment, and evaluation methodologies, accordingly.

The CMS Innovation Center continues to consider methodological refinements to streamline adjustments for duplicative payments and to increase the transparency, predictability, and fairness of overlap decisions and payment adjustments.

## *Partnerships with Other CMS Components and Agencies*

To reduce costs, avoid duplicative effort, and leverage resources, the CMS Innovation Center works closely with other CMS components and other Federal agencies in developing and testing models of improved care delivery and payment, particularly when expertise required for such a model test is already available elsewhere within CMS or in another agency.

In some cases, while the CMS Innovation Center takes the lead, other CMS components are involved in implementing and monitoring certain model tests. Examples include:

- The Center for Clinical Standards and Quality, which managed aspects of the Transforming Clinical Practice Initiative;
- The Center for Medicaid and CHIP Services, which manages the Medicaid Innovation Accelerator Program;
- The Center for Medicare, which manages the Medicare Accountable Care Organization Track 1+ Model;
- The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office), which manages the Medicare-Medicaid Financial Alignment Initiative and the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents; and

- The Center for Program Integrity, which manages the Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Medicare Prior Authorization Model.

In addition, the CMS Innovation Center has partnered with other Federal agencies to develop and improve its models and initiatives. Examples of these Federal agency partners include:

- The Administration for Children & Families;
- The Administration for Community Living;
- The Agency for Healthcare Research and Quality;
- The Centers for Disease Control and Prevention;
- The Department of Housing and Urban Development;
- The Health Resources & Services Administration;
- The Office of the Assistant Secretary for Planning and Evaluation;
- The Office of the National Coordinator of Health Information Technology; and
- The Substance Abuse and Mental Health Services Administration.

For the Medicare Diabetes Prevention Program (MDPP) expanded model, in particular, CMS has relied on a close partnership with the Centers for Disease Control and Prevention (CDC). Rather than develop separate metrics and certification processes for MDPP suppliers, the CMS Innovation Center requires prospective suppliers to achieve certification through the *Centers for Disease Control and Prevention Diabetes Prevention Recognition Program*.[32]

## *Advancing Best Practices: Efficiencies from Learning and Diffusion*

Every CMS Innovation Center model includes a plan of action to ensure that lessons learned and best practices identified during the test are broadly and effectively utilized to improve model tests and, where possible, public programs and the health care system at-large.

These learning systems can involve, among other things, technical support, site visits, virtual meetings with participant presenters, affinity group calls moderated by project officers, national summits, the development and circulation of case studies, informational blogs on model-specific topics, inter-model communications, and model-wide analyses of performance metrics.

[32] For details, see Centers for Disease Control and Prevention Diabetes Prevention Recognition Program.

In effect, the CMS Innovation Center creates model-specific learning collaboratives that promote broad and rapid dissemination among participants of evidence-based best practices that have the potential to deliver higher quality care for Medicare, Medicaid, and CHIP beneficiaries at a lower cost to the Medicare, Medicaid, and CHIP programs.

In addition, the CMS Innovation Center leverages claims data, patient surveys, and other data to deliver actionable feedback to health care providers, suppliers, and other model participants about their performance in model tests, while encouraging participants to use their own performance data to drive continuous improvement in outcomes.

## B. Conducting Congressionally Mandated or Authorized Demonstrations

The CMS Innovation Center is responsible for implementing a number of specific demonstration projects authorized by statute. For example, in accordance with section 1866E of the Social Security Act, the CMS Innovation Center is testing the Independence at Home Demonstration—a home-based primary care model that provides incentive payments to health care providers that meet designated quality measures and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. The findings from these demonstrations may inform changes in CMS policies, as well as the development and testing of new models, if appropriate. Note that these demonstrations are not conducted under section 1115A authority and therefore are not the focus of this report. However, a list of demonstrations implemented or evaluated by the CMS Innovation Center during the current period of this report is included in Appendix I.

## C. Evaluating Results and Advancing Best Practices

Section 1115A(b)(4) requires the CMS Innovation Center to conduct an evaluation of CMS Innovation Center models. It specifies that evaluations must include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria, as well as changes in spending. As noted earlier, the Secretary of Health and Human Services is required to take the evaluation into account in deciding whether to expand the duration and scope of a model.

The CMS Innovation Center routinely and rigorously assesses the impact of each model on quality and expenditures, generally using independent evaluators. The evaluations include advanced statistical methods and carefully defined and selected comparison groups, as appropriate, to ensure that models deemed to be successful represent true opportunities for high-value investments of taxpayer dollars.

Central to this evaluation approach is the recognition that evaluators must not only assess results, but also understand the context that generates those results. For each model, the CMS Innovation Center tailors the collection of qualitative information to the needs of the model with the goal of integrating the qualitative information with quantitative findings in order to accurately identify and understand the model's impact.

During model implementation, data on performance and outcomes measures is collected and reviewed at prescribed intervals. CMS conducts independent evaluations of CMS Innovation Center models based on quantitative and qualitative data and releases these findings publicly. Reports posted online include cumulative-to-date information and in-depth analyses on the model. In addition to the highly detailed evaluation reports, the CMS Innovation Center also releases a two-page findings-at-a-glance summary for many of the model evaluations. These present the key findings and takeaways in a more accessible, less-technical form.

Together, these reports and findings-at-a-glance summaries provide stakeholders with information on the impact of the model on health care expenditures and utilization, health outcomes, and, where feasible, beneficiary and health care provider experiences with care, and site-specific results. Results from the most recently published report from each model evaluation have been summarized with their respective model descriptions in Section Three of this Report to Congress, and links to all evaluation reports issued to date are included in Section Six.

## D. Model Tests Eligible for Expansion

The statute provides the Secretary of Health and Human Services (the Secretary) the authority under Section 1115A(c) of the Social Security Act to expand through rulemaking the duration and scope of a model tested under section 1115A(b) or a demonstration project tested under section 1866C, including implementation on a nationwide basis.

For the Secretary to exercise this authority, the Secretary must determine that an expansion would either reduce spending without reducing quality of care or improve quality of care without increasing spending. In addition, the CMS Chief Actuary must certify that expansion of the model would reduce or not increase net program spending; and the Secretary must determine that the expansion would not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary's expansion determinations are made taking into account evaluations performed by CMS under section 1115A(b)(4).

Three CMS Innovation Center models have met the statutory criteria to be eligible for expansion, namely: (1) the Pioneer Accountable Care Organization (ACO) Model (as tested in its first two years), (2) the Health Care Innovation Award's Y-USA Diabetes Prevention Program model test (DPP), and (3) the Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Medicare Prior Authorization Model.[33,34]

[33] The RSNAT Medicare Prior Authorization Model is being expanded in accordance with section 515(b) of MACRA.

[34] The certification of the HHVBP Model for nationwide expansion of the HHVBP Model through rulemaking was announced on January 8, 2021. This falls outside the period of report.

- The Pioneer ACO Model generated more than $384 million in savings to Medicare over its first two years—an average of approximately $300 per-participating-beneficiary-per-year with no adverse effects on quality of care or patient experience.[35]

- The DPP model test saved Medicare an estimated $278 per-beneficiary-per-quarter, which covered program costs and helped participants lose an average of five percent of their body weight to significantly reduce their risk of developing diabetes.

- The RSNAT Medicare Prior Authorization Model saved an estimated $136 million for End-Stage Renal Disease (ESRD) beneficiaries in 2017. The Chief Actuary estimated a range of annual gross savings of between $57 million and $253 million for a RSNAT Medicare Prior Authorization Model expansion. The CMS Chief Actuary certified the model for expansion, finding that even using the most conservative assumptions, the projected savings from expansion would significantly outweigh the cost of program administration.

  On September 22, 2020, CMS announced a nationwide expansion of the RSNAT Medicare Prior Authorization Model after the Secretary determined it met the statutory criteria for nationwide expansion under section 515(b) of MACRA, which references the expansion criteria under section 1115A(c)(1) through (3) of the Social Security Act.

Congress has also acted in two instances to require CMS to include additional states in models. The Bipartisan Budget Act of 2018 required the Medicare Advantage Value-Based Insurance Design Model (VBID) to include all states beginning in 2020, and MACRA required additional states to be included in the RSNAT Medicare Prior Authorization Model.

Section 515(b) of MACRA requires the Secretary to expand the RSNAT Medicare Prior Authorization Model to all states if the requirements in paragraphs (1) through (3) of section 1115A(c) of the Social Security Act are met. As noted above, on September 22, 2020, CMS announced a nationwide expansion of the RSNAT Medicare Prior Authorization Model after the Secretary had determined it meets the statutory criteria for nationwide expansion under section 515(b) of MACRA, which references the expansion criteria under paragraphs (1) (3) of section 1115A(c) of the Social Security Act.

[35] The Pioneer ACO Model was certified for expansion based on the findings from its first two years of model testing, though the model was tested over a total of five performance years. Through improvements in provider and patient engagement, data-driven care management, and population health, Pioneer ACO Model participants continued to show high patient satisfaction as well as sustained clinical quality in later years of the model. At the conclusion of the fifth performance year of the model, almost 80 percent of Pioneer ACO Model participants were still operating as ACOs in either the Pioneer ACO Model, the Next Generation ACO Model, or in Track 3 of the Medicare Shared Savings Program, which was created using lessons learned from the Pioneer ACO Model.

## *Pioneer Accountable Care Organization Model*

The CMS Innovation Center launched the Pioneer Accountable Care Organization (ACO) Model in 2012 with 32 ACOs. The model was designed for health care organizations and health care providers that were already experienced in coordinating care for patients across care settings. In the model, organizations agreed to an initial three-year period of performance with the option to extend for two additional years. The model came to an end in December 2016.

The Pioneer ACO Model evaluation reported favorable results on both cost and quality measures for the first two performance years of the model test. In May 2015, the CMS Chief Actuary certified[36] that the Pioneer ACO Model, as tested in the first two performance years of the model, was eligible for expansion and that expansion would reduce net program spending. At that time the Secretary of Health and Human Services determined that expansion would maintain or improve the quality of patient care without limiting coverage or benefits. The model was the first CMS Innovation Center model to meet the statutory requirements for expansion by the Secretary of HHS.

After the Pioneer ACO Model met the statutory requirements for expansion, CMS incorporated several successful elements of the Pioneer ACO Model into Track 3 of the Medicare Shared Savings Program through notice and comment rulemaking (42 CFR Part 425). These elements include prospective alignment of beneficiaries, higher levels of shared savings and losses, and waiver of the Skilled Nursing Facility (SNF) Three-Day Rule to allow coverage of SNF services without a prior three-day inpatient hospital stay. Pioneer ACO participants continued to show high patient satisfaction as well as clinical quality in later years of the model, as they refined their strategies for engaging providers and beneficiaries and analyzing data to improve care management and population health. By the final year of the Pioneer ACO Model, about 80 percent of ACOs were continuing to participate in the Pioneer ACO Model, the Medicare Shared Savings Program, or the first year of the Next Generation ACO Model, reflecting the growth in opportunities for ACOs to take on higher degrees of financial risk.

## *Y-USA Diabetes Prevention Program Model*

In 2012, the CMS Innovation Center awarded a Health Care Innovation Award (in Round One) to The Young Men's Christian Association (YMCA) of the USA (Y-USA) to test whether the Diabetes Prevention Program (DPP) could be successfully provided by non-physician and community-based organizations to Medicare beneficiaries with pre-diabetes to reduce expenditures or enhance quality.

The Y-USA DPP model test was derived from the DPP administered by the CDC. The DPP is a structured health behavior change program delivered in community or health care settings by trained community health workers or health professionals. Awardees participating in the

[36] For information about this certification, see Certification of Pioneer ACO Model Savings.

Health Care Innovation Awards Round One had a three-year period of performance, from June 2012 to June 2015. The Y-USA DPP received a one-year no-cost extension to June 2016.

At the conclusion of the model, a total of 6,947 participants enrolled in the model (counting only those who completed at least four sessions), which was 88.7 percent of those recruited (those who attended at least one session). In addition, Y-USA kept participants engaged with the model. For example, 6,199 participants completed at least nine sessions. The average was 17.3 sessions completed. Each additional session that participants attended was associated with a 0.42 percent loss in weight. Those who attended at least nine sessions achieved significantly more weight loss (6.23 percent) than those who attended fewer than nine sessions.

The Y-USA DPP Model was associated with significant reductions in Medicare spending—$278 per-participating-beneficiary-per-quarter across three years—relative to the comparison group. The average probability of savings over three years is 77.4 percent. Savings were greater among program completers than among non-completers.

Model participants were also significantly less likely to be hospitalized or have an emergency department visit during the period of performance. The model did not affect readmissions.

In March 2016, the CMS Chief Actuary certified that expansion of the DPP Model would not result in an increase in net program spending, and the Secretary determined that expansion would maintain or improve patient care without limiting coverage or benefits. As a result, the DPP Model became the second CMS Innovation Center model to meet the statutory requirements for expansion.

On July 15, 2016, CMS issued the Calendar Year (CY) 2017 Physician Fee Schedule proposed rule, which included a proposal to expand the DPP Model to the Medicare program through a broadened model test called the Medicare Diabetes Prevention Program (MDPP) Expanded Model. The Final Rule[37] was published in the Federal Register November 16, 2016.

The CY 2017 and 2018 Medicare Physician Fee Schedule Final Rules finalized aspects of the expansion that enable organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers. Policies in the CY 2018 Physician Fee Schedule Final Rule included the MDPP payment structure, additional supplier enrollment requirements, and supplier compliance standards aimed to enhance program integrity.

The MDPP expanded model is described in more detail in Section 3.

[37] To view the Medicare Program Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017 Final Rule (CMS-1654-CN2) in the Federal Register, visit https://www.federalregister.gov/documents/2016/11/18/2016-27733/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions/.

### *Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport*

The Chief Actuary of CMS certified in March 2018 that a nationwide expansion of the Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Medicare Prior Authorization Model would reduce net program spending.[38] On September 22, 2020, CMS announced a nationwide expansion of the RSNAT Prior Authorization Model after the Secretary determined it met the statutory criteria for nationwide expansion under section 515(b) of MACRA, which references the expansion criteria under section 1115A(c)(1) through (3) of the Social Security Act.

The Chief Actuary's analysis confirmed that significant reductions in total ambulance spending persisted through 2017 for the population with ESRD in the model states. The Chief Actuary estimated a reduction in RSNAT expenditures of approximately $136 million for ESRD beneficiaries in 2017. The Chief Actuary also estimated a range of $57 million to $253 million annual gross savings for the RSNAT Medicare Prior Authorization Model expansion. The analysis found that even using the most conservative assumptions, the projected savings from expansion would significantly outweigh the cost of program administration.

## E. CMS Innovation Center Priorities

During this reporting period, the CMS Innovation Center has, where pertinent to its mission, focused on model testing and operational improvements that increase the transparency, responsiveness, and effectiveness of its model tests. It has developed cost-saving efficiencies in technology to both support and manage model tests and to facilitate communications and reporting for the Quality Payment Program. It has enhanced its outreach to stakeholders through Requests for Information, meetings with health care providers and innovators, listening sessions, webinars, and Notices of Proposed Rulemaking, as well as through improvements to the CMS Innovation Center website. To improve its operations and model testing, the CMS Innovation Center has conducted a comprehensive review of its administrative processes and current model tests, as described in the Introduction to this Report to Congress in the section titled "CMS Review of CMS Innovation Center Model Testing."

### *The CMS Innovation Center's Model Testing Priorities*

The CMS Innovation Center has been protecting taxpayer dollars and innovating in payment models by designing and redesigning model tests and initiatives in ways that (1) increase the proportion of health care paid for through value-based arrangements and (2) meet the following specific goals:

[38] For information about this certification, see RSNAT Medicare Prior Authorization expansion certification.

- Empowering and incentivizing primary care providers to improve efficiency and quality of care;
- Increasing participation in Advanced Alternative Payment Models (APMs);
- Using competition to reduce prices and improve outcomes in Medicare fee-for-service;
- Empowering patient and provider choice;
- Creating physician specialty models, including but not limited to:
    - Developing innovative payment options for radiation oncology services;
    - Improving management of chronic kidney disease and end-stage renal disease;
    - Better managing the care of patients with serious illness, who account for a disproportionate share of Medicare expenditures;
- Testing cutting-edge private payer utilization management techniques, including prior authorization, in CMS programs;
- Developing new and innovative value-based insurance designs within Medicare Parts C and D;
- Appropriately aligning incentives for emergency medical transport suppliers;
- Developing prescription drug models;
- Refining Medicare Advantage models;
- Encouraging state-based and local innovation, including Medicaid-focused models;
- Improving and supporting health care in rural and under-served areas;
- Facilitating telehealth and improving the interoperability of electronic health records; and
- Integrating fragmented care at the state and regional level to improve beneficiary experience.

These priorities contribute to the wider goal of providing beneficiaries with high-quality health care that is affordable, accessible, and sustainable.

## *The CMS Innovation Center's Technology and Data Priorities*

The CMS Innovation Center has leveraged technology and data to reduce unnecessary burden, increase efficiencies, reduce administrative costs, and improve the beneficiary experience. Effective use of technology and data has facilitated model test solicitations, the monitoring and evaluation of model tests, requests for information, communication with model participants and stakeholders, and the submission and analysis of data for the Quality Payment Program, among other things.

The result for participants, providers, and suppliers has been reduced paperwork and more time with patients, helping model participants focus more directly on improving performance and contributing to better health outcomes. The result for the CMS Innovation Center has been quicker response times, lower costs, improved record keeping, and increased precision.

Taking advantage of technology has enabled CMS and health care providers to collect and share data on quality, outcomes and other metrics—giving health care providers actionable feedback on how they are performing and improving CMS' ability to track monitoring, continuous quality improvement, and evaluation. CMS also uses technology to drive learning system support for model tests—as a vehicle for increasing collaboration and communication among participants, sharing best practices, and providing technical assistance. During the period of report, for example, CMS has launched 32 collaboration sites/portals for model participants, which facilitate participant-to-participant collaboration and sharing of best practices to support model learning systems.

The CMS Innovation Center has fostered and enabled the use of health information technology (HIT) through model tests and other initiatives. Many model tests include requirements for participants to use HIT certified under the Office of the National Coordinator for Health Information Technology's Health IT Certification Program, thereby ensuring that participants have technology tools that meet core capabilities, such as enabling the exchange of patient data with other providers.

Recent HIT initiatives include the Artificial Intelligence Health Outcomes Challenge (AI-HOC)—a competition open to all industry sectors to develop artificial intelligence solutions to aid in predicting unplanned admissions and adverse events, for potential use by the CMS Innovation Center in testing innovative payment and service delivery models and in ongoing efforts to promote use of interoperable data exchanges by model participants, in accord with the Interoperability and Patient Access Final Rule.[39] In addition, many model tests create flexibilities and incentives for providers and suppliers to engage with new or emerging technologies.

[39] To view the CMS Interoperability and Patient Access Final Rule (CMS-9115-F) in the Federal Register, visit: https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

In addition, the CMS Innovation Center is using data collection and data analytics tools to validate and ensure quality in Alternative Payment Model (APM) data provided by the APM Program Analysis Contractor. At the same time, these tools consolidate and centrally store various types of APM data, such as data regarding Eligible Clinicians and Qualifying APM Participant Status in the Quality Payment Program (QPP). This technology also provides automated data transmission to the Quality Payment Program via an Application Programming Interface.

Model testing in a performance-based payment environment depends on technology and data not only to reduce burden, improve outcomes, and assist beneficiaries; but also to better gauge performance, adjust practices accordingly, achieve milestones, and improve on benchmarks. For instance, in the Comprehensive Primary Care Plus Model, CMS created Data Feedback Reports for the more than 3,000 practices participating in the model. The reports supply CMS-collected data to primary care practices to help them succeed in value-based care arrangements.

CMS has also distributed 275,000 individual claims files to 790 Accountable Care Organizations (ACOs) from January 2018–April 2020, on a monthly or as-requested basis. These totals are for the CMS Innovation Center's Next Generation ACO, Comprehensive ESRD Care, and Vermont All-Payer models, and for the Center for Medicare's Medicare Shared Savings Program. The Medicare Shared Savings Program claims feeds shared are consistent with regulation. The counts for the CMS Innovation Center only for the same period are 31,427 individual claims files for 99 unique ACOs. ACOs rely on this data to manage their health care operations and make clinical improvements.[40]

## F. Increasing the Market Profile of Value-Based Care

### *Rewarding Value through the Quality Payment Program*

The CMS Innovation Center continues to play a critical role in developing policy and processes for the Quality Payment Program, which rewards clinicians with financial incentives for providing high-quality care to Medicare patients and reduces payments to clinicians who are not meeting program requirements. The Quality Payment Program began in January 2017; it implements provisions of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which made changes to the way that Medicare pays physicians and other clinicians for Covered Professional Services under Medicare Part B.

The Quality Payment Program pays for value in health care through the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The CMS Innovation Center develops and operates most Advanced APMs; CMS has determined that ten CMS Innovation Center APMs meet the criteria for Advanced APMs for the 2020 Qualifying APM Participant (QP) Performance Period. Currently, by participating in an Advanced APM and meeting certain thresholds of patient counts or payments, eligible clinicians can attain QP

[40] The given numbers reflect cumulative data from the entire performance period to date of the cited model tests.

status and earn a five percent APM Incentive Payment. QPs are also excluded from reporting to the MIPS track of the program—reducing administrative burden—and from the MIPS payment adjustment.

In Performance Year 2018, 183,306 eligible clinicians achieved QP status. These QPs received an APM Incentive Payment in 2020. The five percent APM Incentive Payments are scheduled to sunset after Performance Year 2022 (Payment Year 2024). Beginning in 2026, QPs will receive payment based on an annual update to the conversion factor of 0.75 percent, and clinicians who are not QPs will receive payment based on an annual update to the conversion factor of 0.25 percent.

Starting in Performance Year 2019, eligible clinicians are able to become QPs through the All-Payer Option. To qualify for this option, eligible clinicians must participate in a combination of Advanced APMs with Medicare and Other Payer Advanced APMs. Other Payer Advanced APMs are non-Medicare payment arrangements that meet Other Payer Advanced APM criteria, which are similar to the Advanced APM criteria for Medicare.

The CMS Innovation Center has reduced burden on eligible clinicians participating in the Quality Payment Program, and is continuing to help broaden participation in Advanced APMs. The CMS Innovation Center is working in consultation with clinicians to increase the number and variety of models available so that a wide range of eligible clinicians, including those in small practices and rural areas, have the option to participate.

The Transforming Clinical Practice Initiative (TCPI), which ran from 2015 to 2019, provided technical assistance to more than 140,000 clinicians to help them to achieve health care transformation, improve the quality of care they deliver, and prepare for successful participation in APMs. The CMS Innovation Center continues to provide access to tools and resources developed through the TCPI.

For more information on the Quality Payment Program, including a comprehensive list of Advanced APMs, see the Quality Payment Program Webpage and the Quality Payment Program Resource Library.

## *Accelerating the Adoption of Alternative Payment Models*

The Health Care Payment Learning and Action Network (LAN) was launched in March 2015 to accelerate the adoption of APMs across the public and private sectors. The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

The LAN published an APM Framework in 2016, establishing a common nomenclature for defining and tracking U.S. health care payments. In a refreshed version published in 2017, the Framework classifies APMs into four categories and eight subcategories, specifying decision

rules to standardize classification efforts. It lays out core principles for designing APMs and forms the basis of the LAN's annual APM Measurement Effort.

The annual LAN APM Measurement Effort captures actual health care spending data from the following four sources: a LAN-administered survey (a number of health plans choose to report APM data directly to the LAN); a survey conducted by America's Health Insurance Plans (AHIP); a survey conducted by the Blue Cross Blue Shield Association (BCBSA); and internal data already collected by the Centers for Medicare & Medicaid Services (CMS) for the external reporting of Traditional Medicare APM data.

Aggregate data from each of these sources, historically representative of more than 75 percent of the covered lives in the U.S., are combined to produce a national number. Traditional Medicare has tracked and reported APM adoption publicly since 2015, and the other market segments (Medicare Advantage [MA], Medicaid, and Commercial) started reporting by line of business for CY 2017, and will continue to do so. See below for the LAN APM Measurement Effort's results by CY and line of business, and for the data sources and metrics.

The following table shows the percentage of U.S. health care payments tied to Category 3 APMs (built on fee-for-service architecture) and Category 4 APMs (built on population-based payment,) by calendar year:

| **PERCENT OF U.S. HEALTH CARE PAYMENTS IN CATEGORY 3 & 4 APMs** | | | | |
|---|---|---|---|---|
| **Insurance Type** | **CY 2015** | **CY 2016** | **CY 2017** | **CY 2018** |
| National APM | 23% | 29% | 34% | 36% |
| Traditional Medicare | 26% | 31% | 38% | 41% |
| Medicare Advantage | N/A | N/A | 50% | 54% |
| Medicaid | N/A | N/A | 25% | 23% |
| Commercial | N/A | N/A | 28% | 30% |

The data shows gradual but consistent increases in the percent of health care payments made through Category 3 and 4 APMs in all four reporting years, with the exception of Medicaid payments through such APMs from CY 2017 to CY 2018, which declined from 25 percent to 23 percent.

## *The Physician-Focused Payment Model Technical Advisory Committee*

Section 101(e)(1) of MACRA (42 USC § 1395ee(c)) created the Physician-Focused Payment Model Technical Advisory Committee (PTAC). A Federal Advisory Committee Act (FACA) committee, PTAC reviews proposals for Physician-Focused Payment Models (PFPMs) submitted by individuals and stakeholder entities to assess the extent to which proposed models meet ten criteria for PFPMs set forth in the Quality Payment Program Final Rule (42 CFR § 414.1465). PTAC typically holds quarterly public meetings to deliberate and vote on proposed models. PTAC subsequently submits its comments and recommendations to the Secretary on each proposal. The Secretary, in turn, must review PTAC's comments and recommendations and post a detailed response on the CMS website.

The Secretary has responded to all of the comments and recommendations submitted by PTAC through September 30, 2019. As of May 2020, the Secretary had responded to PTAC's comments and recommendations on the following submissions: two PFPM proposals voted on in March 2019; one PFPM proposal voted on in June 2019; and one PFPM proposal voted on in September 2019. The Secretary's responses are posted on the CMS website.[41] As of September 30, 2019, PTAC had received a total of 36 PFPM proposal submissions.[42]

The PTAC provides an independent, expert-reviewed avenue for health care providers, associations, coalitions and individuals to share their ideas for PFPMs with HHS and the public. The PTAC's thoughtful discussions, comments, and recommendations have been a highly valued contribution to HHS' thinking about how to achieve health care priorities and goals.

HHS is currently exploring how ideas from the proposed models recommended by PTAC may be used in making refinements to existing payment and service delivery models and/or to those models in development at the CMS Innovation Center. The proposed models submitted to PTAC, PTAC's thoughtful comments, and discussions with submitters have directly and indirectly contributed to the progress of value-based transformation in health care.

The Secretary's responses to comments, recommendations from PTAC, and additional information about PTAC are posted on the CMS Innovation Center's Physician-Focused Payment Models Webpage.

[41] Secretary responses to Physicial-Focused Payment Model (PFPM) proposals.
[42] List of submissions for Physician-Focused Payment Models.

## G. Engaging Stakeholders

Section 1115A(a)(3) requires the CMS Innovation Center—in carrying out its duties under Section 1115A—to "consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management." Accordingly, the CMS Innovation Center has since its inception consulted and worked with stakeholders across the country, other Federal agencies, and other components within the Department of Health and Human Services (HHS) to help design CMS Innovation Center models.

### *Stakeholder Engagement Activities in the Past Two Years*

During the reporting period, the CMS Innovation Center has actively sought input from a broad array of stakeholders to: (1) identify promising new payment and service delivery models; (2) inform the design of model tests it is developing; (3) implement new model tests; and (4) improve existing model tests.

CMS Innovation Center staff routinely meet with health care innovators, clinicians, professional associations, beneficiary groups, subject matter experts, sister agencies, states, other payers, and other stakeholders to listen to suggestions for future model tests and to receive feedback on current model tests. Guidance from researchers is gathered through interviews and consultation with experts. Hundreds of ideas for improving health care have been shared with us through the Idea Portal on the CMS Innovation Center website. And the CMS Innovation Center has held dozens of model-related listening sessions, webinars, and information-sharing sessions, engaging thousands of innovators from around the country.

In addition, the CMS Innovation Center interacts with people interested in service delivery and payment innovation through its website, social media outreach, and an email listserv. Since 2012, the listserv audience has grown from 30,000 to more than 126,000. During the same period, followers of the CMS Innovation Center Twitter account have increased from 5,000 to more than 56,000. The CMS Innovation Center website averaged nearly 200,000 page views per month during the period of this report, reflecting sustained stakeholder engagement. Each of these communication channels continually updates innovators in the field on new funding and learning opportunities.

The CMS Innovation Center invites and seeks specific input on the design of potential models through vehicles that are open to all stakeholders. These include Requests for Information (RFIs), notice and comment rulemaking, press conferences, and "open door" phone conferences.

Examples of the role of stakeholder engagement at the CMS Innovation Center include outreach for the Value-Based Insurance Design (VBID) Model; the Emergency Triage, Treat, and Transport (ET3) Model; the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model; the Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC)

options of the Kidney Care Choices (KCC) Model; and the Coronavirus Disease 2019 Public Health Emergency (PHE) response.

- *Stakeholder Outreach for the Value-Based Insurance Design (VBID) Model:* In January 2019, the CMS Innovation Center announced that beginning in calendar year 2021, Medicare Advantage Organizations participating in the VBID Model could include the Medicare hospice benefit in their Part A benefits package. Since this announcement, the CMS Innovation Center has met with 140 stakeholders. These stakeholders have included 35 health care plans, 25 trade associations, and 80 hospices. In 2019, the CMS Innovation Center held more than 250 meetings with stakeholders concerning the VBID hospice benefit announcement.

- *Stakeholder Outreach for the Emergency Triage, Treat, and Transport (ET3) Model:* On February 14, 2019, the CMS Innovation Center announced the ET3 Model, a new payment model for unscheduled ambulance services which will enable Medicare Fee-For-Service (FFS) beneficiaries to receive the most appropriate level of care at the right time and place, with the potential for lower out-of-pocket costs. The model design was informed by six prior and more focused Emergency Medical Service (EMS)-related model tests that the CMS Innovation Center had supported and evaluated through the Health Care Innovation Awards, Rounds One and Two, as well as multiple stakeholder meetings with EMS providers. During the reporting period, the CMS Innovation Center held an in-house summit with key EMS stakeholders, and arranged beneficiary focus group discussions of Emergency Medical Services through the CMS Office of Communications.

  The announcement of the ET3 Model was made at a special event in Washington D.C., with a number of ambulance, EMS, and Emergency Medical Technician (EMT) associations in attendance. Since the announcement, the CMS Innovation Center has met with 67 stakeholders concerning the ET3 Model.

- *Stakeholder Outreach for the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, the Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) options of the Kidney Care Choices (KCC) Model:* On July 10, 2019, HHS and CMS announced the proposed End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, in which participation would be required, and the optional Kidney Care Choices Model, which includes the Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) options.

  The announcement was made at a special event in Washington D.C. as part of the Advancing American Kidney Health Executive Order. After the announcement, the CMS Innovation Center hosted a listening session on the models with feedback from a number of kidney care providers, associations, and kidney-health experts. A Notice of Proposed Rulemaking (NPRM) for the mandatory ETC Model and Radiation Oncology Model was issued on July 10, 2019, with the comment period closing on September 16,

2019. The CMS Innovation Center received a total of 329 comments from stakeholders on the NPRM. CMS issued the Final Rule on September 29, 2020.[43]

- *Stakeholder Outreach in Response to the Coronavirus Disease 2019 PHE:* In response to the Coronavirus Disease 2019 PHE, the CMS Innovation Center joined other CMS components in a concerted effort to communicate with and support health care providers and other model participants who were struggling to respond to the PHE. The CMS Innovation Center and other components jointly developed flexibilities in health care payment and reporting to help these providers and model participants. In consultation with participants in and applicants to model tests, the CMS Innovation Center developed further flexibilities—on a model-by-model basis—including delayed model start dates and temporary suspension of some reporting requirements to support continued participation in model tests and to maintain the integrity of the model and evaluation design. The overall PHE response for model tests is described in Section 3 of this report. Model-specific flexibilities are listed in the relevant New and Continuing Models entries.

As a means of contributing to a national discussion of Alternative Payment Models, the CMS Innovation Center continues to support and participate in the Health Care Payment Learning & Action Network (LAN),[44] as previously discussed in this report. The LAN is a network of more than 7,000 payers, providers, purchasers, patients, product manufacturers, policymakers, and others mobilized around the shared mission of promoting APMs and reducing barriers to APM participation as a means of reducing the cost of care and improving patient experiences and outcomes. The LAN provides thought leadership, strategic direction, and ongoing technical support for efforts to accelerate our health care system's adoption of APMs.

## *Requests for Information and Rulemaking Activity*

During the period of this report, the CMS Innovation Center issued two formal Requests for Information (RFIs) and six Notices of Proposed Rulemaking (NPRMs) to seek input from stakeholders on ongoing and potential models and a demonstration. It also announced one Final Rule. These are described below.

[43] "Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures; Rule," *85 Federal Register* 189 (September 29, 2020), pp. 61114-61381. Available at: https://www.federalregister.gov/documents/2020/09/29/2020-20907/medicare-program-specialty-care-models-to-improve-quality-of-care-and-reduce-expenditures.

[44] The LAN is convened and independently managed by the CMS Alliance to Modernize Healthcare (CAMH), a contractor-operated Federally Funded Research and Development Center (FFRDC).

*Requests for Information (RFIs) Issued During the Period of Report*[45]*:*

- Center for Medicare & Medicaid Innovation. *Request for Information on Direct Contracting—Geographic Population-Based Payment Model Option.*[46] Available at: https://innovation.cms.gov/files/x/dc-geographicpbp-rfi.pdf.

- Centers for Medicare & Medicaid Services. *Request for Information for the Development of a CMS Action Plan to Prevent Opioid Addiction and Enhance Access to Medication-Assisted Treatment Value in Opioid Use Disorder Treatment*. [47] Available at: https://www.cms.gov/About-CMS/Story-Page/Opioid-SUPPORT-Act-RFI.pdf.

*Rulemaking Activity during the Period of Report:*

- "Medicare Program; International Pricing Index Model for Part B Drugs; Advance Notice of Proposed Rulemaking with Comment," *83 Federal Register* 210 (October 30, 2018), pp. 54546-54561.

- "Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures; Proposed Rule," *84 Federal Register* 138 (July 18, 2019), pp. 34478-34595.

- "Medicare Program; Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Proposed Rule," *85 Federal Register* 36 (February 24, 2020), pp.10516-10550.

- "II. Q. 2. Changes to the Comprehensive Care for Joint Replacement (CJR) Model To Extend the Length of Performance Year 5 by Three Additional Months and To Change the Extreme and Uncontrollable Circumstances Policy To Account for the COVID-19 Pandemic" of the regulation, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Interim Final Rule with Comment Period," *85 Federal Register* 66 (April 6, 2020), p. 19263

- "II. Q. Innovation Center Models" of the regulation, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Interim Final Rule with Comment Period," *85 Federal Register* 66 (April 6, 2020), pp. 19262-19264.

[45] In November 2019, the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) held a Public Listening Session and released an informal Request for Information (RFI) to gather feedback on a potential Oncology Care First (OCF) Model. Comments received at that time are still being reviewed and considered.

[46] Posted to CMS.gov on April 22, 2019.

[47] Posted to CMS.gov on September 20, 2019.

- Multiple sections, including "II. L. Medicare Shared Savings Program," of the regulation, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program; Interim Final Rule with Comment Period," *85 Federal Register* 90 (May 8, 2020), pp. 27573-27587.

- "Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures Rule," *85 Federal Register* 189 (September 29, 2020), pp. 61114-61381.

# 3. Review of CMS Innovation Center Activities

## *Overview of CMS Innovation Center Model Testing*

Between October 1, 2018 and September 30, 2020, the CMS Innovation Center has announced or tested 38 payment and service delivery models and initiatives aimed at reducing expenditures under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care that beneficiaries receive. Collectively, the health care providers participating in CMS Innovation Center models are furnishing services to Medicare, Medicaid, and/or CHIP beneficiaries in all 50 states, the District of Columbia, the Northern Mariana Islands, and Puerto Rico. The CMS Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders.

This section of the report is divided into two subsections. S*ubsection A* includes models and initiatives authorized and funded by section 1115A of the Social Security Act that were announced during the period of this report. *Subsection B* includes models and initiatives authorized and funded by section 1115A of the Social Security that were announced prior to October 1, 2018, and either continued through or ended during the period of this report.

In all cases, the periods of performance listed at the beginning of each of the ensuing model entries reflect the current model test timelines, including changes made in response to the Coronavirus Disease 2019 Public Health Emergency (PHE). As a result, the timelines reported here may vary from previously announced periods of performance.

## *Coronavirus Disease 2019 PHE Model Test Flexibilities*

The CMS Innovation Center delayed the implementation of a number of new model tests or changed their periods of performance due to the Coronavirus Disease 2019 Public Health Emergency (PHE). The changes were made through Interim Final Rules (these IFCs are noted in Section 2 Part H, under the heading "Requests for Information and Rulemaking Activity") and revised participation agreements. Timelines may be subject to further change as the PHE evolves.

The CMS Innovation Center also made changes through the same means in the period of performance for many continuing model tests due to the Coronavirus Disease 2019 PHE. Other adjustments were made for both new and continuing model tests—in payment design, reporting requirements, and quality measures—to enable participants to remain in the model tests without harm during the PHE and to maintain the integrity of the model design.[48] All such changes were also created through IFCs and modified participation agreements. These flexibilities, noted in the model test descriptions, may be subject to further change as the PHE evolves.

The CMS Innovation Center developed these temporary flexibilities in consultation with other CMS components and in the context of requests from model test participants. They are designed to offer viable pathways for participants to remain in the model tests despite the impact of the Coronavirus Disease 2019 PHE; to enable systematic monitoring of model test performance while temporarily reducing related reporting requirements on model participants; and to facilitate a transition back to the original model test design. The CMS Innovation Center also consulted extensively with other CMS components to ensure that these adjustments and the related flexibilities were feasible and aligned with parallel adjustments and flexibilities created for the Medicare and Medicaid programs, including permanent value-based payment programs.

As the CMS Innovation Center developed appropriate Coronavirus Disease 2019 PHE-related adjustments for model test terms of participation it focused on:

- Utilizing flexibilities that already exist in current model design;
- Continuing sufficient incentives to participate in value-based arrangements;
- Ensuring equity and consistency across models;
- Minimizing risk to both model participants and the Medicare Trust Funds;
- Minimizing delays in new model implementation while providing additional opportunities for participation in new models;
- Minimizing reporting burden; and
- Simultaneously addressing potential overlaps between the COVID-related adjustments and flexibilities for model tests and parallel adjustments and flexibilities for other CMS programs and payments.

[48] For details, see CMS Innovation Center Models COVID-19 Related Adjustments.

Additional information regarding the implementation of these changes was provided to model participants by CMS. In some cases, the changes involved amendments to participation agreements and other model test documents.

These Coronavirus Disease 2019 PHE model test adjustments and flexibilities supplemented emergency rules and waivers granted under section 1135 of the Act specifically to address the PHE.

## A. New Models and Initiatives Announced Since the 2018 Report to Congress

The ten new model tests and initiatives described below were announced after October 1, 2018. Several of them include multiple options or tracks, but these have not been counted as separate model tests. Examples include the Global and Professional Direct Contracting (GPDC) Model and the Kidney Care Choices (KCC) Model.

In accord with CMS Priorities, model tests and, as applicable, their component options and tracks are designed to empower patient and health care provider choice, as well as to broaden the scope of payment and delivery innovations being tested and to improve model testing efficiencies.

As noted earlier, CMS has made changes through Interim Final Rules (these are noted in Section 2 Part H, under the heading "Requests for Information and Rulemaking Activity"), and revised participation agreements in the period of performance for a number of these model tests in response to the Coronavirus Disease 2019 PHE.

The periods of performance listed at the beginning of the ensuing model entries are those under which model tests are currently operating, rather than the periods of performance announced prior to the Coronavirus Disease 2019 PHE.

Other flexibilities—in payment design, reporting, and quality measures—have been created to enable participants to remain in the model tests without harm during the public health emergency and to maintain the integrity of the model design. All such changes are noted in Coronavirus Disease 2019 PHE Flexibilities subsections. These flexibilities might be subject to further change as the Coronavirus Disease 2019 PHE evolves.

### *Artificial Intelligence Health Outcomes Challenge*

**Announcement Date:** March 27, 2019

**Anticipated Performance Period:** N/A

**Participants:** Open to any non-Federal entities

**Number of Participants:** Over 300 Launch Stage Applicants; 25 Stage 1 Participants; up to 7 Stage 2 Participants

**Geographic Scope:** Open globally, although private entities must be incorporated in and maintain a primary place of business in the United States, and individuals—whether participating singly or in a group—must be citizens or permanent residents of the United States to receive prize money

***Coronavirus Disease 2019 PHE Flexibilities:*** The Center for Medicare and Medicaid Services (CMS) is seeking to support the community of organizations that are responding to the public health emergency stemming from the Coronavirus Disease 2019 PHE. In turn, CMS delayed some of the relevant timelines and ultimately announced the Stage 2 participants on October 29, 2020, and the winners of the Challenge on April 30, 2021.[49]

**Description:** The CMS Artificial Intelligence Health Outcomes Challenge (AI-HOC) is an opportunity for innovators to demonstrate how AI tools—such as deep learning and neural networks—can be used to predict unplanned hospital and Skilled Nursing Facility (SNF) admissions and adverse events. Partnering with the American Academy of Family Physicians and Arnold Ventures, the CMS AI-HOC engages with innovators from all sectors—not just from health care—to harness AI solutions to predict health outcomes for potential use in CMS Innovation Center payment and service delivery models. CMS is carrying out this challenge under the authority of Section 24 of the Stevenson-Wydler Technology Innovation Act of 1980 (15 U.S.C. 3719), as amended, and section 1115A of the Social Security Act to stimulate innovation that has the potential to advance the missions of CMS and the CMS Innovation Center.

AI tools have the potential to transform large volumes of structured and unstructured data into actionable insights that can reduce inefficiencies and enable transformations in health care practice and delivery. Recent advances in deep learning and neural networks have shown some success in predictions for health outcomes, but barriers remain to implement these tools at scale. Quality and availability of data limit the range of questions that AI Models can effectively answer, and the current health care payment system that often pays for volume instead of value does not provide incentives to utilize advanced data science in improving beneficiary health outcomes. The CMS Innovation Center is interested in better leveraging technology in testing its models, improving the utility of the data feedback to model participants in order to improve the quality of care and reduce costs. This Challenge is focusing solely on Medicare beneficiaries and data due to the quality, validity, and availability of Medicare data.

[49] A list of participants advancing to Stage 2.

Competition Objectives:

1. For Stage 1, use AI, including but not limited to deep learning methodologies,[50] to predict unplanned hospital and SNF admissions, and adverse events within 30 days[51] for Medicare beneficiaries, based on a data set of Medicare administrative claims data, including Medicare Part A (hospital) and Medicare Part B (professional services).

2. For Stage 2, use AI, including but not limited to deep learning methodologies, to predict unplanned hospital and SNF admissions, as well as adverse events, within 30 days for Medicare beneficiaries, as well as a standard target, based on a Part A and Part B data set.

3. For both Stage 1 and Stage 2, develop innovative strategies and methodologies to: explain the AI-derived predictions to front-line clinicians and patients to aid in providing appropriate clinical resources to model participants, and increase use of AI-enhanced data feedback for quality improvement activities among model participants.

On April 7, 2020, CMS informed AI-HOC Stage 1 participants of a temporary pause in the Challenge due to the Coronavirus Disease 2019 PHE, with a resume date of Monday, June 29, 2020. The following revised timeline for the AI Challenge was established:

- Launch Stage
    - Participants submitted applications from March 27–June 18, 2019, 5 p.m. ET
    - CMS announced participants that advanced to Stage 1 on October 30, 2019 (previously projected date in the initial publication of this Announcement was August 2, 2019)

[50] Deep learning is part of a broader family of machine learning methods based on learning data representations, as opposed to task-specific algorithms.

[51] Participants should be aware of the lag inherent in claims submission and processing, which would implicitly limit the inputs of a real-time AI model to claims that actually were processed and visible to the Medicare claims system. In practice this means that claims would not be visible to the AI engine until the claim effective date (and most likely not until the 'IDR load date' several days after the claim effective date). Many claims would therefore not be available to an AI engine until weeks or months after the 30-day window has passed. Participants should be aware of this limitation so that models take into account when claims would actually become visible to the claims system.

- Stage 1
    - Stage 1 participants submitted the CMS Data Use Agreement (DUA) requests for Limited Data Set (LDS) files by December 2, 2019
    - CMS provided LDS files to Stage 1 participants qualified to receive the data on December 5, 2019
    - Participant Stage 1 project packages due July 2020
    - CMS announces participants that will move on to Stage Two ("finalists") October 2020
- Stage 2
    - Stage 2 finalists submit requests for LDS files with additional data by the end of November 2020
    - CMS provides LDS files with additional data to Stage 2 finalists qualified to receive the data in November 2020
    - Finalist Stage 2 project packages due by the end of January 2021

CMS announced winners in April 2021.

All Launch Stage submissions were reviewed to ensure that they met eligibility and other requirements. A multi-disciplinary evaluation panel of experts reviewed and scored qualified entries for all stages of the AI Health Outcomes Challenge based on defined evaluation criteria stated in the announcement and on the AI Health Outcomes Challenge webpage.

**Evaluation Status/Results:** N/A

**Webpage:** Additional information is available at the AI Health Outcomes Challenge webpage and at the CMS website.

## *Community Health Access and Rural Transformation Model*

**Model Announcement Date:** August 11, 2020

**Anticipated Model Performance Period:**

- Community Transformation Track: January 1, 2023–December 31, 2028
- Accountable Care Organization (ACO) Transformation Track: Spring, 2022–December 31, 2026

**Model Participants:**

- Community Transformation Track: Lead Organizations (entities which include, but are not limited to, State Medicaid Agencies, State Offices of Rural Health, local public health departments, Independent Practice Associations), and Academic Medical Centers, Hospitals, and state Medicaid Agencies

- ACO Transformation Track: Rural ACOs

**Number of Participants:**

- Community Transformation Track: Up to 15 Lead Organizations

- ACO Transformation Track: Up to 20 ACOs

**Geographic Scope:** Rural communities across the U.S.

**Model Description:** The Community Health Access and Rural Transformation (CHART) Model will provide rural communities with investment funding to improve their health care delivery systems, creating value-based payment models that give rural providers the financial stability to move from volume to value. CHART will give rural communities the flexibility necessary to design custom, innovative approaches to delivering high-quality care that best suit individual community needs. Specifically, the model will test whether upfront funding coupled with aligned financial incentives increases operational flexibility, and whether robust technical support enables rural health care providers to transform care on a broad scale and increase uptake of Alternative Payment Models (APMs) in ways that improve access to high-quality care for rural beneficiaries while reducing Medicare and Medicaid expenditures.

The CHART Model will offer two tracks for rural communities to implement APMs: (1) the Community Transformation Track and (2) the ACO Transformation Track. Under the Community Transformation Track, participating rural hospitals will receive financial flexibilities through a predictable capitated payment, operational flexibilities, and benefit enhancements. The capitated payment is a prospectively set total amount of revenue which provides rural hospitals with a stable revenue stream that creates incentives to reduce both fixed costs and avoidable utilization. Under the ACO Transformation Track, rural entities will receive upfront payments to establish rural ACOs that participate in two-sided risk arrangements through the Medicare Shared Savings Program, Building on the success of the ACO Investment Model (AIM), these upfront payments will help rural entities engage in value-based payment efforts and transition to Advanced Alternative Payment Model (Advanced APM) status.

**Evaluation Status/Results:** The evaluation of CHART will assess whether providing rural entities with alternative payment options with upfront funding leads to an impact on Medicare and Medicaid beneficiaries' access to care, total cost of care, and the quality of

care received. The evaluation will use a claims-level analysis of Medicare and Medicaid data as well as site visits and annual surveys to examine whether CHART is able to lead to savings to Medicare and Medicaid as well as maintain or improve the quality of care provided to beneficiaries receiving care from participating entities.

**Webpage:** Additional information is available at the CHART Model webpage.

## *Emergency Triage, Treat, and Transport Model*

**Model Announcement Date:** February 14, 2019

**Anticipated Model Performance Period:** Delayed start as a result of the Coronvirus Disease 2019 PHE. Anticipated performance period: January 1, 2021–December 31, 2025.

**Model Participants:** Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers will participate in the payment model. In addition, a future Notice of Funding Opportunity (NOFO) will invite eligible state and local governments, their designees or other entities that operate or have authority over a Public Service Answering Point to apply to receive cooperative agreement funding to establish or expand medical triage lines.

**Number of Participants:** A total of 205 applicants have been invited to participate in the Emergency Triage, Treat and Transport (ET3) Model. A final list of ET3 Model participants will be made available after selected applicants have signed a participation agreement with CMS. CMS also anticipates funding up to 40 cooperative agreement recipients to establish or expand medical triage lines.

**Geographic Scope:** The ET3 Model is nationwide. Applicants selected to participate in the ET3 Model are Medicare-enrolled ambulance service suppliers or ambulance providers in 36 states and the District of Columbia. Future cooperative agreement recipients will be from the same geographic areas as the participating ambulance services suppliers and providers.

***Coronavirus Disease 2019 PHE Flexibilities:***

Since applicants selected for participation in the ET3 Model are currently involved in responding to the Coronavirus Disease 2019 PHE, CMS decided to delay the start of the ET3 Model from May 1, 2020 until January 2021.

**Model Description:** The ET3 Model is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. CMS will continue to pay to transport a Medicare FFS beneficiary to a hospital emergency department or other Medicare-covered destination. In addition, under the model CMS will

pay participants to: (1) transport to an alternative destination, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), and (2) furnish or arrange for a qualified health care partner to provide treatment in place, either at the scene of the 911 emergency response or via telehealth. The model will allow beneficiaries to access the most appropriate emergency services at the right time and place. The model will also encourage state and local governments, their designees, or other entities that operate or have authority over one or more public safety answering points to promote successful model implementation by establishing a medical triage line for low-acuity 911 calls. As a result, the ET3 Model aims to improve quality and lower costs by reducing avoidable transports to emergency departments (ED) and unnecessary hospitalizations following those transports.

**Evaluation Status/Results:** For low-acuity patients, the evaluation will assess savings to Medicare and possibly Medicaid that result from substituting transports to alternative destinations and treatment in place for ED visits and transports to other Medicare-covered destinations. Potential savings may result from care provided at lower cost facilities (such as urgent care centers, CMHCs, physician offices) and modalities (such as telehealth in treatment in place). The evaluation will test an important savings assumption that the model will reduce related inpatient admissions, post-acute care, and readmissions for low-acuity patients. To measure whether the model achieved savings, the evaluation design will use two methods of claims data analyses: (1) a pre/post analysis of the transport services furnished in the participants' model geographic area, and (2) comparing the costs associated with emergency ambulance transport episodes (including one, three, and ten days following an emergency response) to similar episodes in geographic areas not serviced by ET3 model participants. The statistical analyses will be supplemented by interviews and site visits with ambulance providers, EDs, alternative destinations, and treatment-in-place practitioners. The evaluation will assess quality using the quality/performance metric being developed for use in the model for purposes of a future performance-based payment, as well as other claims-based metrics.

**Webpage:** Additional information is available at the ET3 Model webpage.

## *End-Stage Renal Disease Treatment Choices Model*

**Model Announcement Date:** Model announced and Notice of Proposed Rulemaking issued July 10, 2019. Publication date of Final Rule in *Federal Register*: September 29, 2020.

**Anticipated Model Performance Period:** Delayed start (relative to the start date proposed in the Notice of Proposed Rulemaking) as a result of the Coronavirus Disease 2019 PHE. Start date: January 1, 2021.

**Model Participants:** Managing Clinicians (MCs) and End-Stage Renal Disease (ESRD) facilities. A Managing Clinician is a Medicare-enrolled physician or non-physician

practitioner who furnishes treatment and bills the Monthly Capitation Payment (MCP) for managing one or more adult ESRD beneficiaries.

**Number of Participants:** CMS selected ESRD facilities and MCs to participate in the model according to their location in randomly selected geographic areas and in a manner that will account for approximately 30 percent of ESRD facilities and MCs in the 50 States and District of Columbia.

**Geographic Scope:** CMS selected 30 percent of hospital referral regions across the country. ESRD facilities and MCs in hospital referral regions for which at least 20 percent of the component ZIP Codes are located in Maryland will be included in the model's interventions, unless otherwise excluded, in a manner consistent with the ongoing Maryland Total Cost of Care Model.

**Model Description:** One of the goals of the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model is to give ESRD beneficiaries the freedom and choice of treatment that works best with their lifestyle. For example, if a beneficiary chooses home dialysis, they would have greater flexibility to adjust the hours and frequency of their treatment. Under the ETC Model, CMS will make certain payment adjustments to encourage participating ESRD facilities and MCs to ensure that ESRD beneficiaries have access to different treatment options and receive education about these options, in order to preserve or enhance the quality of care furnished to Medicare beneficiaries while reducing Medicare expenditures.

As finalized, the ETC model will make Medicare payment adjustments for the ESRD facilities and MCs selected to participate in the model. Payment to ESRD facilities and MCs not selected to participate in the model will not be affected.

To implement a model test that would require participation on the part of certain health care providers, CMS issued a Notice of Proposed Rulemaking (NPRM). Specifically, CMS' proposals for the ETC Model were included in the proposed rule entitled, "Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures." This NPRM was issued on July 10, 2019, and the comment period closed on September 16, 2019. CMS reviewed all public comments received during the comment period before establishing final policies. CMS announced the final rule on September 18, 2020.

To minimize the potential for selection effects, CMS is requiring participation in the ETC Model. Selection effects occur when only the potential participants who would benefit financially from a model choose to participate. The consequent selection bias can reduce the amount of savings that a model can generate. Requiring participation for certain models also helps CMS understand the impact of a model test on a variety of provider types so that the resulting data is more broadly representative.

CMS selected ESRD facilities and MCs to participate in the ETC Model according to their location in randomly selected geographic areas and in a manner that will account for approximately 30 percent of ESRD facilities and MCs in the 50 states and District of Columbia. ESRD facilities and MCs in hospital referral regions for which at least 20 percent of the component ZIP Codes are located in Maryland will be included in the ETC Model's interventions, unless otherwise excluded, in a manner consistent with the ongoing Maryland Total Cost of Care Model.

Across the U.S., certain ESRD facilities and MCs selected for participation will nonetheless be excluded from certain portions of the model's interventions because they serve low volumes of adult ESRD beneficiaries.

Two types of payment adjustments will apply under the ETC Model. The first is a uniformly positive adjustment on Medicare claims for home dialysis and home dialysis-related services during the initial three years of the model, providing an additional payment to selected ESRD facilities and MCs for supporting beneficiaries dialyzing at home. The second adjustment will apply to both home and in-center dialysis and related claims, and could be either positive or negative, depending on the participant's rates of home dialysis and kidney transplants among attributed beneficiaries. ESRD beneficiaries will be attributed on a month-by-month basis. An ESRD beneficiary will be attributed to the ESRD facility accounting for the most of his or her dialysis claims during the month, and to the MC billing his or her MCP for the month. CMS will also attribute pre-emptive transplant beneficiaries to participating MCs based on the methodology outlined in the final rule.

These adjustments, either upward or downward, will be made to the Adjusted ESRD Prospective Payment System per Treatment Base Rate for participating ESRD facilities and to the amount otherwise paid under Medicare Part B with respect to MCP claims. Greater positive and negative adjustments for model participants will be phased in over the five-year performance period of the model.

**Evaluation Status/Results:** The ETC Model evaluation will measure the model's impact on the rates at which beneficiaries with ESRD benefits receive home dialysis or transplants. The impact analysis also will examine the effect of the ETC Model on key outcomes, including improved quality of care and quality of life, and decreased Medicare expenditures and utilization. The implementation component will describe and assess how ETC participants implement the model, including how they deal with barriers to change and serve as facilitators of change. In addition, this part of the evaluation will examine if there are differences between efforts to increase home dialysis and increase transplants. Findings from both analyses will be synthesized to provide comprehensive evaluation results.

**Webpage:** Additional information is available at the ETC Model webpage.

## *Global and Professional Direct Contracting Model*

**Model Announcement Date:** April 22, 2019

**Anticipated Model Performance Period:** Six-year performance period that began on April 1, 2021, with an implementation period that began on October 1, 2020.

**Model Participants:** A Direct Contracting Entity (DCE) is an organization participating in the Global and Professional Direct Contracting Model, pursuant to a Participation Agreement with CMS. A variety of entities are eligible to participate as part of a Direct Contracting Entity (DCE), including health systems, physician practices, provider groups, payers, community-based organizations, and Programs of All-Inclusive Care for the Elderly organizations. Direct Contracting Participant Providers and Preferred Providers must be Medicare-enrolled providers or suppliers.

**Number of Participants:** To be determined

**Geographic Scope:** Nationwide

***Coronavirus Disease 2019 PHE Flexibilities:***

In response to concerns expressed by applicants and to better preserve the research design of the Global and Professional Direct Contracting (GPDC) Model, the CMS Innovation Center:

- Delayed start of the first performance year of the model to April 1, 2021;
- Planned for a 2021 performance year of fewer than 12 months (April 1, 2021–December 31, 2021);
- Adjusted the financial methodology for the model to reflect the altered duration of the 2021 performance year;
- Will adjust quality benchmarks to reflect the altered duration of the 2021 performance year; and
- Created an application cycle during 2021 for a second cohort to launch January 1, 2022.[52]

**Model Description:** The Global and Professional Direct Contracting (GPDC) Model tests private sector approaches to risk-sharing arrangements and payment. The goal is to reduce expenditures and preserve or enhance quality of care for beneficiaries in Medicare fee-

[52] As this Report to Congress was being prepared for release, CMS decided not to issue this Request for Applicants.

for-service (FFS). The GPDC Model builds on lessons learned from initiatives involving Medicare Accountable Care Organizations (ACOs), such as the Medicare Shared Savings Program and the Next Generation ACO (NGACO) model test. The GPDC Model leverages innovative approaches from Medicare Advantage (MA) and, as noted earlier, from private sector risk-sharing arrangements.

The Global and Professional Direct Contracting Model test provides new opportunities for a variety of organizations to participate in value-based care arrangements. In addition to organizations that have traditionally provided services to a Medicare FFS population, Direct Contracting will provide new opportunities for organizations without significant experience in FFS to enter into value-based care arrangements.

The Global and Professional Direct Contracting (GPDC) Model test takes significant steps toward providing a prospectively determined revenue stream for model participants. The GPDC Model test also includes a reduced set of quality measures (in comparison to existing initiatives and prior model tests) that focus more on outcomes and beneficiary experience than on process.

There are three types of DCEs, with different characteristics and operational parameters: (1) Standard DCEs are comprised of organizations that generally have experience serving Medicare FFS beneficiaries; (2) New Entrant DCEs comprised of organizations that have not traditionally provided services to a Medicare FFS population; and (3) High-Needs Population DCEs that serve Medicare FFS beneficiaries with complex needs as defined by CMS.

There are two voluntary risk-sharing options available for 2021: Professional and Global. A separate but related model test—the Geographic Direct Contracting Model—was announced after the end of the current period of report, on December 3, 2020.[53,54]

1. **The Professional Option** offers a lower risk-sharing arrangement—50 percent of savings and losses—and provides Primary Care Capitation (PCC), a capitated, risk-adjusted monthly payment for enhanced primary care services provided by DC Participant Providers and those Preferred Providers participating in PCC.

2. **The Global Option** offers a higher risk-sharing arrangement—100 percent of savings and losses—and provides two payment alternatives: either PCC or Total Care Capitation (TCC), a capitated, risk-adjusted monthly payment for all services provided by DC Participant Providers and those Preferred Providers participating in TCC.

[53] Information about this model is available at Geographic Direct Contracting Model.
[54] As this Report to Congress was being prepared for release, the Geographic Direct Contracting Model was under review.

The risk-sharing options available in the Global and Professional Direct Contracting (GPDC) Model test seek to reduce program expenditures and improve quality of care and health outcomes for Medicare beneficiaries through alignment of financial incentives and an emphasis on beneficiary choice and care delivery. Concurrently, these options seek to maintain or increase access to care for beneficiaries, including patients with complex, chronic conditions and seriously ill populations. Specifically, to help ensure that care quality is improved and beneficiary choice and access are protected, CMS will withhold a meaningful percentage of the benchmark subject to performance on quality of care, while also monitoring model participants to ensure that beneficiaries' access to care is not adversely affected as a result of the model.

The risk-sharing options under the Global and Professional Direct Contracting (GPDC) Model also present an opportunity to test novel methods for organizations to manage Medicare FFS expenditures. Further, through refinements in CMS benchmarking methodology and risk adjustment, CMS is aligning financial incentives to attract organizations that manage the complex, chronic, and seriously ill beneficiary populations.

**Evaluation Status/Results:** The evaluation of the Global and Professional Direct Contracting Model will assess whether prospective, capitated payments increase beneficiaries' access to quality care while lowering ineffective and wasteful health care utilization. The mixed methods study design will seek to understand the experience and impact of this model for participating organizations, health care providers, and aligned beneficiaries. Where possible, subgroup analyses will be used to examine whether specific capitation payment levels and risk arrangements impact quality, cost, and patient satisfaction with care.

**Webpage**: Additional information is available at the GPDC Model webpage.

## *Kidney Care Choices Model*

**Model Announcement Date:** July 10, 2019

**Anticipated Model Performance Period:** January 1, 2022–To Be Determined[55]

**Model Participants:** Kidney Contracting Entities (KCEs) and Kidney Care First (KCF) practices

**Number of Participants:** To be determined (the Request for Applications closed on January 22, 2020)

**Geographic Scope:** Nationwide

[55] As this Report to Congress was being prepared for release, this and certain other performance periods were updated.

**Coronavirus Disease 2019 PHE Flexibilities:** To create necessary flexibilities for participants in the Kidney Care Choices Model, we will:

- Delay start of the first Performance Period for cohort #1 to April 1, 2021[56];
- Adjust the model's timeline to reflect a nine-month duration for the first Performance Year;
- Adjust financial benchmarks (and quality benchmarks, if necessary) to reflect a nine-month duration for the first Performance Year;
- Create an application cycle during 2021 for a second cohort to launch January 1, 2022; and
- Provide participants the option to delay until launch of the second cohort.

**Model Description:** Kidney Care Choices (KCC) will build upon the existing Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model structure. This model enables dialysis facilities, nephrologists, and other health care providers to form ESRD-focused Accountable Care Organizations (ACOs) to manage care for beneficiaries with ESRD by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease (CKD) Stages 4 and 5 and ESRD, to delay the onset of dialysis, and to guide beneficiaries through the kidney transplantation process. The model will have four payment options: (1) the CMS Kidney Care First (KCF) Option; (2) the Comprehensive Kidney Care Contracting (CKCC) Graduated Option; (3) the CKCC Professional Option; and (4) the CKCC Global Option. The design of the Kidney Care Choices model also draws on the recently announced Primary Care First Model and Direct Contracting Model.

The patient is a key component of the model design. The tendency now is for patients with kidney disease to undergo the most expensive treatment path, with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment. By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision-making for their care.

The beneficiary alignment process will be the same for the KCF and CKCC Options. Beneficiaries who meet the following criteria, among other criteria, will be eligible to be aligned to participants in these Options: (1) Medicare beneficiaries with CKD Stages 4 and 5; (2) Medicare beneficiaries with ESRD receiving maintenance dialysis; and (3) Medicare beneficiaries who were aligned to a KCF practice or KCE by virtue of having

[56] An additional delay until January 1, 2022 for cohort #1 was announced March 5, 2021.

CKD Stage 4 or 5 or with ESRD and receiving dialysis that subsequently receive a kidney transplant.

Alignment will take into consideration where a beneficiary receives the majority of his or her kidney care. When an aligned beneficiary receives a kidney transplant, he or she will remain aligned to that model participant for up to three years following a successful kidney transplant or until the time a kidney transplant fails, at which point the beneficiary could be re-aligned if he or she meets the requirements for alignment by virtue of his or her ESRD. While a beneficiary who receives a kidney transplant remains aligned to the entity post-transplant, their expenditures will not be counted unless they are realigned after returning to dialysis.

The Kidney Care First Option will be open to participation by nephrology practices and their nephrologists only, subject to meeting certain eligibility requirements.

In the KCF Option, participating nephrology practices will receive adjusted fixed payments on a per-patient basis for managing the care of aligned beneficiaries with late-stage chronic kidney disease and patients with ESRD. For example, one of the KCF Option payments will be an adjusted monthly capitated payment for managing the care of beneficiaries with ESRD. The payments will be adjusted based on the participating practice's performance on quality and utilization measures compared to the participating practice's own experience and national standards. In addition, participating practices who guide beneficiaries through the kidney transplantation process will receive a bonus payment for every aligned beneficiary who receives a kidney transplant. The kidney transplant bonus will be paid in installments, based on whether the transplant remains successful for up to three years after the surgery.

The CKCC Options include the Graduated, Professional, and Global Options. In these options the capitated payments will be similar to the capitated payments under the KCF Option. However, in the CKCC Options, the KCEs—which consist of nephrologists, transplant providers, and other health care providers, including dialysis facilities—will take responsibility for the total cost and quality of care for their patients, and in exchange, can receive a portion of the Medicare savings they achieve.

KCEs participating in the CKCC Options are required to include nephrologists or nephrology practices and transplant providers, while dialysis facilities and other types of providers and suppliers are optional participants in KCEs.

As in the KCF Option, KCEs participating in one of the three CKCC options will receive adjusted payments for managing the care of beneficiaries with CKD Stages 4 and 5 and ESRD, along with the kidney transplant bonus payment.

The three CKCC Options will have distinct accountability frameworks, as follows:

- CKCC Graduated Option: This payment arrangement is based in part on the existing CEC Model One-Sided Risk Track—allowing certain participants to begin under a lower-reward one-sided risk model and incrementally phase into accepting greater risk and greater potential reward.

- CKCC Professional Option: This payment arrangement is based on the Professional Option of the Global and Professional Direct Contracting (GPDC) Model—with an opportunity to earn 50 percent of shared savings or be liable for 50 percent of shared losses based on the total cost of care for Part A and B services.

- CKCC Global Option: This payment arrangement is based on the Global Option of the GPDC Model—with risk for 100 percent of the total cost of care for all Parts A and B services for aligned beneficiaries.

**Evaluation Status/Results:** The KCC evaluation will measure whether the financial incentives being tested in this model result in better cost and quality outcomes for beneficiaries with chronic kidney disease and kidney failure. The impact analysis will examine the effect of the KCC Model on key outcomes, including improved quality of care and quality of life, and decreased Medicare expenditures and utilization. For example, the impact analysis will examine changes in disease progression and care coordination. The implementation analysis will examine barriers to and facilitators of change, as well as how nephrologists and facilities respond to the KCC payment structure. In addition, the evaluation will examine if there are changes to transplant wait-listing rates, as well as greater utilization of transplantation. Findings from both analyses will be synthesized to provide comprehensive evaluation results.

**Webpage:** Additional information is available at the KCC Model webpage.

## *Maternal Opioid Misuse Model*

**Model Announcement Date:** October 23, 2018

**Anticipated Model Performance Period:** January 1, 2021–December 31, 2024. Note: this performance period reflects a six-month delayed start due to the Coronavirus Disease 2019 PHE.

**Model Participants:** State Medicaid agencies and care-delivery partners

**Number of Participants:** Ten state Medicaid agencies are participating in the model, working with 32 care-delivery partners

**Geographic Scope:** The model will enroll women across Colorado, Indiana, Maine, Maryland, and West Virginia. In Missouri, New Hampshire, Louisiana, Tennessee, and Texas, enrollees will be limited to specified areas of these states.

**Model Description:** CMS created the Maternal Opioid Misuse (MOM) Model in response to the surge in substance use-related illness and death in recent years, particularly in pregnant women. Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes, including preterm labor and complications related to delivery. These problems are frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs. Infants exposed to opioids before birth also face negative outcomes, with a higher risk of being born preterm, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS). In addition, Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the $1.5 billion annual cost of NAS. Despite the acknowledged and costly burden of maternal opioid misuse, numerous barriers have impeded the delivery of well-coordinated, high-quality care to pregnant and postpartum women with Opioid Use Disorder (OUD), including the following:

- Lack of access to comprehensive services during pregnancy and the postpartum period, even though state Medicaid programs may be able to provide the necessary coverage through state plan amendments or waivers;

- Fragmented systems of care, which miss a critical opportunity to effectively treat women with OUD at a time when they may be especially engaged with the health care system; and

- Shortage of maternity care and substance use treatment providers for pregnant and postpartum women with OUD covered by Medicaid, especially in rural areas where the opioid crisis is magnified.

The primary goals of the MOM Model are to: (1) improve quality of care and reduce costs for pregnant and postpartum women with OUD as well as their infants; (2) expand access, service-delivery capacity, and infrastructure based on state-specific needs; and (3) create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

These goals will be achieved through a variety of approaches, including:

- Supporting the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services.

- Leveraging CMS Innovation Center authorities and existing Medicaid flexibility to pay for sustainable care for the model population.

- Strengthening capacity and infrastructure by investing in institutional and organizational capacity to address key challenges in providing coordinated and integrated care.

State Medicaid agencies will implement the model with one or more "care-delivery partners" in their communities. Funding will be available for state awardees over the course of the five-year model in three distinct model periods: Pre-implementation (Year 1), Transition (Year 2), and Full Implementation (Years 3-5).

Care delivery will begin in Year 2 of the model, the Transition Period. By Year 3, the start of the Full Implementation Period, states must develop strategies to cover and pay for all model services that are not otherwise covered by Medicaid. The MOM Model design supports each awardee's ability to quickly begin delivering coordinated and integrated care to pregnant and postpartum women with OUD during the Transition Period, while supporting states in developing a long-term coverage and payment strategy that aligns with their state Medicaid program.

**Evaluation Status/Results:** The evaluation of the MOM Model will assess whether offering medication-assisted treatment in combination with behavioral health services and care coordination for pregnant women with OUD improves care quality and reduces costs for this population of women and their infants. The evaluation plans to use Medicaid claims from the Transformed-Medicaid Statistical Information System linked to vital records and women's medical chart data to investigate costs and health outcomes for women within each state. The program will develop comparison groups within states or from other states to verify outcomes. Because the model population is small and because state contexts vary, the evaluation will also conduct robust qualitative investigations to assess local contexts, individual women's experiences, and care access and quality for model participants.

**Webpage:** Additional information is available at the MOM Model webpage.

## *Part D Payment Modernization Model*

**Model Announcement Date:** January 18, 2019

**Anticipated Model Performance Period:** January 1, 2020–December 31, 2024

**Model Participants:** Eligible standalone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs)

**Number of Participants:** Two participants (1 PDP and 1 MA-PD)

**Geographic Scope:** National

**Model Description:** The Part D Payment Modernization (PDM) Model will test the impact of a revised Part D program design and improved alignment of financial risk incentives on overall Part D prescription drug spending and beneficiary out-of-pocket costs. The model aims to reduce Medicare expenditures while preserving or enhancing quality of care for beneficiaries.

The model aims to decrease total Part D program spending by:

- Creating new incentives for Part D plans, beneficiaries, and providers to choose drugs with lower list prices to better manage catastrophic phase federal reinsurance subsidy spending by introducing two-sided risk to align payment incentives for plan sponsors with their enrollees and CMS; and
- Providing several programmatic flexibilities to ensure Medicare beneficiaries are able to maintain affordable access to the prescription drugs they need.

In Contract Year 2021, model participants can choose to offer features from the following range of programmatic flexibilities and model design elements:

- Medication Therapy Management+ (MTM+) (new for 2021);
- Limited Initial Days' Supply for Specific Covered Part D Drugs (new for 2021);
- Cost-Sharing Smoothing (new for 2021);
- Part D Rewards and Incentives Programs;
- Reduction or Elimination of Cost-Sharing on Generic Drugs and Biosimilars for Low-Income Subsidy Beneficiaries; and
- Updated Plan Timeliness from 72 to 96 hours for Standard Initial Coverage Determinations.

**Evaluation Status/Results:** The evaluation of PDM will assess whether changing the program design and improving incentives in Part D for plan sponsors has an impact on quality of care, plan bids, and overall enrollee costs. The evaluation will also inform whether plans are better able to manage Part D spending in response to benefit changes in the model while maintaining or improving quality of care. The evaluation will rely on existing data such as Medicare claims-based data, plan bids, and plan characteristics files to perform quantitative analyses primarily focused on identifying the impacts of the model.

**Webpage:** Additional information is available at the PDM Model webpage.

## *Part D Senior Savings Model*

***Model Announcement Date:*** March 11, 2020

***Anticipated Model Performance Period:*** January 1, 2021–December 31, 2025

***Model Participants:*** Certain pharmaceutical manufacturers; Part D sponsors

***Number of Participants:*** Three pharmaceutical manufacturers; 76 Part D sponsors[57]

***Geographic Scope:*** National

***Model Description:*** The Part D Senior Savings Model will test the impact of offering beneficiaries an increased choice of enhanced alternative Part D plan options that offer lower out-of-pocket costs for insulin. CMS is testing a change to the Medicare Coverage Gap Discount Program to help Part D sponsors, through eligible enhanced alternative plans, offer a Part D benefit design that includes predictable $35 copays for a 30-day equivalent supply of a broad range of insulins in the deductible, initial coverage, and coverage gap phases by applying Part D sponsor supplemental benefits after the manufacturer-provided discount on the negotiated price.

The model aims to reduce Medicare expenditures while preserving or enhancing quality of care for beneficiaries, and to provide beneficiaries with additional Part D prescription drug plan (PDP) choices for beneficiaries, through both standalone PDPs and Medicare Advantage (MA) plans that provide Part D prescription drug coverage (MA-PDs).

Specifically, CMS is enabling health plan innovation to offer beneficiaries lower prescription drug out-of-pocket costs by waiving a current programmatic disincentive for Part D sponsors to design prescription drug plans that offer supplemental benefits to lower beneficiary cost-sharing in the coverage gap phase of the Part D benefit for insulin.

While Part D sponsors may currently offer prescription drug plans that provide lower cost-sharing for brand and other applicable drugs in the coverage gap, if a Part D sponsor chooses to design its benefit that way, the sponsor would accrue costs that pharmaceutical manufacturers would normally pay. Those costs are then passed on to beneficiaries in the form of higher supplemental premiums.

Because Part D sponsors compete to offer Medicare beneficiaries affordable prescription drug coverage, only a few sponsors design a benefit that has supplemental benefit coverage for brand or other applicable drugs in the coverage gap. Since brand and other applicable drugs are the set of medications that often cost beneficiaries the most, beneficiaries in the coverage gap end up paying 25 percent of the negotiated price in the coverage gap, which may closely mirror the list price of the medication. That amount is often significantly higher than cost-sharing in the initial coverage phase and can represent a financial burden for Medicare beneficiaries.

Part D sponsors participating in the model will offer beneficiaries plan choices that provide broad access to multiple types of insulin that are marketed by model-participating pharmaceutical manufacturers at a maximum $35 copay for a 30-day supply in the deductible, initial coverage, and coverage gap phases of the Part D benefit. This predictable

[57] As this Report to Congress was being prepared for release, the number of participating pharmaceutical manufacturers increased from three to four.

copay will provide improved access to and affordability of insulin to improve care management for beneficiaries who require insulin.

To encourage broad Part D sponsor participation, CMS is providing Part D sponsors the option of additional risk corridor protection for Calendar Year (CY) 2021 and CY 2022 for plan benefit packages (PBPs) that have higher enrollment than average from insulin-dependent diabetic patients, when the PBP meets qualifying criteria. Through the model, CMS is also testing how participating Part D sponsors may best encourage healthy behaviors and medication adherence through Part D Rewards and Incentives Programs.

***Evaluation Status/Results:*** The evaluation of the Part D Senior Savings Model will address whether providing Part D sponsors a redesigned Medicare Coverage Gap Discount Program has an impact on costs to Part D beneficiaries, Part D plans, Medicare, beneficiary health outcomes, and quality of care. The evaluation will employ a mixed-methods approach, using qualitative and quantitative data such as interviews with plan sponsors and focus groups with prescribers and beneficiaries, and existing data such as Medicare Part D claims-based data, plan bids, and plan characteristics files to assess the impacts of the model.

**Webpage:** Additional information is available at the Part D Model webpage.

## *Primary Care First Model Options*

**Model Announcement Date:** April 22, 2019

**Anticipated Model Performance Period:** Six performance years, with two staggered cohorts of practices each participating for a five-year performance period: one cohort from January 1, 2021 through December 31, 2025; and the second cohort from January 1, 2022 through December 31, 2026. The anticipated start dates for the cohorts of the pending Serious Illness Population (SIP) option are April 1, 2021 and January 1, 2022.[58]

**Model Participants:** Primary care practices and physician practices that specialize in care for seriously ill populations

**Number of Participants:** Participant selection process ongoing

**Geographic Scope:** 26 regions or states: Alaska, Arkansas, California, Colorado, Delaware, Florida, Greater Buffalo region, Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii, Louisiana, Maine, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, North Hudson-Capital region (New York), Ohio and Northern Kentucky region

[58] The Serious Illness Population option is currently under review.

(statewide in Ohio and partial state in Kentucky), Oklahoma, Oregon, Rhode Island, Tennessee, and Virginia

**Coronavirus Disease 2019 PHE Flexibilities:** To create necessary flexibilities for participants in the Primary Care First Model Options, the CMS Innovation Center:

- Delayed the start of the Performance Period for the Serious Illness Population Option. The Primary Care First Model's Seriously Ill Population Option is currently under review. CMS looks forward to sharing additional information when available; and

- Started the general Primary Care First General Model Option January 1, 2021.

**Model Description:** The Primary Care First (PCF) Model Options test whether financial risk and performance-based payments that reward primary care practitioners and other clinicians for easily understood, actionable outcomes will reduce total Medicare expenditures, preserve or enhance quality of care, and improve patient health outcomes. In PCF, CMS provides payment to participating practices through a simplified total monthly payment that allows clinicians to focus on caring for patients rather than on their revenue cycle.

Both PCF model options incentivize providers to reduce hospital utilization and total cost of care by offering potentially significant incentives through performance-based payment adjustments. PCF aims to improve quality of care—specifically patients' experiences of care, and key outcome-based clinical quality measures, which may include controlling high blood pressure, managing diabetes mellitus, and screening for colorectal cancer.

**Evaluation Status/Results:** PCF will test whether rewarding value and quality by offering this new payment structure will reduce expenditures, maintain or improve quality, and improve patient health outcomes. A robust mixed-methods approach will be used to assess how the model is being implemented and model impacts such as total Medicare expenditures, hospitalization rates, emergency department visit rates, process-of-care outcomes, readmission rates, beneficiary experience of care, and beneficiary health-related quality of life.

**Webpage:** Additional information is available at the PCF webpage.

## *Radiation Oncology Model*

**Model Announcement Date:** July 10, 2019; Final Rule issued September 29, 2020

**Earliest Possible Model Performance Period:** January 1, 2022–December 31, 2025[59]

**Model Participants:** Hospital outpatient departments (HOPDs) and physician group practices (PGPs), including freestanding radiation therapy centers, that furnish radiotherapy

**Number of Participants:** 400 HOPDs and 600 PGPs

**Geographic Scope:** A randomized selection of Core-Based Statistical Areas (CBSAs) in the United States, excluding Maryland, Vermont, and the U.S. territories

**Model Description:** The Radiation Oncology (RO) Model addresses several long-standing challenges with respect to payment for radiotherapy (RT) services in Medicare. In November 2017, CMS published a Report to Congress on "the development of an episodic alternative payment model" for RT services in response to the 2015 Patient Access and Medicare Protection Act. The report identified three key reasons why radiation therapy is ready for payment and service delivery reform, namely: (1) the lack of site neutrality for payments, (2) incentives that encourage volume of services over the value of services, and (3) coding and payment challenges.

The RO Model aims to improve quality of care and reduce expenditures for Medicare beneficiaries by encouraging use of evidence-based guidelines for RT to treat cancer and by using a predictable, site-neutral, prospective episode-based payment. The RO Model was designed to qualify as a Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM) and an Advanced APM.

The RO Model is designed to test whether replacing fee-for-service (FFS) payments for RT services with prospective episode-based payments will reduce costs while continuing to deliver high-value RT care. In addition, by reducing the financial incentive to provide more services in the current payment systems, physicians will have more flexibility to provide fewer fractions of radiation, when clinically appropriate, while also improving clinical care and patient experience.

The RO Model provides prospective payments for most RT services furnished during a 90-day episode of care for 16 cancer types. Episodes are split into two parts: a Professional Component (PC) and a Technical Component (TC), as these services are sometimes furnished by separate providers and suppliers, and paid for through different payment systems. Episode payments are based on a site-neutral, trended national base rate that is adjusted for each participant's historical expenditures, case mix, and geographic location. Both the PC and TC prospective payment amounts are subject to a CMS discount, a

[59] The Consolidated Appropriations Act, 2021 (H.R. 133) enacted on December 27, 2020 includes a provision that prohibits implementation of the Radiation Oncology Model prior to January 1, 2022, effectively delaying. the start date by six months. CMS intends to address the delay through notice and comment rulemaking.

quality withhold, and an incorrect payment withhold. In Performance Year 3, the prospective payment amount will also be subject to a patient experience withhold.

Any Medicare-enrolled PGP, freestanding radiation therapy center, or HOPD that furnishes included RT services to RO beneficiaries in a ZIP Code linked to a randomly selected CBSA is required to participate in the RO Model unless they meet certain exclusionary criteria or qualify for the low-volume opt-out for the upcoming performance year. Participant and comparison groups contain approximately 30 percent of all eligible episodes in eligible geographic areas or CBSAs.

To be included in the RO Model, a Medicare beneficiary must receive included RT services in a ZIP Code linked to a selected CBSA from an RO participant during the model test's performance period for a cancer type that meets the criteria for inclusion in the RO Model. Beneficiaries also must have traditional Medicare FFS as their primary payer, be eligible for Medicare Part A, and enrolled in Medicare Part B. Individuals who meet these requirements and are enrolled in a clinical trial for RT services for which Medicare pays routine costs are also included the RO Model.

**Evaluation Status/Results:** The evaluation of the RO Model will assess whether the use of evidence-based guidelines for RT to treat cancer using a predictable prospective bundled payment will improve the quality of care and reduce expenditures, as evidenced by changes in RT utilization patterns (including the number of fractions and types of RT), RT costs for Medicare Fee-for-Service beneficiaries in the RO Model (including Medicare-Medicaid dually eligible beneficiaries); changes in utilization and costs for other services that may be affected as a result of the RO Model; performance on clinical care process measures; patient experience of care; and provider experience of care. The evaluation will estimate the RO Model's effects on quality, expenditures, and other outcomes of interest. It will control for patient differences and other factors that directly or indirectly affect the RO Model impact estimate, including demographics, comorbidities, program eligibility, and other factors. The evaluation will conduct analyses at the CBSA, participant, and the beneficiary levels.

**Webpage:** Additional information is available at the RO Model webpage.

## B. Continuing Models and Initiatives

The 28 model tests and initiatives listed below were announced prior to October 1, 2018, and either continued through or ended during the period of this report.

CMS has made changes through Interim Final Rules (as noted above in Section 2 Part H, under the heading "Requests for Information and Rulemaking Activity") and revised participation agreements in the period of performance for a number of these model tests in response to the Coronavirus Disease 2019 Public Health Emergency (PHE).

In all cases, the periods of performance listed at the beginning of the ensuing model entries are those under which model tests are currently operating, rather than the periods of performance announced prior to the Coronavirus Disease 2019 PHE.

Other flexibilities have also been created by the same means—in payment design, reporting, and quality measures—to enable participants to remain in the model tests without harm during the Coronavirus Disease 2019 PHE and to maintain the integrity of the model design. As above, all such changes are noted in Coronavirus Disease 2019 PHE Flexibilities subsections. These flexibilities may be subject to further change as the crisis evolves.

## *Accountable Health Communities Model*

**Model Announcement Date:** January 5, 2016

**Model Performance Period:** May 1, 2017–April 30, 2022

**Model Participants:** Community-based organizations, health care practices, hospitals and health systems, and local governmental entities (all serving as community bridge organizations)

**Number of Participants:** 29

**Geographic Scope:** Rural and urban communities across 277 counties in 21 states

**Model Description:** In January 2016, the CMS Innovation Center issued a Notice of Funding Opportunity (NOFO) for the Accountable Health Communities (AHC) Model. The AHC Model was developed based on emerging evidence that addressing health-related social needs (HRSNs) through enhanced clinical-community linkages can improve health outcomes and reduce costs. The AHC Model tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries—including those who are dually eligible—impacts total health care costs and inpatient and outpatient health care utilization.

Over a five-year period of performance, CMS is testing two promising service delivery approaches:

- Assistance Track: Provides person-centered community service navigation services to help high-risk beneficiaries access community services to address certain identified health-related social needs.

- Alignment Track: Provides person-centered community service navigation services to help high-risk beneficiaries access community services to address certain identified health-related social needs, and encourages partner alignment to ensure that community services are available and responsive to the needs of beneficiaries.

When the AHC Model launched, the Notice of Funding Opportunity (NOFO) offered funding for an additional track—the Awareness Track. However, CMS withdrew the Awareness Track funding opportunity because the agency did not receive enough qualified applications to move forward.

AHC awarded up to $111 million in cooperative agreements to 32 community bridge organizations to implement the model during the five-year performance period. Assistance Track awardees were awarded up to $2.57 million per recipient, and Alignment Track awardees were awarded up to $4.51 million per recipient. There are currently 29 community bridge organizations participating in the model—11 in the Assistance Track and 18 in the Alignment Track. Bridge organizations that were awarded cooperative agreements include community-based organizations, health care practices, hospitals and health systems, and local governmental entities. Awardees are located in rural and urban communities across 277 counties in 21 states. These bridge organizations are partnering with some 175 hospitals, 474 primary care practices, 87 behavioral health providers and 224 other types of clinical delivery sites.

Bridge organizations participating in the model worked with their community partners during the start-up phase of the model to establish screening and referral protocols, finalize and memorialize arrangements, and develop health information technology solutions to effectuate data-sharing.

Bridge organizations began the implementation phase on a rolling basis from May 2018 through December 2018 as data-sharing infrastructure was ready. As of June 2020, bridge organizations and partnering clinical delivery sites have offered more than 1.2 million screenings to Medicare and Medicaid beneficiaries, and screenings identified 216,807 beneficiaries with at least one health-related social need. All of these beneficiaries were eligible to receive referrals to community resources. More than 68,000 beneficiaries have accepted navigation services through the model. Through navigation services, those beneficiaries reported that over 31,000 of their health-related social needs were resolved.

**Evaluation Status/Results:** The evaluation of AHC will assess whether systematically identifying and addressing health-related social needs of community-dwelling Medicare and Medicaid beneficiaries and aligning community resources improves health outcomes and reduces utilization. The evaluation of both the Assistance Track and the Alignment Track will examine health outcomes, including whether the interventions in each track reduce beneficiaries' total health care costs and utilization of health care services.[60]

**Webpage:** Additional information is available at the AHC Model webpage.

[60] The first evaluation report from the AHC Model was released after the period of report, in December 2020.

## *ACO Investment Model*

**Model Announcement Date:** October 15, 2014

**Model Performance Period:** April 1, 2015–December 31, 2018

**Model Participants:** Medicare Shared Savings Program Accountable Care Organizations (ACOs)

**Number of Participants:** 45 ACOs

**Geographic Scope:** 38 states: Alabama, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, Vermont, Washington, West Virginia, and Wyoming

**Model Description:** The ACO Investment Model (AIM) was designed for organizations participating as ACOs in the Medicare Shared Savings Program. AIM was a pre-paid shared savings model that built on experience learned from the Advance Payment ACO Model. AIM was developed to encourage new ACOs to form in rural and underserved areas (Test 1) and current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk (Test 2).

During the Report to Congress performance period, there were 45 ACOs participating with 45,626 providers to serve 485,029 beneficiaries in 38 states. Over the model's total performance period, 47 ACOs participated with 45,754 providers to serve 492,114 beneficiaries in 38 states.

Approximately 75 percent of AIM participants primarily served rural areas. AIM participants were required to participate in the Medicare Shared Savings Program, and may have been part of an Advanced Alternative Payment Model (APM), depending on which track they were in.

The ACO Investment Model was available to:

1. New Medicare Shared Savings Program ACOs that joined in 2015 or 2016. AIM sought to encourage uptake of coordinated, accountable care in rural geographies and areas where there has been little ACO activity by offering pre-payment of shared savings in both up-front and ongoing per-beneficiary-per-month payments. CMS believed that encouraging participation in areas of low ACO penetration would spur providers in new markets to focus on improving care outcomes for Medicare beneficiaries.

2. ACOs that joined the Medicare Shared Savings Program starting in 2012, 2013, or 2014. Here, AIM was designed to help ACOs succeed in the Medicare Shared Savings Program and encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings.

AIM ACOs had until the end of December 2018 to finish spending the approximately $96 million in pre-paid shared savings that was distributed to them.

**Evaluation Status/Results:** The third evaluation report of AIM was released in September 2020 and covered AIM ACOs' first three performance years. Among the 41 Test 1 ACOs (mainly established in rural or underserved areas), the evaluation found $526.4 million in significantly lower spending achieved relative to non-ACO beneficiaries, or $381.5 million (2.5 percent) in savings to the Medicare program after subtracting AIM payments and earned shared savings. The evaluation also generally found greater reductions in total Medicare spending relative to similar non-AIM Shared Savings Program ACOs. AIM ACO beneficiaries reported similar patient experiences of care as other non-ACO beneficiaries. About 60 percent of AIM ACO representatives reported that they would not have participated in the Medicare Shared Savings Program without AIM payments.

**Webpage:** Additional information is available at the ACO Investment Model webpage.

## *Bundled Payments for Care Improvement Advanced Model*

**Model Announcement Date:** January 9, 2018

**Anticipated Model Performance Period:** October 1, 2018–December 31, 2023

**Model Participants:** Medicare-enrolled Acute Care Hospitals and Physician Group Practices, which can participate as Convener Participants or Non-Convener Participants; entities that are not Medicare-enrolled Acute Care Hospitals or Physician Group Practices can participate only as Convener Participants. Convener Participants bring together one or more Episode Initiators (EI) to participate in the model and facilitate coordination among them.

**Number of Participants:** In Model Years 1 and 2, there were 1,299 participants. In Model Year 3 (2020), there are 1,707 participants.

**Geographic Scope:** Participation was open to eligible participants nationwide. Participants are located in 49 states, plus Washington, DC.

**Coronavirus Disease 2019 PHE Flexibilities:**

In response to concerns expressed by participants, the following flexibilities have been incorporated into the model via amendments to Participation Agreements for the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model:

- CMS is offering participants the option to eliminate both upside and downside risk by excluding all Clinical Episodes (CEs) from Reconciliation for Model Year 3 (2020).

- For BPCI Advanced participants who choose to remain in two-sided risk, CMS is offering participants the option to exclude from Reconciliation those Clinical Episodes that include a COVID-19 diagnosis during the episode.

- At present, the plan is for quality reporting to continue during Model Year 3 (2020) and for the timeline for BPCI Advanced to stay the same.

**Model Description:** Building on the lessons learned and ongoing experience of the Bundled Payments for Care Improvement (BPCI) Model, BPCI Advanced is designed to align incentives for reducing costs while improving coordination and quality of care. BPCI Advanced uses a bundled payment methodology that involves combining the payments for physician, hospital, and other health care provider services into a single bundled payment amount. This amount is calculated based on the expected costs of all items and services furnished to a beneficiary during an episode of care. Payment models that provide a single bundled payment to health care providers can motivate care redesign by adopting best practices, reducing deviation from standards of care, and providing a clinically appropriate level of services for patients throughout the Clinical Episode.

Entities receiving a bundled payment may realize a gain or loss, based on how successfully they manage resources and total costs throughout each episode of care. A bundled payment also creates an incentive for providers and suppliers to coordinate and deliver care more efficiently because a single bundled payment will often cover services furnished by various health care providers in multiple care delivery settings.

BPCI Advanced includes two types of participants: Convener Participants and Non-Convener Participants. Both participant types bear financial risk under the model. A Convener Participant can be a Medicare-enrolled provider or supplier or any other type of entity that brings together multiple downstream entities referred to as Episode Initiators. Convener Participants facilitate care coordination among Downstream Episode Initiators and bear (and apportion) financial risk under the model. A Non-Convener Participant is either an Acute-Care Hospital (ACH) or a Physician Group Practice (PGP) that is an Episode Initiator and bears financial risk only for itself rather than on behalf of a Downstream Episode Initiator. Episode Initiators are limited to Acute Care Hospitals and Physician Group Practices.

In Model Years 1 and 2, there were 1,299 participants, including 832 Acute Care Hospitals and 715 Physician Group Practices as Episode Initiators. CMS offered an additional application opportunity to participate in the model beginning at the start of Model Year 3 (January 2020). At that time, participants who had signed participation agreements with CMS for Model Years 1 and 2 were offered an opportunity to add or drop Clinical Episodes and Episode Initiators. As of February 10, 2020, 1,707 participants had signed participation agreements with CMS.

In Model Years 1 and 2, Participants were held accountable for at least one Clinical Episode, and were able to choose from 29 inpatient and three outpatient Clinical Episodes, comprised of both medical and surgical episodes. In Model Year 3, additional Clinical Episodes were added, and 33 inpatient and 4 outpatient Clinical Episodes were offered. The length of the Clinical Episode depends on the site of service. For inpatient Clinical Episodes, the episode length is the start of the inpatient admission (Anchor Stay) plus 90 days beginning the day of discharge. For the outpatient Clinical Episodes, the episode length is the start of the outpatient procedure (Anchor Procedure), plus 90 days beginning on the day of completion of the outpatient procedure. Both Convener Participants and Non-Convener Participants are not permitted to drop active Clinical Episodes, nor add new Clinical Episodes, except when expressly permitted by CMS. The same limitation applies to the withdrawal or addition of Downstream Episode Initiators by a Convener Participant.

The model aims to broadly engage Participants across geographic areas, with varying demographic attributes of their patient populations, organization size, and clinical types. In addition to the different Participant types, the model also aims to involve a broad range of Medicare-enrolled practitioners, including participating physicians and non-physician practitioners.

BPCI Advanced aims to reduce Medicare fee-for-service (FFS) expenditures and to improve the quality of care and health outcomes for Medicare beneficiaries. Success will be measured by the reduction in Medicare FFS expenditures for Clinical Episodes relative to historical expenditures, as well as by improved performance on quality measures and health outcomes.

BPCI Advanced is an Advanced Alternative Payment Model (Advanced APM), meaning that participating clinicians who meet certain participation thresholds may obtain Qualifying APM Participant (QP) status in the Quality Payment Program, which began in 2019.

**Evaluation Status/Results:** The first evaluation report from BPCI Advanced was released in June 2020 and covers the model from its beginning October 1, 2018 through March 31, 2019.[61] The report describes Participants and Episode Initiators; their participation

[61] The first evaluation report from BPCI Advanced was released after the period of report, in April 2021.

decisions, including their choices of Clinical Episodes; and the reach of the model. As of March 1, 2019, there were 334 unique participating entities that represented 715 hospitals and 580 Physician Group Practice Episode Initiators. Most participating hospitals and Physician Group Practices joined the model as Downstream Episode Initiators under a Convener Participant, and many cited similar reasons for entering the model, such as financial opportunity and the opportunity to gain experience in bundled payment models.

There was generally broad participation in BPCI Advanced as 22 percent of eligible hospitals and 23 percent of eligible clinicians nationwide were BPCI Advanced Episode Initiators. Up to 16 percent of BPCI Advanced eligible discharges and outpatient procedures were at a BPCI Advanced Hospital or were attributed to a BPCI Advanced Physician Group Practice. However, BPCI Advanced Hospital Episode Initiators were more likely to be larger, urban facilities that were part of a health system located in more competitive markets than all eligible hospitals. Although there was participation in all 32 Clinical Episodes, most BPCI Advanced Episode Initiators were participating in fewer than five. For all 32 Clinical Episodes, the median historical payment for BPCI Advanced Hospital Episode Initiators was higher than the median historical payment for eligible hospitals that did not participate in the Clinical Episode. Future reports will include estimates of the impact of the model on payments, utilization and quality of care, and Medicare program savings, in addition to beneficiary-reported outcomes on functional status and satisfaction.

The first evaluation report does not include a Medicare program savings analysis, but the CMS Innovation Center has conducted an internal review that revealed the model was resulting in significant financial losses to Medicare.[62] CMS recently announced changes for Model Year 4, beginning January 1, 2021. One of these announced changes is designed to improve target price accuracy for both CMS and model participants.[63]

**Webpage:** Additional information is available at the BPCI Advanced Model webpage.

## *Comprehensive Care for Joint Replacement Model*

**Model Announcement Date:** July 9, 2015

**Model Performance Period:** April 2016–September 2021

**Model Participants:** Hospitals

**Number of Participants:** 474 hospitals as of December 2019

[62] Brad Smith, "CMS Innovation Center at 10 Years – Progress and Lessons Learned," *New England Journal of Medicine*, January 13, 2021.

[63] For details, see the Communication about new pricing methodology sent to BPCI Advanced participants.

**Geographic Scope:** 67 metropolitan statistical areas (MSAs) in the following states: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, and Wisconsin

**Coronavirus Disease 2019 PHE Flexibilities:**

In response to concerns expressed by participants, the following flexibilities have been incorporated into the Comprehensive Care for Joint Replacement (CJR) Model test via amendments to Participation Agreements:

- Removed downside risk by capping actual episode payments at the target price for episodes with a date of admission to the anchor hospitalization between January 31, 2020 through the termination of the emergency period (as described in section 1135(e) of the Social Security Act) (see CMS-1744-IFC);

- Delayed the annual reconciliation report release to June 22, 2020; and

- Extended Performance Year 5 through March 2021 (see CMS-8585-FR-71142).

**Model Description:** The Comprehensive Care for Joint Replacement (CJR) Model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements (also known as "CJR episodes") to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. The model was implemented through notice and comment rulemaking in a final rule published November 24, 2015. Certain model policies were modified in two subsequent final rules which took effect May 21, 2017 and January 1, 2018.

As of April 1, 2016, there were approximately 800 acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) that were included in the CJR Model, although only 684 of these hospitals had at least one CJR episode during Performance Year 1 (PY 1). On February 1, 2018 participant requirements changed (described in greater detail below). Hospitals that had been participating in the Bundled Payments for Care Improvement (BPCI) Model joined the CJR Model upon BPCI's completion date in October 2018. Due to these changes, as of December 2019, the total number of participating providers was 474; 399 of these 474 providers are located in the 34 mandatory MSAs while 75 of these 474 providers are located in the voluntary MSAs. The list of participating providers is available on the CJR webpage listed at the end of this section.

There were 47,426 CJR episodes during PY 1; 101,377 CJR episodes in PY 2; 64,651 episodes in PY 3. PY1 represented six months of episodes, which began April 1, 2016 and ended October 4, 2016. PY 2 episodes spanned a full calendar year and included the full cohort of 67 MSAs. PY 3 episodes also spanned a full calendar year, but the cohort was reduced (see explanation below). The reconciliation for PY 4 initiated in April 2020; final episode counts are not yet available.

The CJR Model has two tracks. Only Track 1, where participating providers attest to Certified Electronic Health Record Technology (CEHRT), is an Advanced Alternative Payment Model (APM) under the Quality Payment Program.

The CJR Model is in its fifth performance year. With few exceptions, hospitals paid under the IPPS and located in 67 selected MSAs listed in the November 24, 2015 final rule were required to participate in the model for the first two performance years. As of February 1, 2018, participation requirements were changed as finalized in the December 1, 2017 final rule. While participation for providers in 34 of the 67 areas was required, CJR participant hospitals in the 33 voluntary areas, along with those hospitals in all 67 areas identified as low-volume or rural, were given a one-time opportunity during January 2018 to voluntarily opt-in to the CJR Model for the remainder of the model. Those providers eligible for voluntary participation that chose not to opt in had all of their CJR PY 3 episodes cancelled.

On February 24, 2020, the CMS Innovation Center issued a Notice of Proposed Rulemaking for a Three-Year Extension and Modification of the Comprehensive Care for Joint Replacement (CJR) Model. The subsequent Final Rule was released on May 3, 2021.[64] See the following section for a description of the proposed Extension and Modification of CJR.

**Evaluation Status/Results:** The second evaluation report from the CJR Model[65] was released in June 2019, and covers the first and second performance periods (April 2016–December 2017). The evaluation indicates that a range of hospitals, with a range of resources and circumstances, can and do successfully respond to the incentives under a mandatory episode-based payment approach for LEJR episodes to reduce per-episode payments while maintaining quality. LEJR episodes in the CJR Model areas had total episode payments 3.7 percent lower than control group episodes. On average across all LEJR episodes, total Medicare standardized (wage-adjusted) episode payments went down by $997 more for CJR episodes between the baseline and the intervention periods than for control group episodes, which resulted in an estimated $146.3 million reduction in Medicare payments. The report found that a variety of markets, hospitals, and patient

[64] For details, see "Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Medicare and Medicaid Programs; Policies and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." *86 Federal Register* (May 2, 2021), p. 23496-23576.

[65] The third evaluation report on the CJR Model was released after the period of report, in November 2020.

types were able to significantly reduce episode payments. Reductions in total episode payments were driven by shifts to less intensive post-acute care settings and shorter lengths of stay. After accounting for the $128.9 in reconciliation payments made to hospitals, the estimated savings to the Medicare program was $17.4 million. While the CJR model reduced average episode payments, due to the wide range around the estimated decrease CMS cannot conclude with statistical certainty that the CJR Model resulted in savings to Medicare in its first two performance years.

The CJR model did not impact the number of unplanned readmissions, emergency department visits, or mortality. CJR Model and comparison group patient survey respondents reported making similar gains in functional status from before their hospitalization to after the end of the episode, and reported similar satisfaction with their overall recovery, care management, and care transitions experiences. While the majority of patients reported needing some level of caregiver support, CJR beneficiaries reported needing slightly more help than comparison beneficiaries. Hospitals reported making changes along the clinical care pathways with a heavy focus on provider and patient education. Additional hospital care redesign strategies include engaging caregivers in the process, same-day ambulation, coordinating with post-acute care facilities, and following up with patients after hospital discharge.

**Webpage:** Additional information is available at the CJR Model webpage.

## Comprehensive Care for Joint Replacement Model Three-Year Extension and Modification

**Model Announcement Date:** Contingent on proposed rule. Please note that this Three-Year Extension and Modification of the Comprehensive Care for Joint Replacement (CJR) Model is not considered a separate model test.

**Anticipated Model Performance Period:** If finalized, extends the existing five-year CJR Model described above for three additional performance years.

**Model Participants:** Hospitals

**Number of Participants:** Anticipate approximately 350 hospitals

**Geographic Scope:** 34 metropolitan statistical areas (MSAs) in the following states: Alabama, Arkansas, California, Connecticut, Florida, Indiana, Kentucky, Louisiana, Mississippi, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Utah

**Model Description:** The Comprehensive Care for Joint Replacement (CJR) Model aims to support better and more efficient care for Medicare FFS beneficiaries undergoing hip

and knee replacements (also called lower extremity joint replacements or LEJR) in hospital inpatient and outpatient settings.

On February 24, 2020, CMS issued a Notice of Proposed Rulemaking for a Three-Year Extension and Modification of the Comprehensive Care for Joint Replacement (CJR) Model. The Final Rule was released on May 3, 2021.[66]

The CJR Model was implemented on April 1, 2016, and had been scheduled to end on September 30, 2021 (under changes to the model in response to the Coronavirus Disease 2019 PHE). The Final Rule extends the model end-date to December 31, 2024. In accord with recommendations from the Office of the Actuary, the Final Rule revises certain aspects of the CJR Model, including the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements and the appeals process. In addition, the rule would eliminate the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments for certain recipients. Should the rule be finalized, it would also extend the additional flexibilities provided to hospitals in certain Medicare program rules in a manner consistent with the revised episode of care definition.

**Evaluation Status/Results:** If the CJR Model Extension is adopted, the evaluation will be integrated into the ongoing evaluation of the CJR Model. The evaluation will examine the degree to which the model as configured under the extension, including the addition of outpatient episodes and target pricing updates, is able to achieve impacts on episode spending and net savings. The evaluation will continue to examine whether the model results in reductions in emergency room visits, readmissions, complications or mortality. The evaluation will use an analysis of Medicare claims to explore financial impacts and a combination of post-acute care assessment data and claims to determine whether the model resulted in improved quality of care provided to beneficiaries receiving treatment from participating hospitals.

**Webpage:** Additional information is available at the CJR Model webpage.

## *Comprehensive End-Stage Renal Disease Care Model*

**Model Announcement Date:** April 15, 2014

**Anticipated Model Performance Period:** October 1, 2015–March 31, 2021

**Model Participants:** End-Stage Renal Disease Seamless Care Organizations (ESCOs)

[66] For details, see "Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing; Medicare and Medicaid Programs; Policies and Regulatory Revisions in Response to the COVID-19 Public Health Emergency." *86 Federal Register* (May 2, 2021), p. 23496-23576.

**Number of Participants:** 33 End-Stage Renal Disease Comprehensive Care Organizations (ESCOs)

**Geographic Scope:** The ESCOs are in the following states: Alabama, Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington.

**Coronavirus Disease 2019 PHE Flexibilities:**

To create necessary flexibilities for participants in the Comprehensive ESRD Care (CEC) Model, we plan to:

- Reduce 2020 downside risk for those months affected by the Public Health Emergency;
- Cap ESCOs' gross savings upside potential at 5 percent gross savings;
- Remove COVID-19 inpatient episodes;
- Remove 2020 financial guarantee requirement;
- Make 2020 quality reporting optional and use the higher of 2019 or 2020 quality scores; and
- Extend the model until March 31, 2021.

**Model Description:** The Comprehensive End-Stage Renal Disease Care (CEC) Model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the CEC Model, CMS is partnering with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The model builds on findings from the Pioneer Accountable Care Organization (ACO) Model, Next Generation ACO Model, and the Medicare Shared Savings Program.

In the CEC Model, dialysis facilities, nephrologists and other providers join together to create an ESCO to coordinate care for aligned beneficiaries. ESCOs are accountable for clinical quality and cost of care provided to aligned ESRD beneficiaries, as measured by Medicare Part A and B spending, including all spending on dialysis services. This model encourages dialysis providers to think beyond their traditional roles in care delivery, and creates incentives for them to provide patient-centered care that will address beneficiaries' health needs, both inside and outside of the dialysis facility.

There are 33 ESCOs participating in the CEC Model, with a total of 81,880 ESRD beneficiaries in the model as of March 2020. There are 3,659 providers in the model as of March 2020. Of the 33 ESCOs in the model, 29 include dialysis facilities owned by Large Dialysis Organizations (LDOs)—23 from Fresenius, three from DCI, three from DaVita— and four include dialysis facilities owned by Non-Large Dialysis Organizations (Non-LDOs, namely: Rogosin Institute, Northwest Kidney Centers, Atlantic Dialysis, and Centers for Dialysis Care). The 29 ESCOs with LDOs are able to receive shared savings payments but also are liable for shared losses (two-sided risk). ESCOs with participation by dialysis facilities owned by non-LDOs have the option to participate in either a two-sided risk track or a one-sided risk track where they will be able to receive shared savings but will not be liable for shared losses. All 29 ESCOs with LDOs participate in two-sided risk arrangements and qualify as Advanced APMs, while all four ESCOs with Non-LDOs participate in one-sided financial risk. Thirteen of the ESCOs began the Model on October 1, 2015, and 24 additional ESCOs joined beginning January 1, 2017. There are no plans to add more ESCOs.

**Evaluation Status/Results:** The second evaluation report from CEC[67,68] was released in September 2019, and covers the first two performance years (October 1, 2015–December 31, 2017). The report found that CEC reduced Medicare spending by $68 million. This represents a 1.8 percent decrease. It should be noted, however, that this decrease in Medicare payments does not take into account shared savings payments made to ESCOs. When these payments are accounted for, Medicare experienced net losses of $46 million. Lower spending was driven by reductions in hospitalizations and accompanying services such as readmission and institutional post-acute care. There was a 4 percent reduction in the number of hospitalizations and a 6 percent reduction in hospitalizations due to ESRD complications.

The report also found that ESCOs are changing care delivery to meet CEC Model goals. ESCOs increased access to dialysis care by extending facility hours, increasing capacity at facilities, and improving flexibility around appointment scheduling. ESCOs enhanced non-dialysis care by identifying especially vulnerable beneficiaries to hospitalizations and increased care management efforts. To improve patient-centered care and communication, ESCOs prepared beneficiaries for dialysis treatment and provided contact information to triage concerns in an effort to avoid unnecessarily hospitalizations.

**Webpage:** Additional information is available at the CEC Model webpage.

[67] The third evaluation report from the CEC model was released after the period of report, in November 2020.
[68] The fourth evaluation report from the CEC model was released after the period of report, in March 2021.

## *Comprehensive Primary Care Plus Model*

**Model Announcement Date:** April 2016

**Anticipated Model Performance Period:** Six performance years, with two staggered cohorts of participating practices, each participating for a five-year performance period—one cohort from January 1, 2017 through December 31, 2021 and the second from January 1, 2018 through December 31, 2022

**Model Participants:** Primary Care Practices

**Number of Participants:** 2,851

**Geographic Scope:** 18 regions or states: Arkansas, Colorado, Hawaii, Greater Kansas City Region (Kansas and Missouri), Louisiana, Michigan, Montana, Nebraska, North Dakota, Greater Buffalo Region of New York, North Hudson-Capital Region (New York), New Jersey, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region (Pennsylvania), Rhode Island, and Tennessee

**Model Description:** Comprehensive Primary Care Plus (CPC+) is an advanced primary care model that aims to strengthen primary care through state-based multi-payer payment reform and care delivery transformation. CPC+ was built on the foundation and lessons learned from the original Comprehensive Primary Care Model.

The CPC+ Model includes two primary care practice tracks ("Track 1" and "Track 2") that have differing care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. The care delivery requirements ensure practices in each track have the processes and skills to deliver better care. The multi-payer payment redesign gives practices greater financial resources and the flexibility to make appropriate investments to improve the quality and efficiency of care and reduce unnecessary health care utilization. The CPC+ Model provides practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback to guide their decision-making.

Track 2 of the CPC+ Model is more advanced and requires CPC+ practices to develop the capabilities necessary to deliver advanced primary care in collaboration with a health IT vendor(s). The CPC+ Model's multi-payer design brings together CMS, commercial insurance plans, and state Medicaid agencies to provide the financial support necessary for practices to make fundamental changes in their care delivery. The CPC+ Model also promotes alignment and integration with Medicare Accountable Care Organizations (ACOs) by allowing CPC+ practices to participate in both CPC+ and a Medicare Shared Savings Program ACO. CMS determined CPC+ regions based on sufficient and aligned multi-payer interest in the model. CMS entered into a Memorandum of Understanding (MOU) with more than 60 payer partners who share CMS' commitment to alignment on

payment, data sharing, and quality metrics in the CPC+ Model. CMS also entered into MOUs with more than 60 health IT vendors that support the CPC+ practices participating in Track 2 of the model.

**Evaluation Status/Results:** The second evaluation report for CPC+ was released in July 2020, and covers the second year of the model for practices that started participation in CPC+ in January 2017. As expected at this point in the model, CPC+ has had no discernible effect on total cost of care, not accounting for the model payments CMS makes to practices participating in CPC+. After factoring in the model payments, the model resulted in a net loss to Medicare of 1.9 percent for Track 1 and 3.3 percent for Track 2. The report did find some modest favorable effects on service use and quality, including a reduction of 1.3 percent in emergency department visits for beneficiaries attributed to practices in both Track 1 and Track 2. Effects on these health care outcomes may emerge with more time as CPC+ practices deepen and expand care delivery changes. The report also found that participating primary care practices continued to receive substantial support from CMS and partner payers, and practices continued to transform the way they provide care. Compared to the first year of participation in the model, more practices had care management staff in place, screened patients for behavioral health needs, and improved coordination with emergency departments and hospitals.

**Webpage:** Additional information is available at the CPC+ webpage.

## *Health Care Payment Learning and Action Network*

**Announcement Date:** January 2015

**Participants:** Payers, providers, purchasers, patients, product manufacturers, policymakers

**Number of Participants:** More than 7,000

**Geographic Scope:** Nationwide

**Initiative Description:** The Health Care Payment Learning & Action Network (LAN) is a public-private learning collaborative (or network) built on the principle that sharing information about successful models, aligning key design components of Alternative Payment Models (APMs), and encouraging concerted implementation of APMs will increase the rate of APM adoption across the country and lead to reduced costs and improved quality.

The LAN is convened and independently managed on behalf of CMS by the contractor who operates the CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center (FFRDC). Its two Executive Forums—the CEO Forum and the Care Transformation Forum—meet regularly to provide recommendations about how to accelerate the adoption of APMs across the public and private sectors.

The LAN mobilizes a network of more than 7,000 payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to promote APMs and reduce the barriers to APM participation as a means to lower cost of care and improve patient experiences and outcomes.

**Original LAN Goals and Measurement Effort:** The LAN was launched in March 2015 to accelerate the adoption of APMs across public and private sectors with a shared national goal of tying 30 percent of U.S. health care payments to APMs by the end of 2016, and 50 percent by the end of 2018.

The LAN published an APM Framework in 2016, establishing a common nomenclature for defining and tracking U.S. health care payments. In a refreshed version published in 2017, the Framework classifies APMs into four categories and eight subcategories, specifying characteristics of each category to standardize classification efforts. These characteristics—essentially principles that can guide decisions about APM design—have been widely influential among health care payers and purchasers.

The APM Framework also forms the basis of the LAN's annual APM Measurement Effort, which tracks the national progress in efforts to accelerate public and private sector adoption of APMs. A description of the LAN APM Measurement work and its findings in tabular form are presented in Part 2, Section G of this report under the heading, "Accelerating the Acceptance of Alternative Payment Models."

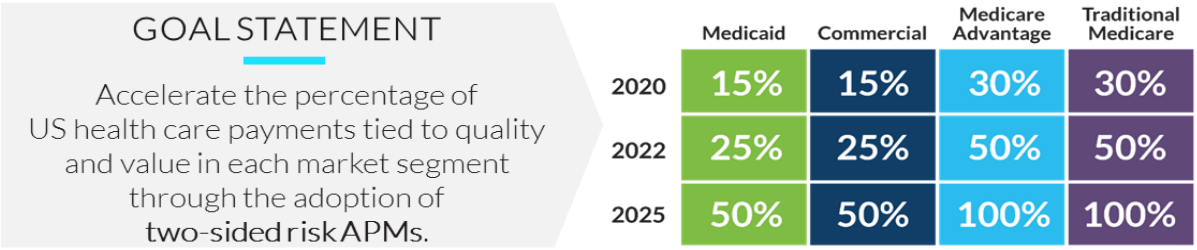
The data has shown gradual but consistent increases in the percentage of health care payments made through Category 3 and 4 APMs (which include two-sided risk), with the exception of Medicaid payments through such APMs, which declined from 25 percent to 23 percent.

***New LAN Goals:*** The LAN recognizes an urgent need to substantially transform the way health care is paid for and delivered, acknowledging that current rates of health care spending will soon become unsustainable. To that end, at the October 2019 LAN Summit, the LAN established new goals that reflect the perceived importance of accelerating the adoption of two-sided risk APMs.

The figure below shows the new LAN goals for APM adoption in Medicaid, commercial health insurance, Medicare Advantage, and traditional Medicare. The targets vary because different markets and lines of business are progressing at different rates. The targets are aspirational, intended to concentrate and encourage efforts to accelerate adoption of APMs throughout the public and private health care sectors.[69]

[69] The LAN Goal Statement and its Learning and Action Network Targets for APM Adoption are intrinsic to the LAN's efforts to accelerate adoption of APMs. They neither reflect CMS planning nor obligate CMS model development and payment to conform to these goals and targets.

**New Learning and Action Network Targets for APM Adoption**




As the targets for APM adoption suggest, the LAN is focusing on increasing the acceptance of APMs with two-sided risk, based on the theory that such APMs offer a more sustainable approach to health care payment, at least in regard to value-based care.

***New LAN Structure:*** Under the LAN 2.0 structure, there are two Executive Forums: the CEO Forum and the Care Transformation Forum. These Forums bring together health care leaders committed to shaping the strategic direction of value-based payment.

The LAN will continue to measure the progress of payment reform through its APM Measurement Effort and to report the results at the annual LAN Summit, which brings together hundreds of payers, providers, purchasers, policymakers, product manufacturers, patients, media and more to share resources and best practices, and align around transforming health care payment.

In response to the Coronavirus Disease 2019 Public Health Emergency (PHE), the LAN Health Care Resiliency Initiative has launched to strengthen payment transformation relating to pandemic response efforts. This multi-stakeholder initiative will identify best practices initiated during the PHE that encourage scalable value transformation, along with facilitation and support resources to encourage continued APM transitioning. Collectively, these efforts should present actionable response and recovery steps during the present PHE, and better prepare stakeholders for APM adoption during future pandemics.

In the coming year, the LAN will engage with Executive Forum members and other organizations to convene action-oriented work groups and undertake strategic initiatives to address specific barriers to increased adoption of two-sided risk APMs.

**Webpage:** Additional information is available at the LAN website.

## *Home Health Value-Based Purchasing Model*

**Model Announcement Date:** November 2015

**Model Performance Period:** January 1, 2016–December 31, 2020

**Model Participants:** Medicare-certified Home Health Agencies

**Number of Participants:** Approximately 1,800

**Geographic Scope:** Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington

**Coronavirus Disease 2019 PHE Flexibilities:**

In response to the Coronavirus Disease 2019 Public Health Emergency (PHE), the Home Health Value-Based Purchasing (HHVBP) Model implemented two policies on reporting in the Interim Final Rule with comment period published in May 2020. The policies implemented were:

- Aligning HHVBP Model data submission requirements with any exceptions or extensions granted for purposes of the Home Health Quality Reporting Program during the PHE; and

- Allowing exceptions or extensions to the new measures' data reporting requirements under the HHVBP Model during the PHE and, in accordance with this policy, granting exceptions to HHVBP new measures data reporting requirements for the April and July 2020 submission periods.

**Model Description:** The HHVBP Model is designed to test whether higher payment incentives can significantly change health care providers' behavior to improve quality of care by shifting Medicare-certified home health agencies (HHAs) from volume-based to value-based purchasing. CMS believes stronger incentives will improve HHAs' investment in transforming care delivery.

The specific goals of the model are to: (1) provide incentives for better quality of care with greater efficiency, (2) study new potential quality and efficiency measures for appropriateness in the home health setting, and (3) enhance the current public reporting process.

In the Calendar Year (CY) 2016 Home Health Prospective Payment System Final Rule—effective January 1, 2016—CMS implemented the HHVBP Model in nine states through notice-and-comment rulemaking. All Medicare-certified HHAs that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington participate in the model.

Annual payment adjustments are based on each HHA's total performance score (TPS) for the applicable performance year, which is based on quality metrics and data reporting. Payments are adjusted incrementally over the course of the model in the following manner:

- A maximum payment adjustment of three percent (upward or downward) in CY 2018;
- A maximum payment adjustment of five percent (upward or downward) in CY 2019;
- A maximum payment adjustment of six percent (upward or downward) in CY 2020;
- A maximum payment adjustment of seven percent (upward or downward) in CY 2021; and
- A maximum payment adjustment of eight percent (upward or downward) in CY 2022.

In the CY 2017 Home Health Prospective Payment System Final Rule, CMS finalized several changes to the model's design, including calculation of benchmarks and achievement thresholds; cohort size requirements; timeframe for submission and reporting period for new measure data; implementation of recalculation and reconsideration processes, and removal of four measures. The CY2017 Final Rule also provided an update on the progress toward developing public reporting of performance under the HHVBP Model.

In the CY 2018 Home Health Prospective Payment System Final Rule—in addition to summarizing the comments received on possible quality measures for future consideration—CMS finalized the following changes to the HHVBP Model:

- Amended the definition of "applicable measure" to mean a measure for which a competing HHA has provided a minimum of 40 completed surveys for Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) measures for purposes of receiving a performance score for all HHCAHPS measures, beginning with Performance Year (PY) 1; and
- Removed the Outcomes and Assessment Information Set (OASIS)-based measure—Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care—from the set of applicable measures for PY 3 and subsequent years.

In the CY 2019 Home Health Prospective Payment System Final Rule, CMS finalized the following changes to the HHVBP Model:

- Removed the Influenza Immunization Received for Current Flu Season and the Pneumococcal Polysaccharide Vaccine Ever Received OASIS process measures beginning with PY 4 (CY 2019);

- Replaced three individual, functional OASIS measures with one composite self-care measure and one composite mobility measure; and

- Reweighted the applicable measure set and changed the improvement point scoring methodology. The reweighting changed the OASIS-based measures category to a weight of 35 percent, the claims-based measures category to a 35 percent weight, and the HHCAHPS measures category to 30 percent. The maximum improvement points that could be awarded was reduced from ten points to nine points.

Included in the HHVBP Model's applicable measure set are measures that have the potential to follow patients across multiple settings, reflect a multi-faceted approach, and foster the intersection of health care delivery and population health. The HHVBP Model also studies measures self-reported by competing HHAs that are outside of the set of quality measures currently used by CMS, or "New Measures," which we believe fill gaps in the National Quality Strategy (NQS) Domains not completely covered by existing measures in the home health setting. All competing HHAs are required to submit data on the New Measures via the HHVBP's secure portal; reporting on them accounts for ten percent of the HHA's TPS.

**Evaluation Status/Results:** The third evaluation report from the HHVBP Model was finalized in September 2020 and covers three Performance Years of the model (Calendar Years 2016-2018). The evaluation observed improvements in quality of care and a reduction in Medicare expenditures. Agencies in model states improved their aggregate TPS scores by 4.6 percent more than comparison state HHAs in the first Performance Year, 5.3 percent more in the second Performance Year, and 4.0 percent more in the third year. This increase was driven primarily by relatively greater improvements in OASIS-based outcome measure scores. Among home health users in HHVBP states, average Medicare spending decreased 1.2 percent for the home health episode plus 30 days following the episode, for total savings of $423 million across the three years. Spending decreased primarily during the home health episode itself, driven by reductions in hospitalization payments. In interviews with agencies, HHAs reported reinforcing existing quality improvement strategies, initiating new practices in patient education, and scheduling more skilled nursing visits early in an episode of care in response to the greater weight placed on the hospitalization and emergency department utilization measures in CY 2019.

**Webpage:** Additional information is available at the HHVBP webpage.

## *Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents*

**Model Announcement Date:** August 27, 2015 (Phase Two)

**Model Performance Period:** October 1, 2016–September 30, 2020 (Phase Two)

**Model Participants:** Enhanced Care and Coordination Provider (ECCP) organizations and partnering long-term care (LTC) facilities and practitioners

**Number of Participants:** 243 LTC facilities and 871 practitioners as of September 1, 2020

**Geographic Scope:** Alabama, Colorado (Phase Two only), Indiana, Missouri, Nevada, New York, and Pennsylvania

**Model Description:** Unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare and Medicaid. Through Phases One and Two of the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (NFI), CMS tested strategies to reduce avoidable hospitalizations for long-stay residents of nursing facilities. Since Phase Two is a refinement of Phase One, both phases are described below:

- Phase One (NFI 1—ended prior to the reporting period): The Initiative funded seven organizations, known as Enhanced Care and Coordination Providers (ECCPs), to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities. These organizations provided clinical staff and/or staff training in partnership with 143 nursing facilities to test evidence-based interventions over a four-year period.

- Phase Two (NFI 2): CMS implemented a second phase of the Initiative to test whether three new Fee-For-Service (FFS) payments for nursing facilities and practitioners could further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.

The payment reforms aimed to reduce avoidable hospitalizations by funding higher-intensity interventions in nursing facilities for residents who might otherwise be hospitalized upon an acute change in condition. The Initiative included FFS billing codes for practitioners to diagnose and treat acute changes in condition in the nursing facility setting at the same payment rate as a comparable visit in a hospital setting.

There were two separate categories of participating facilities. The "Payment-Only" group consisted of facilities newly selected to participate in Phase Two and eligible to bill for the model payments. These facilities did not participate in Phase One, and did not receive any of the clinical or educational interventions from Phase One. The "Clinical + Payment"

group consisted of facilities continuing from Phase One with ECCP-funded Registered Nurses and Advanced Practice Registered Nurses on site and also eligible to bill for the new payments.

**Evaluation Status/Results:** The second and third evaluation reports for NFI 2 assessed the effectiveness of the NFI 2 payment model during Initiative Year 1 (October 1, 2016–September 30, 2017) and Initiative Year 2 (October 1, 2017–September 30, 2018), respectively.[70] The evaluations used a mixed-methods approach to provide a holistic understanding of NFI 2's effect on utilization and expenditure measures for eligible residents by comparing them to a nationally derived non-Initiative population of nursing facility residents who would meet the Initiative eligibility criteria. The evaluation found evidence that payment reforms led to a consistent pattern of improved outcomes among eligible residents in the Payment-Only facilities during Initiative Year 1. In Initiative Year 2, however, there were not consistent patterns in the effects observed nor were there statistically significant changes. Overall, eligible residents in Clinical + Payment facilities did not experience reductions in hospital-related utilization and expenditures further than what was achieved in NFI 1 in either year. The evaluation observed statistically significant increases in some utilization and expenditure measures in the majority of ECCPs.

**Webpage:** Additional information is available at the NFI 2 webpage.

## *Integrated Care for Kids Model*

**Model Announcement Date:** August 23, 2018

**Anticipated Model Performance Period:** January 1, 2020–December 31, 2026

**Model Participants:** State Medicaid Agencies and local health care providers

**Number of Participants:** Eight awardees

**Geographic Scope:** 22 rural and urban counties across seven states: Connecticut, Illinois, New Jersey, New York, North Carolina, Ohio, and Oregon

**Model Description:** The Integrated Care for Kids (InCK) Model is a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children under 21 covered by Medicaid and the Children's Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. Some programs also include pregnant women over age 21 who are covered by Medicaid. The model offers states and local providers support to address these priorities through a

[70] The fourth evaluation report from NFI 2 was released after the period of report, in March 2021.

framework of child-centered care integration across behavioral, physical, and other providers.

The goals of the InCK Model are to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable Alternative Payment Models (APMs). The InCK Model will support states and local providers in conducting early identification and treatment of children with health-related needs across settings. Participants will integrate care coordination and case management across physical and behavioral health and other local service providers to provide child- and family-centered care. Through the APM developed under this model, states and local providers will share accountability for cost and outcomes.

**Evaluation Status/Results:** The evaluation of the InCK model will assess whether integrated health-related services, in combination with state-based APMs, result in reduced total health care expenditures and improved quality of care. Specifically, the evaluation plans to assess the model's impact on Medicaid and CHIP-covered inpatient utilization and emergency department use, cost of care to Medicaid and CHIP, and whether model participation reduces rates of out-of-home placement among attributed children. The evaluation will consider the Transformed-Medicaid Statistical Information System and other state program data (from state and Federal nutrition or housing programs, for example) for model participants against a matched in-state comparison group. Because state contexts and goals for individual programs vary, the evaluation will also include a robust qualitative analysis to investigate issues specific to states and localities, the functionality of child-services partnership councils, caregiver perceptions of quality and access, and direct patient experiences of older children and youth.

**Webpage:** Additional information is available at the InCK Model webpage.

## *Maryland All-Payer Model*

**Model Announcement Date:** January 10, 2014

**Model Performance Period:** January 1, 2014–December 31, 2018

**Model Participants:** Hospitals

**Number of Participants:** 47 hospitals

**Geographic Scope:** All acute care hospitals in the state of Maryland

**Model Description:** Maryland operates the nation's only all-payer hospital rate regulation system. Under this system, Maryland sets rates for hospital services, and all third-party payers pay the same rate. From 1977 until December 2013, Maryland set payment rates for Medicare services that would otherwise be reimbursed under the Inpatient Prospective

Payment System and Outpatient Prospective Payment System pursuant to a waiver under section 1814(b)(3) of the Social Security Act.

Effective January 2014, Maryland entered into a new agreement with CMS to implement the Maryland All-Payer Model, a five-year hospital payment model. Under the terms of this agreement, Maryland agreed to meet a number of quality targets and limit annual cost growth for all payers including Medicare. The purpose of this model was to test the impact of transformation in the context of an all-payer rate setting system. Specifically, the model tested whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per-capita basis is an effective model for advancing better care, better health, and reduced costs.

The Maryland All-Payer Model (MDAPM) offered significant flexibility to the state in operationalizing the model for stakeholders. It contains design elements such as a quality target to reduce readmissions, and programs like the Care Redesign Program, which is intended to engage physicians, reduce provider burden, and facilitate productive partnerships between health care providers to make the patient experience more consistent and positive across care settings.

The agreement between Maryland and CMS provided for the following:

- Maryland elected that Maryland hospitals would no longer be reimbursed by Medicare in accordance with its previous statutory waiver in section 1814(b)(3), which is based on Medicare payment per-inpatient-admission, in exchange for the new CMS model based on Medicare per-capita total hospital cost growth;

- Maryland agreed to generate $330 million in Medicare savings over a five-year period of performance, measured by comparing Maryland's Medicare per-capita total hospital cost growth to the national Medicare per-capita total hospital cost growth;

- Maryland agreed to limit its annual all-payer per-capita total hospital cost growth to 3.58 percent, the 10-year compound annual growth rate in per-capita gross state product;

- Maryland committed to achieving a number of quality targets to improve the care for Maryland residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. These targets include:

    - Readmissions: Maryland committed to reducing its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate to the national rate over five years.

- Hospital Acquired Conditions: Maryland committed to achieving an annual aggregate reduction of 6.89 percent in 65 Potentially Preventable Conditions over five years for a cumulative reduction of 30 percent.

- Population Health: Maryland agreed to submit annual reports demonstrating its performance along various population health measures.

Under the All-Payer Model, Maryland also committed to achieving several delivery transformation goals, including moving 80 percent of its hospital revenue into population-based payments over the five-year performance period.

This statewide model covered all Maryland residents, including approximately 856,500 Medicare Fee-for-Service (FFS) beneficiaries. There were 47 acute care hospitals waived from the Inpatient Prospective Payment System and Outpatient Prospective Payment Systems, and instead paid in accordance with the Maryland All-Payer Model and regulated by Maryland's All-Payer hospital rate-setting organization. Under the Maryland All-Payer Model, the state moved all 47 acute care hospitals into hospital global budgets in which all payers in aggregate paid hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. Hospitals continue to operate under global budgets in the Total Cost of Care Model.

**Evaluation Status/Results:** The final evaluation report for MDAPM was released November 2019, and covered four and a half years of Medicare data and four years of both Medicaid and commercial payer results. Total Medicare expenditures declined by 2.8 percent ($975 million) and total hospital expenditures declined by 4.1 percent ($796 million), relative to a comparison group of non-Maryland hospitals with similar characteristics, without shifting costs to other parts of the health care system. A 17.2 percent reduction in outpatient department service expenditures and a 31 percent reduction in emergency department (ED) visits drove Medicare hospital savings. Commercial insurance had 6.1 percent slower growth in total hospital expenditures, but not in total expenditures. Inpatient admissions declined for both Medicare beneficiaries (7.2 percent) and commercial plan members (1.5 percent), although the decline was statistically significant only for Medicare. Inpatient admissions and ED visits also trended downward for the Maryland Medicaid population. Admissions for ambulatory care sensitive conditions decreased more for both Medicare beneficiaries in Maryland (6.7 percent) and for commercial plan members (6.1 percent) relative to their comparison groups. Although Maryland hospitals focused on improving patient experience, patient satisfaction scores were unaffected. Patient experience ratings were historically lower in Maryland than in comparison hospitals prior to the start of MDAPM, and this trend continued.

Because the state's all-payer rate-setting system harmonizes payment rates across payers, Medicare payment rates are relatively higher in Maryland compared to what they would be under the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS). Medicare payments to Maryland hospitals would be 40 percent

($798 million) lower annually under IPPS and 63 percent lower ($499 million) annually under OPPS. However, these findings do not signal how much Medicare would actually save if Maryland hospitals operated under IPPS and OPPS, because they do not account for changes in utilization that would likely occur under prospective payment. After accounting for utilization changes, the estimated difference in annual total Medicare payments is closer to $263 million.

**Webpage**: Additional information is available at the MDAPM Model webpage.

## *Maryland Total Cost of Care Model*

**Model Announcement Date:** May 14, 2018

**Anticipated Model Performance Period:** January 1, 2019–December 31, 2026

**Model Participants:** Acute Care Hospitals, Primary Care Practices, other non-hospital providers and suppliers, care transformation organizations

**Number of Participants:** 1,866

**Geographic Scope:** State of Maryland

**Coronavirus Disease 2019 PHE Flexibilities:**

In response to the Coronavirus Disease 2019 PHE, in March 2020, the CMS Innovation Center announced flexibilities for Maryland Primary Care Program (MDPCP) participant reporting in the Maryland Total Cost of Care Model (Maryland TCOC). Specifically, the CMS Innovation Center:

- Delayed MDPCP practice care transformation requirements and financial reporting in the MDPCP Portal until Fall 2020;

- Will hold practices harmless for the 2019 Performance Year electronic Clinical Quality Measures (eCQM) reporting requirements. The CMS Innovation Center typically collects information on three eCQMs from MDPCP practices used to reconcile the Performance-Based Incentive Payment (PBIP). However, reporting for eCQMs closed on March 31, 2020, and many participating practices faced challenges reporting the quality data in light of the PHE; and,

- Will not recoup the 2019 PBIP in Fall of 2020. Because of the preceding "hold harmless" flexibility for quality data reporting, and because the Coronavirus outbreak has interfered with CMS' efforts to collect the necessary survey data, CMS lacks the performance data necessary to reconcile the 2019 PBIP under the terms of the MDPCP participation agreement.

In response to the Coronavirus Disease 2019 PHE, in March 2020, the CMS Innovation Center also announced flexibilities for the following Maryland hospital quality and value-based payment programs under the Maryland TCOC Model: the Quality-Based Reimbursement (QBR) program; the Maryland Hospital Acquired Conditions (MHAC) program; the Readmission Reduction Incentive Program (RRIP); and the Potentially Avoidable Utilization (PAU) Savings program. Specifically, CMS is:

- Suspending reporting requirements for these programs for services furnished between January 1, 2020 through June 30, 2020; and

- Making optional the data submission deadlines for these programs (above) between October 1, 2019 and December 31, 2019.

These flexibilities align with the exception and extensions CMS announced on March 22, 2020, under which no data reflecting services provided January 1, 2020–June 30, 2020 will be used in CMS's calculations for Medicare quality reporting and value-based purchasing programs generally.

**Model Description:** CMS and the state of Maryland are partnering to test the Maryland Total Cost of Care (TCOC) Model, which sets a per-capita limit on Medicare total cost of care for beneficiaries in Maryland. The Maryland TCOC Model is the first CMS Innovation Center model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The Maryland TCOC Model builds upon the CMS Innovation Center's Maryland All-Payer Model, which had set a limit on per-capita hospital expenditures in the state.

The Maryland All-Payer Model, launched in 2014, established global budgets for certain Maryland hospitals to reduce Medicare hospital expenditures and improve quality of care for beneficiaries. Global budgets provide hospitals with a fixed amount of revenue for the upcoming year. A global budget encourages hospitals to eliminate unnecessary hospitalizations and other unnecessary utilization. Under the All-Payer Model, Maryland achieved significant savings for Medicare and improved quality. However, the Maryland All-Payer Model focused solely on the hospital setting, constraining the state's ability to sustain its rate of Medicare savings and quality improvements. The Maryland TCOC Model builds on the success of the Maryland All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the state to a sustainable growth rate in per-capita total cost of care spending for Medicare beneficiaries.

The Maryland TCOC Model sets Maryland on course to achieve fixed amounts of per-capita total cost of care savings to Medicare during each model year between 2019 and 2023. The model's financial targets are structured to obtain a total of more than $1 billion in Medicare total cost of care savings by the fifth Performance Year of the model (2023).

The Maryland TCOC Model includes three programs:

- The Hospital Payment Program (HPP) tests population-based payments for Maryland hospitals. In Maryland's HPP, each hospital receives a population-based payment amount to cover all hospital services provided during the course of the year. The HPP creates a financial incentive for hospitals to provide value-based care and to reduce the number of unnecessary hospitalizations, including readmissions.

- The Care Redesign Program (CRP) allows hospitals to make incentive payments to physician group practices and other non-hospital health care providers and suppliers who partner and collaborate with the hospital and perform care redesign activities aimed at improving quality of care and reducing the total cost of care for Medicare beneficiaries. A participating hospital may make incentive payments only if it has attained certain savings under its fixed global budget, and the total amount of incentive payments made cannot exceed such savings. Thus, the CRP and distribution of incentive payments under the program does not increase overall Medicare expenditures. To participate in the CRP, a hospital must enter into a CRP participation agreement with CMS and the state.

- The Maryland Primary Care Program (MDPCP) is structured to incentivize primary care practitioners and practices in Maryland to offer advanced primary care services to their patients. All participating practices receive a risk-stratified per-beneficiary-per-month payment directly from CMS intended to cover care management services—the care management fee (CMF). To support the flexible delivery of even more comprehensive and coordinated care, CMS will pay Track 2 Participant Practices the Comprehensive Primary Care Payment (CPCP), which is part upfront per-beneficiary-per-month (paid quarterly) and part reduced fee-for-service payment (paid based on claims submission). The MDPCP also offers a Performance-based Incentive Payment (PBIP) to participating practices intended to incentivize them to reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements.

In September 2019, CMS solicited proposals from third-party payers operating in Maryland for the MDPCP. CMS selected and has entered into a Memorandum of Understanding (MOU) with one payer (CareFirst) beginning January 2020. Under this MOU, the payer has committed to aligning with the principles of advanced primary care in MDPCP, including a commitment to aligned financial incentives, care management, quality measures, data sharing, and practice learning.

The Maryland TCOC Model also includes an Outcomes-Based Credits framework, which is intended to incentivize statewide investment in population health and alignment across care transformation under the model. Within this framework, the state is able to receive

credit for savings from population health improvements, which is structured as a discount in the amount of the Outcomes-Based Credits that will be applied to the state's actual TCOC used in calculating the state's performance against the model's savings targets. The amount of these Outcomes-Based Credits will be based on the savings from the population health improvements. CMS has approved one Outcomes-Based Credit methodology related to reduction in diabetes incidence, and expects to approve at least two additional Outcomes-Based Credit methodologies.

During the final three years of the model, CMS and the state will negotiate an expanded model test, a new model test, or a transition to the national prospective payment systems.

**Evaluation Status/Results:** The evaluation of the Maryland TCOC Model will test whether the model provides better patient-centered care and improves patient health and selected population health measures. It will also test whether the state delivered total cost of care savings to the Medicare program. Using quantitative and qualitative methods, the evaluation will examine key outcomes, including total Medicare and Medicaid expenditures, utilization (for example, hospitalization rates, unplanned readmissions, and emergency department visit rates), population health, and beneficiary experience of care.

**Webpage:** Additional information is available at the Maryland TCOC Model webpage**.**

## *Medicaid Innovation Accelerator Program*

**Announcement Date:** July 2014

**Model Performance Period:** July 1, 2014–September 30, 2020

**Participants:** Medicaid Agencies

**Number of Participants:** 52 Medicaid agencies have received direct technical assistance from IAP

**Geographic Scope:** All 50 states, territories, and the District of Columbia

**Model Description:** In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a collaborative initiative between the Center for Medicaid and CHIP Services and the CMS Innovation Center. The goal of IAP is to improve the care and health of Medicaid beneficiaries and to reduce costs by supporting states' ongoing delivery system and payment reforms through targeted technical assistance, tool development, and cross-state learning opportunities. IAP has worked with 47 states, four territories, and the District of Columbia through direct technical assistance opportunities (for example, state collaboratives with individualized coaching and peer-to-peer learning). More than half of these states and territories participated in three or more IAP technical assistance opportunities.

As a result of a multi-stakeholder engagement process conducted prior to IAP, CMS selected and designed four program areas that addressed technical assistance gaps identified by states: (1) reducing substance use disorders; (2) improving care for Medicaid beneficiaries with complex care needs and high costs; (3) promoting community integration through long-term services and supports; and (4) integrating physical and mental health.

- ***Reducing Substance Use Disorders (SUD):*** IAP works with states to better identify individuals with SUD, expand coverage for effective treatment, and enhance practices delivered to beneficiaries. IAP has worked with various cohorts of states on analyzing and using data to design these reforms, as well as assisting with achieving them. In addition, IAP held roundtables and affinity groups focused on medication-assisted treatment activities.

- ***Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs:*** IAP created two technical resources to assist Medicaid agencies with using data analytics to better understand Medicaid populations with serious mental illness (SMI). IAP also provided direct technical assistance for states to create state Medicaid SMI profiles.

- ***Promoting Community Integration Through Long-term Services and Supports (LTSS):*** IAP supports Community Integration through LTSS in two ways: (1) the Housing-Related Services and Partnerships track supports three cohorts of state partnerships; and (2) the Value-Based Payment for Home and Community-Based Services track supports 22 states in designing and implementing value-based payment strategies.

  As part of IAP's efforts to support ongoing Medicaid delivery system reforms, targeted technical assistance and tools were offered to states in four functional areas: (1) data analytics, (2) quality measurement, (3) performance improvement, and (4) value-based payment and financial simulations. This targeted support represents an opportunity for states to build their capacity in key delivery system reforms. IAP integrates functional areas across the program areas, in addition to offering direct technical assistance to state Medicaid agencies and developing related tools.

- ***Data Analytics:***

  - *Medicare-Medicaid Data Integration:* As part of a multi-year project that ended in March 2019, IAP worked with five states in providing one-on-one technical support to address the challenge of requesting, accessing, and integrating Medicare and Medicaid data for the purposes of care coordination for the dually eligible population.

- *Data Analytics:* IAP offered targeted technical assistance to states around a variety of data analytic activities, such as designing an analytic strategy and integrating non-Medicare data. Since IAP's inception, it has supported four cohorts of eight to ten states.

- *Developing Data Analytic Capacity to Support Reduction of Maternal Mortality (MM) and Severe Maternal Morbidity (SMM):* IAP provided technical assistance to seven Medicaid agencies in an effort to improve their data analytic capacity to better understand MM and SMM among Medicaid beneficiaries. IAP's technical assistance also supported these Medicaid agencies in building partnerships at the state and local level to reduce MM and SMM.

- ***Value-Based Payment and Financial Simulations:***

  - Value-Based Payment and Financial Simulations: The IAP provided individualized technical assistance for states interested in designing, developing, or implementing value-based payment approaches. Further, if a state sought to pursue a particular value-based payment approach, the IAP conducted financial simulations for them. IAP has supported three cohorts of eight to ten states.

  - Children's Oral Health Initiative Value-Based Payments: IAP completed its 24-month technical assistance opportunity in summer 2019. Three states worked with IAP to select, design, and test value-based payment approaches in this area.

  - Maternal and Infant Health Initiative Value-Based Payments: IAP completed its 24-month technical assistance opportunity in summer 2019. Four states worked with IAP to select, design, and test value-based payment approaches focused on maternal and infant health outcomes.

  - Measurement Development and Measure-Related Resources: IAP developed quality measures in key gap areas across the IAP's program areas and also created measurement-related issue briefs for states.

  - Performance Improvement: IAP integrated performance improvement tools and techniques into many of its program and functional area technical assistance opportunities.

Most of IAP's program and functional areas host national webinars and develop resources/tools based on information from direct technical assistance interactions. All 50 states and the District of Columbia have participated in national dissemination webinars.

**Evaluation Status/Results:** An interim report was released in March 2018, and covers the period July 2014–July 2017.[71] The IAP has helped raise states' awareness of ongoing Medicaid reforms through technical support. One-on-one coaching, in particular, was highly valued by participants. Technical support allows exploration of substantive and operational concepts both broadly and deeply, thereby enhancing lessons learned by participants. Participants have begun to implement some of these lessons learned through their experiences with the IAP; however, not enough time has passed for the evaluation to fully assess states' success.

**Webpage:** Additional information is available at the IAP Model webpage.

## *Medicare Accountable Care Organization Track 1+ Model*

**Model Announcement Date:** December 20, 2016

**Anticipated Model Performance Period:** January 2018–December 2021

**Model Participants:** Track 1 Medicare Shared Savings Program Accountable Care Organizations (ACOs)

**Number of Participants:** 55 ACOs

**Geographic Scope:** Nationwide

**Coronavirus Disease 2019 PHE Flexibilities:**

The CMS Innovation Center worked with the Center for Medicare to develop necessary flexibilities for all ACOs participating in the Medicare Shared Savings Program, including ACOs participating in the Track 1+ Model. CMS will make the following financial, quality, and timeline adjustments:

- Adustments to Beneficiary Assignment Methodology and Financial Calculations
    - Removing inpatient episodes of care for treatment of COVID-19 from benchmarks and other financial calculations.
    - Applying the Medicare Shared Savings Program Extreme and Uncontrollable Circumstances policy to 2020 financial reconciliation.
    - Expanding the list of primary care services used for beneficiary assignment in recognition of the increased use of telehealth and other technology-based services, starting on January 1, 2020, and continuing for any benchmark or

[71] The final evaluation report from IAP was released after the period of report, in December 2020.

performance years that include any months during the Coronavirus Disease 2019 PHE.

- Quality Adjustments
    - Extending the quality measure reporting deadline from March 31, 2020 to April 30, 2020; and allowing the Extreme and Uncontrollable Circumstances policy to apply when the quality reporting period is extended.
    - Applying the Medicare Shared Savings Program Extreme and Uncontrollable Circumstances policy to 2019 and 2020 reporting.
    - Continuing to monitor impact on 2020 quality reporting.
- Model Timeline Adjustments
    - Offering a voluntary option to extend the participation agreement for one performance year through December 2021.

**Model Description:** CMS developed the Track 1+ Model to test a payment design that incorporated more limited downside risk than was then available in Track 2 or Track 3 of the Medicare Shared Savings Program. The Track 1+ Model was designed to encourage more practices, especially small practices, to advance toward performance-based risk, and allowed ACOs that include hospitals—from large institutions to small rural hospitals—to participate. In January 2018, 55 Track 1+ Accountable Care Organizations (ACOs) joined the model, and as of January 1, 2020, there were 20 participating ACOs. The Track 1+ Model is an Advanced APM, and eligible clinicians participating in Track 1+ Model ACOs have the potential to earn an incentive payment through the Quality Payment Program.

Our early experience and initial evidence with the design of the Track 1+ Model demonstrated that the availability of a lower-risk, two-sided model, was an effective way to encourage ACOs to take on risk. The lower level of risk offered under the Track 1+ Model was positively received by the industry and much of the methodology was incorporated into Level E of the new BASIC Track under the Medicare Shared Savings Program, which was finalized in the December 2018 "Pathways to Success" Final Rule. ACOs were able to apply to the Track 1+ Model in 2018, and starting July 1, 2019, existing Track 1+ ACOs were given the option to complete the remainder of their agreement period as Track 1+ ACOs or terminate their current participation agreement and apply to enter a new Medicare Shared Savings Program agreement period under either the BASIC track (Level E) or the ENHANCED track.

The Track 1+ Model tests an innovative design for a two-sided risk model, offering a two-part structure for determining the maximum level of the ACO's loss liability according to the composition of ACO participants; applying either a revenue-based

loss-sharing limit—a percentage of the ACO participants' Medicare Fee-for-Service (FFS) revenues—or a benchmark-based loss-sharing limit—a percentage of the ACO's updated historical benchmark. The Track 1+ Model's lower risk is testing and continues to provide information to determine whether:

- ACOs that accept performance-based risk have greater incentives to drive more meaningful change in providers' and suppliers' behavior, specifically lowering the growth in Medicare FFS expenditures while maintaining or improving the quality of beneficiaries' care;
- An alternative performance-based risk participation option will work for organizations that are not experienced with performance-based risk and the Accountable Care framework, and for more risk-averse organizations;
- An alternative performance-based risk option might be effective in retaining ACOs that might otherwise have terminated their participation in the Medicare Shared Savings Program if required to enter a Medicare Shared Savings Program track with higher levels of risk;
- A less burdensome repayment mechanism requirement encourages participation in performance-based risk by physician-only ACOs and ACOs that include rural ACO providers and suppliers, which typically are less well-funded and more risk-averse; and
- A model that includes these features might encourage more rapid progression to performance-based risk.

**Evaluation Status/Results:** Track 1+ provided the Medicare Shared Savings Program with a significant increase in participation under downside risk that provided an evidence base for the design of the BASIC track recently added to the program. Track 1+ continues to provide a benchmark against which varying higher levels of financial risk sharing can ultimately be compared, including the ENHANCED track and models tested by CMMI. It also may offer a baseline against the similar risk sharing required in BASIC track level E to isolate whether other program changes are effective (for example the method for adjusting benchmarks and calculating updates).

**Webpage:** Additional information is available at the Shared Savings Program webpage.

## *Medicare Advantage Value-Based Insurance Design Model*

**Model Announcement Date:** September 2015

**Anticipated Model Performance Period:** January 1, 2017–December 31, 2024

**Model Participants:** Medicare Advantage Organizations (MAOs)

**Number of Participants:** 14 MAOs for Plan Year 2020

**Geographic Scope:** Eligible Medicare Advantage (MA) plan types in all states and territories may apply to participate in the Medicare Advantage Value-Based Insurance Design (VBID) Model. In Plan Year 2020, MAOs are offering VBID Plan Benefit Packages (PBPs) in the following 30 states and Puerto Rico: Arizona, California, Connecticut, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia

**Model Description:** Through the VBID Model, CMS is testing a broad array of complementary Medicare Advantage (MA) health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dually eligible individuals, and improve the coordination and efficiency of health care service delivery. Overall, the VBID Model contributes to the modernization of the MA program and tests whether these model components improve health outcomes and lower expenditures for MA enrollees.

***Historical Overview of the VBID Model:*** In the first three years of the Model (2017-2019), CMS limited participation to MA plans in states selected to be generally representative of the national MA market, including urban and rural areas, areas with both high and low average Medicare expenditures, areas with high and low prevalence of low-income subsidies, and areas with varying levels of penetration of and competition within MA. In the first two years of the Model, CMS identified a limited number of chronic conditions from which MAOs could choose to target additional supplemental benefits and reduced cost-sharing. In Year three of the Model (2019), CMS permitted plans to target based on chronic conditions proposed by the plan, rather than a limited list of chronic conditions.

In addition, beginning with the 2020 Performance Year for the model, it was broadened to all states and territories and revised to allow MAOs greater flexibility in designing their PBPs in accordance with the Bipartisan Budget Act of 2018.

***The VBID Model in 2020 and Future Years:*** In 2020 and 2021, the VBID Model is being modified to include broader changes than those proposed or introduced into MA in recent years. In comparison to recent MA programmatic changes, the VBID Model not only allows organizations to further target benefit design to enrollees based on chronic conditions, but also on certain socioeconomic characteristics. The model is also testing a requirement for MA plans to provide Wellness and Health Care Planning (including Advance Care Planning) for all enrollees in VBID PBPs, as well as authority for broader Rewards and Incentives Programs (RI Programs) than are permitted under 42 C.F.R. § 422.134. This includes allowing an MA-PD plan to offer rewards in connection with Part D benefits, which is not permitted under the current regulation. Beginning 2021, the

model is testing the first-ever carve-in of the Medicare Hospice Benefit Component into the MA program, as well as new supplemental benefit flexibilities for plans in accordance with Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors. Each of these are described in more detail below.

For Plan Year 2020, 14 MAOs offering MA benefits to PBPs with 1.2 million enrollees are providing tailored model benefits and RI Programs to more than 280,000 beneficiaries in 30 states and Puerto Rico.

***New Flexibilities that Implement Executive Order 13890 on Protecting and Improving Medicare for Our Nation's Seniors:*** Beginning in plan year 2021, and in response to Executive Order 13890 on Protecting and Improving Medicare for our Nation's Seniors, the VBID Model will test two new model components: (1) flexibility to share beneficiary rebate savings more directly with beneficiaries, and (2) new and innovative technologies and/or U.S. Food and Drug Administration (FDA) approved medical and supplemental benefits for targeted enrollees.

***Complete List of VBID Model Flexibilities Available for Participating MAOs:*** In addition to the required Wellness and Health Care Planning Strategy, participating MAOs may implement one or more of the following as part of the test of alterantive payment and service delivery models for Medicare Advantage:

1. ***VBID Flexibilities***

    - Targeted to beneficiaries based on chronic condition and/or socioeconomic status:

        - Primarily and Non-primarily health-related Supplemental Benefits, which might include new and existing technologies or FDA-approved medical devices (New for 2021);

        - Use of high-value providers and/or participation in care management programs/disease management programs; and

        - Reductions in cost sharing for basic benefits (Part A and B), supplemental benefits and covered Part D drugs.

    - Offered Uniformly Across All Plan Enrollees (that is, non-targeted):

        - New for 2021: Flexibility to share beneficiary rebate savings more directly with beneficiaries in the form of cash or monetary rebates, and

        - New for 2021: A Medicare hospice benefit component for eligible enrollees who elect hospice (see below).

2. ***Part C and D Rewards and Incentives Programs (RI Programs):*** In addition to the

Part C rewards and incentives that may be offered to enrollees for completing healthy activities by MAOs today, MAOs in the model have additional flexibility to offer rewards connected to the Part D benefit offered in their MA-PD plans. Examples of Part D rewards and incentives programs may include but are not limited to rewards and incentives designed to promote participation in medication therapy management programs, preventive health services (such as receiving covered Part D vaccines), and engagement in activities designed to help enrollees better understand their Part D plan benefits, costs, and therapeutic-equivalent coverage alternatives, including biosimilars and generics.

3. ***VBID Hospice Benefit Component:*** In January 2019, CMS announced that beginning in CY 2021 MAOs participating in the VBID Model could include the Medicare hospice benefit in their Part A benefits package. Under current law, MA plans are prohibited from covering the Part A hospice benefit. By including the Medicare hospice benefit in the MA benefits package, CMS will test the impact on service delivery and quality of MA plans providing all original Parts A and B Medicare items and services, including the hospice benefit. Additionally, CMS is testing how inclusion of the hospice benefit component in the MA plan's benefit package can improve beneficiary care through greater care coordination, reduced fragmentation, and transparency in line with recommendations by the Office of Inspector General, the Medicare Payment Advisory Commission and others.

**Evaluation Status/Results:** The evaluation report for the first three years (2017-2019) of the Medicare Advantage Value-Based Insurance Design (VBID) Model was released in September 2020 and covers enrollment from 2017 through 2019, costs from 2017 through 2018, and utilization for 2017 (due to differences in timing of data availability).

VBID is improving utilization outcomes by increasing the use of many high-value services, such as increased primary care provider visits, specialist visits, and 30-day drug refills. Care coordination was improved, but no other changes were detected among health outcomes or quality measures, which usually take a longer time to materialize.

Beneficiary participation increased from 2017 to 2018 and remained relatively constant from 2018 to 2019, with significant differences in participation between (a) plans that had required beneficiaries to complete certain activities—such as participation in a care management or disease management program—to receive benefits, and (b) those plans without these participation requirements. Plans did express some challenges in how they make beneficiaries aware of VBID and engage them in associated care management/disease management activities.

Overall, VBID is not yet generating savings, but also is not costing CMS additional money.

**Webpage:** Additional information is available at the VBID Model webpage.

## *Medicare Care Choices Model*

**Model Announcement Date:** June 2014

**Anticipated Model Performance Period:** January 1, 2016–December 31, 2021

**Model Participants:** Hospices

**Geographic Scope:** There are 85 hospices operating in 32 states (as of December 2019)

**Coronavirus Disease 2019 PHE Flexibilities:**

To create necessary flexibilities for participants in the Medicare Care Choices Model, CMS extended the model through December 2021.

**Model Description:** The Medicare Care Choices Model (MCCM) tests whether eligible Medicare and dually eligible beneficiaries would choose to receive hospice support services earlier if they could also continue to receive benefits related to the treatment for their terminal condition. According to the Medicare Payment Advisory Commission's March 2016 *Report to Congress: Medicare Payment Policy*, less than half of Medicare beneficiaries who died enrolled in hospice care, and the median length of stay in hospice was a relatively short 17 days. Under the Medicare hospice benefit, a beneficiary must forgo Medicare payment for treatment aimed at curing the terminal condition and this may affect whether a beneficiary chooses hospice care. In the MCCM, enrollees may continue such treatment.

The model is designed to look at how this flexibility impacts quality of care and satisfaction of the beneficiary, family, and caregivers, as well as whether it reduces Medicare expenditures. Under MCCM, selected hospices furnish support services available under the Medicare hospice benefit that cannot be separately billed under Medicare Parts A and B. These services include nursing, social work, hospice aide, hospice homemaker, volunteer (direct services), chaplain, bereavement, nutritional support, and respite care services (in-home only).

CMS pays a per-beneficiary-per-month (PBPM) fee of $400 to participating hospices for each month a beneficiary is enrolled in the model (except for a reduced fee of $200 in the first month if enrollment is less than 15 days) for model services provided. Providers and suppliers continue to bill Medicare when furnishing reasonable and necessary services covered by Medicare that are not covered by the model. Medicare continues to cover treatment of the beneficiary's terminal condition.

As of December 31, 2019, the model has enrolled 5,356 beneficiaries, and 85 hospices operating in 32 states are participating in the model.

**Evaluation Status/Results:** The second evaluation report from MCCM[72] was released in February 2020, and included descriptive findings on implementation and beneficiary enrollment from the start of the model on January 1, 2016 through June 30, 2018.

To date, MCCM has increased access to supportive care services for hospice-eligible beneficiaries. Maturation and evolution of the model led to increased beneficiary enrollment, expanded care delivery, and improved participant experience. Enrolled beneficiaries and caregivers reported a high degree of satisfaction with MCCM. The model offered a bridge to the Medicare hospice benefit for 83 percent of MCCM enrollees, as well as counseling, symptom management, and supportive care to beneficiaries who might not otherwise have access to these services.

**Webpage:** Additional information is available at the MCCM webpage.

## *Medicare Diabetes Prevention Program Expanded Model*

**Model Announcement Date:** July 7, 2016

**Anticipated Model Performance Period:** April 2018–September 30, 2024

**Model Participants:** Medicare Diabetes Prevention Program **(**MDPP) Suppliers: organizations that qualify through the Centers for Disease Control certification process to furnish MDPP services, then apply to file Medicare claims and sign up with the MDPP program. These can be traditional health care providers, such as physicians and hospitals, as well as community-based organizations, gyms, state and local health departments, and other qualifying entities.

**Number of Participants:** Approximately 192

**Geographic Scope:** Nationwide

**Coronavirus Disease 2019 PHE Flexibilities:** To create necessary flexibility for participants in the Medicare Diabetes Prevention Program Expanded Model, the deadline for submitting the quarterly Crosswalk file was extended this year to July 15, 2020.

**Model Description:** In March 2016, under delegation of authority by the Secretary, CMS determined that the MDPP model test, tested through a Round One Health Care Innovation Award, met the criteria for expansion.[73] The MDPP Expanded Model was developed through two rounds of rulemaking in the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) Final Rule and the CY 2018 PFS Final Rule. Rulemaking resulted in the creation of a new provider type, MDPP suppliers, and the establishment of MDPP as

[72] The third evaluation report from MCCM was released after the period of report, in October 2020.
[73] For a review of the expansion decision, see Section 1, Part D in this Report to Congress.

a new preventive service for all eligible beneficiaries with Part B coverage through Original Medicare or Medicare Advantage.

The MDPP Expanded Model uses an evidence-based, structured health behavior change intervention to prevent the onset of type 2 diabetes. MDPP services consist of up to two years of sessions furnished in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies. The program's primary goal is at least five percent weight loss by participants. Services are furnished in community and health care settings by coaches, such as trained community health workers or health professionals. MDPP suppliers are paid according to a performance-based payment structure for achieving beneficiary attendance and weight loss goals. The MDPP benefit is once-per-lifetime for each qualifying beneficiary.

The goals of the MDPP Expanded Model are to prevent or delay progression from prediabetes to type 2 diabetes in beneficiaries with prediabetes, and to reduce Medicare costs for services related to type 2 diabetes.

MDPP supplier enrollment began on January 1, 2018, and MDPP services were available as of April 1, 2018. Enrollment will be continuous, with no limits on the number of MDPP suppliers who can enroll or on the number of beneficiaries who can receive MDPP services.

**Evaluation Status/Results:** The evaluation of the MDPP Expanded Model will assess the effectiveness of a new Medicare benefit which provides Medicare beneficiaries who have prediabetes access to the Diabetes Prevention Program, and will be based on previously established outcomes of the program. Analyzing data from the Centers for Disease Control and Prevention, MDPP suppliers, and Medicare claims data, the evaluation will assess whether MDPP participation results in weight reduction and has an impact on health outcomes (such as incidence of diabetes), as well as health care expenditures among Medicare beneficiaries with prediabetes compared to a similar group of beneficiaries who have not participated in the expanded model.[74]

**Webpage:** Additional information is available at the MDPP Expanded Model webpage.

## *Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport Model*

**Model Announcement Date:** May 22, 2014

**Anticipated Model Performance Period:** December 1, 2014–December 1, 2020. While the model ended under CMS Innovation Center authority on December 1, 2020, it was

[74] The first evaluation report from MDPP was released after the period of report, in March 2021.

expanded in accordance with MACRA and will continue without interruption in the current states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia. Due to the Coronavirus Disease 2019 Public Health Emergency (PHE), at this time CMS is delaying implementation of the expansion to additional states.

**Model Participants:** Ambulance suppliers

**Number of Participants:** 381 ambulance suppliers serving 6,575 Medicare beneficiaries as of December 31, 2019

**Geographic Scope:** The District of Columbia and eight states: Delaware, Maryland, Pennsylvania, New Jersey, North Carolina, South Carolina, Virginia, and West Virginia

**Model Description:** In May 2014, the CMS Innovation Center, in collaboration with the CMS Center for Program Integrity, announced that it would begin testing the Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Medicare Prior Authorization Model. CMS focused the model on RSNAT services due to the high incidences of improper payments for these services as reported by the Department of Health and Human Services' Office of Inspector General, as well as concerns about beneficiaries receiving services that are not medically necessary.

The objective of the model is to test whether prior authorization helps reduce improper payments and reduce Medicare costs while maintaining or improving quality of care. The model does not create additional documentation requirements. It requires the same information that has always been necessary to support Medicare payment, but earlier in the process. This helps to confirm that all relevant coverage, coding, and clinical documentation requirements are met before the beneficiary is served and before the claim is submitted for payment.

The RSNAT Medicare Prior Authorization Model started in South Carolina, New Jersey, and Pennsylvania in December 2014. These states were chosen because of their high Medicare expenditures for repetitive scheduled non-emergent ambulance transports. Section 515(a) MACRA broadened the scope of the model to Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia in January 2016. The model was originally scheduled to end on December 1, 2017, and was extended through December 1, 2020.

In September 2020, CMS announced a nationwide expansion of the RSNAT Medicare Prior Authorization Model after the Secretary determined it met the statutory criteria for nationwide expansion under section 515(b) of MACRA, which references the expansion criteria under section 1115A(c)(1) through (3) of the Social Security Act.

**Prior Authorization Process:** The ambulance supplier or beneficiary is encouraged to submit to their Medicare Administrative Contractor (MAC) a request for prior authorization along with all relevant documentation to support Medicare coverage of the service. The MAC reviews the request and provides a provisional affirmative or non-affirmative decision within a specified timeframe. A claim submitted with an affirmative prior authorization is paid as long as all other requirements are met, and a claim submitted with a non-affirmative decision is denied (with appeal rights available).

Unlimited resubmissions are allowed. If an ambulance supplier chooses to forego prior authorization and submits a claim without a prior authorization decision, the claim is stopped for pre-payment review. The model includes an expedited review process to address circumstances where the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. However, requests for expedited reviews are extremely rare since the model applies only to non-emergent services.

A provisional affirmative prior authorization decision can approve up to 40 round trips within a 60-day period for beneficiaries with acute conditions or up to 120 round trips within a 180-day period for beneficiaries with chronic conditions. Beneficiaries who need additional transports require another prior authorization request.

**Evaluation Status/Results:** The final evaluation report from the RSNAT Medicare Prior Authorization Model was released in May 2021, and covers the first five years of model implementation.[75] Findings indicate that prior authorization was successful in reducing RSNAT and total Medicare spending. The model reduced RSNAT service expenditures by 76 percent (approximately $750 million over five years) for the population examined: beneficiaries with End-Stage Renal Disease and/or severe pressure ulcers in the model states relative to a comparison group of similar states. This decrease in RSNAT service expenditures, in turn, caused total Medicare fee-for-service expenditures to decrease by 2.4 percent ($1 billion over five years) for the population examined. Overall, the model had few to no adverse effects on the quality of care or access to care.

**Webpage:** Additional information is available at the RSNAT Medicare Prior Authorization Model webpage.

## *Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dually Eligible Individuals*

**Model Announcement Date:** July 1, 2011

**Model Performance Period:** Each state demonstration has a unique start date. The first was the Washington Managed Fee-for-Service Model demonstration on July 1, 2013.

[75] The final evaluation report from the RSNAT Model was released after the period of report, in May 2021.

CMS has offered states the opportunity to extend each demonstration. Current state demonstration end dates range from December 31, 2020 through December 21, 2023, with extensions under consideration in a number of states. Demonstrations in Colorado and Virginia ended on their originally scheduled end dates of December 31, 2017.

**Model Participants:** State Medicaid Agencies and health plans

**Geographic Scope:** 12 active demonstrations in 11 states

**Model Description:** CMS developed the Medicare-Medicaid Financial Alignment Initiative (FAI) to establish innovative models of care for dually eligible beneficiaries. Through this initiative and related work, CMS is partnering with states to test state-specific demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for dually eligible beneficiaries. The initiative includes a capitated model and a managed fee-for-service model. Under the capitated model, a state, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, coordinated Medicare and Medicaid services.

Under the managed fee-for-service model, a state and CMS enter into an agreement by which the state is eligible to benefit from a portion of the savings from initiatives that improve quality and reduce costs to Medicare and Medicaid.

In 2019, CMS continued to partner with states and health plans under the initiative. As of September 1, 2019, there were 12 demonstrations in 11 states testing new models.[76] Ten of these demonstrations, including two in New York, were testing the capitated model, serving more than 400,000 beneficiaries as of September 1, 2019.[77] One of these demonstrations, in Washington, was testing the managed Fee-for-Service (FFS) demonstration, serving approximately 31,000 beneficiaries as of September 1, 2019. CMS was partnering with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving nearly 41,000 dually eligible beneficiaries as of September 1, 2019.

Approved demonstrations are at different stages of implementation. Start dates range from July 2013 for the Washington managed FFS demonstration to July 2016 for the Rhode Island capitated demonstration. The Virginia and Colorado demonstrations concluded as scheduled on December 31, 2017. In both states, enrollees will continue to have access to

76 California, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, Rhode Island, South Carolina, Texas, and Washington.

77 California, Illinois, Massachusetts, Michigan, New York (two) , Ohio, Rhode Island, South Carolina, and Texas.

care coordination and support services through integrated care initiatives that build upon demonstration experiences.

| Medicare-Medicaid Financial Alignment Initiative Enrollment by State | | |
|---|---|---|
| **State** | **Geographic Area** | **Enrollment (as of 9/1/2019)** |
| California | 7 of 58 counties | 111,774 |
| Illinois | 21 of 102 counties | 59,625 |
| Massachusetts | 9 of 14 counties | 23,056 |
| Michigan | 25 of 83 counties | 39,481 |
| Minnesota | Statewide | 40,941 |
| New York Fully Integrated Duals Advantage (FIDA) | 6 of 62 counties | 2,564 |
| New York FIDA I/DD | 9 of 62 counties | 1,372 |
| Ohio | 29 of 88 counties | 78,551 |
| Rhode Island | Statewide | 14,636 |
| South Carolina | 38 of 46 counties | 15,121 |
| Texas | 6 of 254 counties | 39,920 |
| Washington | Statewide | 31,001 |
| Total Enrollment | | 458,042 |

**Evaluation Status/Results:** Through the period of this report, CMS has released the first independent evaluation reports for California, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, and Washington. Additionally, the second evaluation reports have been released for Massachusetts, Minnesota, and Washington, and the third evaluation reports have been released for Massachusetts and Washington. Performance data from demonstration reporting and other sources is also available on the Medicare-Medicaid Coordination Office website.

Highlights from the evaluation reports of the Washington MFFS demonstration include statistically significant reductions in gross Medicare Parts A and B expenditures of $150

million[78] for the first three years of the demonstration, achieved by reducing inpatient, skilled nursing facility, and nursing facility use. Reductions in expenditures and changes in service utilization have been fairly consistent over time in Washington. Preliminary savings calculations from the actuarial analysis—used for performance payment purposes—through the first four demonstration periods of the Washington demonstration also show reductions in gross Medicare Parts A & B expenditures of $167 million.[79]

Overall, four of five capitated model demonstrations with reports that contain utilization results to date have shown significant declines in inpatient facility utilization. An increasing portion of beneficiaries in the capitated demonstrations have rated their health plans a "9" or "10" (with "10" being the best). We have also observed increasing access to care coordination within the capitated model demonstrations, including a 36 percent increase in health risk assessment completion and a 66 percent increase in care plan completion from 2014 to 2019.

**Webpage:** Additional information is available at the FAI Model webpage.

## *Million Hearts®: Cardiovascular Disease Risk Reduction Model*

**Model Announcement Date:** May 2015

**Anticipated Model Performance Period:** January 3, 2017–December 31, 2021

**Model Participants:** Health care organizations, including primary and cardiovascular care providers

**Number of Participants:** 319 organizations

**Geographic Scope:** The model supports participant organizations in 46 states as well as the District of Columbia and Puerto Rico.

**Model Description:** The Million Hearts® Cardiovascular Disease Risk Reduction Model (MH Model) is a five-year model test of a performance-based payment model designed to prevent heart attacks and strokes. The MH Model is a randomized controlled trial that promotes improved cardiovascular disease (CVD) outcomes and reduced utilization through evidence-based care, including atherosclerotic disease risk calculation, stratification, and risk management. As of 2019, the model supports participant organizations in 46 states plus Washington D.C. and Puerto Rico.

The MH Model incentivizes practices to calculate risk for all eligible Medicare beneficiaries by using the American College of Cardiology/American Heart Association

[78] We expect revised numbers to be available shortly, based on updated determinations about the beneficiaries that the evaluation considers to be eligible for the demonstration and adjustments to the evaluation methodology.

[79] Washington can qualify to share in up to 50 percent of the gross savings.

Atherosclerotic Cardiovascular Disease (ASCVD) ten-year pooled cohort risk calculator, and to develop risk modification plans based on beneficiary risk profiles. Half of all selected applicants were randomly assigned to the intervention group, with the remaining selected applicants assigned to the control group.

Intervention Group participant organizations (POs) are paid a one-time $10 per-beneficiary fee to calculate beneficiaries' ASCVD risk scores. Low- and medium-risk beneficiaries do not continue their participation in the model, while beneficiaries who receive a score of 30 percent or greater are considered high-risk. Providers are required to engage in shared decision-making with their high-risk beneficiaries and to re-assess their risk annually.

Payments in Year One included an additional $10 per-beneficiary-per-month Cardiovascular Care Management (CVD CM) payment for risk management for their high-risk beneficiaries. During Years Two through Five, POs are able to receive a monthly risk reduction payment of up to $10 per beneficiary based on the average aggregate reduction of their high-risk beneficiary ASCVD risk scores. Seventy-five Intervention Group POs earned risk-reduction payments in Year Three, Performance Period One (January–June 2019).

Control Group POs are not asked to implement ASCVD risk calculation, but they are asked to submit clinical data on Medicare beneficiaries for comparison to Intervention Group practices. Data collection will occur in Years One through Three. POs are paid a $20 per-beneficiary payment (based on the estimated costs of preparing and transmitting the required data) for each reporting cycle.

At the end of Year Three (2019), 7,160 providers were participating in the model, and 99,232 beneficiaries were validated and aligned to active POs. All model POs receive clinical practice improvement activities credit towards their Merit-Based Incentive Payment System (MIPS) requirements.

**Evaluation Status/Results:** The second evaluation report for the Million Hearts Model describes how the model was run during its first two and a half years and presents early estimates of its impact on heart attacks, strokes, mortality, and spending.[80] The Million Hearts Model has led providers to more systematically apply the current standard of CVD care, including modest increases in the use of statins and anti-hypertensive medications.

Among high-risk enrollees in the intervention group with follow-up clinical data, CVD risk scores decreased by an average of eight percentage points (or 20 percent) one year after enrollment—driven mainly by decreases in blood pressure. These changes have not yet had an impact on the rate of first-time heart attack or stroke, or in Medicare spending.

[80] The third evaluation report from the Million Hearts Model was released after the period of report, in November 2020.

However, the model appears to have reduced the likelihood of dying among medium- and high-risk beneficiaries by about seven percent, with the likelihood of dying of all causes seven percent lower in the intervention group than the control group. The model also appears to have increased the rate of CVD hospitalizations and emergency department (ED) visits, with the outpatient ED visit rate among the medium- and high-risk enrollees seven percent higher in the intervention than the control group.

**Webpage:** Additional information is available at the Million Hearts Model webpage.

## *Next Generation Accountable Care Organization Model*

**Model Announcement Date:** March 10, 2015

**Anticipated Model Performance Period:** January 1, 2016–December 31, 2021[81]

**Model Participants:** Medicare Accountable Care Organizations (ACOs)

**Number of Participants:** Currently 39 ACOs participating

**Geographic Scope:** 33 states and the District of Columbia

**Coronavirus Disease 2019 PHE Flexibilities:** To create necessary flexibilities for participants in the Next Generation Accountable Care Organization Model (NGACO), we will:

- Extend the period of performance by one year, from December 2020 to December 2021, and
- Offer an amendment to the Next Generation ACO Model Participation Agreement to:
    - Reduce downside risk for Performance Year (PY) 2020 by reducing shared losses by the proportion of months during the Performance Year affected by the Public Health Emergency and the percentage of Next Generation Beneficiaries who reside in an area affected by the PHE;
    - Cap the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as shared savings or paid by the ACO as shared losses at 5 percent;
    - Remove episodes of care for treatment of COVID-19 triggered by an inpatient service from the accrued expenditures used to calculate shared savings and

[81] As this Report to Congress was being prepared for release, CMS announced a special opportunity for NGACO participant ACOs to enter the GPDC Model test and start performance in January 2022.

shared losses for PY 2020;

- Remove all episodes of care for treatment of COVID-19 triggered by an inpatient service from the beneficiary experience accrued in calculating the Performance Year Benchmark;

- Use a retrospective regional trend, rather than solely a prospective base-year trend, to calculate the Performance Year Benchmark for PY 2020; and

- Remove the requirement for the ACO to maintain a financial guarantee for PY 2020.

**Model Description:** The Next Generation ACO (NGACO) Model builds upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program.

NGACO Model participants have the opportunity to take on greater levels of financial risk than ACOs in other current initiatives. While the ACOs in this model are at greater financial risk, they also have a greater opportunity to share in the model's savings.

The ACOs are able to select from flexible payment options that support ACO investments in care improvement infrastructure and clinical process workflows by providing regular cash flow payments to allow ACOs to make those investments.

Like the Pioneer ACO Model, the NGACO Model allows beneficiaries to choose to be aligned to the ACO, and tests beneficiary incentives for seeking care with Next Generation ACO providers and suppliers. The NGACO Model includes benefit enhancements designed to provide ACOs with greater flexibility in care delivery, including a conditional waiver of the requirement for a three-day inpatient hospital stay prior to admission to a Skilled Nursing Facility. The NGACO Model's benefit enhancements also include the option to use telehealth in circumstances not otherwise permitted under Medicare, including providing coverage for teledermatology and teleophthalmology services furnished using asynchronous store and forward technologies, and to use post-discharge home visit services for care coordination.

Beginning in 2019, the NGACO Model began using an updated financial methodology, and implemented new benefit enhancements and beneficiary engagement incentives including a waiver to permit certain cost-sharing support arrangements for Part B services; a waiver to allow the use of gift cards to incentivize certain beneficiaries to participate in chronic disease management programs; and a waiver increasing the availability of in-home care to beneficiaries at risk of hospitalization. The quality measures and reporting requirements used in the NGACO Model continue to closely follow those used in the Medicare Shared Savings Program.

The NGACO Model began its fifth Performance Year on January 1, 2020. There are 39 ACOs made up of approximately 64,000 health care providers participating in the

NGACO Model for 2020. These ACOs serve about 1.4 million beneficiaries across 33 states and the District of Columbia. The NGACO Model is an Advanced APM under the Quality Payment Program.

**Evaluation Status/Results:** The third evaluation report for the NGACO Model describes the effects of the model during its first three Performance Years (2016–2018) across 62 ACOs that participated in the model in one of three ACO cohorts. Participation in the NGACO Model increased from 18 ACOs participating in the first Performance Year (2016) to 50 ACOs in the third year (2018). The proportion of model ACOs electing full risk (100 percent) as opposed to partial risk (80 percent) also increased from 17 percent of ACOs in 2016 to 56 percent of ACOs in 2018. During the three-year period examined, the evaluation found that participating ACOs invested in the following four areas in response to the model's incentives:

- Improved data analytic capacity to manage prospectively aligned populations;
- Engagement with beneficiaries through care management activities and annual wellness visits;
- Engagement with physicians using financial and non-financial incentives; and
- Cultivation of partnerships with skilled nursing facilities (SNFs) to improve delivery of post-acute care (PAC).

During 2016-2018, the NGACO Model successfully reduced total Medicare Part A and B spending, but was associated with an increase (loss) in net Medicare spending. Cumulative Medicare Parts A and B spending declined by a statistically significant $348.6 million relative to similar non-NGACO beneficiaries in the same markets. Reductions in spending in post- acute care settings and professional services contributed to this decline. However, once shared savings payments to participant ACOs and coordinated care reward (CCR) payments across the first three years totaling $466.1 million are included, the model's net spending did not decline. The cumulative net Medicare spending impact of the model totaled a statistically significant $118 million increase (0.4 percent increase) in Medicare expenditures. Overall, the NGACO Model was not associated with notable changes in quality either in readmissions or ambulatory care sensitive inpatient admissions.

**Webpage:** Additional information is available at the NGACO Model webpage.

## *Oncology Care Model*

**Model Announcement Date:** February 2015

**Anticipated Model Performance Period:** July 1, 2016–June 30, 2022

**Model Participants:** Physician Group Practices

**Number of Participants:** As of February 2020, 139 physician group practices were participating in the model, representing approximately 25 percent of Medicare Fee-for-Service (FFS) chemotherapy-related cancer care, and 10 third-party payers.

**Geographic Scope:** Nationwide

**Coronavirus Disease 2019 PHE Flexibilities:** To create necessary flexibilities for participants in the Oncology Care Model (OCM), the following flexibilities are in place:

- An option for OCM practices to elect to forgo both upside and downside risk for performance periods affected by the PHE;
- For OCM practices that remain in one- or two-sided risk for the performance periods affected by the PHE, removal of COVID-19 episodes from reconciliation for those performance periods;
- Making the following reporting optional for the PHE-affected performance periods:
    - Aggregate-level reporting of quality measures; and
    - Beneficiary-level reporting of clinical and staging data;
- Making optional reporting for cost and resource utilization and practice transformation in July/August 2020; and
- Extension of the model for one year—through June 2022.

**Model Description:** The OCM aims to provide higher quality, more highly coordinated oncology care at lower cost to Medicare. The OCM launched on July 1, 2016, and with the one-year extension described above, is anticipated to run for six performance years.

The CMS Innovation Center designed the Model in collaboration with stakeholders from the medical, consumer and business communities who believed an alternative model for oncology care would better support beneficiaries and clinicians' work with their patients. Under OCM, practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer. OCM incentivizes participating physician practices to comprehensively and appropriately address the complex care needs of Medicare beneficiaries receiving chemotherapy treatment, and heighten the focus on furnishing services that improve the patient experience and/or health outcomes. OCM episodes of care span six months following the initiation of chemotherapy treatment for cancer. OCM incorporates a two-part payment system for participating practices. The first is a monthly per-beneficiary-per-month payment for the duration of the episode, referred to as the OCM Monthly Enhanced Oncology Services (MEOS) payment. The MEOS payment helps pay for the OCM practices' costs related to increased care coordination and access for Medicare FFS

beneficiaries receiving chemotherapy services. The second part of the payment system is a performance-based payment that practices may be eligible to receive if they are able to lower the total cost of care, while delivering high-quality care for beneficiaries during the episode.

To calculate the performance-based payment, all Medicare Part A and Part B expenditures as well as certain Part D expenditures during the episode are included in the total cost of care, compared against a risk-adjusted target, and then adjusted by a quality score. Beginning in mid-2019, clinical data related to the stage of cancer at diagnosis have been used to inform the target prices.

As of February 2020, there were 139 physician practices and ten third-party payers participating in OCM. These numbers have changed since the CMS Innovation Center launched the model. The model started with 17 participating payers, but five of the third-party payers have since left the model, and three of the third-party payers consolidated their participation and now participate as one. The participating practices are heterogeneous in terms of practice size, ownership, and location. Both of the OCM two-sided Risk Arrangement tracks are considered to be an Advanced Alternative Payment Model under the Quality Payment Program.

**Evaluation Status/Results:** The evaluation report from OCM on Performance Periods 1 through 3 was released in July 2020, and covers six-month episodes initiated for FFS Medicare beneficiaries receiving chemotherapy for cancer care between July 2016 and January 2018 that ended by July 2018.[82] Episode payments for high-risk cancers (all eligible cancers except those designated as low-risk breast, low-intensity prostate, and low-risk bladder cancers) declined in the first three performance periods by $430 per episode ($p<0.05$, -1.1 percent), but these impacts were offset by increases in episode payments of $130 per episode ($p<0.10$, 1.8 percent) for low-risk cancers, leading to a non-statistically significant overall gross reduction in spending. After accounting for the distribution of incentive payments in the first two performance periods, OCM resulted in significant net losses to Medicare of nearly $90M in Performance Period 1 (2.7 percent of baseline episode payments) and $65M in Performance Period 2 (2.0 percent of baseline episode payments).

OCM had no impact on overall beneficiary cost-sharing or on patient-reported out-of-pocket spending for cancer-related expenses. In an examination of utilization in the last 30 days of life for decedents, OCM led to a relative reduction in hospitalizations and intensive care unit (ICU) use including a significant 1.1 percent relative decrease in inpatient hospitalizations (-2.1 percent change from baseline) and a significant 0.9 percentage point relative decrease in the likelihood of an ICU stay (-3.7 percent change from baseline). From a quality perspective, OCM practices report helping patients address financial barriers and side-effects, and fill prescriptions on time. Additionally,

[82] The evaluation report from OCM on Performance Periods 1-5 was released after the period of report.

oncologists think OCM improves patient care, and patients are better informed about their treatment because of OCM.

**Webpage:** Additional information is available at the OCM webpage.

## *Part D Enhanced Medication Therapy Management Model*

**Model Announcement Date:** September 25, 2015

**Anticipated Model Performance Period:** January 1, 2017–December 31, 2021

**Model Participants:** Part D standalone basic Prescription Drug Plans (PDPs)

**Number of Participants:** Six Part D Sponsors

**Geographic Scope:** The model is being tested in five Part D Regions that comprise 11 states: Region Seven (Virginia), Region 11 (Florida), Region 21 (Louisiana), Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming), and Region 28 (Arizona).

**Model Description:** The Part D Enhanced Medication Therapy Management (MTM) Model is an opportunity for Prescription Drug Plans (PDPs) in selected regions to offer innovative MTM programs aimed at improving the quality of care while also reducing costs.

The Enhanced MTM Model tests whether providing selected plans with regulatory flexibility to design and implement innovative programs and aligning financial incentives can more effectively achieve key goals for MTM programs, including:

- Improving compliance with medication protocols and protocols for high-cost drugs; ensuring that beneficiaries get the medications they need; and ensuring that those medications are used properly;
- Reducing medication-related problems, such as duplicative or harmful prescriptions, polypharmacy, or suboptimal treatments;
- Increasing patients' knowledge of their medications to achieve their own or their prescribers' therapy goals; and
- Improving communication among prescribers, pharmacists, caregivers, and patients.

CMS grants participating PDPs a waiver of existing MTM regulations that define both the target population and the MTM services that can be provided to enable plans to target barriers to optimal medication usage at an individual level. Services provided under the

Model are funded through a separate payment to plans, outside of the standard bid/premium structure. Plans that are successful at reducing their members' medical expenditures are eligible for a performance incentive in the form of a reduction in enrollee premiums for a future model year. In addition, the Part D Enhanced MTM Model provides participating plans with access to Medicare Parts A and B claims data in order to facilitate effective targeting of beneficiaries at high risk of medication-related issues.

In 2017, 2018, and 2019 six Part D Sponsors participated in the Model, enrolling over 1.7 million beneficiaries in 22 participating plan benefit packages. The Part D Enhanced MTM Model is currently being tested and is scheduled to run until December 31, 2021.

**Evaluation Status/Results:** The first evaluation report of the Part D Enhanced MTM Model[83] was released in October 2019. It includes descriptive findings on Model implementation and beneficiary enrollment from the start of the Model in January 2017 through August 2018. Findings to date indicate that because of the Model's financial incentives and flexibility in targeting criteria, over 1.3 million beneficiaries (or 71.7 percent of enrollees in participating plans) in 2017 were eligible to access Enhanced MTM services across the 22 participating plan benefit packages offered by six sponsors. Prior to the Model, only about 7.9 percent of beneficiaries were eligible to access MTM services in 2016. Perspectives from the workforce engaged in service provision and enrolled beneficiaries are largely positive. Participating sponsors, however, have reported challenges with engaging beneficiaries and prescribers in their programs, timely identification of beneficiaries who are experiencing a transition of care, and integration of community pharmacists in service provision.

**Webpage:** Additional information is available at the MTM Model webpage.

## *Pennsylvania Rural Health Model*

**Model Announcement Date:** January 12, 2017

**Anticipated Model Performance Period:** January 1, 2019–December 31, 2024

**Model Participants:** Acute care hospitals and critical access hospitals (CAHs) in rural Pennsylvania

**Number of Participants:** 13 hospitals participating as of Performance Year 2 (2020)

**Geographic Scope:** Commonwealth of Pennsylvania, with a particular focus on rural areas

[83] The second evaluation report on the Part D Enhanced MTM Model was released after the period of report, in November 2020.

**Model Description:** The Pennsylvania Rural Health Model (PARHM) seeks to increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare and Medicaid, and improving the financial state of acute care hospitals and CAHs in rural Pennsylvania to ensure continued access to care. Pennsylvania, through the Pennsylvania Department of Health (PA-DOH), is the state partner working with CMS to jointly administer this model. The state continues to play a central role in designing and operationalizing the model.

The two key components of this model are hospital global budgets and deliberate hospital care delivery transformation. Under this model, participating rural hospitals are paid based on all-payer global budgets—a fixed amount that is set in advance for inpatient and outpatient hospital-based services, and paid throughout the year by Medicare Fee-for-Service (FFS) and other participating payers. In addition, participating rural hospitals will thoughtfully redesign care delivery in accordance with their CMS- and State-approved Rural Hospital Transformation Plans to improve quality of care and meet the needs of their local communities. By doing so, the model tests whether the predictable nature of the global budgets will enable participating hospitals to invest in quality and preventive care and to tailor services to rural beneficiaries. In addition, other payers in Pennsylvania, including Medicaid and commercial plans, may participate in the model.

In the model design, CMS planned to provide up to $25 million in funding to help Pennsylvania begin its implementation of the model. Pennsylvania is also contributing funding for the operation of the model. The first cooperative agreement of $10 million was awarded to the Pennsylvania Department of Health (PA-DOH), in fiscal year 2017 for the purpose of accelerating setup, supporting technical assistance for hospitals, and planning for the Rural Health Redesign Center (RHRC). On November 27, 2019, the Pennsylvania state legislature created the RHRC. The PA-DOH planned to transfer responsibilities for model implementation after the RHRC was formally established in May 2020.

As PARHM moved into the implementation stage, the second Cooperative Agreement for Pennsylvania was developed to support several activities: model operations, global budget administration, data analytics, technical assistance, and quality assurance. CMS expects to award Pennsylvania up to $15 million subject to the availability of funds and Pennsylvania's ability to meet specific milestones over the three budget periods.

In drafting the Terms & Conditions for this award, CMS developed specific milestones and contingent funding in recognition of the importance of meeting the hospital participation scale targets to achieving the model's overall savings targets. As a result, CMS restricted the Budget Period 1 award amount to $3 million out of the up-to $7 million available, since Pennsylvania did not reach the Rural Hospital Participation Scale Target of 18 hospitals for Performance Year 2 (2020), with only 13 hospitals participating in the model that year.

The Payer Participation Scale Target for Performance Year 1 (2019) is defined as having 75 percent or more of the eligible net patient revenue for each of the participating rural hospitals come from participating payers under a global budget for that Performance Year (PY). The scale target rises to 90 percent for PYs 2-6. The most recent annual progress report submitted by the Commonwealth demonstrated non-compliance with the Payer Participation Scale Targets for both PYs 1 and 2.

Pennsylvania recruited Aetna as a participating payer starting in PY 2, joining the state Medicaid program, and Gateway, Geisinger, Highmark, and UPMC as the private payers in PARHM. These payers, together with Medicare FFS, cover almost half of the insured population in Pennsylvania.

Under this model, Pennsylvania is responsible for attaining and maintaining the following three population health and access goals: (1) increase access to primary and specialty services; (2) reduce deaths related to substance use disorder (SUD) and improve access to treatment for opioid abuse; and (3) reduce rural health disparities through improved chronic disease management and preventive screenings. To address these goals, participating rural hospitals have identified strategies in their Rural Hospital Transformation Plans for Performance Years 1 and 2, ranging from enhanced care management, telehealth, improving emergency department utilization, enhancing operational efficiency and creating increased access to services such as substance use, behavioral health, and palliative care. Participating rural hospitals are required to engage local stakeholders in designing and implementing these activities to meet the needs of their community.

**Evaluation Status/Results:** The evaluation of PARHM will assess whether hospital global budgets and deliberate care transformation can improve the financial stability of hospitals to ensure continued access to care while also improving the health outcomes of their local populations and reducing hospital spending and total cost of care. The analyses will examine the model's impact on hospital spending across service types and the quality of care received by patients at the hospitals. Additionally, qualitative analyses will examine hospital experiences with model implementation. The hospital's effect on total cost of care, the quality of care received by individuals living in the geographic areas surrounding the hospitals, and population health outcomes will also be examined.

**Webpage:** Additional information is available at the PARHM webpage.

## *State Innovation Models, Round Two*

**Model Announcement Date:** July 2012 (Round One); May 2014 (Round Two)

**Model Performance Period:** April 2013–September 2016 (Round One); February 2015–January 2019 (Round Two)

**Model Participants:** State Agencies

**Number of Participants and Geographic Scope:** Round Two funding has been provided to 28 states, three territories and the District of Columbia, representing approximately 60 percent of the U.S. population.

**Model Description:** The State Innovation Models (SIM) initiative tested the ability of state governments to use their policy and regulatory levers to accelerate health care payment and delivery transformation efforts in their states. The goal was to move the majority of care for the state population from volume to value-based, multi-payer delivery systems that improve the quality of care and the health of the population. SIM also sought to lower health care costs by engaging stakeholders and employing enabling strategies such as health information technology and exchange, new workforce models, data analytics, and alignment of quality metrics. The CMS Innovation Center provided funding and technical assistance to states to design and test their State Health Innovation Plans.

SIM consisted of two rounds of funding, and two types of awards in each round: Model Design Awards and Model Test Awards. SIM Round One began in April 2013, providing $30 million to 19 Design states and $240 million to six Test states. SIM Round Two was launched in February 2015, providing $45 million in design funding to 17 states, three territories, and the District of Columbia, as well as more than $600 million in funding to 11 Test states, all of which were initially Round One Design states. Unlike other CMS Innovation Center models, SIM did not test a specific delivery system or payment model. Rather, SIM focused on developing the infrastructure necessary to enhance coordination and communication across the care continuum. For example, several states developed all-payer databases, and shared admission-discharge-transfer data—important tools for care coordination.

To achieve model goals, the CMS Innovation Center partnered with several other CMS components (including the Center for Medicaid and CHIP Services, the Center for Clinical Standards and Quality, and the Center for Medicare), as well as other Federal agencies (including the Office of the National Coordinator for Health Information Technology, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, and the Health Resources & Services Administration), to align and leverage other Federal delivery system reform programs and opportunities within the context of each state's health care landscape.

All Round One Design and Test states completed their period of performance prior to current Period of Report. Likewise, because the Round Two Design States were designing (rather than testing), they had a shorter period of performance than Round Two Test States. Round Two Design States had all completed their SIM design period of performance and submitted their State Health System Innovation Plans in 2016. As of January 31, 2020, all Round Two Test states have also now completed their performance periods.

SIM developed robust reporting and learning systems that tracked and catalogued all technical assistance requests and resources while providing opportunities for states to learn and implement best practices adopted by other states into their own delivery system environment. Further, each state was required to perform a self-evaluation which required the state to consistently assess progress on achieving its milestones and revise its innovation plan based on data and stakeholder input.

Several Round Two Test states began developing proposals for Medicare participation in their state-based delivery and payment models (in accordance with updated guidance for Medicare Alignment in Multi-Payer Models under the State Innovation Models Initiative announced by the CMS Innovation Center in October 2017), but redirected their efforts in response to the CMS Innovation Center's focus on multi-state model development. The CMS Innovation Center continues to develop multi-state, multi-payer model tests.

**Evaluation Status/Results:** The third Model Test evaluation report from SIM Round Two released in March 2019 provides implementation findings through March 30, 2018. States are using their policy and regulatory levers to transform their health care delivery systems. States are engaging behavioral health providers and integrating care with other forms of delivery; increasing investment in and harnessing the power of health IT; and prioritizing quality measure alignment across payers and models. In addition, states are working with their stakeholders to increase screening, referrals, and other social services to improve care coordination. Many states have also instituted screenings for social determinants of health. States are investing in their health care workforce by training and certifying community health workers.

**Webpage:** Additional information is available at the SIM Round Two webpage.

## *Transforming Clinical Practice Initiative*

**Model Announcement Date:** October 23, 2014

**Model Performance Period:** August 1, 2015–September 30, 2019

**Model Participants:** Health care organizations, associations, and systems

**Number of Participants:** 12 Support and Alignment Networks and 29 Practice Transformation Networks

**Geographic Scope:** Nationwide

**Model Description:** A nationwide peer-based learning initiative supporting practice transformation, the Transforming Clinical Practice Initiative (TCPI) was launched in 2015 to help clinicians providing ambulatory care in any specialty achieve large-scale improvements in health care quality and prepare to operate successfully under value-based payment arrangements.

TCPI was designed to provide technical and learning system support for clinicians interested in transitioning their practices to value-based care. Its goals included improving health outcomes; reducing costs; reducing avoidable Emergency Department visits and hospitalizations along with unnecessary testing and procedures; increasing practice enrollment in Alternative Payment Models (APMs); and substantively adding to the evidence base for practice transformation.

To guide these efforts, CMS developed the TCPI Change Package, which described the changes needed to transform clinical practice and meet the TCPI goals of: (1) patient-centered care design; (2) continuous, data-driven quality improvement; and (3) sustainable business operations.

To accomplish the TCPI goals, CMS made awards to Support and Alignment Networks and Practice Transformation Networks to engage practices and clinicians in practice transformation in a number of ways. The peer-based learning networks—Practice Transformation Networks (PTNs)—worked with clinicians and practices to develop core competencies in quality measurement, continuous quality improvement, and the business practices essential to value-based payment. CMS made TCPI awards to 29 PTNs, including a mix of large health care systems and quality improvement collaborations.

In addition, Support and Alignment Networks (SANs) drove the recruitment of clinicians and practices, developed or expanded vehicles for supporting transformation (such as practice registries and decision support tools), and actively disseminated successful efforts to their broader networks and professional sectors. CMS made TCPI awards to 10 SANs, including national and regional professional associations and public-private partnerships. CMS made awards to two additional organizations in September 2016, which were called SAN 2.0s. SAN 2.0s functioned similarly to PTNs.

SANs reached 417,350 clinicians through 1,058 events and activities, with 119,525 continuing medical education credits claimed. Clinicians were also eligible to receive Merit-based Incentive Payment System (MIPS) Improvement Activity credits through participation in technical assistance engagements that utilized specific key SAN assets.

The SANs published 47 articles in peer review journals and produced a special supplement of the *Annals of Family Medicine* on "Lessons from Practice Transformation." Other communications channels such as newsletters, blogs, podcasts, social media, and e-mail blasts were used to further disseminate TCPI's Change Package concepts beyond the SAN's direct membership and to engage their professional sectors in practice transformation.

The TCPI model concluded in September 2019. The TCPI Impact Evaluation is currently being conducted by Mathematica, Inc., and will continue until September 2021.

**Evaluation Status/Results:** The TCPI Impact Evaluation currently focuses on assessing the effects of TCPI on health care spending, use, and quality outcomes through the duration of the model test and beyond, as well as the enrollment of practices in Medicare Alternative Payment Models (APMs). The evaluation also assesses the impact for several subgroups of interest: primary care, specialty care, mixed primary and specialty care, small rural practices and SAN interventions.

To date, evaluation findings for a majority of TCPI aims have been inconclusive with regards to effects on health care spending and quality outcomes. This is due to the fact that data-driven practice transformation requires significant time to allow for the data to mature. It is anticipated that quality improvement built during the TCPI performance period would generate impacts during the final years of the model and beyond, and an analysis of those years of the model will be incorporated into a final evaluation report. The future reports will include updated Medicare analyses examining the longer-term impacts during the model, including utilizing data from Medicaid and other payer sources based on data availability.

Practices that participated in TCPI in some way were more likely to join Medicare APMs than matched comparisons. A total of 17.3 percent of practices that were involved in TCPI and 8.9 percent of matched comparison practices joined a Medicare APM; the estimated regression-adjusted impact was 74 percent ($p < 0.01$). Estimated impacts were large, favorable, and statistically significant ($p < 0.01$) within each subgroup—primary care (106 percent), specialty care (66 percent), mixed primary and specialty care practices (41 percent), practices with three or fewer clinicians (121 percent), and rural practices (86 percent). Estimated impacts were also large and statistically significant during each of the three years of follow-up after practices enrolled in SANs or PTNs.

**Webpage** Additional information is available at the TCPI Model webpage.

## *Vermont All-Payer Accountable Care Organization Model*

**Model Announcement Date:** October 26, 2016

**Anticipated Model Performance Period:** January 1, 2017–December 31, 2022

**Model Participants:** Medicare Accountable Care Organizations (ACOs) in Vermont

**Number of Participants:** Currently one ACO—OneCare Vermont—is the only ACO operating in the Vermont All-Payer Accountable Care Organization Model.

**Geographic Scope:** State of Vermont

**Coronavirus Disease 2019 PHE Flexibilities:**

To create necessary flexibilities for participants in the Vermont All-Payer ACO Model, CMS will:

- Offer an amendment to the Vermont Medicare ACO Initiative Participation Agreement to:
    - Remove episodes of care for treatment of COVID-19 triggered by an inpatient service from the performance year expenditures used to calculate shared savings and shared losses for Performance Year (PY) 2020;
    - Use retrospective regional trend, rather than a prospective base-year trend for PY 2020;
    - Reduce downside risk for PY 2020 in an amount determined by multiplying the shared losses by the percentage of total months during the PY affected by an extreme and uncontrollable circumstance such as the Coronavirus Disease 2019 Public Health Emergency (PHE), as defined in 42 C.F.R. § 400.200, and the percentage of Initiative Beneficiaries who reside in an area affected by the PHE; and
    - Modify PY 2020 quality measures and continue to monitor impact of the PHE on PY 2020 quality reporting.

These flexibilities are intentionally similar to those created in response to the Coronavirus Disease 2019 PHE for the Next Generation ACO Model and the Medicare Shared Savings Program.

**Model Description:** The Vermont All-Payer ACO Model (VT APM) offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state. Under VT APM, the state commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant health care payers. The Model aims for broad ACO participation throughout the state, across all the significant payers and the majority of the care delivery system, to make redesigning the entire care delivery system an effective business strategy for Vermont providers and payers.

By establishing state and ACO-level accountability for health outcomes for the state's entire population, VT APM incentivizes collaboration between the care delivery and public health systems necessary to achieve these outcomes. Vermont will focus on achieving Health Outcomes and Quality of Care Targets in four areas prioritized by Vermont: (1) substance use disorder, (2) suicides, (3) chronic conditions, and (4) access to care. Vermont is accountable for three categories of measures for each of the four priority areas: Population-level Health Outcomes Targets, Health Care Delivery System Quality Targets, and Process Milestones.

VT APM limits the annualized per-capita health care expenditure growth for all major payers to 3.5 percent and limits Medicare per-capita health care expenditure growth for Vermont Medicare beneficiaries to at least 0.2 percentage points below that of projected national Medicare growth.

Under the VT APM, Vermont encourages Vermont payers and health care providers to participate in ACO arrangements so that by the end of 2022, 70 percent of all Vermont insured residents—including 90 percent of Vermont Medicare beneficiaries—will be aligned to a participant in an ACO arrangement. ACO initiatives continue to have payer-specific benchmarks and financial settlement calculations, but the design of a scale target ACO initiative (for example, payment based on quality measures, risk arrangement, payment mechanisms, and beneficiary alignment methodology) is closely aligned across payers.

The Vermont Medicare ACO Initiative is a Medicare Fee-for-Service ACO initiative tailored to Vermont, offered by CMS to ACOs in Vermont under VT APM. The Vermont Medicare ACO Initiative is largely based on the Next Generation ACO Model, and supports ACO design alignment with other Vermont payers' ACO initiatives. The Green Mountain Care Board, Vermont's health care regulatory body, has a significant role in setting the Vermont Medicare ACO Initiative Performance Year benchmarks in accordance with standards specified by CMS and subject to CMS approval.

Medicaid is a critical health care payer in the VT APM. In 2016, CMS approved a five-year extension of Vermont's section 1115(a) Medicaid demonstration, which enables Medicaid to participate in VT APM. Specifically, the 1115(a) Medicaid demonstration promotes delivery system and payment reform by allowing Vermont Medicaid to enter into ACO arrangements that align with other health care payers' ACOs.

The Vermont Medicare ACO Initiative qualifies as an Advanced Alternative Payment Model under CMS' Quality Payment Program, allowing physicians and other clinicians to potentially qualify for Advanced Alternative Payment Model incentive payments. The Vermont All-Payer ACO Model began January 1, 2017, and is scheduled to conclude December 31, 2022 with six Performance Years (PY 0–PY 5), each spanning a full calendar year.

**Evaluation Status/Results:** The evaluation of the VT All-Payer ACO Model will assess whether the flexibility given to the state in return for greater accountability has an impact on total cost of care, health care utilization, and the quality of care received by patients. The effect of the model on total cost of care, health care utilization, and quality of care will be examined at both the state-level and ACO-level. The evaluation will also examine the model's impact on the state's population health.

**Webpage:** Additional information is available at the VT APM webpage.

# 4. Beneficiaries and Individuals Included in CMS Innovation Center Activities

CMS estimates that during the period of this report more than 27,850,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care, or will soon be receiving care from more than 528,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives described in Sections Three and Four of this Report to Congress.

The number of beneficiaries and individuals estimated to be included in each CMS Innovation Center model test and initiative is listed in Table One below. The table also describes the range of impact of each model test and initiative, breaking down the aggregate number of beneficiaries and individuals specifically covered by Medicare Fee-for-Service (FFS), Medicare Advantage, Medicaid and the Children's Health Insurance Program (CHIP), Medicare and Medicaid dually eligible beneficiaries, private insurance, and those either uninsured or not covered by any of the aforementioned payers.

***Table One:*** *Estimated number of beneficiaries and individuals currently or previously included in models or other initiatives implemented under section 1115A of the Social Security Act between October 1, 2018 and September 30, 2020. A comprehensive listing of all models and initiatives currently administered by the CMS Innovation Center is contained in Appendix I.*

**Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives**

**(Estimate as of September 30, 2020)**

| INITIATIVE | TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84] | RANGE OF IMPACT[85] |
|---|---|---|
| Accountable Health Communities Model | 508,848[86] | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible |

[84] Values represent estimated unique counts between October 1, 2018 and September 30, 2020, unless otherwise specified.

[85] Certain exclusions to beneficiary eligibility for inclusion in these models may apply. Specific information can be obtained by visiting respective CMS Innovation Center web pages.

[86] This count represents the total number of beneficiaries who received a screening. Of this total, 52,494 eligible high-risk beneficiaries were offered and accepted navigation services under the model.

## Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives

**(Estimate as of September 30, 2020)**

| INITIATIVE | TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84] | RANGE OF IMPACT[85] |
|---|---|---|
| | | enrollees (160,250)<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (71,305)<br>• Standalone Medicaid beneficiaries (277,293)<br>• Medicare and Medicaid dually eligible enrollees (76,033)[87] |
| ACO Investment Model | 485,029 | This model ended on December 31, 2018, and included:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees[88] |
| Artificial Intelligence Health Outcomes Challenge | Not Applicable[89] | |
| Bundled Payments for Care Improvement Advanced Model | 835,226 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (835,226)<br>• Medicare and Medicaid dually eligible enrollees (197,003)[90] |

[87] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

[88] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.

[89] The Artificial Intelligence Health Outcomes Challenge is an infrastructure improvement challenge initiative and does not directly serve beneficiaries.

[90] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| Community Health Access and Rural Transformation Model | Data Not Yet Available[91] | |
| Comprehensive Care for Joint Replacement Model | 123, 294 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (123,294)<br>• Medicare and Medicaid dually eligible enrollees (13,136)[92] |
| Comprehensive End-Stage Renal Disease Care Model | 95,922 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (95,922)<br>• Medicare and Medicaid dually eligible enrollees (26,060)[93] |
| Comprehensive Primary Care Plus Model | 2,708,201 | This multi-payer model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and |

[91] Model is pre-operational.
[92] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[93] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| | | Medicaid dually eligible enrollees (2,708,201)<br>• Medicare and Medicaid dually eligible enrollees (333,702)[94] |
| Emergency Triage, Treat, and Transport Model | Data Not Yet Available[95] | |
| End-Stage Renal Disease Treatment Choices Model | Data Not Yet Available[96] | |
| Global and Professional Direct Contracting Model | Data Not Yet Available[97] | |
| Health Care Payment Learning and Action Network | Not Applicable[98] | |
| Home Health Value-Based Purchasing Model | Not Applicable[99] | |
| Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, Phase Two | 30,072 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees[100] |
| Integrated Care for Kids Model | Data Not Yet Available[101] | |

[94] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[95] Model was pre-operational.
[96] Model was pre-operational.
[97] Model was pre-operational.
[98] This is a national quality improvement initiative that has only indirect effects on beneficiaries.
[99] This model is being conducted in nine model test states. It has no direct beneficiary impact.
[100] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.
[101] Model was pre-operational.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| Kidney Care Choices Model | Data Not Yet Available[102] | |
| Maryland All-Payer Model | 727,779 | This multi-payer model ended on December 31, 2018, and included:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (196,178)<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (20,172)<br>• Stand-alone Medicaid beneficiaries (197,422)<br>• Individuals with private insurance (314,007)<br>• Medicare and Medicaid dually eligible enrollees (36,792)[103] |
| Maryland Total Cost of Care Model | 2,656,239 | This multi-payer model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (674,501)<br>• Medicare Advantage beneficiaries, including |

[102] Model was pre-operational.

[103] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| | | Medicare and Medicaid dually eligible enrollees (76,009)<br>• Stand-alone Medicaid beneficiaries (671,053)<br>• Individuals with private insurance (1,234,676)<br>• Medicare and Medicaid dually eligible enrollees (96,367)[104] |
| Maternal Opioid Misuse Model | Data Not Yet Available[105] | |
| Medicaid Innovation Accelerator Program | Not Applicable[106] | |
| Medicare Accountable Care Organization Track 1+ Model | 1,388,436 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,388,436)<br>• Medicare and Medicaid dually eligible enrollees (155,863)[107] |

[104] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[105] Model is pre-operational.
[106] This is a national quality improvement initiative that has only indirect effects on beneficiaries.
[107] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

## Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives

**(Estimate as of September 30, 2020)**

| INITIATIVE | TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84] | RANGE OF IMPACT[85] |
|---|---|---|
| Medicare Advantage Value-Based Insurance Design Model | 1,268,636[108] | This model includes:<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,268,636)<br>• Medicare and Medicaid dually eligible enrollees (281,733)[109] |
| Medicare Care Choices Model | 2,831 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including dually eligible enrollees[110] |
| Medicare Diabetes Prevention Program Expanded Model | 2,886 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,463)<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,423)<br>• Medicare and Medicaid dually eligible enrollees (202)[111] |
| Medicare Prior Authorization | 8,970 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, |

[108] Beneficiary counts derived from the model September 2020 monthly plan report.
[109] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[110] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.
[111] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| Models: Repetitive Scheduled Non-Emergent Ambulance Transport Model | | including Medicare and Medicaid dually eligible enrollees[112] |
| Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dually Eligible Individuals | 427,460[113] | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (28,714)<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (398,746)<br>• Medicare and Medicaid dually eligible enrollees (427,460)[114] |
| Million Hearts®: Cardiovascular Disease Risk Reduction Model | 379,983 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (379,983)<br>• Medicare and Medicaid dually eligible enrollees (50,173)[115] |

[112] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.
[113] Beneficiary counts derived from the model's September 2020 monthly plan report.
[114] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[115] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| Next Generation Accountable Care Organization Model | 1,544,841 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,544,841)<br>• Medicare and Medicaid dually eligible enrollees (245,149)[116] |
| Oncology Care Model | 527,998 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (527,998)<br>• Medicare and Medicaid dually eligible enrollees (53,000)[117] |
| Part D Enhanced Medication Therapy Management Model | 1,110,713[118] | This model includes:<br>• Medicare Part D Prescription Drug Plan beneficiaries, including Medicare and Medicaid |

[116] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[117] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[118] Beneficiary counts derived from the model September 2020 monthly plan report.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| | | dually eligible enrollees[119] |
| Part D Payment Modernization Model | 66,477[120] | This model includes:<br>• Part D Prescription Drug Plan and Medicare Advantage Prescription Drug Plan beneficiaries, including Medicare and Medicaid dually eligible enrollees (66,477)<br>• Medicare and Medicaid dually eligible enrollees (13,499)[121] |
| Part D Senior Savings Model | Data Not Yet Available[122] | |
| Pennsylvania Rural Health Model | 657,404 | This model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (105,080)<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (113,022)<br>• Stand-alone Medicaid beneficiaries (133,302)<br>• Individuals with Private Insurance (306,000) |

[119] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.
[120] Beneficiary counts derived from the model September 2020 monthly plan report.
[121] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[122] Model is pre-operational.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| | | • Medicare and Medicaid dually eligible enrollees (18,697)[123] |
| Radiation Oncology Model | Data Not Yet Available[124] | |
| State Innovation Models, Round Two | 12,193,130[125] | This model ended on December 31, 2018, and included:<br>• Medicare Advantage beneficiaries, including Medicare and Medicaid dually eligible enrollees (1,679,809) [126]<br>• Stand-alone Medicaid beneficiaries (7,509,678)<br>• Individuals with private insurance and those who were either uninsured or not covered by any of the aforementioned payers (2,941,660)<br>• State employees (61,983) |
| Transforming Clinical Practice Initiative | Not Applicable[127] | |

[123] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.
[124] Model is pre-operational.
[125] This estimate was compiled using state-reported data from states participating in Round Two of the State Innovation Models Initiative Model Test Awards.
[126] This model does not track Medicare and Medicaid dually eligible enrollee counts as a separate category.
[127] This is a national quality improvement initiative that has only indirect effects on beneficiaries.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| Vermont All-Payer Accountable Care Organization Model | 107,878 | This multi-payer model includes:<br>• Medicare Fee-For-Service beneficiaries, including Medicare and Medicaid dually eligible enrollees (107,878)<br>• Medicare and Medicaid dually eligible enrollees (5,866)[128] |
| **Subtotal One** | Medicare Fee-For-Service, including Medicare and Medicaid dually eligible enrollees | 9,404,867 |
| **Subtotal Two** | Medicare Advantage, including Medicare and Medicaid dually eligible enrollees | 3,629,122 |
| **Subtotal Three** | Stand-alone Medicaid | 8,788,748 |
| **Subtotal Four** | Medicare Part D Prescription Drug Plan and Medicare Advantage Prescription Drug Plan beneficiaries, including Medicare and Medicaid dually eligible enrollees | 1,177,190 |
| **Subtotal Five** | Individuals with Private Insurance and Those Who were Either Uninsured or Not Covered by Any of the Aforementioned Payers | 4,858,326 |

[128] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

| **Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives** **(Estimate as of September 30, 2020)** | | |
|---|---|---|
| **INITIATIVE** | **TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED[84]** | **RANGE OF IMPACT[85]** |
| **Subtotal Six** | Medicare and Medicaid dually eligible enrollees | 2,030,735[129] |
| **ESTIMATED TOTAL** | All Beneficiaries and Individuals | 27,858,253[130] |

## 5. Payments Made on Behalf of Beneficiaries and Individuals Included in Models

Table Two is a cumulative account of the estimated payments made from the inception of the CMS Innovation Center to September 30, 2020 on behalf of beneficiaries included in model tests and initiatives authorized under section 1115A of the Social Security Act.

In addition to payments made to model and initiative participants under section 1115A of the Act, the table includes payments under Title XVIII or XIX, and CMS Innovation Center funds obligated to support the design, implementation, and evaluation of model tests and initiatives developed under section 1115A.

The table represents cumulative obligations less any recoveries of obligated funds over the Fiscal Year (FY) 2010-2020 period for the following: current model tests and initiatives; those that were originally housed in the CMS Innovation Center but are now funded under different authorities and implemented by different CMS components; those that have ended; and those that have been announced but not implemented.

[129] This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

[130] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these "overlaps," see Section 2, Part A: Accounting for Model Test and Alternative Payment Model Overlaps of this report.

Not included in the table are payments made for services on behalf of beneficiaries in accordance with existing payment provisions, except as waived solely for purposes of testing a model.

Note that for model tests and initiatives that have concluded, the cumulative estimated payments reported in this table can decline over time. This decrease is a result of prior year funding recoveries per end-of-year CMS accounting reconciliations.

***Table Two:*** *As of September 30, 2020, estimates of payments made to model participants (including health care providers, states, conveners, ACOs, and others), including payments under Title XVIII or XIX and CMS Innovation Center funds obligated to support activities initiated under Section 1115A.*

*Please note: this table does not include Medicare, Medicaid, and CHIP payment amounts that health care providers or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.*

## Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Accountable Health Communities Model | $90,404,432 | Not Applicable | $34,696,377 |
| ACO Investment Model | $96,694,886 | $127,969,727 | $13,766,305 |
| Advance Payment ACO Model | $67,801,572 | $264,178,642 | $5,885,707 |
| Artificial Intelligence Health Outcomes Challenge[135] | Payments Not Yet Made[136] | Not Applicable | $656,715 |

131 This table excludes administrative costs that are not associated with specific models or initiatives.

132 The column titled "CMS Innovation Center payments made to model participants under section 1115A of the Act in United States Dollars" reflects payments made to participants in the testing of models, such as health care providers, states, conveners, ACOs, and others. These payments are paid through CMS Innovation Center funds as provided under section 1115A of the Social Security Act. These payments were made by September 30, 2020.

133 The column titled "Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States Dollars" reflects payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. For example, certain models (such as the Next Generation ACO Model) include opportunities to share in the savings that health care providers generate for Medicare through reductions in payments under Title XVIII. This column does not include Medicare, Medicaid, and CHIP payment amounts that health care providers or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.

134 The column titled "Other CMS Innovation Center funds under section 1115A obligated to support model design, implementation, and evaluation in United States Dollars" reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2020, September 30, 2020, such as contract awards for administrative and evaluation obligations, but excluding payments listed in the column titled "CMS Innovation Center payments made to model participants under section 1115A of the Act."

135 The Artificial Intelligence Health Care Outcomes Challenge is an infrastructure improvement challenge initiative, and does not directly serve beneficiaries.

136 This table only reflects estimated payments from the period ending in FY 2020. Therefore award payments for the Artificial Intelligence Health Outcomes Challenge are not shown here. They were announced after the end of the Fiscal Year.

# Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Beneficiary Engagement and Incentives Model[137] | Not Applicable | Not Applicable | $8,897,728 |
| Bundled Payments for Care Improvement (Models One-Four) | Not Applicable | Data Not Available | $107,895,473 |
| Bundled Payments for Care Improvement Advanced Model | Not Applicable | Data Not Available | $57,137,131 |
| Community Health and Rural Transformation Model | Payments Not Yet Made | Payments Not Yet Made | $1,117,351 |
| Comprehensive Care for Joint Replacement Model | $19,047 | $333,844,675 | $60,088,424 |
| Comprehensive ESRD Care Model | Not Applicable | $118,171,338 | $111,979,748 |
| Comprehensive Primary Care Initiative | $294,960,165 | $23,815,990 | $98,949,416 |
| Comprehensive Primary Care Plus Model[138] | Not Applicable | $2,234,944,784 | $465,465,397 |

[137] The Beneficiary Engagement and Incentives Model was announced during the period for the 2018 Report to Congress, but rescinded prior to implementation.

[138] The CMS Office of Financial Management has advised that providing separate numbers for CPC+ Track 3 (now PCF) and CPC+ Tracks 1 & 2 is impossible, as all three tracks of the CPC+ model use the same ICIP; all funding apportioned by OMB and the related model program-specific OFM accounting structures treat all CPC+ tracks as one CPC+ model test.

# Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Emergency Triage, Treat, and Transport Model | Payments Not Yet Made | Payments Not Yet Made | $13,541,945 |
| End-Stage Renal Disease Treatment Choices Model | Not Applicable | Payments Not Yet Made | $5,263,841 |
| Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model[139] | Not Applicable | Not Applicable | $6,373,644 |
| Federally Qualified Health Center Advanced Primary Care Practice Demonstration[140] | $45,967,680 | Not Applicable | $24,018,351 |
| Global and Professional Direct Contracting Model | Not Applicable | Payments Not Yet Made | $26,787,109 |
| Health Care Innovation Awards Round One | $826,787,683 | Not Applicable | $93,356,190 |
| Health Care Innovation Awards Round Two | $321,898,293 | Not Applicable | $54,645,254 |

[139] The Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model were developed during the period of the 2018 Report to Congress, but were rescinded.

[140] The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration concluded on October 31, 2014.

## Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Health Care Payment Learning and Action Network[141] | Not Applicable | Not Applicable | $34,695,935 |
| Home Health Value-Based Purchasing Model | Not Applicable | Not Applicable | $40,843,557 |
| Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Two Phases Counted as Two Models) | $211,037,072 | Phase One: Not Applicable. Phase Two: $35,249,833 | $41,537,882 |
| Integrated Care for Kids Model | $23,297,741 | Not Applicable | $6,699,564 |
| Kidney Care Choices Model | Payments Not Yet Made | Payments Not Yet Made | $25,352,999 |
| Maryland All-Payer Model | Not Applicable | Data Not Available | $21,197,715 |
| Maryland Total Cost of Care Model | Not Applicable | $171,099,225 | $27,959,202 |
| Maternal Opioid Misuse Model | $7,448,579 | Not Applicable | $9,113,330 |
| Medicaid Innovation Accelerator Program | Not Applicable | Not Applicable | $93,844,432 |

[141] The Health Care Payment Learning and Action Network is a learning collaborative, and does not directly serve beneficiaries.

# Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Medicare ACO Track 1+ Model | Not Applicable | $219,743,402 | $21,660,975 |
| Medicare Advantage Value-Based Insurance Design Model | Not Applicable | Not Applicable[142] | $21,602,191 |
| Medicare Care Choices Model | Not Applicable | Data Not Yet Available | $25,493,747 |
| Medicare Diabetes Prevention Program Expanded Model | Not Applicable | Not Applicable | $11,720,891 |
| Medicare Part B Drugs Payment Model[143] | Not Applicable | Not Applicable | $2,103,875 |
| Medicare Prior Authorization Model: Non-Emergent Hyperbaric Oxygen Therapy | Not Applicable | Not Applicable | $6,327,021 |
| Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent | Not Applicable | Not Applicable | $38,521,531 |

[142] With the exception of the Hospice benefit, the Medicare Advantage Value-Based Insurance Design Model is not designed to provide any additional payments to MAOs, but is based on the expectation that MAOs will incorporate the model flexibilities into their supplemental benefits and use existing means (the rebate or enrollee premiums) to pay for the benefits.

[143] The Medicare Part B Drugs Payment Model was proposed during the period of the 2020 Report to Congress, but has since been rescinded.

# Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Ambulance Transport Model | | | |
| Medicare-Medicaid Financial Alignment Initiative and State Demonstration to Integrate Care for Dually Eligible Individuals | $92,755,238 | $69,400,000 | $229,075,475 |
| Million Hearts® Initiative[144] | Not Applicable | Not Applicable | Not Applicable |
| Million Hearts®: Cardiovascular Disease Risk Reduction Model | $4,807,880 | Data Not Yet Available | $42,251,125 |
| Most Favored Nation (MFN) Model[145] | Not Applicable | Not Applicable | $127,000 |
| Next Generation ACO Model | $25,280,805 | $1,611,210,510 | $108,749,832 |
| Oncology Care Model | Not Applicable | $123,756,988 | $110,680,827 |
| Part D Enhanced Medication Therapy Management Model | Not Applicable | $256,178,798 | $31,286,498 |

[144] The Million Hearts® Initiative is ongoing. However, prior to this period of report it was transitioned into the Center for Clinical Standards and Quality and is no longer funded under Section 1115A of the Social Security Act.

[145] The Most Favored Nation Model has not been implemented because it is the subject of a nationwide preliminary injunction.

# Estimated Payments for 1115A Model Tests and Initiatives[131]

**Fiscal Years 2010-2020**

| INITIATIVE | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
|---|---|---|---|
| Part D Payment Modernization Model | Not Applicable | Payments Not Yet Made | $1,754,335 |
| Part D Senior Savings Model | Not Applicable | Not Applicable | Data Not Yet Available |
| Partnership for Patients[146] | $459,891,939 | Not Applicable | $104,531,899 |
| Pennsylvania Rural Health Model | $14,498,228 | $140,562,575 | $6,240,500 |
| Pioneer ACO Model | $13,181 | $319,090,315 | $114,157,834 |
| Primary Care First Model Options[147] | Data Not Yet Available | Data Not Yet Available | Data Not Yet Available |
| Radiation Oncology Model | Not Applicable | Data Not Yet Available | $8,627,203 |
| State Innovation Models Round One | $274,265,702 | Not Applicable | $47,136,440 |
| State Innovation Models Round Two | $627,767,876 | Not Applicable | $46,215,323 |
| Strong Start for Mothers and Newborns, Strategy One and Two | $45,332,063 | Not Applicable | $48,705,436 |

[146] Before the period of report, Partnership for Patients transitioned into the Hospital Innovation Improvement Network in the Center for Clinical Standards and Quality and was no longer supported by section 1115A funding.

[147] The CMS Office of Financial Management has advised that providing separate numbers for CPC+ Track 3 (now PCF) and CPC+ Tracks 1 & 2 is impossible, as all three tracks of the CPC+ Model use the same ICIP; all funding apportioned by OMB and the related model program-specific OFM accounting structures treat all CPC+ tracks as one CPC+ Model.

| Estimated Payments for 1115A Model Tests and Initiatives[131]<br>Fiscal Years 2010-2020 | | | |
|---|---|---|---|
| **INITIATIVE** | CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[132] | Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States dollars[133] | Other CMS Innovation Center funds under section 1115A obligated to support design, implementation, and evaluation in United States dollars[134] |
| Transforming Clinical Practice Initiative | $546,306,231 | Not Applicable | $71,920,526 |
| Vermont All-Payer ACO Model | $9,499,549 | $435,643,195 | $18,832,016 |
| **ESTIMATED TOTALS:** | $4,086,661,444 | $6,484,859,996 | $2,609,488,723.12 |

# 6. Results and Recommendations

## A. Results from Evaluations

Since the inception of the CMS Innovation Center, five models have delivered statistically significant savings, including the Maryland All-Payer, Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT), Home Health Value-Based Purchasing (HHVBP), the Pioneer ACO, and the ACO Investment (AIM) models. Other models, such as the Comprehensive ESRD Care (CEC) Model and Comprehensive Care for Joint Replacement (CJR) Model, did not show savings but demonstrated significant improvements in quality.

Evaluation reports for the CEC, HHVBP, and CJR model tests showed significant improvements in quality. For example, the CEC model showed a decrease of emergency dialysis sessions, overall hospitalizations, readmissions, and hospitalization for ESRD-related complications.[148] The HHVBP model showed an average 4.6 percent improvement in home health agencies' quality score. The CJR Model achieved significant reductions in the rates of unplanned readmissions and surgical complications.[149]

[148] An evaluation report covering the first three years of the model was released after the period of reporting for this report, in November 2020.

[149] These findings come from the third evaluation report from the Comprehensive Care for Joint Replacement Model, which was released after the period of report, in November 2020.

More specifically, over the past two years CMS Innovation Center model tests have reported the following results in cost savings and quality improvement:

- The CMS Chief Actuary certified in 2018 that a nationwide expansion of the RSNAT Medicare Prior Authorization Model would reduce net program spending. The Chief Actuary's certification was based on an analysis that confirmed continued significant reductions in total ambulance spending for beneficiaries with End-Stage Renal Disease (ESRD) in the model states, with total program savings of $136 million in 2017. The Chief Actuary also estimated a range of annual gross savings for the RSNAT expansion of $57 million to $253 million. The analysis found that even using the most conservative assumptions, the projected savings from expansion would significantly exceed the cost of program administration.

  The RSNAT Model achieved $1 billion in total Medicare savings among Medicare beneficiaries with ESRD and/or pressure ulcers over its first 2020 quarters (beginning December 2014) relative to the comparison group, an average of $381 per-beneficiary-per-quarter. [150] The Secretary determined that the model meets the statutory requirements for expansion.

- The Maryland All-Payer Model evaluation showed $975 million in total cost of care Medicare savings over the first four and a half years of the model (January 2014–June 2018), a 2.8 percent decline in total Medicare expenditures relative to a comparison group of non-Maryland hospitals with similar characteristics. There was no decline in quality of care as measured by the Consumer Assessment of Healthcare Providers and Services (CAHPS®) Hospital Survey.[151]

- The ACO Investment Model (AIM) evaluation showed $526 million in gross Medicare spending reductions in the first three years of the model (2016–2018). After accounting for all up-front payments—both recouped and unrecouped from shared savings—as well as any additional shared savings payments to participating ACOs, the net savings to Medicare were $382 million.

- Evaluation data for the Home Health Value-Based Purchasing (HHVBP) Model showed cumulative gross savings of $423 million in the first three years of the model (2016–2018). The evaluation has shown that this value-based purchasing model has led to higher quality in home-health agencies within model states compared to home-health agencies in non-model states, and to a reduction in unplanned hospitalizations and use of skilled nursing facilities in model states compared to non-model states.

- The Comprehensive Care for Joint Replacement (CJR) Model evaluation showed a reduction in gross Medicare spending of $146 million through the first two years of the

[150] The final evaluation report from the RSNAT Model was released after the period of report, in May 2021.
[151] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

model (2016–2017).[152] After deducting shared savings payments, the net Medicare savings were $17 million, but were not statistically significant. The CJR Model achieved significant reductions in the rates of unplanned readmissions and surgical complications. There was no decline in quality of care as measured by the unplanned readmission rate, emergency department visits, and mortality rate.

Some CMS Innovation Center models have not generated net savings to Medicare, but have provided valuable insights to inform the design and development of subsequent models or other models with common approaches. These models include:

- The Bundled Payments for Care Improvement (BPCI) Model evaluation to date has found that Medicare payments declined by $824 million ($827 per episode) under Model 2, but after reconciliation payments, there were $197 million in net Medicare losses.[153] Model 3 showed $139 million ($1,138 per episode) in gross Medicare savings, but after reconciliation payments, there was an estimated Medicare loss of $100 million during the first four years of the model (October 2013–September 2017). Technical implementation issues, including the specification of appropriate target prices, may have contributed to these net losses. When BPCI ended, CMS began a new episode-based Advanced Alternative Payment Model, BPCI Advanced, which addresses some of the challenges of the original BPCI Model.

- The Next Generation ACO (NGACO) model evaluation showed $349 million in reduced Medicare Part A and B spending across the first three Performance Years (2016–2018).[154] However, after deducting shared savings and Coordinated Care Reward payments, there was a $118 million increase in net Medicare spending. The model was associated with reduced post-acute care (PAC) and professional services spending, but saw no appreciable declines in hospital utilization and spending. NGACO, along with Medicare Advantage and other private sector risk-sharing arrangements, informed the design of the Global and Professional Direct Contracting (GPDC) Model. The GPDC Model will include two participation options—Global and Professional—under which participants will enter into risk-sharing arrangements with CMS. The CMS Innovation Center has solicited public input regarding a third DC-related option for organizations seeking to target beneficiaries within a specific geographic region.[155] The GPDC Model will allow organizations without significant experience in serving Medicare Fee-for Service (FFS) beneficiaries to enter into value-

[152] An evaluation report covering the first three years of the model was released after the period of report, in November 2020.

[153] An evaluation report covering the entire performance period of the initiative (through September 2018) was released after the period of report, in April 2021.

[154] An evaluation report covering the first three years of the NGACO model was released in September, 2020..

[155] After the period of report, the CMS Innovation Center announced the Geographic Direct Contracting Model as a separate model test. The Geographic Direct Contracting Model is currently under review.

based care arrangements that CMS expects will help reduce program expenditures and improve the quality of care for beneficiaries while reducing provider burden.

- The Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model evaluation showed a $68 million reduction in Medicare spending in the first two years of the model (2016–2017).[156] After taking into account shared savings payments made to the ESRD Seamless Care Organizations, the net Medicare losses were $46 million, but were not statistically significant. Results from the first two Performance Years show specialty-oriented ACOs for beneficiaries with ESRD can reduce spending while improving key quality outcomes; these ACOs decreased both overall hospitalizations and hospitalization for ESRD-related complications. The lessons learned from CEC are being incorporated into the subsequent kidney care models. This includes the Kidney Care Choices (KCC) Model, which features stronger incentives for health care providers to manage beneficiary care for chronic kidney disease (CKD) Stages 4 and 5 and ESRD to delay the onset of dialysis and to incentivize participants to guide beneficiaries through the kidney transplant process.

- The Comprehensive Primary Care Plus (CPC+) Model evaluation did not show any savings to Medicare in the first two years of the model (2017–2018).[157] After taking into account care management fees and performance-based incentive payments, CPC+ increased net expenditures by 2 to 3 percent ($17 and $30 per-beneficiary-per-month for Tracks 1 and 2, respectively). However, lessons learned from CPC+ have informed the design of the Primary Care First (PCF) Model, serving as an important investment in primary care and a stepping-stone towards managing downside risk. The PCF Model launched in all 18 of the current CPC+ markets as well as eight additional regions in 2021.

Some CMS Innovation Center models have only recently been implemented, and therefore have not yet generated any results. This includes model tests for which implementation has been delayed by CMS in response to the Coronavirus Disease 2019 Public Health Emergency (PHE), as noted in the model test entries in Section Three of this report, Review of CMS Innovation Center Activities, and in Appendix I: Models, Initiatives, and Demonstrations Active During Period of Report.

The Secretary of Health and Human Services (the Secretary) has the authority under Section 1115A(c) of the Social Security Act to expand through rulemaking the duration and scope of a model being tested, including implementation on a nationwide basis if the model meets certain statutory criteria. To exercise this authority, the Secretary must determine that an expansion would either reduce spending without reducing quality of care or improve quality of care without increasing spending. In addition, the CMS Chief Actuary must certify that expansion of the model would reduce or not increase net program spending, and the Secretary must

[156] The fourth evaluation report from the CEC Model was released after the period of report, in March 2021.
[157] The third evaluation report from CPC+ was released after the period report, in January 2021.

determine that the expansion would not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary's expansion determinations are made taking into account evaluations performed by CMS under section 1115A(b)(4).

To date, three CMS Innovation Center models have met the criteria to be eligible for expansion in paragraphs (1) through (3) of section 1115A(c), namely: the Pioneer ACO Model (as tested in its first two years), the Health Care Innovation Award's Y-USA Diabetes Prevention Program model test (DPP), and the Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Medicare Prior Authorization Model.[158]

Congress has acted in two instances to require CMS to include additional states in models. The Bipartisan Budget Act of 2018 required the Medicare Advantage Value-Based Insurance Design (VBID) Model to include all states beginning in 2020. In addition, section 515(a) of MACRA required implementing the RSNAT Medicare Prior Authorization Model in additional states, and section 515(b) of MACRA required the expansion of the model to all states if the requirements in paragraphs (1) through (3) of section 1115A(c) of the Social Security Act are met. The Chief Actuary of CMS has since certified that a nationwide expansion of the RSNAT Medicare Prior Authorization Model would meet the requirements of section 1115A(c)(2); and the Secretary has determined that the model meets the requirements for expansion described in section 1115A (c)(1) and (c)(3).

In some cases, the CMS Innovation Center has created new models that build on existing models to take advantage of evaluation findings and new ideas about care delivery and payment learned from physicians and other innovators in the health care community. Examples include the Primary Care First Model, which was developed based on insights from the previous CPC+ and CPC Models; the Maryland Total Cost of Care (TCOC) Model, which built upon the positive results from the previous Maryland All-Payer Model; and the BPCI Advanced Model, which was designed using lessons from the BPCI Model. Existing models are also continually being refined. For example, the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents Phase Two incorporated evaluation findings from Phase One.

The CMS Innovation Center conducts summative evaluations of models, generally reporting on an annual basis. Results from these evaluations are summarized after model test descriptions in this report. Evaluation reports and findings-at-a-glance summaries that have been published to date are included in the table below. As they become available, additional evaluation results will be included in future Reports to Congress, and will inform recommendations regarding model expansions or legislative action.

In addition to evaluating the results of individual model tests, where appropriate the CMS Innovation Center attempts to systematically review and synthesize evaluation results across multiple models with shared or similar programmatic elements. To date, meta-analyses and

[158] The RSNAT Medicare Prior Authorization Model is being expanded under the authority of section 515(b) of MACRA.

systematic reviews have been conducted in the areas of primary care, episode payment models, and state-based models and initiatives.

The primary care review included findings from the Comprehensive Primary Care (CPC) Initiative; the Federally Qualified Health Center (FQHC) Demonstration; Independence at Home (IAH) Demonstration; the Multi-Payer Advanced Primary Care Practice Demonstration; State Innovation Models (SIM), Round One; and Health Care Innovation Award (HCIA) individual awards that CMS identified as focused on primary care redesign.

The episode payment review covered the Bundled Payment for Care Improvement (BPCI) models, the Comprehensive Care for Joint Replacement (CJR) Model, and the Oncology Care Model (OCM).

The state-based review investigated partnerships with 17 Test states through the State Innovation Models (SIM) initiative (Rounds One and Two) and multi-payer models, inclusive of Medicare, in Maryland, Pennsylvania, and Vermont.

These systematic reviews identified shared lessons learned across model evaluations that might help inform future model design and policy-making.[159]

### *Evaluation Reports*

The Table below lists all publicly released evaluation reports from CMS Innovation Center models with activity during the period of this report. Links to the posted reports are embedded in the table.

| **Publicly Released Evaluation Reports** | |
|---|---|
| **INITIATIVE** | **REPORT** |
| Accountable Health Communities Model | First[160] evaluation report |
| ACO Investment Model | First, Second, and Final evaluation reports |

[159] The Cross-Model Evaluation Reviews can be accessed as follows: (1) Primary Care Review ,(2) Episode Payment Models Review; and (3) State-Based Models and Initiatives Review.

[160] The first evaluation report from the Accountable Health Communities Model was released after the period of report, in December 2020.

| Publicly Released Evaluation Reports | |
|---|---|
| **INITIATIVE** | **REPORT** |
| Bundled Payments for Care Improvement (Four Models)[161] | Model One: First and Final evaluation reports<br>Models Two-Four: First, Second, Third, Fourth, Fifth, Sixth, and Seventh[162] evaluation reports |
| Bundled Payments for Care Improvement Advanced Model | First and Second[163] evaluation reports |
| Comprehensive ESRD Care Model | First, Second, Third, and Fourth[164] evaluation reports |
| Comprehensive Care for Joint Replacement Model | First, Second, and Third[165] evaluation reports |
| Comprehensive Primary Care Initiative | First, Second, Third, and Final evaluation reports |
| Comprehensive Primary Care Plus Model | First, Second, and Third[166] evaluation reports |
| Health Care Innovation Awards (Two Rounds Counted as Two Models)[167] | Round One: First, Second, and Third evaluation reports<br>Round Two: First, Second, Third, and Final evaluation reports |
| Home Health Value-Based Purchasing Model | First, Second, and Third evaluation reports |

[161] The period of performance for the Bundled Payments for Care Improvement Models 1-4 ended prior to the period of report; however, the sixth evaluation report was released in June 2020.
[162] The seventh evaluation report from BPCI Models Two-Four was released after the period of report, in April 2021.
[163] The second evaluation report from BPCI Advanced was released after the period of report, in April 2021.
[164] The third and fourth evaluation reports from the Comprehensive ESRD Care Model were released after the period of report, in November 2020 and March 2021, respectively.
[165] The third evaluation report from the Comprehensive Care for Joint Replacement Model was released after the period of report, in November 2020.
[166] The third evaluation report from Comprehensive Primary Care Plus was released after the period of reporting for this report, in January 2021.
[167] The periods of performance for the Health Care Innovation Awards Rounds One and Two ended prior to the period of reporting for this report; however, the final report from Round Two was released in September 2020.

| Publicly Released Evaluation Reports | |
|---|---|
| **INITIATIVE** | **REPORT** |
| Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Two Phases Counted as Two Models) | Phase One: Year Three, Year Four, and Final evaluation reports<br><br>Phase Two: First, Second, Third, and Fourth[168] evaluation reports |
| Maryland All-Payer Model | First, Second, Third, and Final evaluation reports |
| Medicaid Innovation Accelerator Program | Interim and Final[169] evaluation reports |
| Medicare Advantage Value-Based Insurance Design Model | Evaluation Report of the First Three Years |
| Medicare Care Choices Model | First, Second, and Third[170] evaluation reports |
| Medicare Diabetes Prevention Program | First[171] evaluation report |
| Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dually Eligible Individuals | Colorado demonstration: Preliminary Year One Savings Report and Preliminary Year 2 Savings Report<br><br>California demonstration: First Evaluation Report<br><br>Illinois demonstration: First Evaluation Report<br><br>Ohio demonstration: First Evaluation Report<br><br>Massachusetts demonstration: First Evaluation Report, Second Evaluation Report, and Third Evaluation Report<br><br>Michigan demonstration: First Evaluation Report |

[168] The fourth evaluation report from Phase Two of the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents was released after the period of report, in March 2021.

[169] The final evaluation report from the Medicaid Innovation Accelerator Program was released after the period of report, in December 2020.

[170] The third evaluation report from the Medicare Care Choices Model was released after the period of report, in October 2020.

[171] The first evaluation report from the Medicare Diabetes Prevention Program was released after the period of report, in March 2021.

| Publicly Released Evaluation Reports | |
|---|---|
| **INITIATIVE** | **REPORT** |
| | Minnesota demonstration: First Evaluation Report and Second Evaluation Report<br><br>New York demonstration: First Evaluation Report<br><br>South Carolina demonstration: First Evaluation Report<br><br>Texas demonstration: First Evaluation Report<br><br>Washington demonstration: Final Year One and Preliminary Year Two Savings Report, First Evaluation Report, Final Year Two and Preliminary Year Three Savings Report, Second Evaluation Report, Final Year 3 and Preliminary Year 4 Savings Report, and Third Evaluation Report<br><br>These reports, as well as additional cross-state repots, can be found on the model webpage. |
| Medicare Prior Authorization Models | Repetitive Scheduled Non-Emergent Ambulance Transport Model: First Interim Report and Second Interim Report<br><br>Non-Emergent Hyperbaric Oxygen Therapy Model: Interim Report and Final Report |
| Million Hearts®: Cardiovascular Disease Risk Reduction Model | First, Second, and Third[172] evaluation reports |
| Next Generation ACO Model | First, Second, and Third evaluation reports |
| Oncology Care Model | Baseline Period Report, Second, Third, and Fourth[173] evaluation reports |

[172] The third evaluation report from the Million Hearts Model was released after the period of report, in November 2020.

[173] The fourth evaluation report from the Oncology Care Model was released after the period of report, in January 2021.

| Publicly Released Evaluation Reports | |
|---|---|
| **INITIATIVE** | **REPORT** |
| Part D Enhanced Medication Therapy Management Model | First and Second[174] evaluation reports |
| Pioneer ACO Model[175] | Year One, Year Two, Three-Day SNF Waiver, and Final evaluation reports |
| State Innovation Models Initiative (Two Rounds Counted as Two Models) | Model Design and Pre-Test States, Round One: Final Report<br><br>Model Test, Round One: First, Second, Third, Fourth, and Final evaluation reports<br><br>Model Design States, Round Two: Final Report<br><br>Model Test, Round Two: First, Second, and Third evaluation reports |
| The Strong Start for Mothers and Newborns Strategy Two[176] | Year One, Year Two (Volume One and Volume Two), Year Three (Volume One and Volume Two), Year Four (Volume One and Volume Two), and Final (Volume One and Volume Two) evaluation reports |

## B. Recommendations for Legislative Action

This report conforms to the requirements of section 1115A(g) of the Social Security Act. Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President's budget request.

[174] The second evaluation report from the Part D Enhanced Medication Therapy Management Model was released after the period of reporting for this report, in November 2020.

[175] Though the period of performance for the Pioneer ACO Model ended prior to the period of reporting, model is discussed in this report because the model, as tested in its first two years, was certified for expansion under section 1115A(c), and certain features of the model have since been incorporated into the Medicare Shared Savings Program through notice and comment rulemaking.

[176] The period of performance for The Strong Start for Mothers and Newborns Strategy Two ended prior to the period of reporting for this report; however, the final evaluation report was released in November 2018.

# 7. Conclusion

Since the last Report to Congress, the CMS Innovation Center, in accord with statute, has continued to develop and test a broad range of new payment and service delivery models expected to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Plan (CHIP) beneficiaries. From October 1, 2018 to September 30, 2020, the CMS Innovation Center has announced, tested, or issued Notices of Proposed Rulemaking for 38 models and initiatives intended to achieve better care, improve health outcomes, and reduce expenditures for Medicare, Medicaid, and CHIP beneficiaries.

The CMS Innovation Center has been protecting taxpayer dollars and innovating in payment models by designing and redesigning model tests and initiatives in ways that: (1) increase the proportion of health care paid for through value-based arrangements; and (2) meet the specific goals of:

- Empowering and incentivizing primary care providers to improve efficiency and quality of care;
- Increasing participation in Advanced Alternative Payment Models;
- Using competition to reduce prices and improve outcomes in Medicare Fee-for-Service (FFS);
- Empowering patient and provider choice;
- Creating physician specialty models, including but not limited to:
    - Developing innovative payment options for radiation oncology services;
    - Improving management of chronic kidney disease and end-stage renal disease; and
    - Better managing the care of patients with serious illness, who account for a disproportionate share of Medicare expenditures;
- Testing cutting-edge private payer utilization management techniques, including prior authorization, in CMS programs;
- Developing new and innovative value-based insurance designs within Medicare Parts C and D;
- Appropriately aligning incentives for emergency medical transport suppliers;
- Developing prescription drug models;

- Refining Medicare Advantage innovation models;
- Encouraging state-based and local innovation, including Medicaid-focused models;
- Improving and supporting health care in rural and under-served areas;
- Facilitating telehealth and improving the interoperability of electronic health records; and
- Integrating fragmented care at state and regional levels to improve beneficiary experience.

These priorities contribute to the wider goal of providing beneficiaries with high-quality health care that is affordable, accessible, and sustainable.

The evaluation of model tests is driven by the CMS Innovation Center's Research and Rapid Cycle Evaluation Group (RREG), which reviews the program design, research methodology, and the evaluability of all proposed models. RREG oversees both intermediate and final evaluations of model tests, aimed respectively at improving model performance during the period of performance and at providing rigorous and valid summative assessments of a model's impact on the quality and cost of care.

The CMS Innovation Center has also supported health care payment and service delivery reform through its funding of and participation in the Health Care Payment Learning and Action Network (LAN). The LAN brings together private, public, and nonprofit partners with the shared goal of accelerating our health care system's adoption of Alternative Payment Models (APMs). The LAN mobilizes a network of more than 7,000 payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to promote APMs and reduce the barriers to APM participation as a means of reducing the cost of care and improving patient experiences and outcomes.

In addition, the CMS Innovation Center continues to play a critical role in developing policy and processes for the Quality Payment Program, which rewards clinicians with financial incentives for providing high-quality care to Medicare patients and reduces payments to clinicians who are not meeting program requirements. The Quality Payment Program began in January 2017. It implements provisions of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which made changes to the way that Medicare pays physicians and other clinicians for Covered Professional Services under Medicare Part B.

The Quality Payment Program pays for value in health care through the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The CMS Innovation Center develops and operates most Advanced APMs—a total of ten Advanced APMs, as of August 2020. By participating in an Advanced APM and meeting certain thresholds of patient counts or payments, clinicians can attain Qualifying APM Participant

(QP) status and earn a 5 percent APM Incentive Payment. To reduce administrative burden, QPs are also excluded from reporting under MIPS and from the MIPS payment adjustments.

In Performance Year 2018, 183,306 eligible clinicians attained QP status. These QPs will receive an APM Incentive Payment in 2020. The 5 percent APM Incentive Payments are scheduled to sunset after Performance Year 2022 (Payment Year 2024). Beginning in 2026, QPs will receive payment based on an annual update to the conversion factor of 0.75 percent, and clinicians who are not QPs will receive payment based on an annual update to the conversion factor of 0.25 percent.

The CMS Innovation Center has reduced burden on eligible clinicians participating in the Quality Payment Program, and is continuing to help expand participation in Advanced APMs. The center is working, in consultation with clinicians, to increase the number and variety of models available so that a wide range of clinicians, including those in small practices and rural areas, have the option to participate.

The CMS Innovation Center's portfolio of models and initiatives has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico.

CMS estimates that during the period of this report more than 27,850,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 528,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.[177,178,179] For purposes of this report, CMS beneficiaries include individuals with coverage through Medicare Fee-for-Service (FFS), Medicaid, dually eligible beneficiaries, CHIP, and Medicare Advantage.

In addition, value-based health care is delivered to beneficiaries through the Medicare Shared Savings Program, a statutorily mandated ACO program that incorporates lessons learned from CMS Innovation Center model testing and that serves more than 11.2 million beneficiaries

[177] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these "overlaps," see Section 2, Part A of this report, Accounting for Model Test and Alternative Payment Model Overlaps.

[178] The CMS Innovation Center counts beneficiaries and individuals by model test. In specific circumstances, it is possible that an individual might participate or a beneficiary might be included in multiple model tests.

[179] This does not include the number of beneficiaries indirectly affected by the CMS Artificial Intelligence Health Outcomes Challenge, Health Care Payment Learning and Action Network, the Home Health Value-Based Purchasing Model, the Medicaid Innovation Accelerator Program, and the Transforming Clinical Practice Initiative. Nor does it include beneficiaries served by demonstrations, which are not part of the mandated focus of this Report to Congress.

across 517 Medicare ACOs. In total, more than 37.9 million Americans are served by CMS Innovation Center model tests and initiatives and the Medicare Shared Savings Program.[180]

Because a number of these programs, models, and initiatives involve multiple payers or focus on broad areas of quality improvement, millions of other Americans are benefiting from the CMS Innovation Center's activities. Model tests and initiatives driven by the CMS Innovation Center materially contribute to ongoing improvements in the health care system. Models under way and in development at the CMS Innovation Center will help transform health care delivery and payment, moving the country towards a system in which beneficiaries—and eventually all Americans—receive value-based care driven by evidence, performance, reduced cost, and increasing quality.

# Appendix I: Models, Initiatives, and Demonstrations Active during Period of Report

The table below lists all CMS Innovation Center models, initiatives, and demonstrations that were announced or had activity between October 1, 2018 and September 30, 2020. Note that some models, such as those that have/had multiple phases or rounds, may appear in this table, as well as in the table in Appendix II, which lists all previous CMS Innovation projects that did not have activity during this reporting period.

| **List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020)** | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| Accountable Health Communities Model | Tests whether systematic screening and identification of certain health-related social needs, as well as referral | **Announcement:** January 2016<br><br>**Anticipated Performance Period:** | Section 1115A of the Social Security Act |

[180] The Medicare Shared Savings Program is a statutorily mandated ACO program administered by CMS, and is not a CMS Innovation Center model authorized under section 1115A of the Act. This number combines the number of beneficiaries assigned to ACOs participating in the Medicare Shared Savings Program with the number of beneficiaries and other individuals aligned with or attributed to entities participating in CMS Innovation Center models and other initiatives. Additional data is available in this fact sheet.

[181] Performance Periods listed in this Table all reflect anticipated timeframes. In some cases, the starting and/or ending dates have been changed since announcement in response to challenges created by the Coronavirus Disease 2019 Public Health Emergency. As a result, the Performance Periods cited here may differ from the originally announced Performance Periods.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | to community service providers who might be able to address those needs, will impact total health care costs and improve health for Medicare and Medicaid beneficiaries (including beneficiaries who are dually eligible) in targeted communities. | May 1, 2017–April 30, 2022 | |
| ACO Investment Model | Designed to encourage new ACOs to form in rural and underserved areas and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. | **Announcement:** October 2014<br><br>**Performance Period:** April 1, 2015–December 31, 2018 | Section 1115A of the Social Security Act |
| Artificial Intelligence Health Outcomes Challenge[182] | An opportunity for innovators to demonstrate how AI tools—such as deep learning and neural networks—can be used to predict unplanned hospital and skilled nursing facility admissions and adverse | **Announcement:** March 27, 2019<br><br>**Performance Period:** N/A | Section 1115A of the Social Security Act;<br>Section 24 of the Stevenson-Wydler Technology Innovation Act |

[182] The Artificial Intelligence Health Care Outcomes Challenge is an infrastructure improvement challenge initiative, and does not directly serve beneficiaries.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | events for potential use by the CMS Innovation Center. | | of 1980 (15 U.S.C.3719) |
| Bundled Payments for Care Improvement Advanced Model | Tests a new iteration of bundled payments for 35 Clinical Episodes and aims to align incentives among participating health care providers for reducing expenditures and improving quality of care for Medicare beneficiaries. The model qualifies as an Advanced Alternative Payment Model (APM) under the Quality Payment Program. | **Announcement:** January 2018<br><br>**Anticipated Performance Period:** October 1, 2018–December 31, 2023 | Section 1115A of the Social Security Act |
| Community Health and Rural Transformation Model | The model will test whether upfront funding coupled with aligned financial incentives, increased operational flexibility, and robust technical support enable rural health care providers to transform care on a broad scale and increase uptake of Alternative Payment Models (APMs) in ways that improve access to | **Announcement:** August 11, 2020<br><br>**Anticipated Performance Period:** Community Transformation Track Pre-Implementation Period: August 1, 2021–December 31, 2022[183]<br><br>Community Transformation Track | Section 1115A of the Social Security Act |

[183] As this Report to Congress was being prepared for release, this and certain other performance periods were updated.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | high-quality care for rural beneficiaries and reduce Medicare and Medicaid expenditures. | Performance Period: January 1, 2023–December 31, 2028[184]<br><br>Accountable Care Organization (ACO) Transformation Track: Spring, 2022–December 31, 2026[185] | |
| Comprehensive Care for Joint Replacement Model | Designed to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements. | **Announcement:** July 9, 2015<br><br>**Anticipated Performance Period:** April 1, 2016–December 31, 2023, including the extended performance period described below | Section 1115A of the Social Security Act |
| Comprehensive Care for Joint Replacement Model Three-Year Extension and Modification. (Not a new model test.) | This Extension and Modification of the Comprehensive Care for Joint Replacement (CJR) Model is not considered a new model test. This rulemaking cycle will extend the CJR Model | **Announcement:** TBD. Pending release of the Final Rule<br>**Anticipated Performance Period:** Extends the existing five-year CJR Model | Section 1115A of the Social Security Act |

[184] As this Report to Congress was being prepared for release, this and certain other performance periods were updated.

[185] As this Report to Congress was being prepared for release, a delay was anticipated in the performance period for the Accountable Care Organization (ACO) Transformation Track.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | end date to December 31, 2023. The Final Rule revises certain aspects of the CJR Model including the episode of care definition, the target price calculation, the reconciliation process, the beneficiary notice requirements and the appeals process. In addition, it eliminates the 50 percent cap on gainsharing payments, distribution payments, and downstream distribution payments for certain recipients. It also extends the additional flexibilities provided to hospitals related to certain Medicare program rules consistent with the revised episode-of care definition. | for three additional years, ending on December 31, 2023 | |
| Comprehensive ESRD Care Model | An initiative to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. | **Announcement:** April 2014<br><br>**Anticipated Performance Period:** October 1, 2015–March 31, 2021 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| Comprehensive Primary Care Plus Model | A multi-payer model that tests whether payment redesign improves the quality and efficiency of care, and reduces unnecessary health care utilization. | **Announcement:** April 2016<br><br>**Anticipated Performance Period:** January 1, 2017-– December 31, 2021 | Section 1115A of the Social Security Act |
| Emergency Triage, Treat, and Transport Model | The ET3 Model will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. CMS will continue to pay ambulance providers and suppliers to transport a Medicare FFS beneficiary to a hospital emergency department or other Medicare-covered destination. In addition, under the model, CMS will pay participants to: (1) transport to an alternative destination or (2) arrange for a qualified health care partner to provide treatment in place, either at the scene of the 911 emergency response or via telehealth. The model will also encourage state | **Announcement:** February 14, 2019<br><br>**Anticipated Performance Period:** January 1, 2021– December 31, 2025 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | and local governments, their designees, or other entities to promote successful implementation by establishing a medical triage line for low-acuity 911 calls. | | |
| End-Stage Renal Disease Treatment Choices Model | The model will test whether certain payment adjustments will ensure that ESRD beneficiaries have access to different kidney disease treatment options to improve value in health care. | **Announcement:** July 10, 2019. Final Rule published in the *Federal Register* September 29, 2020.<br><br>**Performance Period:** Delayed by publication of Final Rule. Start date January 1, 2021. | Section 1115A of the Social Security Act |
| Global and Professional Direct Contracting Model | The participation options available under the Global and Professional Direct Contracting Model create opportunities for a broad range of organizations to participate with the Centers for Medicare & Medicaid Services (CMS) in testing the next evolution of risk-sharing arrangements to produce value and high-quality health care. The participation options available under the | **Announcement:** April 22, 2019<br><br>**Anticipated Performance Period:** Five-year performance period that began on April 1, 2021, with a six-month implementation period that began on October 1, 2020. | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | Global and Professional Direct Contracting Model also leverage innovative approaches from Medicare Advantage (MA) and private sector risk-sharing arrangements. | | |
| Health Care Payment Learning and Action Network | A national learning collaborative to accelerate the adoption of APMs that includes private payers, purchasers, health care providers, consumers, and states. | **Announcement:** January 2015<br><br>**Performance Period:** N/A | Section 1115A of the Social Security Act |
| Home Health Value-Based Purchasing Model | Designed to test whether higher payment incentives can significantly change health care providers' behavior in a way that shifts Medicare-certified home-health agencies (HHAs) from volume-based to value-based purchasing to improve quality of care. | **Announcement:** November 2015<br><br>**Performance Period:** January 1, 2016–December 31, 2020 | Section 1115A of the Social Security Act |
| Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents Phase Two | Phase Two tests whether three new payments for long-term care facilities and practitioners will further reduce avoidable hospitalizations, lower | **Announcement:** August 2015 (Phase Two)<br><br>**Performance Period:** | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | combined Medicare and Medicaid spending, and improve the quality of care received by facility residents. | Phase Two: October 1, 2016–September 30, 2020 | |
| Integrated Care for Kids Model | A child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and the Children's Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. The model will offer states and local providers support to address these priorities through a framework of child-centered care integration across behavioral, physical, and other providers. | **Announcement:** August 2018<br><br>**Anticipated Performance Period**: January 1, 2021–December 31, 2026 | Section 1115A of the Social Security Act |
| Kidney Care Choices Model | The model will build upon the existing Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) | **Announcement:** July 1, 2019<br><br>**Anticipated Performance Period:** | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | Model structure in which dialysis facilities, nephrologists, and other health care providers form ESRD-focused Accountable Care Organizations (ACOs) to manage care for beneficiaries with ESRD. The model adds strong financial incentives for health care providers to manage the care for Medicare beneficiaries with Chronic Kidney Disease (CKD) Stages 4 and 5 and ESRD to delay the onset of dialysis and to incentivize guiding beneficiaries through the kidney transplantation process. | January 1, 2022– To Be Determined [186] | |
| Maryland All-Payer Model | Designed to test whether an all- payer system for hospital payment that is accountable for the total hospital cost of care on a per-capita basis is an effective model for advancing better care, better health and reduced costs. | **Announcement:** January 2014<br><br>**Performance Period:** January 1, 2014–December 31, 2018 | Section 1115A of the Social Security Act |

[186] As this Report to Congress was being prepared for release, this and certain other performance periods were updated.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| Maryland Total Cost of Care Model | The first CMS Innovation Center model to hold a state fully at risk for the Medicare total cost of care. Beginning January 1, 2019, the model builds upon Maryland's prior Maryland All-Payer Model, which had set a limit on per-capita hospital expenditures in the state. The model commits Maryland to save Medicare over $1 billion by 2023, and creates new opportunities for a range of nonhospital providers and suppliers to participate in this effort to limit Medicare spending across an entire state. | **Announcement:** June 2018<br><br>**Anticipated Performance Period:** January 1, 2019–December 31, 2026 | Section 1115A of the Social Security Act |
| Maternal Opioid Misuse Model | The primary goals of the model are to: improve quality of care and reduce costs for pregnant and postpartum women with Opioid Use Disorder (OUD) as well as their infants; expand access, service-delivery capacity, and infrastructure based on state-specific needs; and create sustainable | **Announcement:** October 23, 2018<br><br>**Anticipated Performance Period:** January 1, 2021–December 31, 2024 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | coverage and payment strategies that support ongoing coordination and integration of care. | | |
| Medicaid Innovation Accelerator Program | Initiative providing states with technical assistance in such areas as data analytics, service delivery, financial modeling, quality measurement, and rapid cycle evaluation to accelerate the development and testing of state-led payment and service delivery innovations. | **Announcement:** July 2014<br><br>**Performance Period:** July 1, 2014–September 30, 2020 | Section 1115A of the Social Security Act |
| Medicare ACO Track 1+ Model | Tests a payment design that incorporates more limited downside risk than is currently present in Tracks 2 or 3 of the Medicare Shared Savings Program. The Track 1+ Model is designed to encourage more practices, especially small practices, to advance to performance-based risk, and also allows ACOs that include | **Announcement:** December 2016<br><br>**Anticipated Performance Period:** January 1, 2018–December 31, 2021 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | hospitals, from large institutions to small rural hospitals, to participate. This opportunity allows eligible clinicians to join an Advanced APM to improve care and potentially earn an incentive payment under the Quality Payment Program. | | |
| Medicare Advantage Value-Based Insurance Design Model | Designed to test whether offering MA plans the flexibility to design and offer reduced cost sharing and/or additional supplemental benefits to enrollees with CMS-specified chronic conditions will encourage consumption of clinically-nuanced high-value services. | **Announcement:** November 2017<br><br>**Anticipated Performance Period:** January 1, 2017–December 31, 2024 | Section 1115A of the Social Security Act |
| Medicare Care Choices Model | Designed to test whether Medicare (including dually-eligible) beneficiaries who meet Medicare (or Medicaid) hospice eligibility requirements will achieve | **Announcement:** June 2014<br><br>**Anticipated Performance Period:** January 1, 2016–December 31, 2021 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | patient-centered goals if they receive hospice services with continuation of curative services and whether these changes will reduce Medicare expenditures. | | |
| Medicare Diabetes Prevention Program Expanded Model | An evidence-based intervention targeted to beneficiaries with pre-diabetes, who have blood sugar that is higher than normal but not yet in the diabetes range. The primary goal of the expanded model is to reduce incidence of diabetes by achieving at least a five percent average weight loss among participants. | **Announcement:** November 2017<br><br>**Anticipated Performance Period:** April 1, 2018–September 30, 2024 | Section 1115A of the Social Security Act |
| Medicare Prior Authorization: Repetitive Scheduled Non-Emergent Ambulance Transport Model | A prior authorization model for repetitive scheduled non-emergent ambulance transport in eight states and the District of Columbia to test whether prior | **Announcement:** May 2014<br><br>**Performance Period:** December 1, 2014–December 1, 2020[187] | Section 1115A of the Social Security Act |

[187] Under MACRA authority, the model will continue without interruption in the current states of Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia beyond December 1, 2020, when the model was previously scheduled to end. Due to the Coronavirus Disease 2019 PHE, CMS is delaying implementation of the expansion to additional states at this time.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | authorization helps reduce expenditures, while maintaining or improving quality of care. | | |
| Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dually Eligible Individuals | Opportunity for states to partner with CMS to implement new integrated care and payment systems to better coordinate care for dually eligible beneficiaries. | **Announcement:** July 2011<br><br>**Performance Period:** Each demonstration has a unique start date. The first was the Washington MFFS model demonstration on July 1, 2013. Current state demonstration end-dates range from December 31, 2020 through December 21, 2023, with extensions under consideration in several states. | Section 1115A of the Social Security Act |
| Million Hearts®: Cardiovascular Disease Risk Reduction Model | Designed to test whether financial incentives for health care providers to use the American College of Cardiology/American Heart Association (ACC/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) risk calculator will promote CVD prevention, improved | **Announcement:** May 2015<br><br>**Anticipated Performance Period:** January 3, 2017–December 31, 2021 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | CVD outcomes, and accountability for costs among Medicare beneficiaries. | | |
| Next Generation ACO Model | An initiative for ACOs experienced in managing the health of populations of patients. It allows participating health care providers to assume higher levels of financial risk and reward than are available under the Medicare Shared Savings Program or were offered under the Pioneer ACO Model. The goal of the model is to test whether strong financial incentives for ACOs can improve health outcomes and lower expenditures. | **Announcement:** March 2015<br><br>**Anticipated Performance Period:** January 1, 2016–December 31, 2021 | Section 1115A of the Social Security Act |
| Oncology Care Model | Designed to test whether payment arrangements that include financial and performance accountability for episodes of care involving chemotherapy will incentivize physician group practices to provide higher quality, more coordinated oncology care at a lower | **Announcement:** February 2015<br><br>**Anticipated Performance Period:** July 1, 2016–June 30, 2022 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | cost to the Medicare Program. | | |
| Part D Enhanced Medication Therapy Management Model | Designed to test whether providing selected basic, stand-alone PDPs with regulatory flexibility to design and implement innovative programs and aligning financial incentives can more effectively achieve key goals for MTM programs. | **Announcement:** September 2015<br><br>**Anticipated Performance Period:** January 1, 2017–December 31, 2021 | Section 1115A of the Social Security Act |
| Part D Payment Modernization Model | The Part D Payment Modernization (PDM) Model will test the impact of a revised Part D program design and improved alignment of financial risk incentives on overall Part D prescription drug spending and beneficiary out-of-pocket costs. The model aims to reduce Medicare expenditures while preserving or enhancing quality of care for beneficiaries. | **Announcement:** January 18, 2019<br><br>**Anticipated Performance Period:** January 1, 2020–December 31, 2024 | Section 1115A of the Social Security Act |
| Part D Senior Savings Model | The Part D Senior Savings Model tests the impact of offering beneficiaries an increased choice of enhanced alternative Part D plan | **Announcement:** March 11, 2020<br><br>**Anticipated Performance Period** | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | options that offer lower out-of-pocket costs for insulin. CMS is testing a change to the Manufacturer Coverage Gap Discount Program (the "Discount Program") to allow Part D sponsors, through eligible enhanced alternative plans, to offer a Part D benefit design that includes a maximum $35 copay for a 30-day equivalent supply of a broad range of insulins in the deductible, initial coverage, and coverage gap phases by applying Part D sponsor supplemental benefits after the manufacturer-provided discount on the negotiated price. | **for Part D Sponsors:** January 1, 2021–December 31, 2025 | |
| Pennsylvania Rural Health Model | Designed to test whether the predictable nature of hospital global budgets will enable participating rural hospitals in Pennsylvania to invest in quality and preventive care, and to tailor the services they deliver to better meet the needs of their local communities. | **Announcement:** January 12, 2017<br><br>**Anticipated Performance Period:** January 1, 2019–December 31, 2024 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| Primary Care First Model Options | The Primary Care First (PCF) Model Options test whether financial risk and performance-based payments that reward primary care practitioners and other clinicians for easily understood, actionable outcomes will reduce total Medicare expenditures, preserve or enhance quality of care, and improve patient health outcomes. In PCF, CMS provides payment to participating practices through a simplified total monthly payment that allows clinicians to focus on caring for patients rather than on their revenue cycle. | **Announcement:** April 22, 2019<br><br>**Anticipated Performance Period:**<br>Cohort One: January 1, 2021–December 31, 2025.<br>Cohort Two: January 1, 2022–December 31, 2026. | Section 1115A of the Social Security Act |
| Radiation Oncology Model | The Radiation Oncology Model aims to improve quality of care and reduce expenditures for Medicare beneficiaries by encouraging use of evidence-based guidelines for RT to treat cancer and using a predictable, site-neutral, prospective episode-based payment. | **Announcement:** Notice of Proposed Rulemaking issued July 10, 2019. Final Rule published in the *Federal Register* September 29, 2020.<br><br>**Performance Period:** To Be Determined | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| State Innovation Models Initiative Round Two | Round Two provided financial, technical, and other support to up to an additional 32 states to develop or implement state health care innovation plans. | **Announcement:** May 2014<br><br>**Performance Period:** February 1, 2015–January 31, 2019 | Section 1115A of the Social Security Act |
| Transforming Clinical Practice Initiative | Tests whether providing support to 140,000 clinician practices in sharing, adapting, and further developing comprehensive quality improvement strategies will lead to greater improvements in patient health outcomes and reduced Medicare, Medicaid, or CHIP program expenditures. | **Announcement:** October 2014<br><br>**Anticipated Performance Period:** August 1, 2015–September 30, 2019 | Section 1115A of the Social Security Act |
| Vermont All-Payer ACO Model | Tests an alternative payment model in which the most significant payers throughout the entire state—Medicare, Medicaid, and commercial health care payers—incentivize health care value and quality, with a focus on health outcomes, In order to transform health care for the entire state and its population, the model uses an aligned payment | **Announcement:** October 2016<br><br>**Anticipated Performance Period:** January 1, 2017–December 31, 2022 | Section 1115A of the Social Security Act |

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | structure for the majority of health care providers in the state's care delivery system. | | |
| **Mandated Demonstrations and Other Initiatives Authorized Under Various Statutes** | | | |
| **Initiative Name** | **Description** | **Announcement and Performance Period** | **Statutory Authority** |
| Frontier Community Health Integration Project (FCHIP) Demonstration | Develops and tests new models of integrated, coordinated health care in the most sparsely-populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. | **Announcement:** August 2016<br><br>**Performance Period:** August 1, 2016–July 31, 2019[188] | Section 123 of the Medicare Improvements for Patients and Providers Act |
| Independence at Home Demonstration[189] | Home-based primary care for Medicare beneficiaries with multiple chronic conditions. | **Announcement:** December 2011<br><br>**Performance Period:** June 1, 2012–September 30, 2017, and January 1, 2019–December 31, 2020[190] | Section 1866E of the Social Security Act |
| Intravenous Immune Globulin (IVIG) Demonstration | Evaluates the benefits of providing payment for items and services needed for the in-home | **Announcement:** August 2014 | P.L. 112-242 Title I - Medicare IVIG |

[188] The FCHIP Demonstration was recently extended for 5 years by the Consolidated Appropriations Act of 2021.
[189] An evaluation report on the Independence at Home Demonstration was released March 2020.
[190] The Independence at Home Demonstration has recently been extended.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| | administration of intravenous immune globulin for the treatment of primary immune deficiency disease. | **Anticipated Performance Period:** October 1, 2014–December 31, 2020 | Access Sec. 101 |
| Medicare Pilot Program For Asbestos Related Disease (Libby, Montana) | Pilot program to provide innovative approaches to furnishing comprehensive, coordinated, and cost effective care—including benefits, items, and services not normally covered by Medicare—for patients with asbestos-related disease in Libby, Montana and limited surrounding areas. | **Announcement:** June 2011<br><br>**Performance Period:** Ongoing | Section 1881A of the Social Security Act (section 10323 of the Affordable Care Act) |
| Rural Community Hospital Demonstration | Designed to test the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals. | **Announcement:** October 2004<br><br>**Anticipated Performance Period:** October 1, 2004–December 31, 2023[191] | Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 |

[191] CMS began conducting the Rural Community Hospital Demonstration in 2004. The demonstration was initiated as a five-year program under its original mandate, section 410A of the Medicare Modernization Act of 2003, and extended for an additional five-year period under sections 3123 and 10313 of the Affordable Care Act. Section 15003 of the 21st Century Cures Act, enacted December 13, 2016, requires another five-year extension period for the demonstration.

| List of Models, Initiatives, and Demonstrations with Activity during the Period of Report (October 1, 2018–September 30, 2020) | | | |
|---|---|---|---|
| **Initiative Name** | **Description** | **Announcement and Anticipated Performance Period[181]** | **Statutory Authority** |
| Value in Opioid Use Disorder Treatment (Value in Treatment), under section 6042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act). | The purpose of the demonstration, as stated in the statute, is to "increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce (Medicare program) expenditures." As required by statute, Value in Treatment will be implemented no later than January 2021. | **Announcement:** May 2020<br><br>**Performance Period:** April 1, 2021–December 31, 2024 | Value in Treatment is a four-year demonstration program authorized under section 1866F of the Social Security Act (Act), which was added by section 6042 of the SUPPORT Act. |

# Appendix II: Previous CMS Innovation Center Model Tests and Demonstrations

The table below lists CMS Innovation Center model tests, initiatives, and demonstrations whose period of performance ended prior to October 1, 2018, and therefore did not have activity during this period of report (October 1, 2018–September 30, 2020).

| PREVIOUS CMS INNOVATION CENTER MODELS, INITIATIVES, AND DEMONSTRATIONS | | | |
|---|---|---|---|
| Advance Payment ACO Model | Prepayment of expected shared savings to certain eligible ACOs to advance development of ACO infrastructure and care coordination. | **Announcement:** November 2011<br><br>**Performance Period:** April 1, 2012–December 31, 2015 | Section 1115A of the Social Security Act |
| Bundled Payments for Care Improvement<br>(Four Models) | Evaluated four different episode payment models around inpatient hospitalization to incentivize care redesign—Model One: Retrospective Acute Care; Model Two: Retrospective Acute Care Episode & Post-Acute Care; Model Three: Retrospective Post-Acute Care; Model Four: Prospective Acute Care. | **Announcement:** August 2011<br><br>**Performance Period:** Model One: April 1, 2013–December 31, 2016<br><br>Models Two–Four: October 1, 2013–September 30, 2018 | Section 1115A of the Social Security Act |
| Community-Based Care Transitions Program (a part of the Partnership for Patients) | Aimed to reduce readmissions by improving transitions of high-risk Medicare beneficiaries from the inpatient hospital setting to home or other care settings. | **Announcement:** 2011<br><br>**Performance Period:** February 1, 2012– January 31, 2017 | Section 3026 of the Affordable Care Act |
| Comprehensive Primary Care Initiative | A multi-payer model that tested the effects of enhanced primary care services, including 24-hour access, care plans, and care coordination and payment reform. | **Announcement:** September 2011<br><br>**Performance Period:** January 1, 2013–December 31, 2016 | Section 1115A of the Social Security Act |

| PREVIOUS CMS INNOVATION CENTER MODELS, INITIATIVES, AND DEMONSTRATIONS | | | |
|---|---|---|---|
| Graduate Nurse Education Demonstration[192] | Designed to increase the nation's primary care workforce by supporting facilities that train Advanced Practice Registered Nurses (APRNs) through payments to eligible hospitals, helping them offset the costs of clinical training for APRN students. | **Announcement:** March 2012<br><br>**Performance Period:** August 1, 2012–July 31, 2018 | Section 5509 of the Affordable Care Act |
| Health Care Innovation Awards Round One | A broad appeal for innovations with a focus on developing the workforce for new care models. | **Announcement:** June 2012<br><br>**Performance Period:** July 1, 2012–June 30, 2015 | Section 1115A of the Social Security Act |
| Health Care Innovation Awards Round Two | A second appeal for innovations with a focus on payment and system delivery reform in four categories for Medicare, Medicaid, and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. | **Announcement:** May 2013<br><br>**Performance Period:** September 1, 2014–September 1, 2017 | Section 1115A of the Social Security Act |
| Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents Phase One | Phase One was an initiative to improve the quality of care and reduce avoidable hospitalizations among long-stay nursing facility residents through cooperative agreements with independent organizations partnering with nursing facilities to test enhanced on-site services and supports. | **Announcement:** March 2012<br><br>**Performance Period:** September 24, 2012–September 23, 2016 (actual start date varied by facility) | Section 1115A of the Social Security Act |

[192] A report to Congress on the Graduate Nurse Education Demonstration was submitted in October 2017.

| PREVIOUS CMS INNOVATION CENTER MODELS, INITIATIVES, AND DEMONSTRATIONS | | | |
|---|---|---|---|
| Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration | Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services. | **Announcement:** November 2011<br><br>**Performance Period:** November 1, 2011–October 31, 2014 | Section 1115A of the Social Security Act |
| Medicaid Emergency Psychiatric Demonstration[193] | Provided Federal matching funds to states for emergency Medicaid admissions to private psychiatric hospitals for beneficiaries ages 21 to 64. | **Announcement:** August 2011<br><br>**Performance Period:** July 1, 2012–June 30, 2015 | Section 2707(e) of the Affordable Care Act |
| Medicare Prior Authorization Model: Non-Emergent Hyperbaric Oxygen Therapy | A prior authorization model for repetitive scheduled non-emergent ambulance transport in Illinois, Michigan, and New Jersey to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. | **Announcement:** May 2014<br><br>**Performance Period:** March 1, 2015–February 28, 2018 | Section 1115A of the Social Security Act |

[193] A report to Congress on the Medicaid Emergency Psychiatric Demonstration was submitted in November 2019.

| PREVIOUS CMS INNOVATION CENTER MODELS, INITIATIVES, AND DEMONSTRATIONS | | | |
|---|---|---|---|
| Million Hearts® Add footnote 197 | National initiative to prevent one million heart attacks and strokes over five years, bringing together communities, health systems, nonprofit organizations, Federal agencies, and private-sector partners from across the country to fight heart disease and stroke. This initiative is not a payment and service delivery model for purposes of section 1115A, but rather is an initiative that was previously operated out of the CMS Innovation Center. | **Announcement:** September 2011<br><br>**Performance Period**: Ongoing, but no longer operated under CMS Innovation Center Authority, nor funded by Section 1115A of the Social Security Act[194] | Section 1115A of the Social Security Act |
| Partnership for Patients[195] | An initiative designed to make hospital care safer, more reliable, and less costly. In 2011, the Partnership was launched as a model test with ambitious targets of reducing preventable hospital-acquired conditions by 40 percent, and 30-day readmissions by 20 percent over a three-year period of performance. | **Announcement:** April 2011<br><br>**Performance Period**: Round One: December 9, 2011–December 8, 2014 Round Two: September 25, 2015–September 24, 2016 | Section 1115A of the Social Security Act |

[194] The Million Hearts® Initiative is ongoing. However, prior to this period of report it was transitioned into the Center for Clinical Standards and Quality, and was no longer funded under Section 1115A of the Social Security Act.

[195] Prior to this period of report, Partnership for Patients transitioned into the Hospital Innovation Improvement Network in the Center for Clinical Standards and Quality, and was no longer supported by section 1115A funding.

| PREVIOUS CMS INNOVATION CENTER MODELS, INITIATIVES, AND DEMONSTRATIONS | | | |
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| Pioneer ACO Model | Gave experienced health care organizations accountability for quality and cost outcomes for their Medicare FFS patients. Doctors and hospitals who formed Pioneer ACOs could share in savings generated for Medicare if they met certain quality performance standards, or they could be required to pay a share of any losses generated. | **Announcement:** May 2011<br><br>**Performance Period:** January 1, 2012–December 21, 2016 | Section 1115A of the Social Security Act |
| State Innovation Models Initiative Round One | Round One provided financial, technical, and other support to states that are either prepared to test, or are committed to designing and testing new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP. | **Announcement:** July 2012<br>**Performance Period:** April 1, 2013–September 30, 2016 | |
| Strong Start for Mothers and Newborns *Strategy One* | Tested the effectiveness of shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women. | **Announcement:** February 2012<br><br>**Performance Period:** December 9, 2011–December 8, 2014 | Section 1115A of the Social Security Act |
| Strong Start for Mothers and Newborns *Strategy Two* | Tested and evaluated a new model of enhanced prenatal care to reduce preterm births (less than 37 weeks) in women covered by Medicaid and CHIP. | **Announcement:** February 2012<br><br>**Performance Period:** February 15, 2013–February 14, 2017 | Section 1115A of the Social Security Act |

# Glossary of Acronyms

| | |
|---|---|
| ACO | Accountable Care Organization |
| ACH | Acute Care Hospital |
| AHA | American Heart Association |
| AHC | Accountable Health Communities Model |
| AI | Artificial Intelligence |
| AI-HOC | Artificial Intelligence Health Outcomes Challenge |
| AIM | ACO Investment Model |
| APCP | Advanced Primary Care Practice Demonstration |
| APM | Alternative Payment Model |
| APP | Alternative Payment Model Performance Pathway |
| ASCVD | Atherosclerotic Cardiovascular Disease |
| BPCI | Bundled Payments for Care Improvement Model |
| BPCI Advanced | Bundled Payments for Care Improvement Advanced Model |
| CAH | Critical Access Hospital |
| CAMH | CMS Alliance to Modernize Healthcare |
| CBSA | Core-Based Statistical Area |
| CCSQ | Center for Clinical Standards and Quality |
| CDC | Centers for Disease Control and Prevention |
| CE | Clinical Episodes |
| CEC | Comprehensive ESRD Care |
| CEHRT | Certified EHR Technology |
| CHIP | Children's Health Insurance Program |
| CHART | Community Health Access and Rural Transformation Model |
| CJR | Comprehensive Care for Joint Replacement Model |
| CKCC | Comprehensive Kidney Care Contracting |
| CKD | Chronic Kidney Disease |
| CMHC | Community Mental Health Center |
| CMS | Centers for Medicare & Medicaid Services |
| CPC | Comprehensive Primary Care Initiative |

| | |
|---|---|
| CPC+ | Comprehensive Primary Care Plus Model |
| CRP | Care Redesign Program |
| CVD | Cardiovascular Disease |
| CVD CM | Cardiovascular Care Management |
| CY | Calendar Year |
| DCE | Direct Contracting Entity |
| DPP | Y-USA Diabetes Prevention Program model test |
| ECCP | Enhanced Care and Coordination Provider |
| ED | Emergency Department |
| EI | Episode Initiators |
| EED | Early Elective Deliveries |
| EMS | Emergency Medical Services |
| EMT | Emergency Medical Technician |
| EPM | Episode Payment Model |
| EQIP | Episode Quality Improvement Program |
| ESCO | End-Stage Renal Disease Comprehensive Care Organization |
| ESRD | End-Stage Renal Disease |
| ETC | End-Stage Renal Disease Treatment Choices Model |
| ET3 | Emergency Triage, Treat, and Transport Model |
| FAQ | Frequently Asked Question |
| FDA | Food and Drug Administration |
| FFRDC | Federally Funded Research and Development Center |
| FFS | Fee-for-Service |
| FQHC | Federally Qualified Health Center |
| GPDC | Global and Professional Direct Contracting Model |
| HHA | Home Health Agency |
| HHCAHPS | Home Health Care Consumer Assessment of Healthcare Providers and Systems |
| HHS | Department of Health and Human Services |
| HHVP | Home Health Value-Based Purchasing Model |
| HIT | Health Information Technology |

| | |
|---|---|
| HOPD | Hospital outpatient department |
| HPP | Hospital Payment Program |
| HRSN | Health-related social needs |
| IAP | Medicaid Innovation Accelerator Program |
| InCK | Integrated Care for Kids Model |
| IPPS | Inpatient Patient Prospective Payment System |
| KCC | Kidney Care Choices Model |
| KCE | Kidney Contracting Entity |
| KCF | Kidney Care First |
| LAN | Health Care Payment Learning and Action Network |
| LDO | Large Dialysis Organization |
| LDS | Limited Data Set |
| LEJR | Lower Extremity Joint Replacements |
| LTC | Long-Term Care |
| MA | Medicare Advantage |
| MAC | Medicare Administrative Contractor |
| MACRA | Medicare Access and CHIP Reauthorization Act of 2015 |
| MAO | Medicare Advantage Organization |
| MC | Managing Clinician |
| MCCM | Medicare Care Choices Model |
| MCP | Monthly Capitation Payment |
| MDAPM | Maryland All Payer Model |
| MEOS | Monthly Enhanced Oncology Services |
| MFFS | Managed Fee-for-Service |
| MH | Million Hearts® Cardiovascular Disease Risk Reduction Model |
| MIPS | Merit-Based Incentive Payment System |
| MM | Maternal Mortality |
| MOU | Memorandum of Understanding |
| MOM | Maternal Opioid Misuse Model |
| MDPCP | Maryland Primary Care Program |
| MSA | Metropolitan Statistical Area |

| | |
|---|---|
| MTM | Medication Therapy Management |
| NAS | Neonatal Abstinence Syndrome |
| NFI 1 | Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents Phase One |
| NFI 2 | Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents Phase Two |
| NGACO | Next Generation ACO Model |
| Non-LDO | Non-Large Dialysis Organization |
| OASIS | Outcomes and Assessment Information Set |
| OCM | Oncology Care Model |
| OPPS | Outpatient Prospective Payment System |
| OUD | Opioid Use Disorder |
| PAC | Post-Acute Care |
| PA-DOH | Pennsylvania Department of Health |
| PARHM | Pennsylvania Rural Health Model |
| PBP | Plan Benefit Package |
| PBPM | Per-Beneficiary-Per-Month |
| PC | Professional Component |
| PCC | Primary Care Capitation |
| PCMH | Patient-Centered Medical Home |
| PDP | Prescription Drug Plan |
| PDM | Part D Payment Modernization Model |
| PFPM | Physician-Focused Payment Model |
| PGP | Physician Group Practice |
| PHE | Public Health Emergency |
| PO | Participant Organizations |
| PTAC | Physician-Focused Payment Model Technical Advisory Committee |
| PTN | Practice Transformation Network |
| PY | Performance Year |
| RFI | Request for Information |
| RHRC | Rural Health Redesign Center |

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|---|---|
| RO | Radiation Oncology Model |
| RSNAT | Repetitive Scheduled Non-Emergent Ambulance Transport |
| RT | Radiotherapy or Radiation Therapy |
| SAN | Support and Alignment Network |
| SIM | State Innovation Models |
| SIP | Serious Illness Population |
| SMM | Severe Maternal Morbidity |
| SNF | Skilled Nursing Facilities |
| SUD | Substance Use Disorders |
| TC | Technical Component |
| TCOC | Maryland Total Cost of Care Model |
| TCPI | Transforming Clinical Practice Initiative |
| TPS | Total Performance Score |
| VBID | Medicare Advantage Value-Based Insurance Design |
| YMCA | Young Men's Christian Association |
| Y-USA | Young Men's Christian Association of the USA |