



Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation

REPORT TO CONGRESS

DECEMBER 2016

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The Center for Medicare and Medicaid Innovation

REPORT TO CONGRESS

1. Executive Summary

The Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by section 1115A of the Social Security Act (the Act) (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center 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 Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. Section 1115A provided \$5 million in fiscal year 2010 and provides a total of \$10 billion for these purposes over the fiscal years 2011 through 2019, as well as an additional \$10 billion each decade thereafter.

Section 1115A(g) 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 third Report to Congress; it focuses on activities between October 1, 2014 and September 30, 2016, but also highlights a number of important activities started during that time period that were announced between September 30, 2016 and December 31, 2016.

To fulfill its mission to test innovative payment and service delivery models, the CMS Innovation Center has worked with stakeholders across the country, other federal agencies, and other components within CMS.

During this time period, the CMS Innovation Center has tested or announced 39 payment and service delivery models and initiatives under section 1115A authority (see the Appendix for a list¹). These models and initiatives support health care providers and health care organizations in testing alternative care delivery and payment models based on three core strategies for improving our health system: improving the way health care providers are paid, improving the way care is delivered, and increasing the availability of information to guide decision-making.

¹The Bundled Payments for Care Improvement Initiative is counted as four separate models; the Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model represent four separate models; the Health Care Innovation Awards and State Innovation Models are each considered two separate models. The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents has two phases and is counted as two separate model tests. The Million Hearts® initiative, Strong Start Strategy One, and the Medicaid Innovation Accelerator Program are not included in this count.

The work of the CMS Innovation Center relies on an understanding—shared by patients, health care providers, and other stakeholders—that our health care system does not consistently reward the quality of care provided, instead rewarding the quantity of services provided. Health care provider and payer-led change is happening in communities across the country. However, moving toward delivering high quality care to CMS beneficiaries and by extension, to all Americans, and paying for this care in smarter ways, requires transforming the system as a whole. CMS Innovation Center models and initiatives are driving the national effort to move towards value-based care.

In September 2016, the Congressional Budget Office (CBO) testified that the CMS Innovation Center’s activities are expected to reduce federal spending by roughly \$34 billion from 2017 through 2026. For more information on the CBO’s testimony before the United States House of Representatives Committee on the Budget, see the CBO testimony [here](#).² CMS Innovation Center models and initiatives have attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serve Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico.

The Centers for Medicare & Medicaid Services (CMS) estimates that a combined 18 million CMS beneficiaries and individuals with private insurance included in multi-payer models, have been impacted by, have received care, or will soon be receiving care furnished by more than 207,000 health care providers participating in CMS Innovation Center payment and service delivery models and initiatives. For purposes of this report, CMS beneficiaries include individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage.³

The CMS Innovation Center is reporting the number of CMS beneficiaries and individuals with private insurance impacted by CMS Innovation Center models and initiatives to fully represent the scope of CMS’ work on Delivery System Reform and multi-payer alignment. For instance, through the Health Care Innovation Awards and the State Innovation Models the CMS Innovation Center is providing millions of dollars in funding and technical assistance to support multiple health care providers and states in the development of health care payment and service delivery models and initiatives. Accurately representing the scope and impact of CMS Innovation Center models and initiatives requires more explicitly listing the different payers supporting these models, as well as aggregating the populations served by all participating payers. In addition, the Medicare Shared Savings Program (Shared Savings Program⁴) serves roughly 7.7 million beneficiaries across more than 430 Medicare

² The testimony indicates that the reduction in federal spending is expected to come almost entirely from the Medicare program.

³ This number does not include the number of beneficiaries and individuals touched by the Transforming Clinical Practice Improvement Initiative.

⁴ The Shared Savings Program is a statutorily mandated ACO program administered by CMS. This number combines the number of beneficiaries and health care providers in the Shared Savings Program with the number of beneficiaries, individuals, and health care providers in CMS Innovation Center models and initiatives. Data on the Shared Savings Program can be accessed [here](#).

Accountable Care Organizations (ACOs). Therefore, in total there are more than 25.7 million Americans who are impacted by CMS Innovation Center model tests and initiatives and the Shared Savings Program.

In January 2015, the Administration announced its Delivery System Reform goals of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APMs) by the end of 2016 and 50 percent by 2018. In March 2016, the Administration announced that it had achieved its 2016 goal for linking Medicare payments to quality or value nearly a year ahead of schedule.⁵

Recognizing that Medicare alone cannot drive sustained progress toward Delivery System Reform, HHS concurrently announced the creation of a Health Care Payment Learning and Action Network (LAN). Through the LAN, managed by a contractor under CMS Innovation Center authority, HHS is working with private payers, employers, consumers, health care providers, states and state Medicaid programs, and other partners to increase the use of alternative payment models in their programs.

As of September 30, 2016 LAN activities have the potential to inform the ways in which health care providers provide value-based care to 128 million Americans, approximately 43 percent of the covered population. LAN participants include 26 commercial health insurance plans, 23 Medicare Advantage plans, 28 Medicaid managed care plans, and two state Medicaid offices. The LAN is described in greater detail later in this report and more information can be found on their website [here](#).

In 2015, Congress passed the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate formula for physician payment updates and added a Merit-Based Incentive Payment System (MIPS) designed to more closely link health care payment to quality and value. From 2019-2024, eligible clinicians who achieve threshold levels of participation in Advanced Alternative Payment Models (Advanced APMs) will be eligible to receive an incentive payment.

Since the MACRA was enacted, the CMS Innovation Center has been instrumental to its implementation. The final rule with comment period to implement the Quality Payment Program was issued on October 14, 2016. Working closely with other CMS and HHS components on implementation of the Quality Payment Program, the CMS Innovation Center has been able to maximize support for eligible clinicians transitioning into APMs by expanding the number and types of available APMs.

CMS conducts an independent evaluation of every CMS Innovation Center model and releases those findings publicly. Reports posted online include cumulative to-date information on the model results and in-depth analyses of the results using quantitative and qualitative data. These reports provide stakeholders with information on the impact of the model as a whole on health care expenditures and utilization, beneficiary and health care

⁵ HHS Press release: [HHS reaches goal of tying 30 percent of Medicare payments to quality ahead of schedule](#).

provider experiences with care, and, where feasible, health outcomes. The reports also often provide site-specific results.

CMS and our stakeholders use this information for continuous improvement and dissemination of best practices. Several CMS Innovation Center models and initiatives have shown favorable impacts on cost and/or quality. Some of the models showing promising results are highlighted below; these offer templates for health care provider innovations in care delivery and payment:

- The Pioneer Accountable Care Organization Model;
- The Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents Phase 1;
- Several awardees in the Health Care Innovation Awards, Round One (including but not limited to the Diabetes Prevention Program⁶);
- Bundled Payments for Care Improvement Initiative Model 2; and
- The Maryland All-Payer Model.

Several CMS Innovation Center models build upon lessons learned from earlier model tests and a growing evidence base in care delivery and payment research. These models include the Oncology Care Model (OCM), the Comprehensive Care for Joint Replacement Model (CJR), the ACO Investment Model, the Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents Phase 2, the Next Generation ACO Model, and the Comprehensive Primary Care Plus Model (CPC+). These initiatives, like all CMS Innovation Center models and initiatives, are designed to gather more focused, valid, and substantive data in support of innovations that show promise in reducing expenditures and preserving or enhancing the quality of care.

Other models and initiatives have been designed to support and accelerate health care transformation through direct technical assistance and spread of lessons learned. These include the Medicaid Innovation Accelerator Program (IAP) and the Transforming Clinical Practice Initiative (TCPI), which build on the State Innovation Models (SIM) and the Partnership for Patients, as well as other CMS Innovation Center models and initiatives. IAP provides technical assistance to states as they transform health care. TCPI provides technical assistance and training to support health care providers transitioning to APMs.

This report summarizes CMS Innovation Center efforts in model testing and stakeholder engagement between October 1, 2014 and September 30, 2016 and describes progress toward reducing expenditures while preserving or enhancing the quality of care. It also includes information on important activities that began during this time period but were announced between September 30, 2016 and December 31, 2016.

⁶ These results are preliminary only and are based on the Health Care Innovations Awards, Round One Year Two Annual Evaluation Report, which can be accessed [here](#).

This report conforms to the requirements of section 1115A and describes the models and initiatives announced and tested under section 1115A authority. Any legislative recommendations related to CMS, including the CMS Innovation Center, would be included in the President's budget request.

2. Introduction

Acting on provisions of the Affordable Care Act, CMS has taken the lead in transforming our health care system into one that delivers better care, spends health care dollars more wisely, and results in healthier people. Instrumental in that effort has been the CMS Innovation Center, established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

The CMS Innovation Center relies on an understanding shared by patients, health care providers, and other stakeholders that our health care system does not consistently reward the quality of care provided, instead rewarding the quantity of services. Health care provider and payer-led transformation is continuing in communities across the country. However, delivering high quality care to all Americans and paying for this care in smarter ways requires transforming the system as a whole. The CMS Innovation Center is driving a national public-private effort to adopt alternative payment models that reward the quality of care over the quantity of services.

In its role as the primary evaluator of alternative payment models, the CMS Innovation Center is testing approaches to care delivery and payment that are drawn from the daily clinical experience and innovative practices of health care providers and other partners in the health care community, building evidence for health care transformation through a collaborative and transparent process. The success of this effort has hinged on the CMS Innovation Center working closely with patients, health care providers, payers, and other stakeholders to achieve real, measurable, and significant results that are improving health and lowering spending. The structure and operations of the CMS Innovation Center uniquely position it to quickly and flexibly incorporate stakeholder feedback and evaluation results to scale successful models.

To date, two CMS Innovation Center models have met the statutory criteria to be eligible for expansion by reducing program spending while preserving or enhancing quality—the Pioneer Accountable Care Organization (ACO) Model and the Diabetes Prevention Program (DPP) Model. 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. Meanwhile, the DPP model has saved Medicare an estimated \$2,650 per beneficiary over a 15-month period, which covered program costs and helped participants lose an

average of 5 percent of their body weight to significantly reduce their risk of developing diabetes.

ACOs, bundled payments, and other preventive and integrated care delivery models are improving clinical practice and delivering better outcomes for patients. This means making it easier for individuals and their families to access high-value, coordinated care; more deeply engage in decision-making; and prioritize prevention and wellness to improve their health. As a result, individuals in CMS Innovation Center models will generally experience better care coordination, expanded access to care, and care that is more in line with their preferences. Clinical quality performance is often higher in many models than in Medicare overall, as are scores on patient experience surveys. Efforts underway through the CMS Innovation Center now serve tens of millions of Americans and involve more than 207,000 health care providers, embedding interventions that reduce costs and improve health outcomes in every state across the country.

Delivery System Reform and the Quality Payment Program

To accelerate transformation, in January 2015, the Administration announced an ambitious delivery system reform initiative supported by the Affordable Care Act that set measurable goals and a timeline for continuing to move the Medicare program, and the health care system at large, toward paying health care providers based on quality and value rather than the quantity of care delivered. Specifically, the Administration set a goal of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by the end of 2016 and 50 percent by 2018. The Administration also set a goal of tying 85 percent of all Medicare fee-for-service payments to quality or value by 2016 and 90 percent by 2018.

At the same time, the Secretary of Health and Human Services announced the creation of the Health Care Payment Learning and Action Network (LAN). Funded by the CMS Innovation Center, the LAN is a public-private effort by public and private payers, purchasers, health care providers, consumers, and states to align and expand development of alternative payment models that improve the quality and value of health care. The LAN provides a forum for generating evidence, sharing best practices, reaching consensus about the design and monitoring of alternative payment models, and removing barriers to health care transformation across the U.S. health care system.

In March 2016, the Administration announced that it had met its 30 percent target nearly a year ahead of schedule. The CMS Innovation Center was instrumental to this pace of change and its continued work is essential to reaching HHS' 2018 goals. The CMS Innovation Center is vital to achieving the Delivery System Reform goals because its alternative payment models, demonstrations, and other relevant projects focus on improving the way health care providers are incentivized, the way care is delivered, and the way information is distributed to achieve better care at lower cost across the health care system.

In April 2015, Congress passed the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) that repealed the Sustainable Growth Rate, streamlined multiple existing programs into one new system known as the MIPS, and provided incentives for eligible clinicians who achieve threshold levels of participation in Advanced APMs. These changes will accelerate the adoption of APMs by building on existing efforts to tie payment to quality and improvements in care delivery, as well as modernizing the way Medicare pays clinicians.

The CMS Innovation Center bears primary responsibility for development of policies and operations to implement the APM incentive provisions of MACRA through the Quality Payment Program. The CMS Innovation Center has been asked to fulfill this role because it is best positioned to not only create new models but also to implement, identify challenges, iterate, and expand improvements based on patient and health care provider feedback.

The CMS Innovation Center's MACRA implementation activities can be summarized as follows:

- **October 1, 2015:** In concert with the Center for Clinical Standards and Quality (CCSQ), issued a Request for Information (RFI) to obtain input on Section 101 of the MACRA regarding the implementation of the MIPS and incentives for participation in Advanced APMs.
- **April 2016:** In concert with CCSQ, the CMS Innovation Center published a proposed rule to implement key provisions of the MACRA through the Quality Payment Program, drawing on input obtained from the RFI and feedback from stakeholders through webinars.
- **May 2016 – July 2016:** Held numerous listening sessions, speaking engagements, and webinars to inform stakeholders about the Quality Payment Program and to seek input on and its development and implementation.
- **July 2016 – October 2016:** In concert with CCSQ, developed and announced the final rule for the Quality Payment Program, which can be accessed at the Quality Payment Program Website [here](#). In the proposed rule, we estimated that 30,000 to 90,000 clinicians would be Qualifying APM Participants (QPs) in 2017. With new Advanced APMs expected to become available for participation in 2017 and 2018, including the Medicare ACO Track 1 Plus (1+), and anticipated amendments to reopen applications to modify current APMs, we anticipate higher numbers of QPs—approximately 70,000 to 120,000 in 2017 and 125,000 to 250,000 in 2018.
- **Ongoing:** In concert with CCSQ, the CMS Office of Technology Services (OTS), and other CMS components, developed technical assistance resources, IT infrastructure, and other program operations to support implementation of the Quality Payment Program.

- **Ongoing:** Collaborating with stakeholders to create, test, and evaluate models that have the potential to become Advanced APMs.

Under the Quality Payment Program, CMS will begin measuring performance for doctors and other clinicians through MIPS in January 2017, with payments based on performance beginning in 2019. Beginning in performance year 2017, CMS will also begin assessing the level of participation in Advanced APMs to identify eligible clinicians that qualify for the APM incentive payments each year from 2019-2024. In addition, beginning in performance year 2019, clinicians may qualify for APM incentive payments that are based in part on participation in Other Payer Advanced APMs, which are developed by non-Medicare payers, such as private insurers or state Medicaid programs, and recognized by CMS.

In light of these upcoming changes, the CMS Innovation Center will significantly enlarge its portfolio of Advanced APMs, expecting the number to increase from 6 Advanced APMs in 2017 to 10 Advanced APMs in 2018. The CMS Innovation Center is the principal pathway for creation of new alternative payment models that does not require legislative action, including in its work the development of models recommended to the Secretary of Health and Human Services by the Physician-Focused Payment Models Technical Advisory Committee (PTAC), described further below. The CMS Innovation Center intends to broaden opportunities for health care providers, including small practices and a wide range of specialties, to participate in these initiatives. It also will provide clinicians more ways to partner with the Medicare program to be paid in ways that support high quality patient care and receive an incentive payment for this participation.

In 2018, CMS expects that about 25 percent of eligible clinicians will participate in Advanced APMs. That would increase the number of clinicians participating in these models (and potentially receiving an incentive payment) from about 70,000 to 120,000 in 2017 to 125,000 to 250,000 in 2018. The CMS Innovation Center will support many of these eligible clinicians through the Transforming Clinical Practice Initiative (TCPI), which is designed to help more than 140,000 practices learn how to manage population health and reduce waste while improving outcomes for millions of patients.

CMS Innovation Center Priorities: 2011-2016

CMS published a Statement of Organization, Functions, and Delegations of Authority for the CMS Innovation Center in the November 17, 2010 *Federal Register* (75 FR 70274). Since that time, the CMS Innovation Center has focused on four main priorities as it carries out its statutory responsibilities:

- a. testing new payment and service delivery models,
- b. conducting congressionally mandated or authorized demonstrations and related activities,
- c. evaluating results and advancing best practices, and

d. engaging stakeholders.

a. 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. During the development of models, the CMS Innovation Center builds on ideas received from stakeholders and consults with clinical and analytical experts, as well as with representatives of relevant federal and state agencies. In addition to informal engagement on model development, at times the CMS Innovation Center has obtained comments via a Request for Information or notice and comment rulemaking.

For example, during the Comprehensive Care for Joint Replacement (CJR) Model notice and comment rulemaking process, the CMS Innovation Center invited the public to submit comments to inform the design of the payment model. CMS received approximately 400 comments. During model implementation, the CMS Innovation Center also met with stakeholders, conducted informational webinars, and developed educational materials for the public. The CJR model team continues to connect with participants and the public through websites, outreach to regional offices, and the dissemination of informational documents and resources.

In general, the CMS Innovation Center solicits model test participants through an open process that includes competitive Funding Opportunity Announcements and Requests for Applications. The selection process follows established protocols to ensure that it is fair and transparent, and that it provides opportunities for potential participants to ask questions regarding the CMS Innovation Center's expectations.

Physician-Focused Payment Model Technical Advisory Committee

The MACRA established a new committee known as the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC is charged with reviewing proposals from outside individuals and stakeholder entities for new physician-focused payment models that meet certain criteria. These criteria have been set forth in the Quality Payment Program final rule. The PTAC will comment on proposals and submit recommendations that they find promising to the Secretary of Health and Human Services. The Secretary, in turn, must review the comments and recommendations submitted by the PTAC and post a detailed response to the comments and recommendations on the CMS website. The CMS Innovation Center is in a prime position to develop and implement any physician-focused payment models that the PTAC and the Secretary recommend and will be instrumental in testing these new ideas from the field as quickly as possible.

For more information, see the [Physician-Focused Payment Model Technical Advisory Committee Webpage](#).

b. Conducting Congressionally Mandated or Authorized Demonstrations and Related Activities

The CMS Innovation Center has responsibility for implementing a number of specific demonstration projects authorized and funded by statute. For example, the Independence at Home Demonstration was authorized by section 3024 of the Affordable Care Act. Each demonstration, initiative, or model is associated with its own funding source, as appropriate. The findings from these demonstrations will inform possible changes in CMS policies, as well as the development and testing of new models, if appropriate.

During the period between October 1, 2014 and September 30, 2016 the CMS Innovation Center operated at least 12 demonstrations or initiatives mandated by statute (in addition to the 39 models and initiatives authorized under section 1115A authority).

For purposes of this report, some models and initiatives appear under the same name but are testing distinctly different approaches to payment and care delivery through multiple phases, rounds, or models.

For example, the Health Care Innovation Awards includes two rounds, which the CMS Innovation Center has counted as two model tests. In addition, some models under the same name have different evaluations. In these cases, models and initiatives are counted separately resulting in the aggregate 39 models and initiatives count. This distinction is also provided next to each model or initiative name where applicable. A list of all demonstrations which were active during the current period of reporting is included in the Appendix. The list below includes the section 1115A models and initiatives that comprise our 39 model and initiatives count for this Report to Congress:

1. Accountable Health Communities Model
2. ACO Investment Model
3. Advance Payment ACO Model
4. Bundled Payments for Care Improvement Model 1
5. Bundled Payments for Care Improvement Model 2
6. Bundled Payments for Care Improvement Model 3
7. Bundled Payments for Care Improvement Model 4
8. Comprehensive Care for Joint Replacement Model
9. Comprehensive End Stage Renal Disease Care Model
10. Comprehensive Primary Care Initiative Model
11. Comprehensive Primary Care Plus (CPC+) Model

12. Federally Qualified Health Center Advanced Primary Care Practice Demonstration
13. Cardiac Rehabilitation Incentive Payment Model
14. Episode Payment Model: Acute Myocardial Infarction
15. Episode Payment Model: Coronary Artery Bypass Graft
16. Episode Payment Model: Surgical Hip and Femur Fracture Treatment
17. Health Care Innovation Awards Round One
18. Health Care Innovation Awards Round Two
19. Health Care Payment Learning and Action Network ⁷
20. Home Health Value-Based Purchasing Model
21. Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents Phase 1
22. Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents Phase 2
23. Maryland All-Payer Hospital Model
24. Medicare Advantage Value-Based Insurance Design Model
25. Medicare Care Choices Model
26. Medicare Diabetes Prevention Program Expanded Model
27. Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals
28. Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy
29. Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport Model
30. Million Hearts®: Cardiovascular Disease Risk Reduction Model
31. Next Generation ACO Model
32. Oncology Care Model
33. Part D Enhanced Medication Therapy Management (MTM) Model

⁷ The Health Care Payment Learning and Action Network is a public-private partnership funded by the CMS Innovation Center under Section 1115A authority.

34. Partnership for Patients
35. Pioneer Accountable Care Organization Model
36. State Innovation Models Round One
37. State Innovation Models Round Two
38. The Strong Start for Mothers and Newborns Strategy 2
39. Transforming Clinical Practice Improvement Initiative ⁸

c. Evaluating Results and Advancing Best Practices

Section 1115A(b)(4) requires the CMS Innovation Center to conduct an evaluation of each CMS Innovation Center model, and it specifies that each evaluation 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 above, the Secretary of Health and Human Services shall take the evaluation into account in decisions to expand the duration and scope of a model or demonstration project under section 1866C.

The CMS Innovation Center, using independent evaluators, routinely and rigorously assesses the impact of each model on quality and cost. The evaluations include advanced statistical methods and carefully defines and selects comparison groups, as appropriate, to ensure that models deemed to be successful represent 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 best identify and understand the impact of the model.

Every CMS Innovation Center model also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both public programs and the health care system at large.

The CMS Innovation Center has created model-specific learning collaboratives that promote broad and rapid dissemination among health care providers of evidence-based best practices that have the potential to deliver higher quality and lower cost care for Medicare, Medicaid, and CHIP beneficiaries. In addition, the CMS Innovation Center leverages claims data, patient surveys, and other data to deliver actionable feedback to health care providers about

⁸ The Million Hearts® initiative, Strong Start Strategy One, and the Medicaid Innovation Accelerator Program are not included in this count.

their performance, while encouraging participants to use their own performance data to drive continuous improvement in outcomes.

d. Engaging Stakeholders

Section 1115A(a)(3) requires the CMS Innovation Center 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 CMS to help design CMS Innovation Center models.

The CMS Innovation Center has actively sought input from a broad array of stakeholders across the country in order to identify promising new payment and service delivery models. The CMS Innovation Center has held model-specific listening sessions, webinars, and information sharing sessions, engaging thousands of innovators from around the country. In addition, hundreds of ideas for improving health care have been shared through the CMS Innovation Center website and CMS Innovation Center staff routinely meet with health care researchers, innovators, clinicians, professional associations, subject matter experts from sister agencies, and other stakeholders to seek feedback on current model tests and to inform the design of future model tests.

Another extensive outreach effort over the past two years has been the Health Care Payment Learning and Action Network (LAN), convened and independently managed by the CMS Alliance to Modernize Healthcare (CAMH), a Federally Funded Research and Development Center (FFRDC) operated by a contractor. The LAN engages public and private payers, purchasers, health care providers, consumers, and states to align development of alternative payment models that improve the quality and value of health care.

Funded by the CMS Innovation Center, the LAN provides a forum for collaboration by participants to help the U.S. health care payment system meet or exceed HHS’ goals for value-based payments and alternative payment models, while helping to inform delivery system and payment reform efforts in the public and private sectors.

To date, more than 7,000 individual patients, public and private payers, purchasers, health care providers, consumers, and states have registered to participate in the LAN, including more than 610 organizations. As of September 30, 2016, LAN activities have the potential to inform the ways in which health care providers provide value-based care to 128 million Americans, approximately 43 percent of the covered population. LAN participants include 26 commercial health insurance plans, 23 Medicare Advantage plans, 28 Medicaid managed care plans, and two state Medicaid offices. In addition, among those LAN participants who have agreed to track their health care payments, 23 percent of those health care payments flowed through alternative payment models in 2015.

Requests for Information Issued in the Past 2 Years

The CMS Innovation Center invites and seeks input in the design of individual models through vehicles that are open to all stakeholders, including Requests for Information (RFI), notice and comment rulemaking, and “open door” phone conferences. Guidance from experts in the field is gathered through interviews, consultation, and technical expert panels.

During this reporting period, the CMS Innovation Center issued five RFIs seeking input from stakeholders on possible models, initiatives, and program implementation under consideration and on anticipated notice and comment rulemaking. These are described below.

Health Plan Innovation Opportunities

In October 2014, the CMS Innovation Center issued an RFI on initiatives to test innovations in plan design, care delivery, beneficiary and health care provider incentives and engagement, and network design in Medicare health plans and Medigap and Retiree Supplemental health plans. The submission period for the RFI concluded on November 3, 2014. The CMS Innovation Center used this input to help develop the Part D Enhanced Medication Therapy Management (MTM) Model and the Medicare Advantage Value-Based Insurance Design (MA-VBID) Model.

The Enhanced MTM Model will test whether providing Part D sponsors with additional payment incentives and regulatory flexibilities will improve medication usage by high-risk enrollees, leading to improved therapeutic outcomes while reducing net Medicare expenditures. The MA-VBID model will provide an opportunity for MA plans to offer reduced cost sharing and/or additional supplemental benefits to enrollees with CMS-specified chronic conditions, in order to encourage the consumption of clinically-nuanced high value services, and to improve health outcomes while lowering expenditures for MA enrollees. Detailed descriptions of both the Enhanced MTM and MA-VBID models are provided in the Review of CMS Innovation Center Activities section of this report.

The Health Plan Innovation Opportunities RFI can be accessed [here](#).

Advanced Primary Care Initiatives

On February 13, 2015, the CMS Innovation Center issued an RFI seeking input on the development of initiatives aimed at improving advanced primary care through mechanisms such as expanding and enhancing primary care services, improving care for complex patients, facilitating connections to the medical neighborhood and community-based services, and moving reimbursement from encounter-based toward value-driven, population-based care. The submission period for the RFI concluded on March 16, 2015. The CMS Innovation Center used this input to help develop the Comprehensive Primary Care Plus Model (CPC+).

The Advanced Primary Care Initiatives RFI can be accessed [here](#).

Medicare Access and CHIP Reauthorization Act of 2015(MACRA)

On October 1, 2015, CMS issued an RFI to obtain input on Section 101 of the MACRA regarding the implementation of the MIPS and incentives for participation in Advanced APMs. The submission period for the RFI concluded on November 17, 2015. The CMS Innovation Center used this input in developing the Quality Payment Program proposed rule and final rule to implement the APM provisions of the MACRA and in the development of Physician-Focused Payment Models (PFPM) criteria for the Physician-Focused Payment Model Technical Advisory Committee (PTAC) pursuant to Section 101 of the MACRA.

Concepts for Regional Multi-Payer Prospective Budgets

On April 14, 2016, the CMS Innovation Center issued an RFI to obtain input on a concept that promotes accountability for the health of a population in a geographically defined community through improved patient-centered care, reduced expenditures, and use of a global budget. The RFI encourages multi-payer participation across states and private payers, and seeks input on ways this concept may serve as an opportunity for rural health care providers to participate in APMs. The submission period for the RFI concluded on May 13, 2016.

The Concepts for Regional Multi-Payer Prospective Budgets RFI can be accessed [here](#).

State Innovation Model Concepts

On September 8, 2016, the CMS Innovation Center issued an RFI to seek input on concepts for a potential state-based initiative. Specific concepts for stakeholders to comment on included: (1) Partnering with states to implement delivery and payment models across multiple payers that could qualify as Advanced APMs or Other Payer Advanced APMs under the Quality Payment Program, making it easier for eligible clinicians to become Qualifying APM Participants (QPs) and earn the APM incentive payment; (2) Implementing financial accountability for health outcomes for an entire state's population; (3) Assessing the impact of specific care interventions across multiple states; and (4) Facilitating alignment of state and federal payment and service delivery reform efforts, and streamlining interactions between the federal government and states. The submission period for the RFI concluded on October 28, 2016.

The State Innovation Model Concepts RFI can be accessed [here](#).

Stakeholder Solicitations and Communications

The CMS Innovation Center has conducted hundreds of interviews and consultations with technical experts and leading health care providers, payers, and researchers to learn from

their innovations and experiences, and has held a Consumer Roundtable Listening Session, as well as scores of webinars each year to announce and explain initiatives and increase stakeholder engagement.

In designing the Comprehensive Primary Care Plus Model (CPC+), for example, the CMS Innovation Center built upon the lessons learned from participants and stakeholders involved in the Comprehensive Primary Care initiative, and feedback received from the 2015 RFI on Advanced Primary Care Initiatives. While developing CPC+, the CPC+ team also conducted structured interviews with over 15 payment policy and primary care delivery experts, including representatives from academia, national and local payers, think tanks, and physician organizations.

The team also held a focus group with 10 primary care thought leaders to provide feedback on the care delivery design. CPC+ integrates many insights from stakeholders across diverse sectors, particularly on the critical role of practice readiness, aligned payment reform, actionable performance-based incentives, and robust data sharing.

As the Accountable Health Communities model was developed, the team met with academic and state experts on social impact funding, with social impact funders and philanthropic organizations, and with the Centers for Disease Control and Prevention, which was developing parallel work on community-driven care transformation. Structured interviews, developed with contractor assistance, were conducted with 4 sites in different regions of the country.

The CMS Innovation Center interacts with people across the country interested in service delivery and payment innovation through its website, social media outreach, and an e-mail listserv (where the public can sign up for email updates on CMS Innovation Center activities). The CMS Innovation Center listserv can be accessed [here](#). Since 2012, the listserv audience has grown from 30,000 to over 78,000 and Twitter followers have increased from 5,000 to more than 32,000.

The CMS Innovation Center website and listserv continually update innovators in the field on new funding and learning opportunities. The site includes search-driven interactive maps that allow state-level views of organizations participating in CMS Innovation Center models.

Details on CMS Innovation Center Authority, Organization, and Operations

The statute provides the Secretary of Health and Human Services with the authority under section 1115A(c) of the Affordable Care Act to expand through rulemaking the duration and scope of a model being tested or a demonstration project under section 1866C, including implementation on a nationwide basis. In order for the Secretary to exercise this authority, an expansion must either reduce spending without reducing quality of care or improve quality of care without increasing spending, CMS' Chief Actuary must certify that expansion of the model would reduce (or not increase) net program spending, and the model must not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The

Secretary's expansion determinations are made based on evaluations performed by CMS under section 1115A(b)(4).

In addition to model expansion determinations, section 1115A also requires that the Secretary of Health and Human Services terminate or modify models tested under section 1115A, at any time after testing has begun and before completion, unless the Secretary determines that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. The CMS Chief Actuary must make a certification with respect to spending.

The CMS Innovation Center works closely with other CMS components and colleagues throughout the federal government in developing and testing CMS Innovation Center models. Some of these CMS components and examples of areas of collaboration include:

- Center for Clinical Standards and Quality (for the Partnership for Patients and the Transforming Clinical Practice Initiative);
- Center for Medicaid and CHIP Services (for the Medicaid Innovation Accelerator Program and the State Innovation Models);
- Center for Medicare (all ACO models, Bundled Payments for Care Improvement Initiative, and the Comprehensive Care for Joint Replacement Model);
- Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Medicare-Medicaid Financial Alignment Initiative and the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents); and the
- Office of Financial Management (for the Prior Authorization Models).

In addition, the CMS Innovation Center partners with other federal agencies to develop and improve our models and initiatives. Some of these federal agency partners include:

- Centers for Disease Control and Prevention;
- Health Resources and Services Administration;
- Agency for Healthcare Research and Quality;
- Office of the National Coordinator of Health Information Technology;
- Administration for Community Living;
- Department of Housing and Urban Development;
- Administration for Children and Families;
- Substance Abuse and Mental Health Services Administration;
- Federal Trade Commission;

- Department of Justice; and the
- Office of the Inspector General.

The CMS Innovation Center is organized to develop and test new payment and service delivery models as well as to support statutory demonstrations and other projects. To better coordinate these models and demonstration projects and to avoid duplication of effort and expense, the former Office of Research, Development and Information was merged with the CMS Innovation Center in early 2011. As a result, the CMS Innovation Center oversees not only initiatives that are authorized under section 1115A, but also activities under several other authorities, including other provisions of the Affordable Care Act and other laws and certain projects authorized by section 402 of the Social Security Amendments of 1967 as amended.

Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination of the work, better gap analysis, avoidance of program overlaps, and more efficient operations, while still maintaining distinct payment streams. For example, demonstrations authorized by section 402 of the Social Security Amendments of 1967 as amended are not funded under section 1115A. Only payment and service delivery models and initiatives authorized under 1115A are covered in detail in this report.

3. Review of CMS Innovation Center Activities

Between October 1, 2014 and September 30, 2016, the CMS Innovation Center has announced or tested 39 new payment and service delivery models and initiatives aimed at reducing expenditures under Medicare, Medicaid, and CHIP and preserving or enhancing the quality of care that beneficiaries receive. Collectively, CMS Innovation Center models and the health care providers participating in them are furnishing services to Medicare, Medicaid, and/or CHIP beneficiaries in all 50 states, the District of Columbia, 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.

The CMS Innovation Center estimates that a combined 18 million CMS beneficiaries and individuals with private insurance have been impacted by, have received care from, or soon will be receiving care from 207,000 health care providers participating in models and initiatives authorized under section 1115A.⁹ For purposes of this report, CMS beneficiaries include individuals with coverage through Medicare FFS, Medicaid, both Medicare and Medicaid (as Medicare-Medicaid enrollees), CHIP, and Medicare Advantage.

This number includes the millions of Americans impacted by CMS Innovation Center models and initiatives that engage thousands of health care providers, payers, and states in model

⁹ This does not include the number of beneficiaries touched by the Transforming Clinical Practice Improvement Initiative.

tests and through quality improvement efforts that extend across the country. Accurately representing the scope and impact of CMS Innovation Center models and initiatives requires more explicitly listing the different payers supporting these models, as well as aggregating the populations served by all participating payers.

Quality improvement initiatives and initiatives that address preventive health, like the Partnership for Patients and Million Hearts®, are reaching thousands of health care providers.¹⁰ Comprehensive state health care transformation efforts driven by the State Innovation Models (SIM) Initiative, under which CMS partners with states to address specific issues in that state, are affecting a steadily increasing percentage of health care providers nationwide. The states participating in SIM represent more than 60 percent of the U.S. population.

Model participants and partners include a broad cross section of health care providers, health organizations and systems, state and local governmental entities, academic institutions, and nonprofit and community organizations engaged in health system transformation. CMS Innovation Center models are testing approaches to improve outcomes and lower costs across the care continuum from prenatal to palliative care and from acute care to community settings. Under each CMS Innovation Center model, beneficiaries retain access to their regular Medicare, Medicaid, and CHIP benefits and the right to select the health care providers and services of their choice.

Further, CMS Innovation Center models focus on improving care delivery and on realigning financial incentives so they reward health care providers and organizations who deliver better care at lower cost. In general, these models also offer health care providers the financial support, technical assistance, and information they need to improve the care of individual beneficiaries and the health of populations. The CMS Innovation Center has engaged private and other governmental payers in testing new care delivery and payment models, including delivery system transformation support at the state level.

The initiatives highlighted in *subsection a*, of this section include only models and initiatives authorized and funded by section 1115A of the Social Security Act that were announced (some of which also had activity) between October 1, 2014 and September 30, 2016. Existing section 1115A models (those announced prior to October 1, 2014) are covered in *subsection b* of this section. The CMS Innovation Center implements and thoroughly evaluates both section 1115A models and initiatives authorized under other authorities to determine their impact on quality and costs. A table identifying all of the activities under the purview of the CMS Innovation Center and their specific statutory authority is provided in the Appendix.

Model Tests Eligible for Expansion

Section 1115A(c) provides the Secretary of Health and Human Services the authority to expand through rulemaking the duration and scope of a model that is being tested under

¹⁰ The Million Hearts® initiative, (which is separate from the Million Hearts Cardiovascular Disease Risk Reduction Model) has not received direct funding from the CMS Innovation Center.

subsection (b) or a demonstration project under section 1866C, including implementation on a nationwide basis.

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

As of September 30, 2016, 2 CMS Innovation Center models tested under section 1115A of the Act have been determined to meet the requirements to be eligible for expansion: the Pioneer ACO Model as it was tested during the first 2 years of the Model, and an award from the Health Care Innovation Awards Round One – Diabetes Prevention Program.

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 3-year period of performance with the option to extend for 2 additional years.

According to the most recent data available, 12 Pioneer ACOs generated almost \$37 million in total savings in 2015.¹¹ At the same time, 6 Pioneer ACOs qualified for shared savings payments of more than \$38 million by meeting quality standards and their savings threshold. In addition, the mean quality score among Pioneer ACOs increased to 92.3 percent in the fourth performance year from 87.2 percent in the third performance year.

The Pioneer ACO Model evaluation also found favorable results on both cost and quality measures following the first 2 performance years. In May 2015, the CMS Chief Actuary certified that the Pioneer ACO Model was eligible for expansion and that expansion would reduce net program spending, and the Secretary determined that expansion would maintain or improve patient care without limiting coverage or benefits. Therefore, the model was the first CMS Innovation Center model to meet the statutory requirements for expansion by the Secretary of Health and Human Services. The CMS Chief Actuary's certification can be accessed [here](#).

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

¹¹ A majority of the 20 ACOs that withdrew from the Pioneer ACO Model since 2012 now participate in the Shared Savings Program.

Shared Savings Program through notice and comment rulemaking. These elements include prospective alignment of beneficiaries, higher levels of shared savings and losses, and waiver of the 3-day-stay rule for skilled nursing facility (SNF) admission.

Health Care Innovation Awards Round One, Diabetes Prevention Program

In 2012, the CMS Innovation Center awarded a Health Care Innovation Award 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 Medicare Diabetes Prevention Program (MDPP) is derived from the DPP administered by the Centers for Disease Control and Prevention (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 Health Care Innovation Awards Round One had a 3-year period of performance, which spanned from June 2012 to June 2015 for the Y-USA with a 1 year no cost extension to June of 2016.

At the conclusion of its original period of performance, the project demonstrated positive results on both cost and quality to the Medicare program. Between June 2012 and June 2015, the Y–USA, in partnership with 17 local YMCAs, the Diabetes Prevention and Control Alliance, and seven other nonprofit organizations, enrolled a total of 6,874 Medicare beneficiaries into the model. According to the second year independent evaluation report of the Y–USA Diabetes Prevention Program model, Medicare beneficiaries demonstrated high rates of participation and sustained engagement in the DPP. Approximately 83 percent of recruited Medicare beneficiaries attended at least 4 core community-based behavior change sessions using a CDC-approved DPP curriculum and approximately 63 percent completed 9 or more core sessions.

Weight loss is a key indicator of success among persons enrolled in a DPP. According to the second year independent evaluation of the Y–USA Diabetes Prevention Program model, those beneficiaries who attended at least 1 core session lost an average of 7.6 pounds while beneficiaries who attended at least 4 core sessions lost an average of 9 pounds. Body mass index (BMI) was reduced from 32.9 to 31.5 among Medicare beneficiaries that attended at least 4 core sessions.

In March 2016, the CMS Chief Actuary certified that expansion of the MDPP would reduce net program spending and the Secretary determined that expansion would maintain or improve patient care without limiting coverage or benefits. As a result, the MDPP model became the second CMS Innovation Center Model to meet the statutory requirements for expansion.

The certification and evaluation report can be accessed [here](#).

On July 15, 2016 CMS issued the Calendar Year (CY) 2017 Physician Fee Schedule proposed rule, which included a proposal to expand DPP to the Medicare program through a broadened model test. The final rule was published in the Federal Register November 16, 2016, and can be accessed [here](#).

The 2017 Physician Fee Schedule rule finalizes aspects of the expansion that will enable organizations, including those new to Medicare, to prepare for enrollment into Medicare as MDPP suppliers.

The MDPP expanded model is explained further in *subsection a* that follows below.

a. New Models and Initiatives Announced since the 2014 Report to Congress

Accountable Health Communities Model

Many of the biggest drivers of health and health care costs are beyond the scope of health care alone. Health-related social needs are often undetected in the clinical care system and, therefore, not addressed by health care providers. These unmet needs can have a major impact on a beneficiary's health and health care utilization. For example, issues such as food insecurity and inadequate or unstable housing may increase the risk of developing chronic conditions and reduce an individual's ability to manage these conditions with associated utilization and cost implications.

On January 5, 2016, the CMS Innovation Center announced the Accountable Health Communities (AHC) Model to address a critical gap between clinical care and community services in the current delivery system. The AHC Model will test whether increased awareness of and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.

The foundation of the AHC Model is universal, comprehensive screening for health-related social needs of community-dwelling Medicare and Medicaid beneficiaries accessing health care at participating clinical delivery sites. The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation.

Over a 5-year period of performance, CMS will implement and test a three-track model based on promising service delivery approaches:

- **Track 1 – Awareness:** Increase beneficiary *awareness* of available community services through information dissemination and referral.
- **Track 2 – Assistance:** Provide community service navigation *assistance* to help high-risk beneficiaries access services.

- **Track 3 – Alignment:** Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries.

Through the AHC Model, CMS will award up to 44 cooperative agreements to award recipients. Awards will range between \$1.17 million and \$4.51 million per award recipient, totaling approximately \$123.8 million over a 5-year period. Eligible applicants are community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service health care providers. Applicants from all 50 states, U.S. Territories, and the District of Columbia are eligible to participate.

In January 2016, CMS issued a funding opportunity announcement (FOA) for all tracks of the model. In addition, in September 2016, after receiving inquiries and stakeholder feedback, CMS issued another FOA to support up to 12 Track 1 awardees (rather than 11, which was announced in the initial FOA). Also after receiving inquiries and stakeholder feedback, CMS decided to make modifications to the Track 1 application requirements to make the model more accessible to a broader set of applicants. These changes include:

- Reducing the annual number of beneficiaries applicants are required to screen from 75,000 to 53,000; and
- Increasing the maximum funding amount per award recipient from \$1 million to \$1.17 million over 5 years.

The AHC Model evaluation will assess the impact of three intervention tracks ((1) awareness, (2) assistance, and (3) alignment) on reducing health care costs, emergency department visits, inpatient hospital admissions, and other health outcomes for community-dwelling Medicare and Medicaid beneficiaries. Tracks 1 and 2 will employ a randomized design where beneficiaries will be stratified by emergency department risk and randomized into control or intervention groups at each participating clinical delivery site.

Because Track 3 is a community-level intervention, the evaluation will require identifying appropriate matching communities and participants for each clinical delivery site. Analytical methods to evaluate outcomes for each track will consist of a descriptive and multivariate analysis, particularly a difference-in-difference estimation which compares the pre-post change in outcomes of interest between the intervention and comparison groups. In addition, qualitative techniques such as site-level interviews and case studies will be used to inform quantitative findings.

For more information, see the [Accountable Health Communities Webpage](#).

ACO Investment Model

In October 2014, the CMS Innovation Center announced the ACO Investment Model (AIM), a model designed to encourage new ACOs to form in rural and underserved areas, and to

encourage current Shared Savings Program ACOs to transition to arrangements with greater financial risk. Like its predecessor, the Advance Payment ACO Model, AIM offers ACOs pre-paid shared savings to enable ACOs to invest in infrastructure and to develop new ways to improve care for beneficiaries.

The AIM is available to:

- **New ACOs that joined the Shared Savings Program in 2016:** AIM seeks to encourage uptake of coordinated, accountable care in rural locations and areas where there has been little ACO activity, by offering pre-payment of shared savings in both upfront and ongoing per-beneficiary-per-month payments. CMS believes that encouraging participation in areas of low ACO penetration may spur new markets to focus on improving care outcomes for Medicare beneficiaries.
- **ACOs that joined the Shared Savings Program starting in 2012, 2013, or 2014:** AIM will help ACOs succeed in the Shared Savings Program and encourage progression to higher levels of financial risk, in an effort to improve the quality of care for beneficiaries and generate Medicare savings.

AIM had two application periods, which occurred in winter 2014 and in summer and fall 2015. There are currently 45 participating ACOs selected from these application periods. ACOs participating in AIM have approximately 10,000 health care providers serving roughly 422,000 beneficiaries across 40 states. The model was designed to encourage ACO development in rural and underserved areas and to encourage current Shared Savings Program ACOs to transition to arrangements with greater financial risk. About 80 percent of AIM ACOs primarily serve rural areas.

AIM encourages participation from ACOs that lack access to capital by offering up-front, initial, and ongoing payments that are eventually reconciled with shared savings. AIM ACOs are generally required to pay back advanced payments.

The evaluation of the model will analyze the performance of AIM ACOs relative to a comparison group, supplemented with key informant interviews, surveys, and marketplace analysis. AIM performance will also be assessed against Advance Payment ACOs by looking at financial and quality performance, the pace at which they return advance payment, and sustainability as far as continued participation and transition to higher risk tracks at the renewal of the three-year participation agreement. There are no evaluation results to date.

For more information, see the [ACO Investment Model Webpage](#).

Comprehensive Care for Joint Replacement Model

The purpose of the Comprehensive Care for Joint Replacement (CJR) Model is to support better and more efficient care for Medicare beneficiaries undergoing the most common inpatient surgeries: hip and knee replacements (also called lower extremity joint replacements or LEJR). The CJR Model tests bundled payments and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals,

physicians, and post-acute care health care providers to work together to improve the quality and coordination of care from initial hospitalization through recovery.

The CJR Model was implemented through notice and comment rulemaking. The CJR Model proposed rule was published in the Federal Register on July 14, 2015, and the comment period concluded on September 8, 2015. After reviewing nearly 400 comments from the public on the proposed rule, the CMS Innovation Center made several major changes, such as changing the model start date to April 1, 2016. The final rule was published in the Federal Register on November 24, 2015 and can be accessed [here](#).

With limited exceptions, all acute care hospitals in 67 geographic areas, defined by metropolitan statistical areas, participate in CJR. On April 1, 2016 798 acute care hospitals in these statistical areas began participation in the CJR Model. These hospitals are all paid under the inpatient prospective payment system.

The episode of care is defined by a hospital admission for MS-DRG 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities) or MS-DRG 470 (Major joint replacement or reattachment of lower extremity without major complications or comorbidities). The episode of care continues for 90 days following patient discharge.

For each performance year, CMS sets Medicare episode prices for each participant hospital that includes payment for all related services furnished to eligible Medicare fee-for-service beneficiaries who receive LEJR procedures at that hospital. All health care providers continue to be paid under Medicare's standard FFS payment system rules and procedures for episode services throughout the year. Following the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) will be compared to the applicable Medicare episode price for the participant hospital.

Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending. There is no downside risk in the first performance year of the model, which is April 1, 2016 – December 31, 2016. For this first performance year, CMS will provide hospitals with their reconciliation results and will pay hospitals additional amounts if applicable based on those results, but CMS will not require hospitals to repay Medicare if expenditures exceeded the episode price.

On December 20, 2016, CMS finalized several changes to the CJR Model through the following final rule: Advancing Care Coordination Through Episode Payment Models and Changes to the Comprehensive Care for Joint Replacement Model, which can be found [here](#). These finalized changes align the financial arrangements policies for CJR and the Episode Payment Models (EPMs); allow for accountable care organizations (ACOs), critical access hospitals (CAHs), and hospitals to be CJR collaborators; modify several terms and policies related to pricing and the reconciliation process; exclude a small number of beneficiaries aligned to certain ACOs from the CJR Model; make small changes to the composite quality

score methodology; and make the CJR Model eligible to be an Advanced APM. More information on the EPMs can be found in later in this section.

The CJR Model evaluation will assess the model's impact on the goals of improved care quality and efficiency, as well as reduced health care costs for lower-extremity joint replacement or reattachment of lower extremity procedures. A range of analytic methods will be used to evaluate key measures of interest including, but not limited to, patient experience of care, access, utilization, outcomes and quality, Medicare expenditures, health care provider costs, and market impact. The evaluation will consider the impact of the CJR Model at the geographic unit level, the hospital level, and the patient level. It will also address factors that could confound or bias the interpretation of the results.

For more information, see the [Comprehensive Care for Joint Replacement Model Webpage](#).

Comprehensive Primary Care Plus Model

On April 11, 2016, the CMS Innovation Center announced Comprehensive Primary Care Plus (CPC+), a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ Round 1 will begin January 1, 2017 and run for 5 years.

CPC+ will include 2 primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. The care delivery redesign will ensure practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback to guide their decision making. The more advanced track will include an enhanced focus on health IT capabilities necessary to delivering advanced primary care.

CPC+'s multi-payer design will bring 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. CPC+ also promotes alignment and integration with ACOs by allowing CPC+ practices to participate in both CPC+ and a Medicare Shared Savings Program ACO. CMS has determined CPC+ regions based on sufficient and aligned payer interest. CMS entered into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics throughout the initiative.

CMS solicited payer partners for Round 1 of CPC+ through May 2016, and in mid-July 2016 opened applications for Round 1 of CPC+ to primary care practices (including practices participating in the Shared Savings Program) within 14 established regions, which include: Arkansas, Colorado, Hawaii, Kansas and Missouri: Greater Kansas City Region, Michigan, Montana, New Jersey, New York: North Hudson-Capital Region, Ohio: Statewide and

Northern Kentucky: Ohio and Northern Kentucky Region, Oklahoma, Oregon, Pennsylvania: Greater Philadelphia Region, Rhode Island, and Tennessee. CMS intends to sign participation agreements with selected practices and MOUs with the more advanced practices' health IT vendors.

To broaden opportunities for Medicare primary care clinicians to participate in Advanced APMs under the Quality Payment Program, CMS will offer a second round (Round 2) of solicitations in 2017 for payers and practices to partner in CPC+ for a 2018 performance year start. In early 2017, CMS will welcome proposals from payers in up to 10 new regions, as well as new payers in any of the existing 14 CPC+ regions. CMS will accommodate up to 5,500 practices across these regions in Rounds 1 and 2. Over two-thousand attendees representing all 50 states participated in the first two introductory webinars and there has continued to be substantial public interest in the model as CMS has continued to hold webinars and reach out to stakeholders.

The evaluation plan for the model has been designed to provide a robust assessment of implementation and impacts using a mixed-methods approach. The evaluation will use site visits, key informant interviews, observations of learning support, surveys, and program data to establish how the intervention was implemented and received. Building on this analysis, the evaluation will use additional survey data and administrative claims to analyze the intervention's impact on beneficiaries and the primary care workforce.

Key outcome and quality measures will include total Medicare expenditures per beneficiary, hospitalization rates, emergency department visit rates, process of care outcomes, readmission rates, beneficiary experience of care, and beneficiary health-related quality of life. Finally, the impact and implementation analyses will be synthesized to attempt to identify the key factors that drive positive impacts.

For more information, see the [Comprehensive Primary Care Plus Model Webpage](#).

Health Care Payment Learning and Action Network

In January 2015, the Administration set a goal of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models (APMs) by 2016 and 50 percent by 2018. In March 2016, the Administration announced that it achieved its 2016 goal nearly a year ahead of schedule.

Recognizing that Medicare alone cannot drive sustained progress towards APMs, HHS announced in March 2015 the formation of the Health Care Payment Learning and Action Network (LAN) and challenged private payers, purchasers, health care providers, consumers, and states to participate in the LAN and advance the adoption of APMs by matching or exceeding the goals set for Medicare. Building upon success in linking payments to quality or value depends upon growing momentum from CMS, the participation of private payers/purchasers and states, and achieving a critical mass of partners adopting new models.

The LAN is a public-private learning collaborative (or network) that brings together private, public, and nonprofit partners to increase multi-stakeholder adoption of effective APMs that have proven to have a favorable impact on health care costs and quality. A contractor, who operates the CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research and Development Center (FFRDC), is convening and independently managing the LAN on behalf of CMS. The LAN posits that sharing information about successful models, aligning payers, health care providers, and patients on key design components of 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 follows several functions as the basis for coordinating efforts to match or exceed HHS's goals across the U.S. health care system, namely:

- Serving as a convening body to facilitate joint implementation of new models of payment and care delivery;
- Identifying areas of agreement around movement toward alternative payment models and how best to analyze data and report on these new payment models;
- Collaborating to generate evidence, share approaches, and remove barriers;
- Developing common approaches to core issues such as beneficiary attribution, financial models, benchmarking, quality and performance measurement, risk adjustment, and other topics raised for discussion; and
- Creating implementation guides for payers, purchasers, health care providers, and consumers.

The LAN is a national collaborative, representing stakeholders from across the country and across the stakeholder spectrum. As of November 2016, there are nearly 57,200 individual LAN participants, with health care providers representing the largest participating stakeholder category (44 percent).

In order to operationalize the network's key functions noted above, the LAN is structured so that a Guiding Committee, comprised of senior executives representing key segments from across health care, provides guidance to the overall work and priorities of the LAN. The Guiding Committee serves as the primary leadership body of the LAN through activities including monthly meetings, various Work Groups, and active stakeholder engagement across the LAN. A list of the LAN Guiding Committee members can be accessed [here](#).

The LAN has also developed an APM framework that consists of 4 payment model categories:

- Category 1 – refers to traditional payments (i.e., FFS) that are not adjusted to account for infrastructure investments, health care provider reporting of data, or health care provider performance on cost and quality metrics;

- Category 2 – refers to traditional payments (i.e., utilize FFS) that are adjusted based on infrastructure payments to improve care or clinical services, regardless of whether health care providers report quality data or perform well on cost and quality metrics;
- Category 3 – refers to APMs whose payments are based on an FFS architecture but provide mechanisms for effective management of a set of procedures, episode of care or all health services provided for individuals. Health care providers that meet cost and quality targets are eligible for shared savings; those who do not may be held financially responsible; and
- Category 4 – refers to APMs whose payments are structured to encourage delivery of well-coordinated, high quality, person level care within a defined budget. Per member per month (PMPM) payments are made to manage all of a patient’s care and/or conditions.¹²

Work Groups are charged with developing practical, actionable, and operationally meaningful recommendations on issues and models that represent the best opportunity for accelerating adoption of APMs. Work Groups are composed of approximately 15 individuals that work over an intensive 6 to 9-month period, and are tasked with addressing barriers to adoption and the critical technical components of payment models.

To date, the following Work Groups have been established:

1. **Alternative Payment Model Framework & Progress Tracking (APM FPT)**: This group has proposed an approach for measuring APM adoption across the U.S. health care system that includes clarity on what should be measured as well as the set of categories (Framework) that enable meaningful reporting.
 - Composed of diverse health care stakeholders, the Work Group deliberated and reached consensus on the high level classification of APMs, resulting in the release of its APM Framework in January 2016, which can be found [here](#). The Framework establishes a common nomenclature upon which progress can be discussed and measured, one of many tools to support a transition towards shared risk and population based payments.
 - A comprehensive, voluntary measurement effort took place over the summer of 2016, capturing proportions of the commercial, Medicaid, and Medicare Advantage markets’ respective spending measured against the LAN APM Framework.
 - 70 plans and 2 states submitted data on actual dollars paid to health care providers during 2015 – those reporting this metric represent nearly 200 million covered lives and health care spending results were as follows:

¹² Health Care Payment Learning and Action Network: [2016 APM Infographic](#).

- 62 percent – Category 1
 - 15 percent – Category 2
 - 23 percent – Categories 3 and 4
- 40 plans and two states submitted data on dollars paid to health care providers based on the contracts that were in place as of January 1, 2016 – those reporting this metric represent more than 128 million covered and health care spending results were as follows (Categories 1 and 2 not reported for this metric):
 - 25 percent – Categories 3 and 4
2. **Population-Based Payment (PBP)**: This group identified the most important elements of population-based payment models for which alignment across public and private payers could accelerate their adoption nationally, with a focus on data sharing, financial benchmarking, performance measurement, and patient attribution. Finalized white papers on those four topics were released in August 2016 and can be found [here](#).
 3. **Clinical Episodes Payment (CEP)**: The group focused on a limited number of clinical conditions and relied heavily on existing work in the clinical domains. This group leveraged the experience of experts in each clinical field identified as an area of focus. White papers on elective joint replacement, maternity, and cardiac care were finalized and released in July 2016 and can be found [here](#).
 4. **Primary Care Payment Model (PCPM)**: This group has collaboratively developed recommendations on the critical components for primary care payment in category 3 or 4 APMs and has released a draft white paper for public comment. A finalized version of the paper is anticipated in the beginning of 2017.
 5. **Primary Care Payer Action Collaborative (PAC)**: The PAC serves as a structure for public and private primary care payers participating in multi-payer primary care payment models, such as CPC+, to address specific operational issues in the implementation of these models. The PAC provides an environment that offers support and resources for payers who are developing solutions to the challenges that occur in primary care alternative payment model implementation, including alignment of data sharing systems, quality measurement implementation, and benchmarking and patient attribution strategies.
 6. **Maternity Multi-Stakeholder Action Collaborative (MAC)**: The MAC is designed to provide support and resources to organizations that want to drive improvement in maternity care outcomes via alternative payment. The objective is to provide MAC participants with opportunities to accelerate the development and implementation of maternity care episode payments. This effort is charged with building off the Clinical Episode Payment Recommendations on Maternity Care white paper.

Lastly, the LAN includes Affinity Groups for LAN participants in specific sectors (e.g., employers/purchasers, patients/consumers, and states) to engage around specific topics and to identify and disseminate knowledge and best practices.

For more information, see the [Health Care Payment Learning and Action Network Webpage](#).

Home Health Value-Based Purchasing Model

The Home Health Value-Based Purchasing (HHVBP) Model, which began on January 1, 2016, 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 Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements; 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 will be adjusted incrementally over the course of the model in the following manner:

- a maximum payment adjustment of 3 percent (upward or downward) in CY 2018;
- a maximum payment adjustment of 5 percent (upward or downward) in CY 2019;
- a maximum payment adjustment of 6 percent (upward or downward) in CY 2020;
- a maximum payment adjustment of 7 percent (upward or downward) in CY 2021; and
- a maximum payment adjustment of 8 percent (upward or downward) in CY 2022.

In the CY 2017 Home Health Prospective Payment System final rule, in addition to providing an update on the progress towards developing public reporting of performance under the HHVBP Model, CMS finalized several changes to the Model design including calculation of benchmarks and achievement thresholds; cohort size requirements; timeframe for submission and reporting period for new measure data; removal of four measures; and implementation of recalculation and reconsideration processes. The final rules regarding the HHVBP Model can be found [here](#).

The HHAs in the HHVBP Model received their first interim performance report in July 2016. Starting in October 2016, the HHAs began submitting data for the three new measures that were not previously reported in current home health data collection systems. Through outreach and education via webinars and Frequently Asked Questions, CMS disseminated information to the HHAs to help them understand the requirements of the Model and prepare them for their first performance report.

The HHVBP Model evaluation will utilize qualitative and quantitative methods to assess the impact of the model. The evaluation would be focused primarily on understanding how successful the model is in achieving improvements in: clinical care process measures; clinical outcome measures (e.g., functional status); utilization outcomes (e.g., length of stay, discharge status, hospital readmission rates, emergency room visits); access to care; and patients' experience of care. The evaluation will also identify appropriate comparison group HHAs and factors that may have the potential to confound the analyses. Plans for analyzing quality and non-quality impacts across patient medical and demographic characteristics will also be presented.

For more information, see the [Home Health Value-Based Purchasing Model Webpage](#).

Medicare Advantage Value-Based Insurance Design Model

In September 2015, the CMS Innovation Center announced the Medicare Advantage Value-Based Insurance Design (MA-VBID) Model. This model provides an opportunity for MA plans to offer reduced cost sharing and/or additional supplemental benefits to enrollees with CMS-specified chronic conditions, in order to encourage the consumption of clinically-nuanced high value services.

VBID generally refers to health insurers' efforts to structure enrollee cost-sharing and other health plan design elements to encourage enrollees to use high-value clinical services – those that have the greatest potential to have a positive impact on enrollees' health. VBID approaches are increasingly being used in the commercial market. Current evidence suggests that the inclusion of clinically-nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality of care and reduce the cost of care for MA enrollees with chronic diseases.

The MA-VBID model will begin January 1, 2017 and run for five years. In October 2016, CMS released an RFI for the second year of the model test, and will accept proposals from MA and MA-PD plans to offer VBID benefits in 2018 through January 20, 2017. The Request for Applications for CY 2018 may be accessed [here](#). In its first year, CMS will test the model in 7 states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. Beginning January 1, 2018, CMS will also test the model in Alabama, Michigan, and Texas.

The MA-VBID evaluation will address whether providing MA plans the opportunity to employ VBID strategies has an overall impact on enrollee health outcomes, behavior, service use, quality of care, as well as costs to health plans, enrollees, and Medicare. Both

quantitative and qualitative analyses will be used to assess the outreach and impact of the model. These analyses will be primarily conducted at the model level. Where possible, and depending upon the composition of the group of participating plans, subgroup analyses will be used to examine whether specific plan characteristics impact plan participation, types of VBID strategies adopted, and quality, cost, and use of services.

For more information, see the [Medicare Advantage Value-Based Insurance Design Model Webpage](#).

Medicare Diabetes Prevention Program (MDPP)

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

Between June 2012 and June 2015, the Y-USA in partnership with seventeen local YMCAs, the Diabetes Prevention and Control Alliance, and seven other leading national nonprofit organizations, enrolled a total of 6,874 Medicare beneficiaries into the program. Enrolled beneficiaries represented a diverse geography across eight states including Arizona, Delaware, Florida, Indiana, Minnesota, New York, Ohio, and Texas. According to the second year independent evaluation of the Y-USA Diabetes Prevention Program model, Medicare beneficiaries' demonstrated high rates of participation and sustained engagement in the DPP. Approximately 83 percent of recruited Medicare beneficiaries attended at least 4 core community-based behavior change sessions.

The Medicare Diabetes Prevention Program (MDPP) expansion was announced in early 2016, when the Secretary of Health and Human Services determined that the Diabetes Prevention Program Model test met the statutory criteria for expansion. On July 7, 2016, CMS issued a notice of proposed rulemaking in the Calendar Year (CY) 2017 Physician Fee Schedule detailing the proposed DPP expansion. CMS notified the public and requested comment on key design parameters of the proposed DPP expansion, including a proposed value-based payment structure, in the 2017 Physician Fee Schedule Proposed Rule

The final rule establishing the expansion was finalized in the Calendar Year 2017 Medicare Physician Fee Schedule (PFS) Final Rule published in November 2016.

The MDPP expanded model is a structured behavioral change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries diagnosed with pre-diabetes. The MDPP expanded model is a CMS Innovation Center model test expanded in duration and scope under section 1115A(c) of the Social Security Act and will be covered as an additional preventive service with no cost-sharing under Medicare. Beginning on January 1, 2018, eligible beneficiaries will be able to access MDPP services in community and health care settings and furnished by coaches that are trained community health workers or health professionals.

The MDPP core benefit is a 12-month intervention that consists of at least 16 weekly core hour-long sessions, over months 1-6, and at least 6 monthly core maintenance sessions over months 6-12, furnished regardless of weight loss. In addition, beneficiaries have access to 3 month intervals of ongoing maintenance sessions after the core 12-month intervention if they achieve and maintain the required minimum weight loss of 5 percent in the preceding three months. Medicare cost-sharing will not apply to MDPP services.

For more information, see the [Medicare Diabetes Prevention Program Webpage](#).

The CMS Chief Actuary's Certification can be accessed [here](#).

The Health Care Innovations Awards, Round One YMCA Diabetes Prevention Program Year Two Evaluation can be accessed [here](#).

Million Hearts®: Cardiovascular Disease Risk Reduction Model

The Million Hearts Cardiovascular Disease (CVD) Risk Reduction Model was announced in May 2015 and will run for a 5-year period. The model promotes CVD prevention, improved CVD outcomes, and accountability for costs among Medicare beneficiaries through risk assessment and risk management. The model financially incentivizes health care providers to use the American College of Cardiology/American Heart Association (ACC/AHA) Atherosclerotic Cardiovascular Disease (ASCVD) risk calculator to prevent heart attacks and strokes.

The Million Hearts CVD model has recruited practices to develop plans to use the ACC/AHA ASCVD calculator, to risk stratify Medicare fee-for-service (FFS) beneficiaries, and to propose innovative service delivery models that reduce risk across their entire patient population. Half of all selected applicants were randomly assigned to the intervention group, with the remaining selected applicants assigned to the control group.

Intervention practices will be paid a one-time \$10 per beneficiary fee to calculate beneficiaries' ASCVD risk scores and to engage patients in shared decision-making.

Year 1 will include an additional \$10 per beneficiary per month Cardiovascular Care Management (CVD CM) payment for risk management for the highest risk patients. During Years 2 through 5, practices will be able to receive a monthly CVD CM payment of up to \$10 based upon the reduction of their high-risk beneficiary ASCVD risk scores.

Control practices will not be asked to implement ASCVD risk calculation; however, they will be asked to submit clinical data on Medicare beneficiaries for comparison to intervention practices. Data collection will occur in Years 1, 2, and 3. Practices will be paid a \$20 per beneficiary payment (based on the estimated costs of preparing and transmitting the required data) for each reporting cycle.

Following notification of award and exclusion of ineligible applications, 516 practices, 260 organizations in the intervention group and 256 organizations in the control group, were enrolled in the model in May 2016 including 19,500 practitioners. Awardees represent 47

states, the District of Columbia, and Puerto Rico, and are projected to provide services to approximately 3.3 million Medicare FFS beneficiaries. Training and onboarding began in July 2016 and the model will start in winter 2016.

The Million Hearts CVD model evaluation will assess the model's impact on health care quality, utilization, and costs. The primary outcome of interest will be the reduction of heart attack, strokes, and transient ischemic attack (TIA). A randomized controlled study of eligible practices will be used to maximize comparability among intervention and control practices.

For more information, see the [Million Hearts Cardiovascular Disease Risk Reduction Model Webpage](#).

Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model (Four Models)

On December 20, 2016 CMS issued final rule to establish episode-based payment models (EPMs) for 3 clinical conditions:

- Acute myocardial infarction (AMI),
- Coronary artery bypass graft (CABG), and
- Surgical hip and femur fracture treatment (SHFFT)

The first performance period for the new episode payment models (the AMI, CABG, and SHFFT Models) and the Cardiac Rehabilitation Incentive Payment Model will begin on July 1, 2017 and run through December 31, 2021. These episode payment models will test bundled payments across a broad cross-section of hospitals to determine the models' impact on quality of care, efficiency of care delivery, enhanced stakeholder engagement, and intra-organizational collaboration.

In addition, the final rule includes a new Cardiac Rehabilitation Incentive Payment Model, which will test incentives for utilization of cardiac rehabilitation and intensive cardiac rehabilitation (CR/ICR). Hospitals will be eligible for incentive payments for services rendered within 90 days of discharge following an AMI or CABG. The model will provide a financial incentive to hospitals that refer beneficiaries to cardiac rehabilitation through a payment linked to the number of rehabilitation sessions attended in order to increase utilization rates. CR/ICR are underutilized evidence-based interventions with a proven track record of improving patient outcomes and enhancing efficiency in health services.

The AMI and CABG Models will be implemented in 98 metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area that has a population of at least 50,000. To leverage existing stakeholder infrastructure, the SHFFT Model will be tested in the 67 MSAs selected for the CJR Model. To be eligible for the CJR Model, eligible MSAs had to have at least 400 eligible CJR cases.

The CR/ICR Model will be implemented in 45 geographic areas also selected for the AMI and CABG Models, defined by MSAs, as well as in 45 geographic areas that were not selected for the AMI and CABG Models. The CR/ICR Model will cover the same 5-year period as the episode payment models. The 90 MSAs selected can be found at the Episode Payment Models webpage listed below. Roughly, 1,120 hospitals will participate in the AMI and CABG Models, 860 hospitals in the SHFFT Model and 1,320 hospitals in the CR Incentive Payment Model.

The evaluation of the EPMs and Cardiac Rehabilitation Incentive Payment Model will include a mix of quantitative analyses to determine the impact of the models on key outcomes (e.g., readmissions, 30-day mortality, differences in utilization of services and total spend for the episode compared to participant prior historical trends). Utilization of services against other comparison groups would also be assessed with an eye to examining factors associated with variations in success under the model. Another set of qualitative analyses would be used to understand the experience of the models at both the hospital and beneficiary level. The evaluations would assess the impact of the models on the aim of better care, better health, and lower costs.

For more information, see the [Episode Payment Models Webpage](#) and the [Cardiac Rehabilitation Incentive Payment Model Webpage](#).

Next Generation ACO Model

On January 1, 2016, the CMS Innovation Center launched the Next Generation ACO Model (NGACO). This model builds upon experience in both the Pioneer ACO Model and the Shared Savings Program. The NGACO Model is testing whether financial incentives for ACOs can improve health outcomes and reduce expenditures for Medicare fee-for-service (FFS) beneficiaries. Among other features, the NGACO Model uses a prospective benchmark, a financial methodology informed by the lessons learned in the Pioneer ACO Model, and several tools to help ACOs improve engagement with beneficiaries. With these features, the CMS Innovation Center is testing and identifying the tools, alternative payment methodologies and share of risk necessary to promote long-term success in accountable care.

Coupled with robust accountability for quality and patient experience and a paired collaborative learning system, NGACOs assume higher levels of financial performance risk (up to 100 percent risk) compared to ACOs in other current initiatives. With greater risk, NGACOs are eligible to share in more of the savings achieved under this model.

Unlike earlier ACO models, NGACOs are measured using prospective financial benchmarks, rather than retrospective benchmarks. Under this approach, ACOs receive their benchmark prior to the start of the next performance year. The benchmarking methodology also seeks to reward NGACOs that achieve efficient spending both nationally and regionally, as well as quality and care improvement. The prospective benchmark gives NGACOs a financial target to plan for and manage effectively through increased investments and engagement in

initiatives to improve health, reduce waste, and deliver better health care and smarter spending.

NGACOs are able to select alternative payment options, including monthly infrastructure payments and population-based payments, which support NGACO investments in care improvement infrastructure and provide a stable and predictable cash flow throughout the performance year. These payments are not in addition to FFS payments to health care providers and do not change a NGACO's benchmark; they simply allow for cash to flow to the NGACO in different ways that may help the NGACO to better allocate funds towards value-based care during the performance year. None of the payment mechanisms offered in the NGACO Model affect beneficiary out-of-pocket expenses.

The NGACO Model allows beneficiaries to voluntarily align to the NGACO and tests beneficiary incentives and certain benefit enhancements when beneficiaries seek care with Next Generation and Next Generation-affiliated health care providers who work together to offer high quality, coordinated care. One such benefit enhancement under the NGACO Model includes a waiver to allow Medicare payment for skilled nursing facility (SNF) stays of beneficiaries aligned to a NGACO who are admitted to approved SNFs without a prior three-day inpatient hospital stay. This payment waiver allows NGACO beneficiaries to receive coverage when admitted to an approved SNF from their home, a physician's office, or an observation status in the emergency room; or when they have been in the hospital for fewer than three days.

The NGACO Model also tests additional benefit enhancements such as increased availability of telehealth and post-discharge home visit services. The quality measures and reporting processes closely follow the Shared Savings Program and Pioneer Model.

There are currently 18 model participants in the first performance year, located in multiple states across the country. These NGACOs have approximately 600,000 aligned beneficiaries. Information on the NGACO participants' names and locations can be found at the link below.

The NGACO model launched a second application round in spring 2016 for a start date of January 1, 2017. CMS received a robust response to the request for applications. CMS will have a final number of NGACO Model participants in late December 2016, after the Participation Agreements with selected ACOs are signed. The NGACO Model will be reopened for another round in 2017 for model performance year 2018.

The NGACO Model evaluation will seek to understand the behaviors of health care providers and beneficiaries, the impacts on quality of care and cost resulting from increased financial risk, the effects of various payment arrangements and enhanced benefits, and the impacts of the model on beneficiary engagement and experience.

The evaluation will include qualitative methodologies to examine patterns in design selection and implementation by ACOs, identify facilitators and barriers to observed effects, and to note important qualitative differences between ACOs. Mixed methods approaches will be

used to estimate the cost, utilization, and quality impacts of model design elements among NGACOs relative to various comparison populations. For some design elements, the evaluation will have an added focus on the model's impact on beneficiary engagement. The evaluation will also include analyses focused on subgroups such as rural ACOs, beneficiaries with multiple comorbidities, and socioeconomically disadvantaged beneficiary populations.

For more information, see the [Next Generation ACO Model Webpage](#).

Oncology Care Model

The Oncology Care Model (OCM) aims to provide higher quality, more highly coordinated oncology care at the same or lower cost to Medicare. The OCM model launched on July 1, 2016 with nearly 200 physician practices and 16 health plans, and will run for 5 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 the model, 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 6 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 \$160 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, which will be compared against a risk-adjusted benchmark to calculate Medicare savings.

The OCM evaluation will assess the effects of the model on quality of care and costs, including whether the model achieves better health, better health care, and lower Medicare per capita costs for OCM beneficiaries. The evaluation will seek to understand what aspects of the model contribute most to success and how contextual factors influence this success.

The evaluation will employ a mixed-methods approach, including rigorous qualitative and quantitative analyses, to answer questions related to OCM's implementation effectiveness; impact on quality of care, health outcomes, utilization, and costs; and lessons learned

regarding stakeholder engagement and scalability. Major primary data collection activities may include practice site visits, surveys, and stakeholder interviews and focus groups. Additional data sources will include, among other things, Medicare FFS claims and practices' clinical and quality measure reporting.

For more information, see the [Oncology Care Model Webpage](#).

Part D Enhanced Medication Therapy Management (MTM) Model

On September 28, 2015, the CMS Innovation Center announced the Part D Enhanced Medication Therapy Management (MTM) Model, which is an opportunity for Part D stand-alone basic 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 will test whether providing selected basic, standalone PDPs 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, including high-cost drugs, ensuring that beneficiaries get the medications they need, and that those medications are used properly;
- Reducing medication-related problems, such as duplicative or harmful prescription drugs, or suboptimal treatments;
- Increasing patients' knowledge of their medications to achieve their or their prescribers' goals of therapy; and
- Improving communication among prescribers, pharmacists, caregivers, and patients.

CMS will grant participating PDPs a waiver of existing MTM regulations that defines both the target population and the MTM services that may be provided in order to enable plans to target barriers to effective medication usage at an individual level. MTM services under the model will be funded through a separate payment to plans, outside of the standard bid/premium structure.

The separate payment is intended to encourage plans to design robust MTM programs. Plans that are successful at reducing their members' medical expenditures will also be eligible for a performance incentive in the form of an increased premium subsidy, lowering costs for enrolled beneficiaries. In addition, the Part D Enhanced MTM Model will provide participating plans with access to Medicare Parts A and B claims data in order to more effectively target groups of beneficiaries at high risk of medication-related issues.

Participants in the Enhanced MTM model will offer interventions beginning on January 1, 2017. The model will run for a 5 year period. The CMS Innovation Center has selected 5 specific regions in which to test the Part D Enhanced MTM Model: Region 7 (Virginia), Region 11 (Florida), Region 21 (Louisiana), Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming), and Region 28 (Arizona). Regions

were selected in order to achieve diversity across a range of geographic, demographic, and market characteristics, and to allow for a sufficiently powered model test with comparison regions.

The evaluation will examine the impact of the Part D Enhanced MTM Model within the framework of better care, improved health, and lower costs. Specifically, the evaluation will examine whether the provision of care management and/or care coordination services by basic standalone PDPs leads to improvements in beneficiary health status and lower overall Medicare program costs.

For more information, see the [Part D Enhanced MTM Model Webpage](#).

Transforming Clinical Practice Initiative

The Transforming Clinical Practice Initiative (TCPI) was announced on October 23, 2014, and it began operations on September 29, 2015. TCPI is designed to help clinicians achieve large-scale practice transformation. The initiative is designed to support more than 140,000 clinician practices over the next three years in sharing, adapting, and further developing their comprehensive quality improvement strategies.

The primary goals of the TCPI are to:

- Support more than 140,000 primary and specialty care clinicians enrolled in Practice Transformation Networks (PTNs) and Support and Alignment Networks (SANs) to achieve practice transformation, and provide education on the implications of the Quality Payment Program for clinicians.
- Build an evidence base on practice transformation so that effective solutions can be scaled. To achieve this, TCPI is designed to develop, capture, and report a standard set of measures, aligned with the overall goals of MACRA and the Quality Payment Program. Best practices and lessons learned will be shared to support practice transformation and practice transitions into alternative payment models.
- Improve health outcomes, reduce unnecessary hospitalizations, and reduce overutilization of other services for 5 million Medicare, Medicaid, and CHIP beneficiaries and other patients.
- Sustain efficient care delivery for Medicare, Medicaid, and CHIP beneficiaries by preparing at least 75 percent of health care providers completing the phases of transformation to move into incentive programs and payment models that reward value (i.e., APMs) upon completion of TCPI; and

TCPI embodies the CMS Innovation Center's commitment to provide health care providers with the tools they need to meet the demands of a complex, changing health care system through large-scale investment in a collaborative peer-based learning initiative. TCPI is

designed to ensure that clinicians who participate will be part of leading and creating positive change for the entire health care system.

Practice Transformation Networks:

TCPI's Practice Transformation Networks (PTNs) are peer-based learning networks designed to coach, mentor, and assist clinicians in developing core competencies specific to practice transformation. This approach allows clinician practices to become actively engaged in the transformation and ensures collaboration among a broad community of practices that creates, promotes, and sustains learning and improvement across the health care system. In total, 29 organizations were awarded cooperative agreements to serve as PTNs. This list can be accessed [here](#).

Support and Alignment Networks:

TCPI's Support and Alignment Networks (SANs) will provide a system for workforce development utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts. Utilizing existing and emerging tools (i.e., continuing medical education, maintenance of certification, core competency development) these networks will help ensure sustainability of these efforts. In addition, SANs will support the recruitment of clinician practices serving small, rural, and medically underserved communities and play an active role in the alignment of new learning. A total of 10 organizations were awarded cooperative agreements to serve as SANs. That list can be found [here](#).

Support and Alignment Networks 2.0:

On September 29, 2016, CMS awarded Support and Alignment Networks (SAN 2.0) cooperative agreements to 2 awardees. To accelerate practice transformation strategies, SAN 2.0 awardees will spread transformation knowledge to participating clinicians to achieve the TCPI goals:

- Improving the quality of care delivered;
- Rapidly transitioning practices through the phases of transformation in preparation for participation in and alignment with APMs; and
- Reducing total cost of care.

Through this initiative, the SAN 2.0 awardees will identify, enroll, and provide tailored technical assistance to advanced practices in an effort to reduce Medicare, Medicaid, and CHIP program expenditures by transitioning practices through the phases of transformation and enhancing the quality, efficiency, and coordination of care.

For more information, see the [Transforming Clinical Practice Initiative Webpage](#).

b. Existing Models and Initiatives Announced Prior to Submission of the 2014 Report to Congress

Advance Payment ACO Model

In the Medicare Shared Savings Program (Shared Savings Program), groups of health care providers meeting criteria specified by the Secretary of Health and Human Services may form Accountable Care Organizations (ACOs) to improve care management for beneficiaries. The Advance Payment (AP) ACO Model was designed to help smaller ACOs with less access to capital to participate in the Shared Savings Program, in which ACOs are eligible to share in savings as long as they meet or exceed quality standards and a target total spending level for a population of fee-for-service (FFS) beneficiaries.

ACOs that participated in the AP ACO Model received an up-front payment and ongoing monthly payments to make important investments in their care management infrastructure, and these advance payments were intended to be repaid through future shared savings. The Shared Savings Program has released financial and quality performance data for the first, second, and third performance years, which can be accessed [here](#).

AP ACOs constituted 15-20 percent of all Shared Savings Program ACOs that started in 2012 or 2013. Of the 36 AP ACOs that started in the model, 33 completed it in good standing, one voluntarily discontinued, and two were terminated by the conclusion of their participation agreement on December 31, 2015. A total of approximately \$68 million in advance payments was distributed to AP ACOs. 17 AP ACOs entirely repaid approximately \$38 million in advance payments. 18 AP ACOs decided to continue to participate in the Shared Savings Program by signing up for another three-year agreement period, allowing an additional \$14 million in advance payments to be potentially recouped from future shared savings.

The Advance Payment ACO Model evaluation is currently examining Advance Payment ACO performance, supplemented with ACO leadership interviews and physician surveys, to measure the spending and utilization of beneficiaries assigned to Advance Payment ACOs relative to other Medicare FFS beneficiaries in their markets. There are no evaluation results to date.

For more information, see the [Advance Payment ACO Model Webpage](#).

Bundled Payments for Care Improvement (Four Models)

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care that link payments for the multiple services provided to beneficiaries during an episode of care. In the BPCI models, episodes of care are triggered by an inpatient stay in an acute care hospital, and organizations enter into payment arrangements that include financial and performance accountability for episodes of care. BPCI participants had the opportunity to choose participation in 1 or more of 48 clinical episodes, representing a range of surgical and medical episodes.

These models are testing whether bundled payments lead to higher quality and more coordinated care at a lower cost to the Medicare program. In Model 1, the episode of care is defined as the inpatient stay in the acute care hospital. Medicare pays the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continues to pay physicians separately for their services under the Medicare Physician Fee Schedule. The first cohort of awardees in Model 1 began in April 2013 and ended in March 2016. An awardee that began participation in January 2014 will end participation in December 2016.

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is triggered by an acute care hospital stay, but begins at the initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency and continues for up to 90 days. Under Models 2 and 3, Medicare continues to make FFS payments. A payment or recoupment amount is then made by Medicare reflecting the aggregate expenditures compared to the target price.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care which lasts the entire inpatient stay. Physicians and other practitioners submit “no-pay” claims to Medicare and are paid by the hospital out of the bundled payment. The first cohorts of awardees in Models 2, 3, and 4 began in October, 2013.

The implementation of Models 2, 3, and 4 was divided into two phases. During Phase 1, also referred to as “the preparation period,” CMS shared data and engaged in education and shared learning activities with participants as they prepared to assume financial risk under Phase 2, the performance, or “risk-bearing,” period. In BPCI the awardee is the entity that assumes financial liability for the episode spending. Episode Initiators are health care providers that trigger BPCI episodes of care; they do not bear risk directly (unless they also serve as an awardee), but participate in the model through an agreement with a BPCI awardee. BPCI Episode Initiators include acute care hospitals, skilled nursing facilities, physician group practices, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals that trigger an episode of care.

CMS announced the first set of BPCI Models 2, 3, and 4 Phase 1 participants in January 2013. By October 2013, some BPCI participants entered into Awardee Agreements with CMS, and began bearing financial risk for some or all of their episodes. CMS required all participants to transition at least one episode into Phase 2 by July 2015 in order to continue participating in the initiative. Awardees were required to transition any remaining episodes into risk by October 2015.

As of July 1, 2016, BPCI has 1148 participants in Phase 2 composed of 305 awardees and 1143 Episode Initiators actively involved in care redesign. The breakdown of participants by health care provider type is as follows: acute care hospitals (360), physician group practices (262), home health agencies (97), inpatient rehabilitation facilities (9), and skilled nursing facilities (658). The difference between the total number of participants and health care providers is due to the fact that some of the Awardees are Awardee Conveners not initiating clinical episodes and are, therefore, not included in the breakdown of participants by health care provider type.

Number of Participants by Models (Awardees and Episode Initiators)

- Model 1 – 1
- Model 2 – 601
- Model 3 – 836
- Model 4 – 10

On April 16, 2015, the CMS Innovation Center announced that awardees in BPCI would be offered the opportunity to extend their participation in Models 2, 3, and 4 through September 30, 2018. The first cohort of awardees in BPCI Models 2, 3, and 4 that began in October 2013 were scheduled to end their participation on September 30, 2016. This extension means that they, along with other organizations that joined later in 2014, have the opportunity to continue their participation in the BPCI models up until September 30, 2018.

The 2014 annual report for Model 1 was released on July 9, 2015 and evaluates the participation of 24 Model 1 Awardees. Impact estimates indicated that Medicare payment increases were *muted* (i.e., increased less than comparisons) for Awardees over the primary period of focus under this model, the inpatient stay (i.e., episode). Medicare payments to other health care providers after the episode period (e.g., physicians, nursing facilities, and rehabilitation hospitals) did increase relative to baseline and comparison hospitals. These Medicare payment findings provide interim insights on potential Model 1 effects.

The second annual evaluation report for BPCI Models 2, 3, and 4 was released on September 19, 2016. The evaluation used Medicare claims data from the first year of the initiative. Future evaluation reports will have greater ability to detect changes in payment and quality due to larger sample sizes and the recent rapid growth in participation of the initiative, which is not reflected in current findings. Key highlights include:

- BPCI-participating health care providers tended to be larger, operate in more affluent urban areas, have higher episode costs, and differed in other ways from health care providers that did not participate. Many indicated that commitment from their leadership and financial investment in consultants or other resources were key to implement BPCI changes.

- 11 out of the 15 clinical episode groups analyzed showed potential savings to Medicare. Future evaluation reports will have more data to analyze individual clinical episodes within these and additional groups;
- Orthopedic surgery under Model 2 hospitals showed statistically significant savings of \$864 per episode. This was because of reduced use of institutional post-acute care (i.e., skilled nursing facility and inpatient rehabilitation facility) following the hospitalization. In addition to cost declines, orthopedic surgery episodes under Model 2 also showed improved quality as indicated by beneficiary surveys. Beneficiaries who received their care at participating hospitals indicated that they had greater improvement after 90 days post-discharge in two mobility measures than beneficiaries from comparison hospitals;
- Cardiovascular surgery episodes under Model 2 hospitals did not show any savings yet but quality of care was preserved. Over the next year, we will have significantly more data available, enabling us to better estimate effects on costs and quality.

For more information, see the [Bundled Payments for Care Improvement Webpage](#).

The Bundled Payments for Care Improvement Model 1, Annual Report 2014 can be accessed [here](#).

The Bundled Payments for Care Improvement Models 2-4, Year 1 evaluation report can be accessed [here](#).

The Bundled Payments for Care Improvement Models 2-4, Year 2 evaluation report can be accessed [here](#).

Comprehensive End Stage Renal Disease Care

More than 600,000 Americans have End Stage Renal Disease (ESRD) and require life sustaining dialysis treatments several times per week. In 2013, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.1 percent of Medicare fee-for-service spending, totaling over \$30.9 billion.

These high costs are often the result of underlying disease complications and multiple co-morbidities, which can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is much higher than the general Medicare population. Because of these complex health needs, beneficiaries often require visits to multiple health care providers and follow multiple care plans, which may be challenging for beneficiaries if care is not coordinated. Enhanced care coordination could offer these beneficiaries a more patient-centered care experience, which may help to improve health outcomes.

The CMS Innovation Center launched the Comprehensive ESRD Care (CEC) Model in October 2015. In the CEC Model, dialysis clinics, nephrologists, and other health care providers join together to create an ESRD Seamless Care Organization (ESCO) to coordinate care for aligned beneficiaries. ESCOs are accountable for clinical quality outcomes and

financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis health care providers to think beyond their traditional roles in care delivery and supports their efforts to provide patient-centered care aimed at addressing beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC Model includes separate financial arrangements for larger and smaller dialysis organizations as they are defined by the United States Renal Data System. Large Dialysis Organizations (LDOs), which have 200 or more dialysis facilities, are eligible to receive shared savings payments. These large dialysis organizations are also liable for shared losses and have higher overall levels of risk compared to their smaller counterparts.

Small Dialysis Organizations, referred to as non-LDOs, include organizations with fewer than 200 dialysis facilities. In recognition of their more limited resources, non-LDOs are eligible to receive shared savings payments, but are not liable for shared losses. Beginning in 2017, they will have the option to be liable for downside financial risk, accompanied by the opportunity for greater shared savings payments.

As of July 1, 2016, the CEC model included 12 LDO ESCOs and one non-LDO ESCO, representing four dialysis companies and 223 nephrologists serving 19,000 beneficiaries in 11 states. In 2016, the CMS Innovation Center launched another solicitation for more ESCOs to apply to join the model in 2017. New ESCOs will be announced on or before January 1, 2017.

The CEC Model evaluation will assess the model's impact by comparing the change between the intervention and a comparison group comprised of similar beneficiaries in similar markets and facilities in utilization, cost, and clinical, and patient satisfaction outcomes before and after the intervention. The evaluation will also include cross-sectional analyses (observation of differences at a point in time) of beneficiary quality of life survey outcomes and a qualitative analysis from site visits to ESCOs.

For more information, see the [Comprehensive ESRD Care Model Webpage](#).

Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a multi-payer collaboration between public and private health care payers to strengthen primary care. The CPC initiative launched in October 2012 and is scheduled to conclude on December 31, 2016.

The CPC initiative is testing whether the provision of 5 CPC functions at each practice site—supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology—can achieve better care, improved health, and reduced costs and inform Medicare and Medicaid policy.

The five “CPC Functions” that comprise the core of the care delivery model are:

1. **Risk Stratified Care Management**: the provision of intensive care management for high-risk, high-need, high-cost patients.
2. **Access and Continuity**: 24/7 access to the care team; empanelment to a designated health care provider or care team with whom patients are able to get successive appointments.
3. **Planned Care for Chronic Conditions and Preventive Care**: proactive, appropriate care based on systematic assessment of patients' needs.
4. **Patient and Caregiver Engagement**: establishment of systems of care that include patients in goal setting and decision making, creating opportunities for patient and caregiver engagement throughout the care delivery process.
5. **Coordination of Care across the Medical Neighborhood**: management by the primary care practice of communication and information flow in support of referrals, transitions of care when care is received in other settings.

The payment model, designed to support the delivery of the 5 CPC functions, consists of a non-visit based PBPM care management payment and shared savings opportunities. The monthly payment for attributed Medicare FFS beneficiaries averaged \$20 PBPM during years 1 and 2 of the initiative (calendar years 2013-14), and has averaged \$15 PBPM in years 3 and 4 (calendar years 2015- 16).

The PBPM care management payment is in addition to the FFS reimbursement practitioners participating in the CPC initiative receive for delivering services to their Medicare patients. Additionally, CMS is offering each CPC practice the opportunity to share in net savings generated from improved care to Medicare FFS beneficiaries attributable to the practice. For each of the 3 separate performance periods (calendar years 2014-16 inclusive), CMS will calculate savings to the Medicare program at the regional level, and any savings will be distributed to practices in that region or regions, according to their performance on quality metrics.

The CPC initiative is being implemented in seven U.S. regions: statewide in Arkansas, Colorado, New Jersey, and Oregon; and regionally in Capital District-Hudson Valley, New York; Cincinnati-Dayton Region, Ohio/Kentucky; and Greater Tulsa, Oklahoma. As of September 30, 2016, roughly 2,160 health care providers were participating in the CPC initiative. The CPC initiative is currently in its fourth and final performance year.

The first and second annual evaluation reports were released in early 2015 and early 2016, respectively¹³. They indicate that across all seven regions combined—measured over the first 2 years of CPC—the initiative has generated nearly enough savings in Medicare Parts A and B health care expenditures to cover the CPC care management fees paid by CMS for attributed Medicare FFS beneficiaries. However, due to the possible unobserved CPC-

¹³ The third annual evaluation report was released after the period of reporting, in December 2016, and can be accessed [here](#).

comparison differences at baseline, the concentration of favorable findings in several regions and their early timing, as well as some unexpected adverse results in other regions, we recommend that these findings be interpreted with caution.

Over the same time period, there were few statistically significant effects on quality-of-care outcomes, but CPC does appear to have slightly improved quality of care for high-risk patients with diabetes and slightly improved patient experience of care.

CPC also publicly released quality and savings results for the first shared savings performance year (2014) in October 2015. In these analyses, CPC practices showed positive quality results, with hospital readmissions lower than national benchmarks and high performance on patient experience measures, particularly on health care provider communication with patients and timely access to care.

According to actuarial analyses used to conduct shared savings calculations, during 2014, the CPC initiative decreased Medicare Part A and Part B spending compared to spending targets. The CPC initiative generated a total of \$24 million in gross savings overall (before accounting for the CPC care management fees) but did not achieve net savings after accounting for the care management fees. Four of the CPC initiative's 7 regions (Arkansas, Colorado, Cincinnati-Dayton region of Ohio/Kentucky, and Oregon) generated gross savings. The Greater Tulsa region decreased costs in excess of the CPC care management fees, generating net savings of \$10.8 million and earning more than \$500,000 in shared savings payments.

For more information, see the [Comprehensive Primary Care Initiative Webpage](#).

The Comprehensive Primary Care Initiative Year 1 evaluation report can be accessed [here](#).

The Comprehensive Primary Care Initiative Year 2 evaluation report can be accessed [here](#).

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

Under the Federally Qualified Health Center Advanced Primary Care Practice (FQHC ACP) Demonstration, CMS tested whether providing financial incentives for FQHCs to obtain National Committee of Quality Assurance (NCQA) Level 3 Patient Centered Medical Home (PCMH) standards would encourage FQHCs to meet such standards; and whether the application of these standards would improve the quality of care and reduce costs for Medicare beneficiaries. FQHCs that met the eligibility criteria for the FQHC ACP Demonstration received the following sources of support:

- A quarterly \$18 care management fee for each eligible Medicare beneficiary;
- Technical assistance from NCQA to help attain NCQA level 3 PCMH recognition (this consisted of help with the biannual Readiness Assessment Survey (RAS) and reviewing applications for recognition);

- Training and assistance through a CMS-sponsored learning system to help FQHCs transform into APCPs;
- Regular feedback reports, first at the FQHC level, then at the beneficiary level. These reports tracked performance on RASs and compared each center with other demonstration sites. They also traced key cost and utilization measures for attributed beneficiaries over time; and
- Additional financial and infrastructure support from the Health Resources and Services Administration (HRSA) to cover the costs of obtaining PCMH recognition and the start-up costs of becoming an APCP.

The demonstration began in November 2011 and had a 3-year period of performance concluding in October 2014. The goal of the demonstration was to have 90 percent of participating FQHCs achieve PCMH recognition by the end of the period of performance.

At the conclusion of the FQHC APCP Demonstration period of performance, there were 434 FQHC sites across 44 states participating in the project. These sites treated approximately 207,000 Medicare patients and received more than \$45 million in care management fees from CMS. Ninety percent of the FQHCs achieved some level of PCMH recognition from NCQA and 80 percent of those FQHCs achieved Level 3 PCMH recognition.

The FQHC APCP Demonstration evaluation found that significantly more FQHCs participating in the demonstration achieved NCQA Level 3 recognition by October 2014 than comparison FQHCs (69 percent compared to 11 percent). Although demonstration FQHCs had better adherence to several evidence-based guidelines compared to comparison FQHCs, they did not have significantly lower costs or utilization than the comparison group during any of the 9 quarters that were analyzed.

For more information, see the [FQHC Advanced Primary Care Practice Demonstration Webpage](#).

The FQHC APCP Demonstration Year 1 evaluation report can be accessed [here](#).

The FQHC APCP Demonstration Year 2 evaluation report can be accessed [here](#).

Health Care Innovation Awards (Two Rounds Counted as Two Models)

Innovation in service delivery and payment reform is occurring throughout the country. The Health Care Innovation Awards (Innovation Awards) were created to accelerate the development and testing of innovations originating in the field. The Innovation Awards fund organizations proposing new payment and service delivery models that hold promise of delivering better care, lower costs, and improved health for people enrolled in Medicare, Medicaid, and CHIP, particularly those with the greatest health care needs.

The CMS Innovation Center issued two solicitations for the Innovation Awards, each receiving a robust response. Collectively, the Innovation Awards have funded interventions in urban and rural areas in all 50 states, the District of Columbia, and Puerto Rico. Awardees encompass a diverse set of organizations, including clinicians, hospitals and health systems, academic medical centers, information technology entrepreneurs, community and faith-based organizations, state and local governmental entities, nonprofit organizations, and advocacy groups.

Round One, announced in November 2011, was a broad solicitation that encouraged applicants to focus on high-risk populations and to include new models of workforce development. There were 107 Round One awards announced in two groups in May 2012 and June 2012.¹⁴ The Round One period of performance was 3 years. Round One models are enhancing primary care, coordinating care across multiple settings, deploying new types of health care workers, helping patients and health care providers make better decisions, and testing new service delivery technologies. More than 1 million Medicare, Medicaid, and CHIP beneficiaries have been served directly through Round One models. Round One concluded on June 30, 2015, but several awardees received No Cost Extensions.

Health Care Innovation Awards Round One

Round One awards cover a broad set of interventions and populations. Model tests were grouped together in seven discrete groups to facilitate their evaluation:

1. **Complex/High Risk Patient Targeting group**: comprised of 23 awards with a shared focus on patients with medically complex conditions at high risk for hospitalization or readmission. Awardees employ diverse approaches to improve the care of these populations including care coordination, redesign of clinical care workflow, patient education and support, financial incentives, and workforce development.
2. **Disease Specific group**: included 18 awards that targeted patient populations with specific diseases or diagnostic profiles. These patients are medically fragile, living in the community, and suffering from specific chronic conditions. They receive treatment from multidisciplinary care teams across various care settings for long durations.
3. **Behavioral Health and Substance Abuse group**: includes 10 awards focusing primarily on mental health and substance abuse services using an array of interventions. Although their initiatives have similar themes (such as workforce development and care coordination), these model tests target different priority populations, such as individuals with schizophrenia or individuals with both a serious mental illness and a chronic physical condition.

¹⁴ One of the awards encompasses two separate initiatives that will be evaluated separately. Accordingly, there are 107 awards and 108 evaluations.

4. **Hospital Setting group**: encompasses 10 awardees providing acute care interventions in the hospital/inpatient setting. These awardees use improved screening, bundled services, workforce training, and technology to deliver better care. Some awardees work with specific subgroups, such as geriatric and intensive care unit patients and patients with delirium, sepsis, and mobility issues. The goal of these interventions is to reduce hospital admissions, readmissions, inpatient length of stay, and cost while improving patient care, experience, and outcomes.
5. **Community Resource Planning, Prevention, and Monitoring group**: includes 24 awardees. The goal of this group is to enhance care coordination and improve access to health care through the use of health information technology, care management, patient navigation, and the delivery of preventive and health promotion services.
6. **Medication Management and Shared Decision-Making group**: comprised of 9 awardees. Medication management initiatives are designed to optimize therapeutic outcomes and reduce adverse events through improved medication use. The Shared Decision-Making programs engage patients in discussion with care teams and case managers to actively participate in choosing the most appropriate health treatments or care management options for their individual needs, taking into account the best scientific evidence available, as well as the patient's values and preferences.
7. **Primary Care Redesign group**: includes 14 awardees that represent a wide range of intervention models, target populations, and organizational settings focused on innovations in the ambulatory care setting.

The first and second evaluation reports for each of these groups were released in April 2015 and May 2016, respectively. These reports assess the impact on a range of quality, utilization, and cost outcomes, including beneficiary experience, for each award individually and for this group of awards as a whole. The reports can be accessed at the following [here](#).

In addition to the 7 model-specific annual evaluation reports, the CMS Innovation Center also awarded a meta-evaluation contract to synthesize and identify themes and lessons learned that span across these 7 groups. The meta-evaluation synthesizes both how awardees are implementing their innovations and what impact those innovations have on their Medicare and Medicaid beneficiaries. The first annual report from the meta-evaluation synthesized findings across the evaluators' first annual reports, included primarily qualitative results about awardee implementation experiences, and serves as a foundational step for subsequent analyses. Key findings include:

- More than 2 years into the model test, the evaluators reported that 76 percent of the awardees had implemented nearly all of their intended program components. Perceived resource adequacy was a key influence on implementation, and its potential role for other outcomes should be investigated. Multisite status and program complexity were unrelated to degree of implementation.

- Inadequate planning caused by a short planning period in the proposal process and inadequate assessment of organizational readiness, was a source of some implementation obstacles. Because many innovations require significant commitment from participants, many awardees also had difficulty enrolling and retaining patients. Additionally, many innovations target vulnerable populations that may face barriers to access. When staffing their innovations, awardees must weigh the benefits and drawbacks of hiring new staff versus using existing staff. Depending on the innovation and innovation context, the optimal staffing strategy will vary.
- A workforce survey fielded to awardee staff to measure satisfaction and team functionality revealed considerable variation in satisfaction and teamwork across respondents and awardees. It also showed that while awardees used a variety of titles for new staff, a considerable proportion did similar tasks, such as care management and care coordination.

Through identifying promising results, lessons learned, and best practices, several Round One awardees have helped to inform the development of new CMS Innovation Center models. For example, the Health Care Innovation Awards Round One—Diabetes Prevention Program was determined to be eligible for expansion in March 2016, as described in more detail above. Elements of another Health Care Innovation Award, to Innovative Oncology Business Solutions, Inc., helped inform the development of the Oncology Care Model.

Innovative Oncology Business Solutions, Inc.—through its Community Oncology Medical Home—reached more than 2,100 cancer patients through seven community oncology practices across the United States. Through comprehensive and coordinated oncology care, the model established pathways that:

- allowed practices to identify and manage symptoms in real time;
- improved patient access to health care providers through same-day appointments and extended night and weekend office hours; and
- provided disease management guidance for practitioners to improve treatment decision-making, symptom recognition, and assistance with patients' self-care, pain management, and caregiver support.

The evaluation report shows that this award demonstrated a significant reduction in hospital readmissions (readmissions (-35 per 1,000 patients, $P < 0.05$) and emergency room visits ((-9 per 1,000 patients, $P < 0.10$) relative to a matched comparison group.

Round One also incorporated a Learning System framework to capture, share, package, and disseminate strategies and resources to help Innovation Award recipients successfully implement their projects and make sustainable improvements in health care system design and delivery. This multifaceted Learning System consisted of all-awardee webinars and virtual meetings; small group interactions; written collaboration products; and a highly interactive CMS Innovation Center collaboration site. Activities and products had

specifically tailored themes based on common issues, challenges, and awardee feedback. Topics included development of driver diagrams to focus improvement, strategies for participant recruitment, measurement of cost savings, data management and reporting, and workforce development. Small group projects connect awardees with common areas of emphasis/populations and allow for ongoing collaboration and sharing of strategies and lessons learned.

Awards were given for a 3-year cooperative agreement period, with continuation contingent upon meeting operational plan milestones. The performance period for Round One began in July 2012 and concluded in June 2015 and several awardees were provided No Cost Extensions.

Health Care Innovation Awards Round Two

The second round of the Health Care Innovation Awards funds applicants who proposed new payment and service delivery models with the greatest likelihood of driving health care system transformation and delivering better outcomes for Medicare, Medicaid, and CHIP beneficiaries. In Round Two, the CMS Innovation Center sought new payment and service delivery models in four broad categories described below. These categories were identified as gaps in the current CMS Innovation Center portfolio and as areas that could result in potential payment models in Medicare, Medicaid, and CHIP.

The four broad categories are:

1. Models designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings.
2. Models that improve care for populations with specialized needs.
3. Models that test the means through which specific types of health care providers might transform their financial and clinical models.
4. Models that improve the health of populations through activities focused on prevention, wellness, and comprehensive care that extend beyond the clinical service delivery setting.

Round Two required each applicant to propose both an innovative care delivery model and a payment model that would support sustainability. Applicants were encouraged to focus on alternative payment models that did not simply expand FFS payments.

In Category One, three awards were made. Of these, one awardee intends to test a model to redirect patients with chronic illness and “super-utilizers” with non-emergent conditions from the emergency room to primary care medical homes. Another will test a combination of several proven tools designed to improve care and reduce hospital admissions for patients at 11 nursing facilities.

In Category Two, 11 awards were made. Examples include one awardee that will test a model using technology-enabled care management, virtual visits, and a peer support network

to promote better care for people living with HIV/AIDS. Another awardee will test a model using a coach and support team to coordinate health and social services for young adults transitioning out of foster care.

In Category Three, there were 13 awards, including one awardee that will test a model for high-need families providing integrated medical, behavioral health, and community-based services, coordinated by a multidisciplinary team. Another awardee will test a model using a medical neighborhood of primary care and specialty health care providers designed to promote evidence-based practices and to avoid unnecessary services and imaging for patients with low back pain.

In Category Four, 12 awards were given. One of these awardees will create a statewide hospital telehealth system to provide optimal stroke care and avoid unnecessary transfer to tertiary care centers. Another will test a model to identify patients with Hepatitis C and provide comprehensive medical and behavioral care. Another will test a combination of LEAN process improvements, chronic disease management, and clinical-community integration across 25 critical access hospitals and 73 associated primary care clinics.

The performance period for Round Two began in September 2014 and extends through June 2017. Round Two awardees are testing new models in all categories and priorities. Lessons learned from Round One have been leveraged in the implementation and management of Round Two awards. These lessons include incorporating operational plans into the application process, soliciting payment models, and requesting financial and actuarial review.

An evaluation will assess the impact of each of the 39 Health Care Innovation Awards Round Two awardees' projects and models of care provided to Medicare, Medicaid, and CHIP beneficiaries on four core measures: hospitalizations, re-hospitalization, emergency department use, and total cost of care. In addition, awardee specific outcome measures will be evaluated. A meta-analysis will be conducted on all 39 awardees with a report at the end of the evaluation award in 2020.

The first annual evaluation report provides an interim assessment of the 39 models, focusing on implementation challenges and successes in the first year of the Health Care Innovation Awards Round Two. The findings from the first year underscore the facilitators and challenges associated with implementing innovations in health care delivery and payment systems. All 39 awardees operationalized their programs, but they modified them as they identified opportunities for improving them in ways that would better serve participants and achieve program goals. Quantitative results will be available in future evaluation reports.

For more information and to access the Round One evaluation reports, see the [Health Care Innovation Awards Webpage](#).

The Round Two Year 1 evaluation report can be accessed [here](#).

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (Two Phases Counted as Two Models)

Nursing facility residents are subject to frequent avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities. Approximately 45 percent of hospitalizations among Medicare-Medicaid enrollees are avoidable, costing the federal government billions in unnecessary expenditures each year. To address this situation, CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in March 2012.

Under the first phase of the Initiative, CMS entered into cooperative agreements with seven organizations functioning as Enhanced Care and Coordination Providers (ECCPs) to test strategies to reduce unnecessary hospitalizations of Medicare-Medicaid enrollees who are long-stay residents of nursing facilities while maintaining or improving quality of care. The selected organizations have partnered with 143 nursing facilities to test evidence-based interventions designed to accomplish this goal over a 4-year performance period. The model served about 16,000 beneficiaries each month.

In August 2015, CMS announced a second phase of the Initiative to test whether three new payments for nursing facilities and practitioners, beginning in October 2016, will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents. As part of this second phase, CMS has entered into new cooperative agreements with six of the ECCPs, which were announced in March 2016. The payments support practitioner engagement in multidisciplinary care planning activities, and allow participating nursing facilities to provide additional services to treat common medical conditions that often lead to avoidable hospitalizations.

The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Phase 1 evaluation indicates that all ECCPs showed a decline in utilization for all-cause hospitalization and potentially avoidable hospitalization, and most of the ECCPs showed a decline in utilization for all-cause emergency department (ED) visit and potentially avoidable ED visits. Total Medicare expenditures and potentially avoidable hospitalization expenditures decreased across all ECCPs. Minimum Data Set-based quality measures indicated no consistent pattern of improvement or decline. The independent evaluation of Phase 2 began in September 2016.

For more information, see the [Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents Webpage](#).

The Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents – Phase 1 Year 3 evaluation report can be accessed [here](#).

Maryland All-Payer Model

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 (IPPS) and Outpatient Prospective Payment System (OPPS) 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 5-year hospital payment model. Under the terms of this agreement, Maryland will meet a number of quality targets and limit annual cost growth for all payers including Medicare. The purpose of this model is to test the impact of transformation in the context of an all-payer rate setting system. Specifically, the model will 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.

The agreement between Maryland and CMS provides 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 agrees to generate \$330 million in Medicare savings over a 5-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 will 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 will achieve a number of quality targets that will improve the care for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries, such as:
 - **Readmissions**: Maryland will reduce its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate to the national rate over 5 years.
 - **Hospital Acquired Conditions**: Maryland will achieve an annual aggregate reduction of 6.89 percent in 65 Potentially Preventable Conditions (PPC) over 5 years for a cumulative reduction of 30 percent.
 - **Population Health**: Maryland will submit an annual report demonstrating its performance along various population health measures.

Under the All-Payer Model, Maryland must also achieve several delivery transformation goals including:

- Maryland will shift 80 percent of its hospital revenue over the 5-year performance period into global payment models.
- Before the start of the fourth year of the model, Maryland will develop a proposal for a new model based on a Medicare total per capita cost of care test to begin no later than after the end of the 5-year period of performance.

This statewide model covers all Maryland residents, including approximately 856,500 Medicare FFS beneficiaries. There are currently 46 acute care hospitals that are waived from the Inpatient Prospective Payment System and Outpatient Prospective Payment Systems, and instead are paid in accordance with the Maryland All-Payer Model and regulated by the Maryland's all-payer hospital rate setting organization. Under the Maryland All-Payer Model, the state has moved all 46 acute care hospitals into hospital global budgets in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. Actuarial analyses and reporting from the state show that:

- **Medicare Savings:** \$116M in Medicare savings, more than a third of the way towards the 5-year goal of \$330M.
- **All-Payer Growth Cap:** 1.5 percent in all-payer hospital cost per capita growth rate, well under the 3.58 percent cap.
- **Medicare Readmissions:** Modest reduction in the gap between Maryland's Medicare FFS 30-day all-cause readmission rate and the national average.
- **All-Payer PPC:** 26 percent reduction in all-payer PPC, equivalent to two-thirds of the 5-year target of 30 percent.
- All Maryland acute care hospitals are participating in the global budget model and Maryland has moved 95 percent of hospital revenue into a population-based payment model.

Using traditional evaluation approaches that examine the impact relative to a counterfactual, the formal Maryland All-Payer Model evaluation is assessing the model's impact on reducing inpatient and outpatient costs, 30-day readmissions, and potentially avoidable admissions over a 5-year period. It is based on a mixed-methods design, using both qualitative and quantitative methods and data to assess both the implementation and the outcomes of the model.

For more information, see the [Maryland All-Payer Model Webpage](#).

Medicaid Innovation Accelerator Program

In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a collaborative initiative with states to promote transformation in state Medicaid delivery and payment systems. The goal of IAP is to improve the care and health of Medicaid

beneficiaries and to reduce costs by supporting states' ongoing service delivery and payment reforms through targeted technical support. IAP works closely with State Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities. IAP has engaged 50 states and DC through its two web-based learning series and 28 states through direct technical support opportunities.

IAP's focus on innovation in Medicaid necessitates a close connection to the ongoing work of the CMS Innovation Center State Innovation Models and with the Office of Medicare-Medicaid Coordination.

As a result of a multi-stakeholder engagement process conducted in the summer 2014, CMS selected and designed four program areas that addressed technical assistance (i.e. program support) gaps identified by states such as: reducing substance use disorders; improving care of Medicaid beneficiaries with complex needs and high costs; promoting community integration through long-term services and supports; and supporting physical and mental health integration. Each of these areas represents a separate, sometimes multi-tiered technical support program for states to improve how care is delivered for these populations.

- **Reducing Substance Use Disorders (SUD)**: Over the last year, 7 states participating in the High-Intensity Learning Collaborative (HILC) strengthened their programs for Medicaid beneficiaries with SUDs. Through a team of experts, IAP offers each HILC state technical support to tailor solutions to its own needs and to develop relevant policy, program, and delivery system reforms. Each state defined measurable goals and used a range of tools, including virtual monthly meetings, in-person workshops, and one-on-one technical support from dedicated coaches. The types of technical support include assistance with resources regarding care transitions and treatment engagement following withdrawal management; model SUD health home and managed care contract language; and administrative claims and managed care organization encounter data standardization. The intensive phase of the work with the seven learning collaborative states ended in January 2016, but IAP will continue to offer ongoing support to these states. Participants include: Kentucky, Louisiana, Michigan, Minnesota, Pennsylvania, Texas, and Washington.

Since March 2015, IAP has hosted 15 "Targeted Learning Opportunities" (TLOs) webinars with 48 states and DC participating. These TLOs connect states to content experts and leading practices across the country on a number of topics within SUD delivery system reform, such as encouraging SUD provider participation in Medicaid and the integration of primary care and SUD services.

In 2015, CMS created a new section 1115 demonstration authority geared to states interested in undertaking broad and deep SUD system transformation efforts, enabling them to provide a full continuum of care by introducing service, payment, and delivery system reforms to improve access to and quality of care for individuals with SUD. CMS has approved several 1115 SUD demonstrations, and through IAP, is providing

ongoing strategic design support to a number of states to support their 1115 SUD proposals.

- **Improving Care for Medicaid Beneficiaries with Complex Needs and High Costs**: A 10-month learning collaborative with five states interested in designing and implementing delivery systems reforms for their Medicaid beneficiaries with complex care needs and high costs. Participating states are offered program support related to enhancing data analytic capacity, designing program elements, and developing payment approaches that support changes in how care is structured and delivered to the participating states' target populations. The program ran from October 2015 to July 2016, but IAP will continue to offer ongoing support to these states. Participants include: the District of Columbia, New Jersey, Oregon, Texas, and Virginia.
- **Promoting Community Integration Through Long-term Services and Supports (LTSS)**: This program area is comprised of two components with two tracks each.
 - The first component, *Medicaid Housing-Related Services and Partnerships* has two tracks.
 - The first track, a 3-part webinar series on Supporting Housing Tenancy, provided states with an overview of tenancy support services, current health care providers, and funding sources. CMS selected 31 states to participate in this series that ran from February 2016-April 2016.
 - The second track, State Medicaid-Housing Agency Partnerships, is targeted program support to eight Medicaid agencies seeking building collaborations with key housing partners in their states. For this intensive, 6-month track, CMS is partnering with several federal agencies on the planning and coordination of the program support: United States Department of Housing and Urban Development; the Substance Abuse and Mental Health Services Administration; the Office of the Assistant Secretary for Planning and Evaluation; and the US Interagency Council on Homelessness. The program runs from May 2016-October 2016. Participants include: California, Connecticut, Hawaii, Illinois, Kentucky, Nevada, New Jersey, and Oregon.
 - The second component of this program area, *Incentivizing Quality and Outcomes*, is designed to support states in the planning or early implementation phase of value-based purchasing strategies for their community-based LTSS population.
 - The first track, focused on supporting states with the planning of value-based purchasing strategies in community-based LTSS programs, runs from April 2016–September 2016. Participants: Indiana, Maryland, Mississippi, New England, Nevada, North Carolina, Ohio, Pennsylvania, and Virginia.
 - The second track, focused on supporting states with the implementation of value-based purchasing strategies in community-based LTSS programs, will

run from October 2016-January 2017. Participants: Massachusetts, New Jersey, Virginia, Washington.

- **Supporting Physical and Mental Health Integration**: This program area will focus on supporting states' spread of physical and mental health integration models and payment approaches through individualized coaching and affinity group activities. The program runs from April 2016-January 2017. Participants include: Nevada, New Hampshire, New Jersey, Puerto Rico, and Washington. IAP is also convening an integration strategy workgroup for Hawaii, Idaho, Illinois, Massachusetts to virtually discuss measuring integration, tying measures to payment, and enhancing health care provider-level integrated care capacity.

As part of IAP's efforts to support ongoing Medicaid delivery system reforms, targeted technical support and tools are also offered to states in four functional areas: data analytics, quality measurement, performance improvement, and payment modeling and financial simulations. In order provide states targeted technical support, IAP designed its functional areas slightly different than the program areas. Through these functional areas, IAP will provide support to states individually or through the development of tools. In FY16, IAP began several activities related to data analytics (i.e., supporting six states per year with access to Medicare-Medicaid data integration assistance and development of data analytic tools) and quality measurement (i.e., developing or refining existing measures to fill gaps under the program area topics).

In June of 2016, IAP began working with states across all four IAP program areas. It is anticipated that the majority of technical support and the development of resources and tools in IAP's functional areas will be launched by the end of 2016.

The goal of the evaluation of the Medicaid IAP is to provide an independent assessment of states' experiences with, and the efficacy of the IAP program to support Medicaid reform efforts. The evaluation will also inform CMS on future use of this initiative for supporting state Medicaid programs. This evaluation will use mostly qualitative methods to (1) evaluate the processes employed in providing targeted support and other resources for their alignment and responsiveness to state needs and the IAP objectives; (2) evaluate the intermediate outcomes of the IAP relative to the aim of supporting ongoing reform efforts; (3) provide real-time performance improvement feedback on these processes to CMS and the targeted support health care provider(s) to allow for ongoing refinement and continuous performance improvement during the implementation period; and (4) support a determination of the appropriateness of the IAP model of targeted support and resources for future CMS use.

For more information, see the [Medicaid Innovation Accelerator Program Webpage](#).

Medicare Care Choices Model

Only 47 percent of eligible Medicare patients use Medicare's hospice benefit and most only for a short period of time. Under section 1812(d)(2)(A) of the Social Security Act, which defines the Medicare hospice benefit (42 CFR 418.24(d)), patients who elect the traditional

hospice benefit must waive the right to Medicare payment for services related to the treatment of the terminal condition.

The Medicare Care Choices Model began in January 2016 to test whether receiving hospice-like support services from certain hospice health care providers while concurrently receiving services provided by their curative care health care providers will improve Medicare beneficiaries' quality of life, increase patient satisfaction, and reduce Medicare expenditures. Hospices are recruiting patients utilizing approved marketing plans and contacts with referral sources. The 5-year model includes over 130 hospices from 39 states across the country. The first cohort of participating hospices began accepting patients under the model in January 2016, and the second cohort will begin to provide services under the model in January 2018. The last patient will be accepted into the model 6 months before the model period is slated to end on December 31, 2020.

The Medicare Care Choices Model evaluation will assess the model's impact on when beneficiaries elect hospice, patterns of care, and quality of life for patients and their families. Cost of care will be examined, including the effect on Medicare and Medicaid expenditures, as well as the process and challenges involved in operating this model. Analyses will be conducted at the aggregate level using secondary data from Medicare and Medicaid claims, clinical records, and quality metrics as well as primary data collected through interviews, surveys, focus groups, and direct observation.

For more information, see the [Medicare Care Choices Model Webpage](#).

Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals

In July 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to establish innovative models of care for dual eligible enrollees. Under this initiative and through related work, CMS is partnering with states to test both a capitated model and a managed fee-for-service (MFFS) model. In the capitated model, the state and CMS enter into a 3-way contract with a health plan which receives a prospective blended Medicare and Medicaid payment to provide comprehensive, coordinated care. Under the MFFS model, the state and CMS enter into an agreement by which the state may benefit from a portion of savings from initiatives that improve quality and reduce costs in the FFS delivery system.

Although the approaches differ in each state demonstration, beneficiaries are eligible to receive all the standard Medicare and Medicaid services and benefits that they are entitled to, as well as additional care coordination, beneficiary protections, and access to enhanced services. As of July 2016, approximately 458,000 beneficiaries were enrolled in the combined Financial Alignment Initiative & State Demonstrations to Integrate Care for Dual Eligible Individuals. Model tests are operating in 13 states, with 2 demonstrations operating in New York.

The Financial Alignment Initiative builds upon and, for some states, incorporates funding from its precursor, the State Demonstrations to Integrate Care for Dual Eligible Individuals,

through which CMS awarded design contracts to 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) in April 2011 to design new approaches to better coordinate care for beneficiaries enrolled in both the Medicare and Medicaid programs.

Eight of these states are now part of the Financial Alignment Initiative, but received implementation funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals. Seven of these eight states have signed Memoranda of Understanding (MOUs) to test new models under the Financial Alignment Initiative. In Minnesota, the eighth state from the State Demonstrations, CMS has signed an MOU to test an alternative model, building on the longstanding Minnesota Senior Health Options program.

As of July 2016, under the Financial Alignment Initiative and State Demonstrations, CMS has entered into MOUs with a total of 13 states: eight states that received awards from the State Demonstrations (California, Colorado, Massachusetts, Michigan, Minnesota, New York, South Carolina, and Washington) and 5 additional states (Illinois, Ohio, Texas, Rhode Island, and Virginia) to integrate care for Medicare-Medicaid enrollees. Ten of these states (California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia) are implementing capitated model demonstrations.

Washington and Colorado are implementing MFFS model demonstrations. Minnesota is implementing an administrative alignment demonstration that involves a set of improvements to simplify the process for beneficiaries to access the services for which they are eligible under Medicare and Medicaid.

Approved demonstrations are at different stages of implementation. The Washington and Colorado MFFS demonstrations began in July 2013 and September 2014, respectively. The Minnesota demonstration became effective in September 2013. Start dates for the capitated model demonstrations range from October 1, 2013, for the Massachusetts demonstration to July 1, 2016 for the Rhode Island demonstration. A second capitated model demonstration in New York for Medicare-Medicaid enrollees with intellectual and developmental disabilities began serving enrollees on April 1, 2016.

CMS and the states continue to invest in and collaborate on monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include the following:

- **Contract Management Team**: For each capitated demonstration, CMS and the state establish a joint contract management team, which represents Medicare and Medicaid staff in overseeing the three-way contract.
- **Funding for Ombudsman Services**: Through funding from CMS and technical support from the Administration for Community Living (ACL), the Demonstration Ombudsman Programs do the following: (1) provide beneficiaries in states with approved demonstrations with access to person-centered assistance in answering

questions and resolving issues; (2) monitor the beneficiary experience; and (3) offer recommendations to CMS, the states, and participating plans. As of July 2016, CMS had made awards to California, Colorado, Illinois, Massachusetts, Michigan, Ohio, Rhode Island, South Carolina, Virginia, and Washington through this funding opportunity.

- **Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs)**: This funding supports local SHIPs and ADRCs in providing beneficiary outreach and one-on-one “options counseling” to states participating in the demonstrations. As of July 2016, CMS had made awards to California, Illinois, Massachusetts, Michigan, New York, Rhode Island, Virginia, and Washington.¹⁵

Specific successes and challenges vary across demonstration sites, but an overall early success of the initiative is that sites are actively engaging stakeholders and making significant investments in hiring and training care coordinators on the needs of Medicare-Medicaid enrollees. Challenges include the fact that sites are redesigning state Medicaid eligibility, enrollment, and data systems to interface with Medicare systems and must locate hard-to-reach beneficiaries in order to conduct assessments and engage them in the care model.

In 2016, CMS released the first annual evaluation reports for the Washington and Massachusetts demonstrations that began in 2013. The first annual reports for the Minnesota demonstration that began in 2013 and for the demonstrations that began in 2014 are expected in fiscal year 2017.¹⁶ The reports that have been released do not contain regression-based quantitative finding for this early period of demonstration experience and do not yet include any Medicaid findings due to limitations in the availability of Medicaid data during the period of time studied.

Highlights from the Washington MFFS demonstration’s first performance period include enrollment increases in every quarter through the end of 2014 with minimal voluntary disenrollment. Rates of inpatient hospital admission, in general, and Ambulatory Care Sensitive Conditions (ACSC) admissions, in particular, were either flat or increasing during the baseline period and appear to be falling in the demonstration period. In total, the Medicare savings for the first demonstration period were \$21.6 million after applying outlier adjustments, representing over 6 percent savings.

Highlights from the Massachusetts One Care demonstration first performance period include findings that beneficiaries who are enrolled in One Care plans are largely satisfied with the care model and demonstration. Results from the 2015 CAHPS survey show that when asked

¹⁵ Note: this is in reference to additional funding CMS has provided to support SHIPs and ADRCs to provide options counseling in states participating in the Financial Alignment Initiative. ACL provides technical support as in the Ombudsman program above.

¹⁶ The first annual report for the Minnesota demonstration was released in December 2016, and can be accessed [here](#).

to provide an overall rating (on a scale of 1 to 10 with 10 being the best) of their One Care plan, most survey respondents ranked it as a 9 or 10. One notable challenge facing the demonstration since its inception has been reaching hard to find eligible beneficiaries and building a cadre of care coordinators sufficient to conduct health assessments and to assist in the development of an Individualized Care Plan for each enrollee.

Plans involved in the demonstration were still seeking to address beneficiary outreach efforts and building care coordinator capacity during the first demonstration year. Service use measures show that demonstration eligible beneficiaries saw decreases in 8 of 13 utilization measures and increases in 4 of 13 measures during the demonstration period versus the baseline period. Similar trends were also observed in the comparison group. There was one exception, the measure for emergency department psychiatric use saw a small increase in episode counts in the demonstration group and small drop in the comparison group. Findings from the evaluations 6 quality measures show that rates were largely stable over the baseline and demonstration period and similar to trends in the comparison group.

For more information, see the [Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals Webpage](#).

A report on the early implementation of the Medicare-Medicaid Financial Alignment Initiative can be accessed [here](#).

Findings from the Washington site demonstration first annual report can be accessed [here](#).

Findings from the Massachusetts site demonstration first annual report can be accessed [here](#).

Medicare Prior Authorization Models

In May 2014, the CMS Innovation Center in collaboration with the CMS Center for Program Integrity, announced that it would begin testing two prior authorization models for repetitive scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy. The models, authorized under Section 1115A, are similar to an earlier prior authorization demonstration for power mobility devices. Repetitive scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy are the focus of these models 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 regarding beneficiaries receiving services that are not medically necessary.

The objective of the models is to test whether prior authorization helps reduce improper payments and reduces Medicare costs while maintaining or improving quality of care. The models do not create additional documentation requirements. They require reporting the same information that has always been necessary to support Medicare payment, but requiring it earlier in the process. This helps to confirm that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

The repetitive scheduled non-emergent ambulance transport model was implemented in South Carolina, New Jersey, and Pennsylvania. Ambulance suppliers or beneficiaries began submitting prior authorization requests on December 1, 2014 for transports occurring on or after December 15, 2014. The non-emergent hyperbaric oxygen therapy model was implemented in Illinois, Michigan, and New Jersey. Facilities or beneficiaries in Michigan began submitting prior authorization requests on March 1, 2015 for treatments occurring on or after April 13, 2015. Facilities or beneficiaries in Illinois and New Jersey began submitting prior authorization requests on July 15, 2015 for treatments occurring on or after August 1, 2015. These states were chosen because of their high Medicare expenditures for repetitive scheduled non-emergent ambulance transports and non-emergent hyperbaric oxygen therapy.

Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) expanded the prior authorization model for repetitive scheduled non-emergent ambulance transport to 6 additional areas: Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia. Ambulance suppliers or beneficiaries began submitting prior authorization requests on December 15, 2015 for transports occurring on or after January 1, 2016.

Both models follow a similar prior authorization process. The ambulance supplier, facility, or beneficiary are 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 under the models. If a health care provider or supplier chooses to forego prior authorization and submits a claim without a prior authorization decision, the claim is stopped for pre-payment review. The models include 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 expected to be extremely rare since both models apply only to non-emergent services.

In the repetitive scheduled non-emergent ambulance transport model, a provisional affirmative prior authorization decision will affirm a specified number of trips (up to 40 round trips), within a 60-day period. In the non-emergent hyperbaric oxygen therapy model, a provisional affirmative prior authorization decision will affirm up to 40 courses of treatment in a year. Beneficiaries who need additional transports or treatments require another prior authorization request.

Outreach and education to participating health care providers and beneficiaries began prior to the start of both models and continue throughout the performance periods through such methods as open door forums, issuance of an operational guide, frequently asked questions

(FAQs), posted on CMS' website, a beneficiary mailing, and educational events and materials issued by the MACs.

The goal of the evaluation is to rigorously assess prior authorization as a means of reducing utilization of medically unnecessary services, thereby reducing costs by decreasing the improper payment rate for these services while maintaining or improving the quality of care provided to beneficiaries. The evaluation will determine the impact of these prior authorization models on service use, quality of care, and Medicare expenditures as well as on health care providers and Medicare program operations. It will also provide information to assist CMS in identifying changes needed before implementing these models nationally. The results will help CMS determine whether and how to expand these prior authorization models to other states and, ultimately, nationwide.

Million Hearts®

The Million Hearts initiative (which is separate from the Million Hearts Cardiovascular Disease Risk Reduction Model described in the previous subsection) brings together communities, health care professionals, health systems, nonprofit organizations, federal agencies, and private-sector organizations around a common goal: preventing 1 million heart attacks and strokes by 2017. Million Hearts calls attention to a small set of changes that can be made in communities and health care systems that support long-term reductions in heart attacks and strokes. Million Hearts also emphasizes the importance of coordination between public health organizations and clinical systems.

The Million Hearts initiative does not receive direct funding from CMS, but CMS supports the Million Hearts objectives in several other ways. For example, CMS has adopted the Million Hearts measure set and embedded it across quality reporting programs and models such as Accountable Care Organizations, the Physician Quality Reporting System,¹⁷ and the Comprehensive Primary Care Initiative. CMS also supports Million Hearts' goals by encouraging clinicians who participate in CMS Innovation Center models to deploy their electronic health record systems to assess and improve their performance, adopt evidence-based tools like hypertension treatment protocols and patient registries, and reach out to patients to address gaps in care. All of these actions are focused on improving health—especially cardiovascular health—for all Americans.

For more information, see the [Million Hearts Webpage](#).

Partnership for Patients

The Partnership for Patients Model is 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

¹⁷ The Physician Quality Reporting System will sunset in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

reducing preventable hospital-acquired conditions by 40 percent and 30-day readmissions by 20 percent over a 3 year period of performance.

Preliminary estimates by the Agency for Healthcare Research and Quality (AHRQ) for 2015 show a 21 percent decline in hospital-acquired conditions (HACs) between 2010 and 2015. In addition, the AHRQ report estimates that “a total of 3.1 million fewer HACs were experienced by hospital patients over the 5 years (2011, 2012, 2013, 2014, and 2015) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. The preliminary 2015 rate is 115 HACs per 1,000 discharges, down from 2013 and 2014, which had held at 121 HACs per 1,000 discharges. We estimate that nearly 125,000 fewer patients died in the hospital as a result of HACs and that approximately \$28 billion in health care costs were saved from 2010 to 2015 due to the reductions in HACs.”¹⁸

AHRQ’s ability to track and monitor patient safety progress in this way, through chart-reviewed data on patient safety topics, has been made possible by the Partnership for Patients Model. Without the investment from CMS and the Partnership for Patients, explicit national data would not exist to demonstrate that safety and quality have improved in the nation’s hospitals at national scale. While the reasons for this progress are not fully understood, there likely are many contributors to the decline in harm, including the Partnership for Patients. Other likely contributing causes include financial incentives created by CMS and other payers’ payment policies, public reporting of hospital-level safety results, and technical assistance offered by the Quality Improvement Organization (QIO) program to hospitals.

The Partnership for Patients Model spanned a period of 4 years, with the initial round taking place from December 2011 to December 2014, and the second round from September 2015 to September 2016. To date, the Partnership for Patients Model has engaged thousands of hospitals in all 50 states and Puerto Rico in an effort to improve patient safety across the nation. In the first round of the Partnership for Patients, CMS awarded 26 Hospital Engagement Network (HEN) contracts that supported approximately 3,700 hospitals.

In the second round of the Partnership for Patients Model, 17 HENs engaged with and supported approximately 3,500 hospitals. The patient harm focus areas have remained the same across both rounds of HEN activity, and include ten core hospital-acquired conditions and 30-day readmissions. Many of the HENs have committed to addressing additional areas of harm, including sepsis and clostridium difficile (along with antimicrobial stewardship), in an effort to support an overall culture of safety in acute care hospitals.

CMS considers large scale improvement networks like Partnership for Patients HENs to be important opportunities to affect rapid change in the health care system in order to generate better care, smarter spending, and healthier people. Through the Partnership for Patients, CMS is engaging the hospital community by quickly implementing well-tested and measurable best practices at a national scale.

¹⁸ Agency for Healthcare Research and Quality: [National Scorecard on Rates of Hospital-Acquired Conditions, 2010 to 2015.](#)

CMS is committed to sustaining the momentum of patient safety efforts on a national scale, and views these activities as an essential component of our mission. CMS has encouraged networks and their participants to seek out opportunities for synergy, alignment, and collaboration across the health care system in order to achieve impact for patients and their families. Alignment of powerful forces is central to the ability to generate breakthrough results.

In keeping with that commitment to alignment and collaboration, in late 2015, CMS elected to integrate the patient safety efforts of both the Hospital Engagement Networks and the QIO program, as patient safety and quality improvement have long been important attributes of both activities. A new set of contracts called Hospital Improvement Innovation Networks (HIINs) were awarded in September 2016 as a support to the overall aims of the QIO 11th Statement of Work. This effort is separate from the Partnership for Patients Model, and the term “Partnership for Patients” is used now as an umbrella term to refer to collaboration among CMS, other federal agencies and private entities and other CMS initiatives toward decreasing patient harm.

For more information, see the [Partnership for Patients Webpage](#).

The Partnership for Patients first interim evaluation report can be accessed [here](#).

The Partnership for Patients second interim evaluation report can be accessed [here](#).

Pioneer Accountable Care Organization Model

The CMS Innovation Center launched the Pioneer Accountable Care Organization (Pioneer 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 3-year period of performance with the option to extend for 2 additional years.

The model tests payment arrangements that hold health care providers accountable for cost, quality, and patient experience outcomes for a defined population of beneficiaries. It uses a shared savings payment methodology with generally higher levels of shared savings and risk compared to the Shared Savings Program. The Pioneer ACO Model also assesses the ability of hospital and physician organizations experienced in care and risk management to achieve savings for Medicare while sustaining or improving the quality of care for beneficiaries.

Pioneer ACOs that demonstrated shared savings during the first 2 performance years and met other criteria were able to transition to a monthly population-based payment starting in performance year 3. The performance of Pioneer ACOs on both financial and quality metrics, including patient experience ratings, is publicly reported by CMS, which can be accessed [here](#).

The Pioneer ACO Model evaluation found favorable results on both cost and quality measures following the first two performance years. Specifically over that time period, the

evaluation found approximately \$385 million in lower spending relative to other FFS Medicare beneficiaries in ACO markets with no apparent differences in quality.

In 2015, the first option year and most recent performance year for which data are available, the actuarial savings calculation showed that the 12 ACOs in the Pioneer ACO Model generated almost \$37 million in total savings, which includes all ACOs' savings and losses. At the same time, 6 Pioneer ACOs qualified for shared savings payments of more than \$38 million by meeting quality standards and their respective shared savings threshold.

The mean quality score among Pioneer ACOs increased to 92.3 percent in the fourth performance year from 87.2 percent in the third performance year. The mean quality score has increased in every year of the model such that it has increased by over 21 percentage points since the first year, where the mean quality score was 70.81 percent.

In May 2015, the CMS Chief Actuary certified and the Secretary determined that the Pioneer ACO Model as it was tested in the first 2 years, was the first CMS Innovation Center model to meet the statutory requirements for expansion by the Secretary. Elements of the model have been incorporated into Track 3 of the Shared Savings Program. The Pioneer ACO Model certification can be accessed [here](#).

In 2016, 9 Pioneer ACOs are presently in their second option year and final performance year. Fourteen former Pioneers are now participating in the Shared Savings Program or the Next Generation ACO Model. These former Pioneer ACOs chose to participate in other ACO initiatives to gain more experience in managing performance-based risk such as the Shared Savings Program and the Next Generation ACO Model. Approximately 400,000 Medicare beneficiaries are currently aligned with Pioneer ACOs in 6 states (Arizona, California, Massachusetts, Michigan, Minnesota, and New York).

For more information, see the [Pioneer ACO Model Webpage](#).

The Pioneer ACO Model Year 1 evaluation report can be accessed [here](#).

The Pioneer ACO Model Year 2 evaluation report can be accessed [here](#).

State Innovation Models (Two Rounds Counted as Two Models)

The State Innovation Models (SIM) initiative is testing the ability of state governments to use their policy and regulatory levers to accelerate health care transformation efforts in their states. The goal is 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 seeks 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 provides funding and technical assistance to states to design and test their State Health Innovation Plans.

SIM consists 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 6 Test states. SIM Round Two was launched in February 2015, providing \$45 million in design funding to 17 states, 3 territories, and the District of Columbia, as well as over \$600 million in funding to 11 test states, all of which were initially Round One Design states.

As described in earlier in this report, the CMS Innovation Center issued an RFI in September 2016 to seek input on concepts for a potential state-based initiative. More information regarding this RFI can be accessed [here](#).

In total, SIM funding has been provided to 34 states, 3 territories and the District of Columbia, representing over 60 percent of the US population. Unlike other CMS Innovation Center models, SIM is not testing a specific delivery system or payment model. Rather, SIM focuses on developing the infrastructure necessary to enhance coordination and communication across the care continuum.

To achieve this goal, the CMS Innovation Center partners with several other CMS components (Center for Medicaid and CHIP Services, Center for Clinical Standards and Quality, and the Center for Medicare), as well as other federal agencies (Office of the National Coordinator for Health Information Technology, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration) to align and leverage other Federal delivery system reform programs and opportunities within the context of each state's health care landscape.

Three of the SIM Round One test states (Arkansas, Maine, and Oregon) are in the final year of their period of performance, and the other three (Massachusetts, Minnesota, and Vermont) have received no-cost extensions and are expected to complete their tests in 2017. The Round Two Design States are scheduled to submit their State Health Innovation Plans in 2016. Eight Round Two Model Test states have completed their implementation year and are currently testing their planned transformation activities.

SIM has developed robust reporting and learning systems that track and catalog all technical assistance requests and resources while providing several opportunities for states to learn and implement best practices adopted by other states into their own delivery system environment. Further, each state must perform a self-evaluation which requires the state to consistently assess progress on achieving its milestones and revising its innovation plan based on data and stakeholder input.

Several test states, from both rounds, are developing proposals for Medicare participation in their state-based delivery and payment models in accordance with guidance announced by the SIM program in April 2015. In order for the CMS Innovation Center to consider participation in the model, it must be patient-centered, broad-based, transformative, accountable for the total cost of care, feasible and able to be evaluated. The CMS Innovation Center also requires that these proposals align with the requirements of Medicare Access and

Chip Reauthorization Act of 2015 and the Department of Health and Human Services' Delivery System Reform goals.

Results from the Round One final report on Model Design and Pre-Test states demonstrate that states are appropriate and necessary leaders of health care transformation. However, a state's reach is limited and partnership is needed to successfully design and implement health care transformation. Early and meaningful engagement of stakeholders allows states time to develop and provide feedback on multiple iterations of the Plan. A short timeframe can keep participants focused and engaged, but it can also preclude consideration of novel or controversial ideas, development of detailed plans, and consensus from key stakeholders.

The second annual report for the federal evaluation of Round 1 Model Test states provides the most current understanding of health outcomes, the reach of the SIM initiative participation in each state, engagement in multi-payer participation, physician survey findings, and health information technology. Regarding health outcomes, only baseline claims data are currently available for Medicaid, the primary target population. However, spillover effects for Medicare and commercial populations are included in the most recent evaluation report. The rate of emergency room visits declined for the commercial populations in Arizona, Massachusetts, and Minnesota and for the Medicare population in Maine and Minnesota. Additionally, there were declines in inpatient readmissions for commercial populations in Arizona and for Medicare beneficiaries in Vermont. There were no significant changes in total expenditures for commercial populations. Declining Medicare expenditures in Maine were observed, but no changes in other Test states.

With an emphasis on primary care, many such health care providers are participating in one or more of the SIM innovation models. The number of primary care physicians participating in patient-centered medical homes (PCMHs) by first quarter 2015 accounted for 13 percent (Maine) to 37 percent (Vermont) of all active primary care physicians in these states.

Early survey findings found that practices already provided coordinated care by assigning patients to specific health care providers or teams, transmitting referral information to specialists, using electronic health records to document medical/progress notes, prescribe medications, and monitor quality-of-care performance at the patient and practice level.

For more information, see the [State Innovation Models Initiative Webpage](#).

The State Innovation Models Initiative Round One, Model Design and Pre-Test States final evaluation report can be accessed [here](#).

The State Innovation Models Initiative Round One, Model Test States Year 1 evaluation report can be accessed [here](#).

The State Innovation Models Initiative Round One, Model Test States Year 2 evaluation report can be accessed [here](#).

Strong Start for Mothers and Newborns

In February 2012, the CMS Innovation Center announced the Strong Start for Mothers and Newborns (Strong Start) initiative, an initiative that aims to reduce preterm births and improve outcomes for newborns and pregnant women. The Strong Start initiative includes two strategies.

Strong Start Strategy 1 was a public-private partnership and awareness campaign to reduce the rate of early elective deliveries prior to 39 weeks for all populations. The Strong Start Strategy 1 campaign period of performance concluded in December 2014.

Building off of Strong Start Strategy 1, Strong Start Strategy 2 tests the effectiveness of specific enhanced prenatal care approaches to reduce the frequency of premature births among pregnant Medicaid or Children's Health Insurance Program (CHIP) beneficiaries at high risk for preterm births. This 4-year initiative includes three evidence-based maternity care service approaches that enhance the current care delivery, and address the medical, behavioral, and psychosocial factors that may be present during pregnancy and contribute to preterm-related poor birth outcomes.

The goal of the initiative is to determine if these approaches to care can reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decrease the anticipated total cost of medical care during pregnancy, delivery, and over the first year of life for children born to mothers in Medicaid or CHIP.

In February 2013, CMS awarded 27 cooperative agreements to test three enhanced prenatal care approaches under Strategy 2:

- **Group Visits**: care that incorporates peer-to-peer interaction in a facilitated setting for providing health assessment, education, and additional psycho-social support.
- **Birth Centers**: care facilitated by teams of health professionals, including nurse midwives and allied health professionals and peer counselors, to provide collaborative care, intensive case management, counseling, and psycho-social support.
- **Maternity Care Homes**: care that emphasizes care coordination and management for expanded access to health services, psycho-social support, education, and health promotion in addition to traditional prenatal care.

An additional component of Strong Start Strategy 2 is the evaluation of enhanced prenatal care through home visiting, as part of the evaluation of two home visiting models under the Maternal, Infant and Early Childhood Home Visiting program, Nurse Family Partnership and Healthy Families America, in partnership with the Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF).

Strong Start Strategy 2 serves women at over 200 health care sites in areas with high rates of preterm birth and infant mortality across 32 states including Puerto Rico and the District of

Columbia. These health care sites comprise a wide range of health care providers and organizations, across rural and urban areas, including universities, hospital systems, community health centers, and nonprofit health organizations.

Enrollments in Strong Start Strategy 2 have increased as the model has progressed. As of September 30, 2016 approximately 44,800 Medicaid and CHIP-eligible women, have enrolled in Strong Start Strategy 2.

Strong Start Strategy 2 began its fourth performance year in February 2016. The model is scheduled to run through February 2018.

Highlights from descriptive results for Strong Start Strategy 2 demonstrate improved participant outcomes. For example, by the end of the second quarter of 2015, women being served by Strong Start Strategy 2 have had lower than average Cesarean section rates, higher rates of vaginal birth after Cesarean section (VBAC), higher rates of breastfeeding, and lower rates of preterm birth by race and ethnicity when measured against national benchmarks. Beneficiaries express overwhelming satisfaction with the prenatal care they are receiving under Strong Start Strategy 2.

For more information, see the [Strong Start for Mothers and Newborns Webpage](#).

The Strong Start for Mothers and Newborns Strategy 2 Year 1 evaluation report can be accessed [here](#).

The Strong Start for Mothers and Newborns Strategy 2 Year 2 evaluation reports (2 volumes) can be accessed at the following links: [Volume 1](#) and [Volume 2](#).

4. Beneficiaries and Individuals Included in CMS Innovation Center Activities

Table 2: Estimated number of beneficiaries and individuals included, or projected to be included in models authorized under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). A comprehensive listing of all initiatives currently administered by the CMS Innovation Center is contained in the Appendix.

BENEFICIARIES AND INDIVIDUALS CURRENTLY OR PREVIOUSLY INCLUDED IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2016)		
INITIATIVE		RANGE OF IMPACT

	BENEFICIARIES AND INDIVIDUALS*	
Accountable Health Communities Model	Data Not Yet Available ⁺⁺	
ACO Investment Model	422,088	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Advance Payment ACO Model	276,000	This model ended on December 31, 2015 and included: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Bundled Payments for Care Improvement Model (Four Models)	153,358	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Comprehensive Care for Joint Replacement Model	56,794	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Comprehensive End Stage Renal Disease Care Model	19,663	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Comprehensive Primary Care Initiative	3,105,826	This is a multi-payer model that includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (288,869) • Medicaid beneficiaries (78,681) • Medicare-Medicaid enrollees (38,276) • Individuals with private insurance (2,700,000)
Comprehensive Primary Care Plus (CPC+) Model	Data Not Yet Available ⁺⁺	
Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model (Four Models)	Data Not Yet Available ⁺⁺	
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	207,074	This model concluded on October 31, 2014 and included: <ul style="list-style-type: none"> • Medicare FFS beneficiaries • Medicare-Medicaid enrollees

⁺⁺ Model is pre-operational.

⁺⁺ Model is pre-operational.

Health Care Innovation Awards Round One	268,147	This number includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (120,707) • Medicaid beneficiaries (49,064) • Medicare-Medicaid enrollees (6,335) • Medicare Advantage beneficiaries (30,078) • CHIP beneficiaries (187) • Individuals with private insurance (61,776)
Health Care Innovation Awards Round Two	308,362	This number includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (8,991) • Medicaid beneficiaries (221,939) • Medicare-Medicaid enrollees (59,714) • Medicare Advantage beneficiaries (5,633) • CHIP beneficiaries (5,857) • Individuals with private insurance (6,228)
Health Care Payment Learning and Action Network	Not Applicable**	
Home Health Value-Based Purchasing Model	Not Applicable***	
Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents (Two Phases Counted as Two Models)	14,174~	This number includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (3,657) • Medicaid beneficiaries (2,226) • Medicare-Medicaid enrollees (8,291)
Maryland All-Payer Hospital Model	6,109,120	This is a multi-payer model that includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (856,526)

** This is a national quality improvement initiative that includes indirect beneficiaries only.

*** This is a quality improvement initiative being conducted in 9 Model states without direct beneficiary participants.

~ This number represents Phase 1 only as Phase 2 data is not yet available.

		<ul style="list-style-type: none"> • Medicaid beneficiaries (1,262,198) • Medicare-Medicaid enrollees (93,228) • Individuals with private insurance (3,897,168)
Medicaid Innovation Accelerator Program	Not Applicable**	
Medicare Advantage Value-Based Insurance Design Model	71,000 [§]	
Medicare Care Choices Model	458	This model number includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Medicare Diabetes Prevention Program Expanded Model	Data Not Yet Available ⁺⁺	
Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals	412,000	This model includes: <ul style="list-style-type: none"> • Medicare-Medicaid enrollees
Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy	359	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport Model	3,106	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Million Hearts®	Not Applicable**	
Million Hearts®: Cardiovascular Disease Risk Reduction Model	3,300,000 [§]	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Next Generation ACO Model	499,386	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
Oncology Care Model	48,750	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (43,760) • Medicare-Medicaid enrollees (4,990)

[§] Projected.

⁺⁺ Model is pre-operational.

^{**} This is a national quality improvement initiative that includes indirect beneficiaries only

Part D Enhanced Medication Therapy Management (MTM) Model	1,600,000 [§]	
Partnership for Patients	Not Applicable**	
Pioneer Accountable Care Organization Model	366,794	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries
State Innovation Models Round One (data is self-reported by states)	3,508,266 ^ℵ	This model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (113,160) • Medicaid beneficiaries (2,212,741) • Individuals with private insurance (1,182,365)
State Innovation Models Round Two (data is self-reported by states)	2,259,884 ^{ℵℵ}	These model includes: <ul style="list-style-type: none"> • Medicare FFS beneficiaries (66,115) • Medicaid beneficiaries (1,964,071) • Medicare Advantage beneficiaries and individuals with private insurance (100,000) • Individuals with private insurance (82,794) • State employees (46,904)
Strong Start for Mothers and Newborns, Strategy One	Not Applicable**	
Strong Start for Mothers and Newborns, Strategy Two	42,408	This model includes: <ul style="list-style-type: none"> • Medicaid beneficiaries (40,374) • CHIP beneficiaries (2,034)

^ℵ This estimate was compiled using state-reported data from states participating in Round One of the State Innovation Models Initiative Model Test Awards.

^{ℵℵ} This estimate was compiled using state-reported data from states participating in Round Two of the State Innovation Models Initiative Model Test Awards.

** This is a national quality improvement initiative that includes indirect beneficiaries only.

**** The estimated total does not include the number of beneficiaries and individuals projected to be included in CMS Innovation Center models and initiatives.

Transforming Clinical Practice Initiative	Not Applicable**	
ESTIMATED TOTAL: 18,082,017****		

5. Payments Made on Behalf of Beneficiaries and Individuals Included in Models

Table 3 below outlines the estimated payments made on behalf of beneficiaries and individuals included in models authorized under section 1115A of the Social Security Act, as well as payments under Titles XVIII and XIX of the Social Security Act, and CMS Innovation Center obligations for each section 1115A model – from model inception to September 30, 2016 – included in this report to support each model and initiative. A comprehensive listing of all demonstrations and other initiatives administered by the CMS Innovation Center is included in the Appendix. In general, payments made under the applicable titles for services on behalf of beneficiaries in CMS Innovation Center models continue to be made in accordance with existing payment provisions. 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.

Table 3: As of September 30, 2016, estimates of payments made to model participants (including health care providers, states, conveners, and others); shared savings or other payments under Title XVIII or XIX made on behalf of beneficiaries; and other CMS Innovation Center funds obligated to support model development and testing.

ESTIMATED PAYMENTS*			
INITIATIVE	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Accountable Health Communities Model	Payments Not Yet Made	Not Applicable	Obligations Not Yet Made

* This table does not include administrative costs that are not associated with specific models or initiatives.

ACO Investment Model	\$51,197,666	\$10,861,491	\$10,752,605
Advance Payment ACO Model	\$67,801,572 ^{§§}	\$110,060,532 ^{***}	\$6,012,339
Bundled Payments for Care Improvement (Four Models)	Not Applicable	Data Not Yet Available	\$77,081,120
Comprehensive Care for Joint Replacement Model	Not Applicable	Payments Not Yet Made	\$25,662,461
Comprehensive End Stage Renal Disease Care	Not Applicable	Payments Not Yet Made	\$56,532,048
Comprehensive Primary Care Initiative	\$293,367,480	\$602,735	\$103,646,769
Comprehensive Primary Care Plus Model	Not Applicable	Payments Not Yet Made	\$66,664,548
Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model (Four Models)	Not Applicable	Payments Not Yet Made	\$335,836
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	\$45,967,680	Not Applicable	\$24,032,862
Health Care Innovation Awards Round One	\$871,891,954	Not Applicable	\$95,494,415

^{§§} Payments made to model participants in the Advance Payment ACO Model represent the advance payments given to ACOs as part of the model, which were distributed under the authority of section 1115A of the Social Security Act.

^{***} Payments to participants in the Advance Payment ACO and ACO Investment Models under Title XVIII or XIX were distributed as shared savings payments under the authority of the Medicare Shared Savings Program. These payments are net of recoupments.

Health Care Innovation Awards Round Two	\$345,462,874	Not Applicable	\$52,234,139
Health Care Payment Learning and Action Network	Not Applicable	Not Applicable	\$11,735,788
Home Health Value-Based Purchasing Model	Not Applicable	Not Applicable	\$18,002,566
Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents (Two Phases Counted as Two Models)	\$111,521,637	Not Applicable	\$31,923,486
Maryland All-Payer Model	Not Applicable	Not Applicable	\$12,551,678
Medicaid Innovation Accelerator Program	Not Applicable	Not Applicable	\$39,369,550
Medicare Advantage Value-Based Insurance Design Model	Not Applicable	Not Applicable	\$8,406,158
Medicare Care Choices Model	Not Applicable	Payments Not Yet Made	\$16,474,439
Medicare Diabetes Prevention Program (expanded from the YMCA model test in the Health Care Innovation Awards, [the “YMCA Diabetes Prevention Program”])	Not Applicable	Payments Not Yet Made	Obligations Not Yet Made

Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals	\$94,140,631	\$7,200,000	\$156,214,789
Medicare Prior Authorization Model: Non-Emergent Hyperbaric Oxygen Therapy	Not Applicable	Not Applicable	\$5,688,132
Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport Model	Not Applicable	Not Applicable	\$28,941,418
Million Hearts®	Not Applicable	Not Applicable	Not Applicable
Million Hearts®: Cardiovascular Disease Risk Reduction Model	Payments Not Yet Made	Payments Not Yet Made	\$13,818,904
Next Generation ACO Model	Not Applicable	\$11,778,620	\$44,511,146
Oncology Care Model	Not Applicable	Payments Not Yet Made	\$58,292,624
Part D Enhanced Medication Management Therapy (MTM) Model	Not Applicable	Payments Not Yet Made	\$10,721,155
Partnership for Patients	Not Applicable	Not Applicable	\$570,925,220
Pioneer Accountable Care Organization Model	\$16,268	\$244,446,885	\$113,126,910

Proposed Medicare Part B Drug Payment Model (this model will not be implemented)	Payments Not Yet Made	Payments Not Yet Made	\$2,700,000 ¹⁹
State Innovation Models Round One	\$278,309,831	Not Applicable	\$48,371,485
State Innovation Models Round Two	\$332,778,386	Not Applicable	\$40,923,818
Strong Start for Mothers and Newborns	\$38,373,162	Not Applicable	\$57,834,856
Transforming Clinical Practice Initiative	\$301,156,553	Not Applicable	\$27,588,820
ESTIMATED TOTALS:	\$2,831,985,694	\$384,950,264	\$1,836,572,086

Note: The column titled “CMS Innovation Center payments made to model participants” reflects payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through CMS Innovation Center funds as provided under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). These payments were made by September 30, 2016.

Note: The column titled “Payments under Title XVIII or XIX made for services on behalf of beneficiaries” 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 Pioneer ACO Model) include opportunities to share in the savings that health care providers generate for Medicare through payment 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.

Note: The column titled “Other CMS Innovation Center funds obligated to support model development and testing” reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2016, September 30, 2016, such as contract awards for administrative and evaluation obligations, but excluding payments listed in other columns.

6. Results and Recommendations

Results from evaluations

¹⁹ The Proposed Medicare Part B Drug Payment Model will no longer be implemented. Roughly \$100,000 of the \$2,700,000 listed here has already been paid to contractors. CMS is in the process of recovering unspent balances from this obligation, pursuant to CMS financial and contractual requirements and processes.

Interim results from some of the first models to be implemented under the authority of Section 1115A of the Social Security Act, namely Partnership for Patients, the Pioneer ACO Model, and the Health Care Innovations Awards Round One (including the Medicare Diabetes Prevention Program), have been included with their respective model descriptions in this report. The CMS Innovation Center will conduct summative evaluations of each model, generally on an annual basis. As they become available, evaluation results will be included in future Reports to Congress, and will inform recommendations regarding model expansions or legislative action.

As noted previously in this Report to Congress, a number of CMS Innovation Center models build upon lessons learned from earlier model tests and a growing evidence base in care delivery and payment research. These models include the Oncology Care Model (OCM), the Comprehensive Care for Joint Replacement Model (CJR), the ACO Investment Model, the Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents Phase 2, the Next Generation ACO Model, and the Comprehensive Primary Care Plus Model (CPC+). Such initiatives are designed to gather more focused, valid, and substantive data in support of specific innovations from precursor model tests that showed promise of reducing cost and improving the quality of care.

Because most model tests require, at a minimum, 4 years to test and formally evaluate, many of the payment and service delivery models and initiatives to speed the adoption of best practices that have been announced by the CMS Innovation Center have not completed their respective periods of performance. Recent model tests and initiatives are still in the early stages of implementation. Therefore, the findings from summative evaluations needed to assess the impact of several new payment and service delivery models are not available. Caution is urged in the interpretation of preliminary findings based on limited data from the early stages of model implementation.

Two model tests, the Pioneer ACO Model and the Health Care Innovation Awards Diabetes Prevention Program, have been determined by the Secretary to be eligible for expansion.

Recommendations for legislative action

This report conforms to the requirements of section 1115A(g). Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President’s budget request.

The table below provides hyperlinks to publicly released evaluation reports.

PUBLICLY RELEASED EVALUATION REPORTS	
INITIATIVE	REPORT
Bundled Payments for Care Improvements (Four Models)	Model 1: Year 1 evaluation report

	Models 2-4: Year 1 and Year 2 evaluation reports
Comprehensive Primary Care Initiative	Year 1 , Year 2 , and Year 3 evaluation reports
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	Year 1 and Year 2 evaluation reports
Health Care Innovation Awards (Two Rounds Counted as Two Models)	Round One: Year 1 and Year 2 evaluation reports Round Two: Year 1 evaluation report
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Two Phases Counted as Two Models)	Phase 1: Year 3 evaluation report
Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals	Early Implementation Report Washington demonstration: Preliminary Findings and First Annual Report Massachusetts demonstration: First Annual Report Minnesota demonstration: First Annual Report
Partnership for Patients	First Evaluation Report Second Interim Evaluation Report ²⁰
Pioneer ACO Model	Year 1 and Year 2 evaluation reports
State Innovation Models Initiative (Two Rounds Counted as Two Models)	Model Design and Pre-Test States, Round One: Final report Model Test, Round One: Year 1 and Year 2 evaluation reports
The Strong Start for Mothers and Newborns Strategy 2	Year 1 evaluation report

²⁰ The second interim evaluation report for the Partnership for Patients was released in December 2016.

	Year 2 evaluation reports (2 volumes): Volume 1 and Volume 2
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7. Conclusion

Since the last Report to Congress, the CMS Innovation Center, in accord with its legislative charge, has continued to develop and test a broad range of new payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries. From October 1, 2014 to September 30 2016, the CMS Innovation Center has announced or tested 39 models and initiatives intended to achieve better care, better health, and lower costs for Medicare, Medicaid, and CHIP beneficiaries.

In September of 2016, the Congressional Budget Office (CBO) testified before the United States House of Representatives Committee on the Budget that the CMS Innovation Center’s activities are expected to reduce federal spending by roughly \$34 billion from 2017 through 2026. For more information, see the CBO testimony [here](#).²¹

The evaluation of model tests is driven by the CMS Innovation Center’s Research and Rapid Cycle Evaluation Group, which reviews the program design, research methodology, and the evaluability of all proposed models and 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.

Collectively, the CMS Innovation Center’s efforts align with the Administration’s Delivery System Reform goals of tying 30 percent of Medicare fee-for-service payments to quality or value through alternative payment models by the end of 2016 and 50 percent by 2018. HHS met the 30 percent goal for 2016 by March, nearly a year ahead schedule. In addition, among those LAN participants who have agreed to track their health care payments, 23 percent of those health care payments flowed through alternative payment models in 2015.

Delivery system transformation has also been supported by the creation of the LAN. Through the LAN, HHS is working with private payers, employers, consumers, health care providers, states and state Medicaid programs, and other partners to align development of alternative payment models to improve the quality and value of health care and to increase the use of alternative payment models in their programs. To date, more than 47,000 individual patients, public and private payers, purchasers, health care providers, consumers, and states have registered to participate in the LAN, including more than 610 organizations. As of September 30, 2016, LAN activities have the potential to inform the ways in which health care providers

²¹ The testimony indicates that the reduction in federal spending is expected to come almost entirely from the Medicare program.

provide value-based care to 128 million Americans, approximately 43 percent of the covered population. LAN participants include 26 commercial health insurance plans, 23 Medicare Advantage plans, 28 Medicaid managed care plans, and 2 state Medicaid offices.

In addition, the CMS Innovation Center has played an important role in developing the proposed rule and the final rule to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 through the Quality Payment Program. These provisions include streamlining multiple quality reporting programs into one new system known as the Merit-based Incentive Payment System (MIPS), providing incentives for sufficient participation in Advanced Alternative Payment Models (Advanced APMs), as well as developing new Physician-Focused Payment Models (PFPMs). On October 14, 2016 and following the review of numerous comments from the public, the Department issued a final rule with comment period to implement the Quality Payment Program.

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 a combined 18 million CMS beneficiaries and individuals with private insurance have been impacted by, have received care, or will soon be receiving care furnished by the more than 207,000 health care providers participating in CMS Innovation Center payment and service delivery models and initiatives.²² For purposes of this report, CMS beneficiaries include individuals with coverage through Medicare FFS, Medicaid, Medicare-Medicaid enrollees, CHIP, and Medicare Advantage.

In an effort to more fully represent the scope of CMS's work on Delivery System Reform and multi-payer alignment, the CMS Innovation Center is reporting the number of CMS beneficiaries and individuals with private insurance impacted by CMS Innovation Center models and initiatives. This approach requires more explicitly listing the different payers supporting these models, as well as aggregating the populations served by all participating payers.

In addition, the Shared Savings Program (which is a statutorily mandated ACO program rather than a CMS Innovation Center model test), serves over 7.7 million beneficiaries across more than 430 Medicare ACOs. Therefore, in total there are 25.7 million Americans served by CMS Innovation Center models and the Shared Savings Program.²³

²² This does not include the number of beneficiaries touched by the Transforming Clinical Practice Improvement Initiative.

²³ The Shared Savings Program is a statutorily mandated ACO program administered by CMS, however it is not a CMS Innovation Center model test authorized under section 1115A of the Act. This number combines the number of beneficiaries and health care providers in the Shared Savings Program with the number of beneficiaries, individuals, and health care providers in CMS Innovation Center models and initiatives. Data on Shared Savings Program can be accessed [here](#).

Because a number of these 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. The efforts of the CMS Innovation Center represent important steps forward in the transformation of the health care system. Models underway and in development will help health care providers, payers, states, and other stakeholders achieve a system in which beneficiaries, and eventually all Americans, receive comprehensive, integrated care driven by evidence, performance, and improving outcomes.

8. Appendix: The CMS Innovation Center Program Portfolio

(All projects that were announced or had activity during the period of October 1, 2014 - September 30, 2016)

THE CMS INNOVATION CENTER PROGRAM PORTFOLIO		
Initiative Name	Description	Statutory Authority
Accountable Health Communities Model	Test whether increased awareness of and access to services addressing health-related social needs will impact total health care costs and improve health for Medicare and Medicaid beneficiaries in targeted communities.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
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.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Advance Payment ACO Model	Prepayment of expected shared savings to certain eligible ACOs to advance development of ACO infrastructure and care coordination.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Bundled Payments for Care Improvement (Four Models)	Evaluate 4 different episode payment models around inpatient hospitalization to incentivize care redesign Model 1: Retrospective Acute Care Model 2:	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

	Retrospective Acute Care Episode & Post-Acute Care Model 3: Retrospective Post-Acute Care Model 4: Prospective Acute Care	
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.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Comprehensive End Stage Renal Disease Care (ESRD)	An initiative to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Comprehensive Primary Care Initiative	A multi-payer model to test the effects of enhanced primary care services, including 24-hour access, care plans, and care coordination and payment reform.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Comprehensive Primary Care Plus Model	A multi-payer payment redesign that will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

<p>Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model (Four Models)</p>	<p>Designed to test bundled payments across a broad cross-section of hospitals to determine the models’ impact on quality of care, efficiency of care delivery, enhanced stakeholder engagement, and intra-organizational collaboration.</p> <p>The Cardiac Rehabilitation Incentive Payment Model will test the impact of providing an incentive payment to hospitals where beneficiaries are hospitalized for a heart attack or bypass surgery based on beneficiary utilization of cardiac rehabilitation and intensive cardiac rehabilitation services in the 90-day care period following hospital discharge.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration</p>	<p>Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals</p>	<p>Opportunity for states to partner with CMS to implement new integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Health Care Innovation Awards Round One</p>	<p>A broad appeal for innovations with a focus on developing the workforce for new care models.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>

<p>Health Care Innovation Awards Round Two</p>	<p>A second appeal for innovations with a focus on payment and system delivery reform in 4 categories for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Health Care Payment Learning and Action Network</p>	<p>A national learning collaborative to accelerate the adoption of APMs that includes private payers, purchasers, health care providers, consumers, and states.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Home Health Value-Based Purchasing Model</p>	<p>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.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Initiative to Reduce Avoidable Hospitalization among Nursing Facility Residents, Phase 1</p>	<p>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.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents, Phase 2</p>	<p>Initiative to test whether three new payments for nursing facilities and practitioners will further reduce avoidable hospitalizations, lower combined Medicare and Medicaid spending, and improve the quality of care received by nursing facility residents.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>

<p>Maryland All-Payer Model</p>	<p>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.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicaid Innovation Accelerator Program</p>	<p>Initiative providing states with technical assistance in such areas as data analytics, service delivery and financial modeling, quality measurement, and rapid cycle evaluation to accelerate the development and testing of state-led payment and service delivery innovations.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicare Advantage Value-based Insurance Design Model</p>	<p>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.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicare Care Choices Model</p>	<p>Designed to test whether Medicare (including dual-eligible) beneficiaries who meet Medicare (or Medicaid) hospice eligibility requirements will achieve patient-centered goals if they receive hospice services with continuation of curative services.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicare Diabetes Prevention Program (expanded from the YMCA model test in the Health Care Innovation Awards, [the “YMCA Diabetes Prevention Program”])</p>	<p>An evidence-based intervention targeted to individuals with pre-diabetes, who have blood sugar that is higher than normal but not yet in the diabetes range. The primary goal of the intervention is to reduce incidence of diabetes by achieving at least a 5 percent average weight loss among participants.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>

<p>Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy</p>	<p>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.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport Model</p>	<p>A prior authorization model for repetitive scheduled non-emergent ambulance transport in eight states and the District of Columbia to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Million Hearts®</p>	<p>National initiative to prevent 1 million heart attacks and strokes over 5 years; brings 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 is part of the infrastructure of the CMS Innovation Center.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)††††</p>
<p>Million Hearts®: Cardiovascular Disease Risk Reduction Model</p>	<p>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 CVD outcomes, and accountability for costs among Medicare beneficiaries.</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>
<p>Next Generation ACO Model</p>	<p>An initiative for ACOs experienced in managing the health of populations of patients. It allows participating health care providers to assume higher levels</p>	<p>Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)</p>

	of financial risk and reward than are available under the current Pioneer ACO Model or the Shared Savings Program. The goal of the Model is to test whether strong financial incentives for ACOs can improve health outcomes and lower expenditures.	
Oncology Care Model	Designed to test whether payment arrangements that include financial and performance accountability for episodes of care involving chemotherapy will incentivize physician-practices to provide higher quality, more coordinated oncology care at a lower cost to the Medicare Program.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Part D Enhanced Medication Management Therapy (MTM) Model	Designed to test whether providing selected basic, standalone PDPs with regulatory flexibility to design and implement innovative programs and aligning financial incentives can more effectively achieve key goals for MTM programs,	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Partnership for Patients	A public-private partnership working to improve the quality, safety, and affordability of hospital care for all Americans. The campaign has the ambitious goals of reducing preventable hospital-acquired conditions (HACs) by 40 percent and 30-day hospital readmissions by 20 percent.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Pioneer Accountable Care Organization Model	This model gives experienced health care organizations accountability for quality and cost outcomes for their Medicare patients. Doctors and hospitals who form Pioneer ACOs can share in savings generated for Medicare if they work to coordinate patient care, keep	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

	patients healthy and meet certain quality performance standards, or they may be required to pay a share of any losses generated.	
State Innovation Models Round One	Provides 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.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
State Innovation Models Round Two	Provides financial, technical, and other support to up to an additional 32 states to develop or implement state health care innovation plans.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Strong Start for Mothers and Newborns	<p>Strategy 1: Tests the effectiveness of shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women.</p> <p>Strategy 2: Tests and evaluates a new model of enhanced prenatal care to reduce preterm births (less than 37 weeks) in women covered by Medicaid and CHIP</p>	Section 1115A of the Social Security Act (section 3021 of the Affordable Care 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.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Mandated Demonstrations and Other Initiatives Authorized Under Various Statutes		
Community-Based Care Transitions Program (a part of the Partnership for Patients)	Reduce readmissions by improving transitions of high-risk Medicare beneficiaries from the inpatient hospital setting to home or other care settings.	Section 3026 of the Affordable Care Act

Private, For-Profit Demonstration Project for the Programs of All-Inclusive Care for the Elderly (PACE)	Study of the quality and cost of private, for-profit entities providing PACE program services under the Medicare and Medicaid programs.	Section 4804 of the Balanced Budget Act of 1997
Frontier Community Health Integration Program (F-CHIP)	Develop and test 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.	Medicare Improvements for Patients and Providers Act Section 123 and Affordable Care Act Section 3126
Graduate Nurse Education Demonstration	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.	Section 5509 of the Affordable Care Act
Independence at Home Demonstration	Home-based care for Medicare beneficiaries with multiple chronic conditions.	Section 1866E of the Social Security Act, as added by section 3024 of the Affordable Care Act
Intravenous Immune Globulin (IVIG) Demonstration	Evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIDD).	P.L. 112-242 Title I - Medicare IVIG Access Sec. 101
Medicaid Emergency Psychiatric Hospital Demonstration	Provides federal matching funds to States for emergency Medicaid admissions to private psychiatric hospitals for beneficiaries aged 21 to 64.	Section 2707(e) of the Affordable Care Act

<p>Medicaid Incentives for Prevention of Chronic Diseases Demonstration</p>	<p>Initiatives to provide incentives to Medicaid beneficiaries who successfully participate in a comprehensive, evidence-based, widely available, and easily accessible program, which has demonstrated success in helping individuals achieve ceasing use of tobacco, controlling or reducing their weight, lowering cholesterol, lowering blood pressure, and avoiding onset of diabetes, or in the case of a diabetic, improving the management of the condition.</p>	<p>Section 4108 of the Affordable Care Act</p>
<p>Medicare Health Care Quality Demonstration—Meridian</p>	<p>This project tests whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs.</p>	<p>Section 646 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003</p>
<p>Medicare Pilot Program For Asbestos Related Disease (Libby)</p>	<p>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.</p>	<p>Section 1881A of the Social Security Act (section 10323 of the Affordable Care Act)</p>
<p>Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration²⁴</p>	<p>State-led, multi-payer collaborations to help primary care practices transform into advanced primary care practices.</p>	<p>Section 402 of the Social Security Amendments of 1967 as amended (42 U.S.C. 1395b-1)</p>
<p>Rural Community Hospital Demonstration</p>	<p>Designed to test the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals.</p>	<p>Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as amended by sections 3123 and 10313 of the Affordable Care Act</p>

²⁴ Note: the Multi-Payer Advanced Primary Care Practice Demonstration concluded on December 31, 2014, however 6 of 8 sites were extended to December 31, 2016.

†††† The Million Hearts initiative does not receive any funding from the CMS Innovation Center.

9. Glossary of Acronyms

ACF	Administration for Children and Families
ACO	Accountable Care Organization
ADE	Adverse Drug Events
ADRC	Aging and Disability Resource Center
AHC	Accountable Health Communities Model
AMI	Acute Myocardial Infarction
AHRQ	Agency for Healthcare Research and Quality
AIM	ACO Investment Model
APCP	Advanced Primary Care Practice Demonstration
APM FPT	Alternative Payment Model Framework & Progress Tracking
APM	Alternative Payment Model
ASCVD	Atherosclerotic Cardiovascular Disease
BPCI	Bundled Payments for Care Improvement
CABG	Coronary Artery Bypass Graft
CAMH	CMS Alliance to Modernize Healthcare
CDC	Centers for Disease Control and Prevention
CEC	Comprehensive ESRD Care
CEP	Clinical Episodes Payment
CHIP	Children's Health Insurance Program
CJR	Comprehensive Care for Joint Replacement
CLABSI	Central Line-Associated Bloodstream Infections
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
COPD	Chronic Obstructive Pulmonary Disease
CPC	Comprehensive Primary Care Initiative

CPC+	Comprehensive Primary Care Plus Model
CVD CM	Cardiovascular Care Management
CR	Cardiac Rehabilitation
ECCP	Enhanced Care and Coordination Provider
EED	Early Elective Deliveries
EP	Eligible Professional
EPM	Episode Payment Model
ESCO ESRD	Seamless Care Organization
ESRD	End Stage Renal Disease
FFRDC	Federally Funded Research and Development Center
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FQHC ADCP	Federally Qualified Health Center Advance Primary Care Practice Demonstration
HEN	Hospital Engagement Network
HHA	Home Health Agency
HHA VBP	Home Health Agency Value-Based Purchasing
HHS	Department of Health and Human Services
HIV/AIDs	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HVBP	Hospital Value-Based Purchasing
IAP	Medicaid Innovation Accelerator Program
IPPS	Inpatient Patient Prospective Payment Systems
ICR	Intensive Cardiac Rehabilitation
LAN	Health Care Payment Learning and Action Network
LDO	Large Dialysis Organization
LEAPT	Leading Edge Advanced Practice Topics
LEJR	Lower Extremity Joint Replacements

MAC	Medicare Administrative Contractor
MACRA	Medicare Access and Chip Reauthorization Act of 2015
MA-VBID	Medicare Advantage Value-Based Insurance Design
MFFS	Managed Fee-for-Service
MIPS	Merit-Based Incentive Payment System
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Area
MS-DRG	Medicare Severity Diagnosis Related Group
MTM	Medication Therapy Management
NCQA	National Committee of Quality Assurance
NGACO	Next Generation ACO Model
NQS	National Quality Strategy
OCM	Oncology Care Model
ONC	Office of the National Coordinator of Health Information Technology
OPPS	Outpatient Prospective Payment Systems
PBP	Population-Based Payments
PBPM	Per-Beneficiary-Per-Month
PCMH	Patient-Centered Medical Home
PDPs	Prescription Drug Plans
PFP	Partnership for Patients
PFPM	Physician-Focused Payment Model
PTAC	Physician-Focused Payment Model Technical Advisory Committee
RAA	Readiness Assessment Survey
RFI	Request for Information
SDO	Small Dialysis Organization
SHIP	State Health Insurance Counseling and Assistance Program
SHFFT	Surgical Hip and Femur Fracture Treatment

SIM	State Innovation Models
TCPI	Transforming Clinical Practice Initiative
TIA	Transient Ischemic Attack
VAP	Ventilator Associated Pneumonia
VBAC	Vaginal birth after C-section