



2022
Report to
Congress



CENTER FOR MEDICARE AND MEDICAID INNOVATION

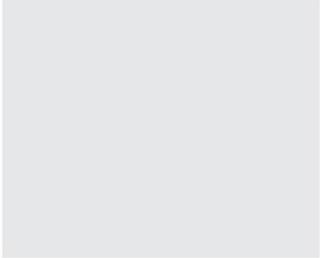


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The Center for Medicare and Medicaid Innovation

2022 REPORT TO CONGRESS

I. Executive Summary

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) for the purpose of testing “innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care” provided to individuals who receive benefits from Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).¹

Section 1115A(g) of the Social Security Act (Act) requires the Secretary of Health and Human Services 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. The CMS Innovation Center is submitting this sixth, biennial report covering model activities conducted between **October 1, 2020 and September 30, 2022** (the period of report). During the period of report, the CMS Innovation Center tested, announced, or issued Notices of Proposed Rulemaking for a total of 32 payment and service delivery models and initiatives under section 1115A authority. In addition, the CMS Innovation Center conducted six congressionally mandated or authorized demonstration projects. The CMS Innovation Center also continued to play a central role in the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

CMS estimates that during the period of this report more than 41,500,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 314,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.²

Driving Health System Transformation

In October 2021, CMS published a White Paper: *Driving Health System Transformation—A Strategy for the CMS Innovation Center’s Second Decade*³. In this paper, the CMS Innovation Center set out a vision for achieving equitable outcomes through high-quality, affordable, person-centered care. To achieve this vision, the CMS Innovation Center has established five strategic objectives: driving accountable care; advancing health equity; supporting innovation;

¹ Section 1115A appropriated \$5 million for fiscal year 2010 and provided a total of \$10 billion for fiscal years 2011–2019, in addition to \$10 billion for each 10-year fiscal period thereafter.

² The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests.

³ <https://innovation.cms.gov/strategic-direction-whitepaper>

addressing affordability; and creating partnerships to achieve system transformation. These strategic objectives guide the CMS Innovation Center’s model testing and priorities.

Moving forward, in addition to evaluating the success of model tests in terms of reductions in cost and improvements in the quality of care, the CMS Innovation Center will also assess model tests’ quality-related impacts on health equity, person-centered care, and health system transformation, in alignment with CMS-wide goals.

Spending and Quality

In alignment with its statutory authority, the CMS Innovation Center aims to test and expand models that have the potential to reduce program costs and improve health care quality for Medicare and Medicaid beneficiaries.

More specifically, over the past two years – between October 1, 2020–September 30, 2022, – CMS Innovation Center model tests have reported the following results in net cost savings and quality improvement. Examples include:

- In May 2021, the final evaluation report of the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Model indicated \$1 billion in total Medicare savings among Medicare beneficiaries with end stage renal disease and/or pressure ulcers over its first 20 quarters (beginning December 2014) relative to the comparison group, averaging a savings of \$381 per-beneficiary-per-quarter. The Secretary of HHS determined that the model met the statutory requirements for nationwide expansion in 2019⁴.
- In October 2020, the CMS Chief Actuary certified that the expansion of the Home Health Value Based Purchasing (HHVBP) Model, which had been implemented in nine randomly selected states, would reduce (or would not result in any increase in) net program spending. The fifth annual evaluation report, published in April 2022, showed cumulative net savings of \$949 million in the first five years of the model. The evaluation has shown that this value-based purchasing model has led to higher quality care in home health agencies within model states compared to home health agencies in non-model states, and to a reduction in unplanned hospitalizations and use of skilled nursing facilities in model states compared to non-model states. The HHVBP Expanded Model began its pre-implementation year on January 1, 2022.
- The Medicare Care Choices Model (MCCM) offered eligible beneficiaries the option to receive hospice services while continuing to receive treatment for their terminal condition. The fourth annual evaluation, released in April 2022, showed substantial reductions in total Medicare spending for deceased MCCM enrollees over four years.

⁴ The Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport Model was expanded under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) authority.

Total Medicare expenditures decreased by 14 percent, generating \$41.5 million in gross Medicare spending reductions and \$33.2 million in net savings after accounting for provider payments. This was largely achieved by reducing inpatient care through increased use of the Medicare hospice benefit. MCCM also improved the quality of end-of-life care. Beneficiaries in MCCM were 26 percent less likely to receive an aggressive life-prolonging treatment in the last 30 days of life and spent six more days at home in the period between MCCM enrollment and death. However, a large number of participants exited the model (60 percent) with enrollment concentrated in a small number of hospices. This, coupled with the small number of beneficiaries served by the model (representing less than one percent of those who lived near participating hospices and met the claims-based MCCM eligibility criteria), limits the generalizability of the model to the broader CMS beneficiary population.

II. Introduction

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by statute in 2010 for the purpose of testing “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” provided to individuals who receive benefits from Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP).⁵ Section 1115A(g) of the Social Security Act (Act) requires the Secretary of the Department 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. The CMS Innovation Center is submitting this sixth, biennial report covering model activities conducted between **October 1, 2020 and September 30, 2022** (the period of report). The Secretary has the authority under section 1115A(c) of the Social Security Act to expand through rulemaking the duration and scope of a model being tested, including implementation on a nationwide basis if the model meets certain statutory criteria.

In the last decade, the CMS Innovation Center has launched more than 50 model tests, with approximately 33 models operational (either launched or continued) during the period of report. These model tests have studied potential improvements in health care payment and delivery for advanced primary care, episode-based care, accountable care, state-based transformation efforts, population health, and health care for specific populations, such as Medicare beneficiaries with end-stage renal disease (ESRD), diabetes, and heart disease.

Also, the CMS Innovation Center is responsible for implementing and evaluating five specific demonstration projects authorized by other statutes. The findings from these demonstrations may inform changes in CMS policies, as well as the development and testing of new models, if appropriate.

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

Since the inception of the CMS Innovation Center, six model tests have delivered **statistically significant savings, net of any incentive or operational payments**, namely: the Pioneer ACO Model; the ACO Investment Model (AIM); the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT); the Home Health Value-Based Purchasing (HHVBP) Model; the Maryland All-Payer (MDAPM) Model; and the Medicare Care Choices Model (MCCM).

Further, two of these models also showed significant improvements in quality; the HHVBP Model exhibited a continued trend with significant improvement in Total Performance Scores⁶ relative to a comparison group⁷, and MCCM showed significant improvements in the quality of care received⁸ at the end of life.

To date, four CMS Innovation Center model tests have met the criteria to be eligible for expansion⁹ in paragraphs (1) through (3) of section 1115A(c), namely: The Pioneer ACO Model (as tested in its first two years), the Health Care Innovation Award’s Y-USA Diabetes Prevention Program (DPP) model test, the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Model, and the Home Health Value Based Purchasing (HHVBP) Model.

Since the CMS Innovation Center’s inception, several models have shown improvements in quality or reduced low value care that generated gross, but not net, savings. These models include but are not limited to the following:

- The Comprehensive Care for Joint Replacement (CJR) Model;¹⁰
- The Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model;
- The Oncology Care Model (OCM); and
- The Million Hearts®: Cardiovascular Disease Risk Reduction Model.

Despite having demonstrated improvements in quality and gross savings, these models did not meet the eligibility requirements for “expansion of successful payment models” under section 1115A(c) of the Act. However, even when a model ends, it continues to have a meaningful impact on the CMS Innovation Center’s work, and longer-term goal of realizing a health care

⁶ The Total Performance Score (TPS) is an aggregate quality score used to compute payment adjustments for home health agencies (HHAs) under the HHVBP Model.

⁷ <https://innovation.cms.gov/data-and-reports/2022/hhvbp-fifthann-rpt>

⁸ <https://innovation.cms.gov/data-and-reports/2022/mccm-fourth-annrpt>

⁹ While the Medicare Care Choices Model generated net savings, low model uptake inhibited the model’s ability to generalize across care settings; for this reason, expansion via rulemaking was not pursued.

¹⁰ The Comprehensive Care for Joint Replacement Model evaluation showed a reduction in gross Medicare spending of \$251.8 million through the first four years of the model test (2016–2019). After deducting shared savings payments, the net Medicare savings were \$21.4 million, but these savings were not statistically significant.

system that achieves equitable outcomes through high quality, affordable, person centered care. Successful elements and other lessons from an ended model often shape subsequent model designs. And, where possible, the CMS Innovation Center helps inform participants in models that are reaching their conclusion of opportunities with other models tested by the Center. This new model may be the successor to the model in which they took part or another model testing ways to support their patients' needs. Further, CMS Innovation Center Accountable Care Organization (ACO) models continue to inform the development of policies under the Medicare Shared Savings Program, a statutory national, voluntary program implemented by CMS that offers providers and suppliers (including physicians, hospitals, and others involved in patient care) an opportunity to create an ACO.

A. The CMS Innovation Center's Strategy Refresh

To inform its Strategy Refresh,¹¹ the CMS Innovation Center examined policy and operational lessons from model tests; performed a literature review; conducted interviews with health policy experts, providers, beneficiary advocates, and other stakeholders; and convened focus groups with agency leaders. Through this process, the CMS Innovation Center identified key lessons learned, as well as next steps for addressing not only health costs and quality of care, but also the impacts of inequity and health disparities. Among the lessons learned from the internal review were the following issues and challenges:

- 1. The full diversity of beneficiaries in Medicare and Medicaid is not reflected in many model tests to date.** Medicare-focused model tests have limited reach to Medicaid beneficiaries and safety net providers. Additionally, many models have not systematically evaluated impacts across beneficiaries with different demographic characteristics.
- 2. Complex payment policies and model overlap rules can sometimes result in conflicting or opposing incentives for health care providers.** Participants face difficulty in joining or continuing in model tests due to investments required for care transformation, complexity of model payment and/or participation parameters, administrative burden, and lack of clarity on long-term strategy for models. Complexity in model test design impedes scalable transformation.
- 3. Accepting downside risk is challenging if providers lack care management tools, sufficient protection against the financial impact of beneficiaries with unpredictably high-costs; and appropriate payment and regulatory flexibilities.** Significant infrastructure investments are often needed to participate in model tests, including electronic health record enhancements, new staff, and data analytic support, especially for safety net providers and those serving Medicaid beneficiaries.
- 4. Certain model test design features, including in some cases voluntary participation, can limit potential savings and impede evaluation due to selection**

¹¹ <https://innovation.cms.gov/strategic-direction-whitepaper>

- bias.** As a result, multi-payer model tests designed for Medicare providers have not consistently led to high levels of participation from Medicaid and commercial payers.
- 5. Many financial benchmarks and risk adjustment methodologies have created opportunities for potential gaming and upcoding among participants—and have therefore reduced savings for Medicare.**
 - 6. Model testing has been focused on meeting the statutory standards for certification and expansion. Transformation can be limited to the duration of the model test.**

In response to these insights, the CMS Innovation Center plans to ensure health equity is embedded in every model test as a key component of quality improvement; streamline the model test portfolio and reduce complexity and overlap to help scale what works; provide tools to support transformation in care delivery that will assist providers in assuming financial risk; design model tests to ensure broad health care provider participation in model tests; redesign financial benchmarks and risk adjustment to improve model test effectiveness, and align models across CMS programs, payers and state to accelerate transformation. These steps will be integral to continuous improvement in model testing, as well as the CMS Innovation Center’s efforts to achieve its new strategic vision for the next decade.

A New Vision for the CMS Innovation Center’s Next Decade

In October 2021, CMS published a White Paper, *Driving Health System Transformation—A Strategy for the CMS Innovation Center’s Second Decade*¹². In this paper, the CMS Innovation Center outlined its new vision: a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. This goal aligns with the CMS broader strategy to serve the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes.

To achieve the CMS Innovation Center’s new vision, a strategic refresh comprised of five objectives was launched: driving accountable care; advancing health equity; supporting innovation; addressing affordability; and creating partnerships to achieve system transformation.

¹² <https://innovation.cms.gov/strategic-direction-whitepaper>



These strategic objectives guide the CMS Innovation Center’s model testing priorities and outline parameters to measure their respective impacts:

1. Driving Accountable Care

Aim: Increasing the number of beneficiaries in a care relationship with accountability for quality and total cost of care.

Measures of Progress:

- All Medicare fee-for-service (FFS) beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.
- The vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.

2. Advancing Health Equity

Aim: Embedding health equity in every aspect of CMS Innovation Center models and increasing focus on underserved populations.

Measures of Progress:

- All new models will require participants to collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health; this data, including protected health information, will be collected in a manner which complies with Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws.
- All new models will include patients from diverse backgrounds, including underserved populations such as rural and historically disadvantaged communities, and safety net

providers, such as community health centers and disproportionate share hospitals.

- All new models will identify areas for reducing inequities at the population level, such as avoidable admissions, and set targets for reducing those inequities.

3. Supporting Care Innovations

Aim: Leveraging a range of supports that enable integrated, person-centered care—such as actionable, practice-specific data, technology, dissemination of best practices, peer-to-peer learning collaboratives, and payment flexibilities.

Measures of Progress:

- All new accountable care and specialty care model and demonstration tests will set targets designed to improve performance of model participants on patient-reported measures such as health and functional status, or a subset of Consumer Assessment of Healthcare Providers and Systems (CAHPS®, a registered trademark of the Agency for Healthcare Research and Quality) measures that assess various domains (for example, communication, access to care) about a patient’s experience with care provided in different settings (for example, hospital, clinician office).
- To the extent possible, all new applicable models and demonstrations will include at least two patient-reported measures as part of the performance measurement strategy for the CMS Innovation Center with at least one of the two being an experience of care survey such as CAHPS.

4. Improving Access by Addressing Affordability

Aim: Pursuing strategies to address health care prices, affordability, and reduce unnecessary or duplicative care.

Measures of Progress:

- Model tests will set targets to reduce the percentage of beneficiaries that forego care due to cost by 2030.
- All models will consider and include opportunities to improve affordability of high-value care for beneficiaries.

5. Creating Partnerships to Achieve System Transformation

Aim: Aligning priorities and policies across CMS and aggressively engage payers, purchasers, states, and beneficiaries to improve quality, to achieve equitable outcomes, to reduce health care costs.

Measures of Progress:

- Where applicable, all new model tests will make multi-payer alignment available by 2030.
- All new model tests will collect and integrate patient perspectives across the life cycle.

These aims and measures are being incorporated into all new model tests and into ongoing redesign work on continuing model tests.

B. Partnerships with Other CMS Components and Federal Agencies

Section 1115A(a)(3) of the Act 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 consulted and worked with components across CMS, the Department of Health and Human Services (HHS), states, and other Federal agencies since its inception. These partnerships are crucial to drive health system transformation, including the adoption of the CMS Innovation Center’s lessons learned into the Medicare and Medicaid programs. Moreover, such partnerships may improve data collection and analysis used to develop models and new initiatives, as well as make changes to existing programs. Federal collaboration can also help examine ways that Federal investments to address social needs can be used more effectively with Medicare and Medicaid payments to achieve improved and more sustainable outcomes.

Throughout model development and improvement, the CMS Innovation Center has routinely collaborated with other CMS components; namely, the Center for Medicare, the Center for Medicaid and CHIP Services, and the Center for Clinical Standards and Quality. The CMS Office of the Actuary reviews model test proposals and implemented models’ evaluations. And, for a model to be expanded under section 1115A(c) of the Act, section 1115A(c)(2) of the Act requires that the Chief Actuary of CMS certify that such expansion would reduce (or not result in any increase in) net program spending under applicable subchapters.

This statutorily required approach not only reduces costs and avoids duplicative effort, it leverages the resources needed to develop and test models of improved care delivery and payment, particularly when expertise required for such a model test is already available elsewhere within CMS or in another agency.

In some cases, for some models tested under the CMS Innovation Center’s authorizing statute, other CMS components are involved throughout the model test process, from initial design through implementation and even expansion. Examples of such models tested within the period of report include, but are not limited to:

- The Center for Clinical Standards and Quality is largely overseeing expansion of the Home Health Value-Based Purchasing (HHVBP) Model, and leads the development of quality measures in various CMS Innovation Center models and pay-for-performance programs;

- The Center for Medicaid and CHIP Services partners with the CMS Innovation Center in managing models that focus on Medicaid beneficiaries, such as the Integrated Care for Kids (InCK) Model and Maternal Opioid Misuse (MOM) Model, and also supports CMS Innovation Center and its model participants in achieving Medicaid alignment for non-Medicaid specific models;
- The Center for Medicare partners with the CMS Innovation Center in shared learning regarding the Medicare Shared Savings Program and in support of the Emergency Triage, Treat, and Transport (ET3) and Medicare Advantage (MA) Value-Based Insurance Design (VBID) Models;
- The CMS Office of Minority Health collaborated with the CMS Innovation Center on the development of the ACO REACH Model, which is a redesign of the GPDC Model;
- The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office), which manages the Medicare-Medicaid Financial Alignment Initiative; and
- The Center for Program Integrity, which manages the Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Model.

In addition, the CMS Innovation Center has partnered with other Federal agencies to develop and improve its models and initiatives. Examples of these Federal agency partners include the Administration for Children & Families; the Administration for Community Living; the Agency for Healthcare Research and Quality; the Centers for Disease Control and Prevention; the Health Resources & Services Administration; the Office of Management and Budget, the Office of the Assistant Secretary for Health; the Office of the Assistant Secretary for Planning and Evaluation; the Office of the National Coordinator of Health Information Technology; and the Substance Abuse and Mental Health Services Administration within HHS; and also the Social Security Administration; and the Department of Housing and Urban Development.

C. Engaging Stakeholders

Stakeholder Engagement Activities in the Past Two Years

During the reporting period, the CMS Innovation Center has actively sought input from a broad array of external stakeholders to help: (1) identify promising new payment and service delivery models; (2) inform the design of model tests it is developing; (3) implement new model tests; (4) improve existing model tests; and (5) expand the adoption of alternative payment models (APMs).

The CMS Innovation Center invites and seeks specific input about the design of potential models through vehicles that are open to all stakeholders. These include notice-and-comment periods during rulemaking, model webinars with Question and Answer segments, office hours

during which model teams are available to answer questions, listening sessions, and “open door” virtual forums.

In addition, stakeholder input and guidance has been gathered through interviews and consultation with experts in the field. CMS Innovation Center staff have routinely met with health care innovators, clinicians, professional associations, beneficiary groups and advocates, subject matter experts, sister agencies, states, payers, and other stakeholders.

Following the launch of the CMS Innovation Strategy Refresh, the CMS Innovation Center has convened listening sessions to engage with innovators from around the country and get their perspectives on how the CMS Innovation Center can better address health equity, beneficiary needs, obstacles to participation in model and other critical issues.

The CMS Innovation Center has informed and interacted with people through its website, social media outreach, and an [email listserv](#). The CMS Innovation Center website averaged nearly 183,000-page views per month during the period of report, reflecting sustained stakeholder engagement. Each of these communication channels is continually updating innovators in the field about new funding and learning opportunities.

Stakeholder Engagement and the CMS Innovation Center’s Strategic Refresh

As part of its Strategic Refresh, the CMS Innovation Center has re-committed to increasing transparency and strengthening communication with stakeholders. To that end, the CMS Innovation Center hosted public events to gain perspective from an array of stakeholders about our vision for a health system that achieves equitable outcomes through high-quality, affordable, and person-centered care. Additional public events focused specifically on the aforementioned CMS Innovation Center’s strategic objectives.

Strategy Refresh Formative Communications Research Focus Groups (August 2021) – 67 participants: Health care administrators and health care providers participated in in-depth interviews where they provided insights on the Innovation Center’s communication of its strategy refresh and informed on how communications can engage its audience and minimize potential opposition to changes. Participants saw the communications as conveying positive ideas about value-based care. While they found the communications did not elicit negative reactions, they found they did not communicate how future models will minimize existing barriers. They saw participation in value-based care, including CMS models, as an important business decision, however, they noted that in order to participate, they need to see clear financial benefits and be reasonably confident that they can achieve program goals and benefits. The administrators and providers both hoped to better understand how the program goals will actually be put into practice, and how models can specifically benefit them and their organizations – both financially and as related to improving patient care.

A Strategy for the CMS Innovation Center’s Second Decade Webinar (October 20, 2021) – 2,000+ attendees: CMS Innovation Center Leadership announced the release of the Innovation

Center Strategy Refresh White Paper, discussed the CMS Innovation Center’s new vision for the next decade, and compiled attendees’ questions and feedback.

CMS Innovation Center Strategy Listening Session (November 18, 2021) – 1,000+ attendees: A panel of stakeholders including provider groups, health plans, and ACOs answered questions related to obstacles participating in value-based/accountable care models and potential improvements. Attendees expressed interest in understanding the Center’s plans to increase focus on downside risk arrangements, multi-payer alignment, and models that consider high-cost specialty care as well as learning about the future expansion of mandatory models that scale successful demonstrations, and models that address maternal and child health and the inclusion of palliative care patients in accountable care relationships. Attendees urged the CMS Innovation Center to consider social determinants of health (SDoH) within future model strategy, opportunities to improve integrated care for dually eligible beneficiaries, and inquired about the CMS Innovation Center plan to improve the collection and use of data to measure health equity. Attendees expressed interest in standardizing data and promoting interoperability to drive innovation, incorporating emerging tech to improve care, and planning for models to include telehealth and other flexibilities.

Roundtable on CMS Innovation Center Health Equity Strategy (December 8, 2021) – 1,000+ attendees: Industry leaders reviewed the CMS Innovation Center’s health equity strategy and discussed ways to eliminate health inequities, mitigate barriers to model participation and improve social needs data collection. Attendees noted a need to consider how health equity barriers can be present within current payment systems, urging the CMS Innovation Center to include emerging technology in future models to accelerate health equity, and asked about the standardization of SDoH data collection, measurement, and analysis as well as definitions used to inform the CMS Innovation Center’s health equity strategy. Attendees noted the need for the CMS Innovation Center to expand its partnerships with local, community-based organizations and to include broader ecosystem stakeholders in models to achieve better outcomes. Attendees also expressed a need for data technical assistance and other support to incentivize participation by health care providers that lack the resources to pursue a data strategy. Attendees emphasized the importance of Medicaid participation in innovative models, especially given the differences in investment and infrastructure across states. They also expressed an interest in model designs that include elements for funding social services and community resources and address considerations for disabilities and intersectional impacts.

Incorporating Beneficiary Perspectives into Model Testing, Implementation, and Evaluation Listening Session (February 9, 2022) – 700+ attendees: Patient advocacy groups, foundations, and research experts shared their insights into how the CMS Innovation Center can better incorporate beneficiary perspectives into model testing, implementation, and evaluation. Attendees requested more targeted learning materials to improve beneficiary engagement and suggested that the CMS Innovation Center attend community listening sessions to hear directly from beneficiaries. Attendees also asked for more information on how the CMS Innovation Center engages patients in decision-making. Participants suggested that the CMS Innovation

Center consider patient feedback through increased transparency around cost and quality, sharing that important costs are often excluded from the conversation around affordability. Feedback emphasized the importance of addressing patients' broader social needs and noted the need for greater accessibility of the CMS Innovation Center's communications materials. Attendees stated that the one-year timeframe to assess model return on investment is too short to demonstrate success. Attendees asked the CMS Innovation Center to share the detailed steps they are envisioning to make meaningful, long-term connections with communities and expressed that there are not sufficient data on some items related to affordability of care, and emphasized the importance of partnering with public and social health organizations.

Roundtable on Safety Net Provider Participation in CMS Innovation Center Models (March 16, 2022) – 600+ attendees: Stakeholders discussed how CMS can support safety net providers as they care for underserved communities and how to increase participation in value-based care models. Attendees expressed an interest in understanding how the CMS Innovation Center will define and measure health equity outcomes and success, and identified the need to include more funding to address SDoH. Attendees noted the need for CMS regulations to be more easily understood by patients and institutions. Participants asked whether the CMS Innovation Center will promote technology adoption among safety net providers and leverage Bureau of Primary Health Care (BPHC) workforce data to inform strategy. They expressed an interest in using ZIP Code and claims data to monitor and forecast care needed in rural communities, and emphasized the need for improving standardization of data to reduce administrative burden and improve the monitoring of real-time performance. Attendees suggested ways to promote universal safety net programs and integrate oral health services in APM design. They shared that financial sustainability and a steep learning curve are risk factors for model participation and recommended that glide paths beginning with upside risk would be most appealing to providers. Attendees noted the need for the CMS Innovation Center to consider monitoring the efficacy of chronic care management (CCM) and remote patient monitoring (RPM) programs in rural, underserved communities.

Value Based Insurance Design Model – Health Equity Incubation Program – Addressing Food and Nutritional Insecurity (March 31, 2022) – 370 attendees: During the second webinar in the Medicare Advantage (MA) Value Based Insurance Design (VBID) Model's Health Equity Incubation Program series, the VBID Model team at the CMS Innovation Center met with national leaders and participated in a discussion around pathways for addressing food and nutritional insecurity. This included strategies for health settings, benefit design model opportunities (including through the VBID Model), implementation challenges and successes, as well as data and evaluation strategies.

Medicare Advantage Value-Based Insurance Design Model (VBID) Beneficiary Roundtable (March 30, 2022) – Nine attendees: The CMS Innovation Center hosted a closed listening session with CMS team members and guest speakers to gather perspectives of experts on the VBID Model's Hospice Benefit Component, hear from beneficiary advocates about beneficiary experiences with serious illness care more broadly as well as changes in care

delivery, and understand what beneficiaries and their caregivers need most from providers in the health care system. Attendees shared that patients are unaware of the various conditions covered by hospice core services due to a perceived lack of standardized definitions for palliative care in Medicare. Further, attendees suggested the CMS Innovation Center consider language that is inclusive of patients' families and caregivers to promote family-centered care. Attendees recommended that the definitions used for palliative care in Medicare should be equitable and culturally-competent. Attendees also suggested that the CMS Innovation Center should consider that families are often unaware of caregiver burden they will experience with the limitations of hospice services, and model designs should promote referral sources with proper knowledge to help family caregivers understand the hospice and palliative care support options. Attendees suggested that the CMS Innovation Center create more accessible systems and explore existing quality measurements to build into the model design.

ACO REACH – Health Equity Webinar (April 5, 2022) – 950 registrants: The ACO REACH Model team hosted a webinar detailing five new model policies developed for performance year 2023 that promote health equity. Specifically, the health equity plan requirement for participants, health equity benchmark adjustment, health equity data collection requirement, nurse practitioner services benefit enhancement and health equity scoring methodology.

Strengthening Equitable Access to Advanced Primary Care Listening Session (April 26, 2022) – 400+ attendees: Patient advocacy groups, provider groups, foundations and research experts shared insights on advanced primary care, specifically challenges in primary care, advancing health equity to underserved populations, and improving coordination between primary and specialty care. Attendees expressed interest in understanding how CMS and primary care payment models can incentivize primary care providers (PCPs) to address SDoH and health equity, and how models can support PCPs working with rural and underserved communities. Attendees asked about the possibility of partnering with other agencies like HRSA on models and encouraged the CMS Innovation Center to promote multi-payer measure alignment across value-based care. They emphasized that independent practices will need support with scaling and standardizing data infrastructure across models and payers. Attendees asked about increasing payments for primary care, and future models that promote access to or reimburse PCPs for providing mental health and preventive services, including those delivered via telehealth. Participants inquired about the role of home-based primary care and Federally Qualified Health Centers (FQHCs) in future innovations, embedding navigation supports at all levels of care, and behavioral health integration in primary care. Attendees also noted the importance of measurements that are indicative of high-quality primary care and reduce administrative burden, and noted that change can be driven through incentivizing the identification and measurement of population health needs.

Value Based Insurance Design Model – Health Equity Incubation Program – Advancing Health Equity in Diabetes Care and Outcomes (June 30, 2022) – 512 attendees: The Medicare Advantage Value-Based Insurance Design (VBID) Model team and national leaders led a discussion on how VBID flexibilities are being leveraged to improve care and outcomes for

enrollees with diabetes as part of their Health Equity Incubation Program. This event began with an overview of the vital need and opportunity to improve care and outcomes for Medicare beneficiaries with diabetes as a means to improve health equity and beneficiary experience, and to prevent the burdensome and costly progression of complications. National experts presented the trends, economic and health burdens, and evidence-based strategies to improve glucose control and medication adherence, including meeting social needs related to food and nutritional security, transportation and drug affordability. A panel of leaders from Medicare Advantage Organizations (MAOs) discussed their programmatic strategies, successes and challenges in using VBID flexibilities to improve care and outcomes for their enrollees with diabetes.

Quality Payment Program Advanced Alternative Payment Model Incentives Listening Session (July 21, 2022) – ~700 attendees: Experts from APM-participating provider organizations, national provider associations, and specialty associations shared insights on the value of the five percent APM Incentive Payment authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as their perspectives on Advanced APM and MIPS participation in light of MACRA’s upcoming changes in incentives. Attendees shared concerns around the end of the APM Incentive Payment after payment year 2024, including the “gap year” in 2025 and the move to differential conversion factors beginning in 2026, and mentioned their efforts to promote to Congress the extension of such payments. Attendees also affirmed their belief in and commitment to APMs and value-based care and shared ideas about how they believe CMS might frame APMs going forward.

Medicare Advantage Outreach (Beneficiary Advocates and Industry) - Session 1 (July 21, 2022) – five attendees: Beneficiary advocacy organizations noted that patients are generally unaware of what is covered by hospice core services and how to seek care outside of it, and that families face significant caregiver burden. Attendees also stated that there is a strong belief that end-of-life care and serious illness care should not reduce the amount of concurrent care that a patient needs. Additionally, participants discussed the beneficiary and caregiver/family experience of care transitions, learning that dually eligible beneficiaries are more likely to face an additional burden of identifying ways to access hospice and palliative care, especially if language barriers exist. When understanding what makes in-network care successful, attendees noted that equity remains crucial to successful outcomes while taking into account critical cultural considerations as well as the potential differences amongst communities (for example rural.) These lessons reinforce CMS’ commitment to improving our current and future models and to ensuring that hospice and palliative care are accessible to all beneficiaries.

CMS Innovation Center’s Approach to Person Centered Care – ‘Engaging with Beneficiaries, Measuring What Matters’ Webinar (September 20, 2022) – 600+ attendees:

The CMS Innovation Center’s leadership hosted a webinar to discuss the CMS Innovation Center’s approach to models and innovations that support person-centered care. Specifically, the webinar discussed how the “Strategy Refresh” is building a more person-centered health system; how CMS Innovation Center model tests will incorporate patient perspectives across

the life cycle of models to ensure patient needs are met; and how patient-reported outcome measures will be leveraged in models to better measure patient experience and outcomes.

Value Based Insurance Design - Health Equity Incubation Program - Leveraging VBID to Improve Equity in Transportation Access (September 25, 2022) – 465 attendees: The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model team and the Administration of Community Living (ACL) led a discussion on how VBID flexibilities are being leveraged to improve equity in transportation access. This event, the third in VBID’s series of Health Equity Incubation Program webinars, began with an overview of the vital need and opportunity to address transportation barriers for Medicare beneficiaries as a means to improve health equity and beneficiary experience. The session started with a presentation by a panel of national experts highlighting the trends in transportation access, the economic and health burdens of transportation barriers, and evidence-based strategies to reduce transportation barriers. The VBID Model team discussed how various flexibilities within the model can be used to improve access and equity in care of enrollees facing transportation barriers. The webinar also featured a panel of leaders from UnitedHealth Group and Medical Card System to discuss their programmatic strategies, successes and challenges in using VBID flexibilities to improve transportation access for their enrollees.

In addition, the CMS Innovation Center encouraged stakeholders to submit written comments or questions about these sessions and the Strategy Refresh via email. More than 100 written comments were received and reviewed by staff.

D. Evaluating Results and Advancing Best Practices

Section 1115A(b)(4) of the Act requires the CMS Innovation Center to conduct an evaluation of CMS Innovation Center models. It specifies that evaluations must include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria, as well as changes in spending by reason of the model.

Using independent evaluators, the CMS Innovation Center routinely and rigorously assesses the impact of each model. Each model evaluation is carefully designed to ensure it will accurately assess model implementation and its impact on cost and quality. In addition to spending and quality, evaluations look at provider and patient experiences with a model, model implementation, and transformation of the health care marketplace around a model. Some evaluation measures such as total spending and hospital utilization are standard across all models, while others are customized to align with specific features of a model such as emergency department utilization, patient-reported outcomes, or spending during an episode of care.

During model implementation, data on performance and outcomes measures is collected, monitored, and reviewed at prescribed intervals. The independent evaluator uses existing administrative and enrollment data and often collects and analyzes additional data from surveys, interviews, focus groups, or site visits to understand how participants implemented a

model and explain how they changed spending or quality for their patients. The evaluations include advanced statistical methods and carefully defined and selected comparison groups, as appropriate, to ensure that models deemed to be successful represent true opportunities for high-value investments of taxpayer dollars.

Additional factors to consider when evaluating a model include whether the model is voluntary or mandatory. Voluntary models are more likely to be at risk for selection bias, which can influence how representative model participants, and ultimately their patient mix, are of the general target population. Further, evaluators must consider the sample size needed to detect an impact from the model intervention, availability of data that will help explain evaluation results, the extent of overlap between the model being tested and other competing or complementary initiatives, and the overall health care landscape.

The independent evaluators produce periodic reports throughout the course of the evaluation that include cumulative-to-date information and in-depth analyses on the model, and the CMS Innovation Center releases these findings publicly. A collection of evaluation reports can be found in Section VII of this report. In addition to the highly detailed evaluation reports, the CMS Innovation Center also releases a two-page summary of findings at-a-glance for many of the model evaluations. These present the key findings and takeaways from the reports in a more accessible, less-technical form.

Together, these reports and at-a-glance summaries provide stakeholders with information on the impact of the model on health care expenditures and utilization, health outcomes, and, where feasible, beneficiary and health care provider experiences with care, and site-specific results. Moreover, these findings are often used to inform the next iterations of model tests. Examples include the Primary Care First Model, which was developed based on insights from the previous CPC+ and CPC Models; the Maryland Total Cost of Care (TCOC) Model, which built upon the positive results from the previous Maryland All-Payer Model; and the BPCI Advanced Model, which was designed using lessons from the BPCI Model. Additional details for models tested under the period of report can be found in Section III. CMS Innovation Center Model Tests. Each model description within this section includes a link to their respective webpages, where all evaluations are published.

Learning and Diffusion

Many CMS Innovation Center models are supported by a learning system that aims to improve and accelerate participants' understanding and success in the models by testing new practices, actively measuring progress, and sharing breakthrough ideas. Learning systems are designed to ensure that learning and improvement are occurring in a continuous, collaborative manner, and that data-driven decisions can optimize the desired outcomes of the models. Learning systems include: an infrastructure for collaboration, sharing, and problem solving; learning activities to address the needs of the model participants; the capability to create and efficiently deploy tools to support learning and improvement, such as readiness assessments, dashboards,

case studies, webinars, and toolkits; and a process for keeping model participants and CMS updated on promising practices.

The CMS Innovation Center conducts stakeholder analyses and engages potential model participants in an effort to recruit high-quality, diverse model applicant pools. Through health equity analyses of existing models, the CMS Innovation Center is seeking to better understand the degree to which model participants are distributed equitably across beneficiary populations and is using that information to inform model design adjustments and identify learning opportunities for model participants serving vulnerable communities. For example, the CMS Innovation Center has examined provider and beneficiary participation in the Comprehensive Primary Care Plus and Primary Care First models and found that there are relatively fewer model participants in underserved areas, including those in low income, Hispanic and rural communities. Explanatory factors include lack of providers participating in the models in these areas, low numbers of underserved beneficiaries in areas where model participants are concentrated, and financial disincentives to serving underserved populations, among others. Model teams are actively seeking to understand which of these factors, or combination of factors, are contributing to this imbalance and how the imbalance can be remedied in future models.

Summative Evaluations of Model Testing

The CMS Innovation Center conducted a series of studies to look at evaluation results across multiple models with shared or similar programmatic elements. The synthesis work identified themes and shared lessons learned in an effort to help inform future model design and policy-making. Three separate topic areas were reviewed as they related to policy priorities within the CMS Innovation Center. These included 1) a review of the majority of Medicare models the CMS Innovation Center has operated during its first decade; 2) palliative care; and 3) dementia. The synthesis of evaluation results across 21 Medicare models looked across the portfolio of CMS Innovation Center models serving Medicare beneficiaries to understand the themes and lessons learned from models focused on acute (for example, episodic models, hospital-based models) and specialty care (for example, oncology, nephrology) models and targeted populations (for example, cancer, end-stage renal disease, lower extremity joint replacement) relative to models focused on primary care and population management, serving broader panels of relatively healthy Medicare beneficiaries through prevention and enhanced care coordination. Initiatives and models focused on palliative care and dementia were reviewed to understand common themes, lessons learned, and best practices to help inform the development of promising new models at CMS.

Synthesis of Evaluation Results across 21 Medicare Models

The objective of this study was to synthesize evaluation results across multiple CMS Innovation Center Medicare models to report on themes across the portfolio to inform future model development. A [white paper](#) and [summary report](#), including tables of synthesis results, were published in July 2022. Details of the results are listed below:

- Evaluation results were compiled for 21 current and former CMS Innovation Center Medicare models operating from calendar years 2012–2020 with at least two years of impact estimates available to assess performance among matured models.
- The CMS Innovation Center examined similar measures available across each of the models, including gross and net Medicare spending, measures of utilization (for example, inpatient admissions, emergency department visits, post-acute care, inpatient readmissions), and quality of care (for example, satisfaction with care, mortality).
- Themes across models fell within two broad categories: 1) acute or specialty care and targeted populations (N=9 models) and 2) primary care and population management (N=12 models). These two groupings had similarities across model participant type and health care provider, intervention used, and the type of beneficiaries that were touched by the intervention.
 - Fourteen of the 21 models demonstrated gross savings to Medicare driven by improvements in inpatient admissions (10 models) and/or post-acute care (fourteen models). For models that paid financial incentives to participants, six had net savings, six incurred net losses, and six models had no impacts on net spending. Quality of care improved in a few models (two improved self-reported beneficiary experience of care and four models improved mortality) but was mostly maintained.
 - Models that focus on reducing acute or specialty care or that targeted specific populations (for example, terminal illness, lower extremity joint replacements) were more likely to show gross savings and generally had larger, more favorable impacts on utilization relative to models focused on primary care and population management which generally serve broader, healthier populations.
 - It is possible that the higher baseline spending of sicker beneficiaries, the inclusion of institutional and specialty care providers, and the more narrowly focused target populations in the acute or specialty care and targeted population models provided more room to cut costs.
 - Primary care and population management models served large panels of relatively healthy, mostly lower-cost Medicare beneficiaries and focused on preventing disease and improving care coordination. Longer time windows for investments in care coordination staffing, clinical workflow redesign, health information technology, and data analytics, as well as greater engagement of primary and specialty care providers, may be needed to reduce spending in primary care and population management models.
 - Even with successful evaluation and transformation efforts, models may face other barriers to national expansion. Generous financial incentives paid to voluntary model participants made it difficult for these models to show net savings as participants often exited the model prior to Medicare realizing returns.

Synthesis of Findings from End-of-Life Care Initiatives

The CMS Innovation Center’s vision for the next decade focuses on high quality, affordable, person-centered care that coordinates care seamlessly and holistically across settings. In the year leading up to their death, Medicare beneficiaries typically have serious illnesses or multiple chronic conditions that require costly services, including inpatient hospitalizations, post-acute care, and hospice care. To inform the development of promising new models at CMS related to end-of-life care, this study synthesized findings from CMS Innovation Center initiatives on palliative care and dementia care with the objective of identifying lessons learned and best practices. Details of the findings are listed below:

- Palliative Care Initiatives
 - This synthesis includes Medicare Care Choices Model, Community Palliative Care: Four Seasons (HCIA Round 2 awardee), Advanced Illness Management: Sutter Health (HCIA Round 1 awardee), and Medicare Health Care Quality–Meridian.
 - Significant increases in Community Palliative Care–Four Seasons, and no significant effect in Medicare Health Care Quality–Meridian. Low enrollment limited the CMS Innovation Center’s ability to detect further impacts.
 - Caregivers across these four initiatives reported that access to palliative support improved their quality of life and that of the enrolled beneficiary.
 - Better integration of palliative care within primary care (for example, medical home, accountable care organizations) may improve the likelihood of favorable impacts by identifying more individuals for palliative care earlier in the disease trajectory.
 - Access to interdisciplinary teams, home visits, and advance care planning could improve end-of-life outcomes, appropriately adapted to the target population and setting.
- Dementia Care Initiatives
 - This synthesis includes Dementia Care Ecosystem: University of California at San Francisco (HCIA Round 2 awardee), Maximizing Independence at Home: Johns Hopkins University (HCIA Round 2 awardee), Alzheimer's and Dementia Care: University of California, Los Angeles (HCIA Round 1 awardee), Aging Brain Care: Indiana University (HCIA Round 1 awardee), and Medicare Alzheimer’s Disease Demonstration and Evaluation.
 - Dedicated staff with expertise in dementia care led to better care experience, trends toward decreased Medicare expenditures, and significantly fewer long-term care admissions (Alzheimer’s and Dementia Care–University of California, Los Angeles).
 - Low engagement with primary care providers limited care coordination and enrollment.
 - 24/7 access to the care team offered the most useful support, according to caregivers.

- Targeting individuals with moderate to severe dementia, showed the best promise (due to the time needed to follow beneficiaries to see results, given the long disease trajectory of dementia).
- Increased intensity of services (for example, more visits or access to respite care) could, potentially, strengthen model effects.

Results showed that innovative strategies are needed to better reach populations that are socially isolated and lack access to dementia screening.

E. CMS Innovation Center Technology and Data Priorities

The CMS Innovation Center has continued to leverage technology and data to reduce unnecessary burden, increase efficiencies, reduce administrative costs, and improve the beneficiary experience. Effective use of technology and data has improved uptake in model Requests for Applications, the monitoring and evaluation of model tests, and allowed for the automation of many requests for information and broad communications with model participants and stakeholders. The CMS Innovation Center continues to iterate and improve the technology supporting the submission and analysis of data for many of its workstreams, including the Quality Payment Program where recent automations have significantly reduced manual review times for staff by several weeks.

Interoperability and standards in data exchange are essential to the success of value-based care where clinicians need to access patient records quickly and easily. To help further the establishment of interoperable data exchanges, many model tests include requirements for participants to use health information technology (HIT) certified under the Office of the National Coordinator (ONC) for Health Information Technology's Health IT Certification Program. This requirement helps to ensure that participants have technology tools that meet core capabilities to enable the successful exchange of patient data with other providers. The CMS Innovation Center has also been collaborating more regularly with ONC to ensure model requirements support the most recent version of the ONC United States Core Data for Interoperability standards.

The CMS Innovation Center has also worked in close collaboration with the CMS Office of Enterprise Data and Analytics (OEDA) to offer model participants the option of using an Application Programming Interface (API) to retrieve claims data to support model operations (in compliance with all applicable HIPAA and other applicable privacy rules and regulations) which enables the faster and more timely delivery of data. Recognizing that not all model participants are yet able to integrate API data delivery into their operations, CMS continued to make model claims data available for secure portal download in the same time period and maintained more than 30 collaboration sites/portals for model participants, which facilitate participant-to-participant collaboration and sharing of best practices to support model learning systems. Further, the CMS Innovation Center also engaged in prototyping Fast Health Interoperability Resource based APIs for future use in the standardized collection of

demographic and social determinants of health data to support the new strategic pillar of advancing health equity for all.

Through the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC), the CMS Innovation Center released model-specific research files for the Next Generation ACO and Comprehensive End-Stage Renal Disease Care models in the summer of 2021. In August 2022, research files were released for the Oncology Care Model, Bundled Payments for Care Improvement Advanced Model, Comprehensive Primary Care Plus Model, Kidney Care Choices Model, Primary Care First Model and the Global and Professional Direct Contracting (GPDC) Model¹³. Each set of files will be updated on a quarterly basis, reflecting changes captured for the prior quarter. The VRDC plans to release data for additional models over time. With these efforts, the CMS Innovation Center is advancing transparency about model performance and supporting external research about its models.

These combined efforts have produced positive results for participants, providers and suppliers, including reduced paperwork and increased time with patients. Ultimately, leveraging technology and data helps model participants focus more directly on improving performance and health outcomes for beneficiaries. The result for the CMS Innovation Center has been quicker response times, lower costs, improved record keeping, and increased precision.

Equity, transparency, and security underlie all CMS Innovation Center initiatives as it continues to incorporate agile software development and human centered design to improve its internal data infrastructure, cloud infrastructure, and processes. These values ensure the CMS Innovation Center continues to consider burden to providers, ability to share methods used to calculate measurements, and standardization of processes to assure security and privacy for the nation's beneficiaries.

Improving Risk Adjustment Methodologies and Financial Benchmarks

Risk adjustment (adjusting payments to account for differences in beneficiary health status and demographic factors) has been a critical component of CMS Innovation Center models, including all accountable care organization (ACO) based models. Without the ability to adjust benchmarks and payments, participants are incentivized only to treat healthy beneficiaries, and the sickest, most vulnerable populations are left out. Financial benchmarks and risk adjustment methodologies have created opportunities for potential model test gaming by participants—and reduced savings for Medicare¹⁴.

¹³ Note that the GPDC model is transitioning to the ACO REACH model as of January 1, 2023. The model ID number (identifying variable in these files) for ACO REACH will remain the same as the model ID for GPDC (ID 63). However, please note that ACO REACH data will not appear in these research files until the 2023 Q2 posting in April, 2023. The January 2023 files will still contain the GPDC participation data as of December 2022.

¹⁴ The CMS Innovation Center has not tested enough models that modify Medicaid financial benchmarks and risk adjustment to draw similar conclusions for Medicaid.

The CMS Innovation Center began an examination of its benchmarking and risk adjustment approaches to provide incentives to encourage participation, especially among providers caring for underserved beneficiaries and ACOs with varying levels of experience, as well as ensure payment accuracy.

An example of such improvements is the redesign of the Global and Professional Direct Contracting (GPDC) Model into the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. Specifically, in response to stakeholder and participant feedback regarding the original design of the GPDC Model, the Innovation Center took steps to improve upon the model's approach to risk adjustment. The GPDC Model will be redesigned and renamed the ACO REACH Model, starting on January 1, 2023. The GPDC Model had already offered the strongest risk adjustment protection to date, compared to other ACO initiatives and Medicare Advantage. The ACO REACH Model's approach to risk adjustment incorporates additional improvements to ACO-level risk score growth constraints by adjusting for beneficiary demographics and using a single reference year. Moreover, to better support the delivery and coordination of care for underserved beneficiaries, the ACO REACH Model will include a health equity benchmark adjustment and require that all model participants develop and implement a robust health equity plan to identify medically underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.

F. Rewarding Value through the Quality Payment Program

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

The Quality Payment Program pays for value in health care through the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). The CMS Innovation Center develops and operates most Advanced APMs; CMS determined that 14 APMs meet the criteria for Advanced APMs for the 2022 Qualifying APM Participant (QP) Performance Period, including the Medicare Shared Savings Program. Currently, by participating in an Advanced APM and meeting certain thresholds of patient counts or payments, eligible clinicians can attain QP status and earn a lump-sum five percent APM Incentive Payment. These APM Incentive Payments are scheduled to sunset after Performance Year 2022 (Payment Year 2024). QPs are also excluded from reporting to the MIPS track of the Quality Payment Program—reducing administrative burden—and from the MIPS payment adjustment.

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

In 2021, 195,564 eligible clinicians, who previously received QP status in Performance Year 2019, received an APM Incentive Payment.

The CMS Innovation Center has sought to reduce the burden on eligible clinicians participating in the Quality Payment Program, and is continuing to help broaden participation in Advanced APMs. The CMS Innovation Center is working in consultation with clinicians to increase the number and variety of models available so that a wide range of eligible clinicians, including those in small practices and rural areas, have the option to participate. For APM participants who are subject to MIPS, CMS has provided a streamlined reporting opportunity through the APM Performance Pathway, and has reweighted MIPS performance categories to account for these clinicians' APM participation such that they are neither asked to duplicate reporting nor be scored twice as a consequence of MIPS.

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

The Physician-Focused Payment Model Technical Advisory Committee

In addition to MIPS, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services (HHS) on proposals for Physician Focused Payment Models (PFPMs). PTAC meets approximately quarterly to review proposals submitted by stakeholders and assess the extent to which they meet 10 criteria that were established by the Secretary¹⁵ in the Quality Payment Program final rule. PTAC then deliberates and votes on whether each proposal meets the Secretary's criteria before submitting its comments and recommendations to the Secretary. The Secretary, in turn, is required to review PTAC's comments and recommendations on whether each proposal meets the Secretary's criteria and post a detailed response on the [CMS website](#).

The Secretary has responded to PTAC's comments and recommendations on two PFPM proposals voted on in September 2020. The Secretary's responses are posted on the CMS website.¹⁶ As of September 30, 2020, PTAC had received a total of 35 PFPM proposal

¹⁵ 42 FR § 414.1465.

¹⁶ [Secretary responses](#) to PFPM proposals.

submissions.¹⁷ CMS has drawn from the PTAC’s recommendations and comments and has incorporated several PFPM design elements into many of the CMS Innovation Center’s payment and service delivery models. For example:

- Proposals from Renal Physician Associates and Dialyze Direct influenced the design of the CMS Innovation Center’s Kidney Care Choices Model;
- Proposed models from the American Academy of Family Physicians, and University of Chicago Medicine helped to shape the Primary Care First Model; and
- A proposed model from the Illinois Gastroenterology Group led to the incorporation of irritable bowel disease episodes into the Bundled Payments for Care Improvement Advanced Model.

Moreover, proposals from a variety of submitters are being explored as they pertain to potential models within the following focus areas:

- Oncology,
- Acute care at home,
- Serious illness; and
- Care coordination.

PTAC has recently held several public meetings to consider how PFPM proposals the Committee has reviewed in the past may include components that can help the Committee to provide additional comments and recommendations to the Secretary on pertinent issues regarding effective payment model innovation.¹⁸ CMS is exploring themes informed by PTAC recommendations and comments on these topics, including:

- Examining the roles of specialty care integration and equity stemming from the June 2022 PTAC public meeting on care delivery model design for population-based models that seek to improve accountability for quality and total cost of care;
- PTAC’s June 2021 Report to the Secretary stemming from the PTAC public meetings on the role of telehealth in optimizing health care delivery and value-based transformation;
- PTAC’s September 2021 Report to the Secretary stemming from the PTAC public meeting on the role of care coordination in optimizing health care delivery and value-based transformation; and
- PTAC’s December 2021 Report to the Secretary stemming from the PTAC public meeting addressing the role of social determinants of health and equity in optimizing health care delivery and value-based transformation.

¹⁷ [List of submissions](#) for Physician-Focused Payment Models.

¹⁸ The Secretary is only required to respond to comments and recommendations that PTAC submits regarding whether PFPM proposals submitted by stakeholders meet the Secretary’s criteria.

G. Accelerating APM Adoption through the Learning and Action Network

Launched in March 2015, the Health Care Payment Learning and Action Network (LAN) is a nationwide collaborative seeking to accelerate the adoption of alternative payment models (APMs) across the public and private sectors. The LAN mobilizes a network of 7,000 payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Every year, the LAN also hosts a LAN Summit, that brings together health care leaders, policymakers, and advocates to seek a common way forward to make healthcare more equitable, accessible, and affordable for all by emphasizing value and patient health over fee-for-service (FFS) models. More than 1,400 stakeholders came together during the virtual December 2021 LAN Summit to discuss the most pressing issues surrounding the payment, delivery, and quality of care in the United States.

New Learning and Action Network Priorities

The LAN includes two Executive Forums: the CEO Forum and the Care Transformation Forum. These Forums bring together health care leaders committed to shaping the strategic direction of value-based payment. Charged with advancing and accelerating APM adoption, the CEO Forum provides guidance on opportunities for strengthening incentives and capacity to accelerate the transition to APMs across markets. Launched alongside the CEO Forum, the Care Transformation Forum (CTF) is designed to influence and shape care delivery transformation necessary for the success of value-based health care and payment. Comprised of clinical executive health care leaders, the CTF's primary focus is identifying the tools and strategies that prepare clinicians for success in delivering high-quality care that improves patient outcomes and reduces costs across a multi-payer environment.

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

The LAN Health Care Resiliency Collaborative launched in January 2021 in response to the Coronavirus Disease 2019 Public Health Emergency (PHE). Its goal is to articulate and commit to the most important short- and long-term actions that can be taken to achieve resiliency in the health care system. This multi-stakeholder initiative identified key actions that payers, providers, and multi-stakeholder groups can take in both the short-term and medium- to long-term to promote more resilient, effective APMs. Building off increased momentum to address health equity and support health system resiliency, the LAN launched

two new initiatives—the Health Equity Advisory Team (HEAT) and the State Transformation Collaboratives (STCs).

The HEAT was convened in June 2021 to help identify and prioritize opportunities to advance health equity through APMs, to influence design principles, and to inform LAN priorities and initiatives. Its goal is person-centered—to leverage APMs to help make needed care more accessible, drive better patient outcomes, and reduce disparities. Patient experiences, priorities, and perceptions are crucial elements the HEAT will explore. The HEAT’s diverse team of regional and national implementers and health equity subject matter experts brings valuable perspectives for and experience with identifying and mitigating health inequities across communities and in the nation’s health care system.

In December 2021, the LAN launched four STCs—partnering with Arkansas, California, Colorado, and North Carolina—to continue to shift the economic drivers away from FFS to a value-based, person-centered approach to health through locally focused Medicaid, Medicare, and multi-stakeholder collaboration and partnership. These state initiatives are dedicated to transforming health care in each state or region within a state and achieving health equity via payment reform.

Through 2022, the LAN engaged with Executive Forum members and other organizations to convene action-oriented work groups and undertake strategic initiatives to further advance health equity and reset the LAN goals to align with the CMS Innovation Center’s new strategic objectives. Specifically, to have all beneficiaries with Parts A and B in a care relationship with accountability for quality and total cost of care by 2030. In support of this goal, the LAN announced a standardized definition for accountable care to ensure stakeholders understand expectations for implementation: accountable care aligns care teams to help realize the best achievable health outcomes for all through comprehensive, high-value, affordable, longitudinal, person-centered care. Along with this definition, the LAN developed a corresponding Accountable Care Commitment Curve that illustrates the varying levels of commitment and sophistication stakeholders can have as it pertains to transforming their organization. In addition to receiving stakeholder feedback and input on these items, the LAN launched the Accountable Care Action Collaborative (ACAC) with the goal of advancing the adoption, evolution, and growth of accountable care relationships in the health care system by forging new partnerships with national organizations with shared goals and commitments.

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

Aggregate data of each of these sources, historically representative of more than 75 percent of the covered lives in the U.S., are combined to produce a national number. The data shows

gradual but consistent increases in the percent of health care payments made through APMs in the reporting years.

III. CMS Innovation Center Model Tests

The 33 model tests described in this section were either active or announced between October 1, 2020 and September 30, 2022. The list is alphabetical with one exception: because the Global and Professional Direct Contracting (GPDC) model is being redesigned and renamed the ACO Realizing Equity, Access, and Community Health model starting on January 1, 2023, we discuss both model designs together. During this reporting period, the CMS Innovation Center also managed and evaluated five congressionally mandated demonstrations. These are described in Section K. CMS estimates that during the period of this report more than 41,500,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 314,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.

Maps showing the geographic scope of each model test and the names of participating organizations are available at: <https://innovation.cms.gov/innovation-models/map>.

Please note: the CMS Innovation Center applied flexibilities and modifications to several models during the Coronavirus Disease 2019 Public Health Emergency (PHE), as described in the model entries below. The CMS Innovation Center also applied evaluation modifications, as appropriate, to ensure impact estimates capture the actual effects of the model and not differences attributable to the PHE.

Accountable Health Communities Model (AHC)

Model Announcement Date: January 5, 2016

Model Performance Period: May 1, 2017–April 30, 2022. Some awardees have received no cost extensions and their period of performance will extend through April 30, 2023.

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

Number of Participants: 28 bridge organizations (10 Assistance Track, 18 Alignment Track) as of April 2022; consisting of community-based organizations, health care practices, hospitals, health systems, and local governmental entities across 328 counties in 21 states partnering with 176 hospitals, 390 primary care practices, 72 behavioral health providers and 427 other types of clinical delivery sites

Geographic Scope: Rural and urban communities across 328 counties in 21 states

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: The AHC Model was developed based on emerging evidence that addressing health-related social needs (HRSNs) through enhanced clinical-community linkages can improve health outcomes and reduce costs. The AHC Model tested whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries—including those who are dually eligible—impacts total health care costs and inpatient and outpatient health care utilization.

Over a five-year period of performance, CMS tested two service delivery approaches:

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

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

AHC awarded up to \$111 million in cooperative agreements to 32 community bridge organizations to implement the model during the five-year performance period. Assistance Track awardees were awarded up to \$2.57 million per recipient, and Alignment Track awardees were awarded up to \$4.51 million per recipient.

Bridge organizations participating in the model worked with their community partners during the start-up phase of the model to establish screening and referral protocols, finalize and memorialize arrangements, and develop health information technology solutions to effectuate data-sharing. Bridge organizations began the implementation phase on a rolling basis from May 2018 through December 2018 as data-sharing infrastructure was ready.

As of December 2021, bridge organizations and partnering clinical delivery sites had offered more than two million screenings to Medicare and Medicaid beneficiaries, and screenings identified 375,412 beneficiaries with at least one health-related social need. All of these beneficiaries were eligible to receive referrals to community resources. More than 129,000 beneficiaries have accepted navigation services through the model. Through navigation services, those beneficiaries reported that more than 75,000 of their health-related social needs

were resolved. Alignment Track bridge organizations convened their Advisory Boards quarterly to ensure that community services were available and responsive to the needs of beneficiaries. Advisory Boards are composed of a diverse set of stakeholders from the community including beneficiaries, community service provider organization representatives, and representatives from their state Medicaid agencies.

Evaluation Status/Results: The evaluation of the Alignment and Assistance tracks is examining health outcomes, including whether the interventions in each track reduce beneficiaries' total expenditures and utilization of health care services, such as emergency department visits and unplanned readmissions.

The First Evaluation Report was released in December 2020 and covers May 1, 2017 through December 31, 2019. The report shows that the combination of one or more HRSNs and two or more self-reported emergency department visits in the past 12 months identified a high-cost, high-use population. Beneficiaries who qualified to participate in the AHC Model were more likely to and were disproportionately more likely to have Medicaid and be non-White and, among Medicare beneficiaries, disabled. More than half of navigation-eligible beneficiaries reported more than one core need, with food insecurity being the most commonly reported HRSN. Almost 30 percent of beneficiaries with a food, housing, transportation or utilities need reported having three or more of these needs.

There were high rates of acceptance of navigation services but limited evidence that HRSNs were resolved. Although 74 percent of eligible beneficiaries accepted navigation, only 14 percent of those who completed a full year of navigation reported having any HRSNs resolved.

Navigation-eligible Medicare FFS beneficiaries in the Assistance Track had a 9.4 percent reduction in emergency department visits in the first year after enrollment, as compared to the control group. The model has not yet had an impact on other outcomes such as total expenditures or unplanned readmissions. The First Evaluation Report did not include outcomes for the Alignment Track, as sufficient data were not yet available to generate reliable impact estimates. Future reports will address impacts on Medicaid beneficiaries, who account for a preponderance of enrollees, as well as for the Alignment Track.

In response to declines in utilization due to the PHE, the CMS Innovation Center allowed flexibilities to enable awardees to adapt their workflows to expand telephonic screening and screening associated with a virtual clinical visit.

Webpage: Additional information is available at the [AHC Model webpage](#).

Artificial Intelligence Health Outcomes Challenge (AI)

Announcement Date: March 27, 2019

Performance Period: Challenge winners announced April 21, 2021

Participants: Open to any non-Federal entities

Number of Participants: More than 300 Launch Stage applicants; 25 Stage 1 participants; Seven Stage 2 participants; one Grand Prize Winner and one Runner-Up

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

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: To accommodate shifting priorities among Participants due to the PHE, CMS temporarily paused the Artificial Intelligence Health Outcomes Challenge (AI-HOC) for three months and restarted the Challenge on June 29, 2020. The Challenge resumed normal activities at that time.

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

Competition Objectives:

1. For Stage 1, use AI, including but not limited to deep learning methodologies, to predict unplanned hospital and SNF admissions, and adverse events within 30 days for Medicare beneficiaries, based on a data set of Medicare administrative claims data, including Medicare Part A (hospital) and Medicare Part B (professional services).
2. For Stage 2, use AI, including but not limited to deep learning methodologies, to predict unplanned hospital and SNF admissions, as well as adverse events, within 30 days for Medicare beneficiaries, as well as a 12-month mortality target, based on a Part A and Part B data set.

3. For both Stage 1 and Stage 2, develop innovative strategies and methodologies to: explain the AI-derived predictions to front-line clinicians and patients to aid in providing appropriate clinical resources to model participants.

In Stage 2, the participants further refined the solutions that they developed in the prior stage to help predict unplanned hospital and skilled nursing facility admissions and adverse events, and additionally developed predictive algorithms to identify beneficiaries at risk of mortality in 12 months, as mentioned above. The finalists worked to address sources of bias in their solutions that could have the potential to affect health disparities in their submissions.

CMS announced Stage 2 Participants on October 29, 2020 and announced one grand prize winner, ClosedLoop.ai, and one runner-up, Geisinger, on April 21, 2021. The winners were distinguished by their consistent strong performance across all competition elements while generating the best prediction accuracy results. Of the \$1.65 million in total prizes to participants, Arnold Ventures contributed \$300,000 and the AAFP contributed \$340,000.

Evaluation Status/Results: N/A

Webpage: Additional information is available at the [AI Health Outcomes Challenge webpage](#).

Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)

Model Announcement Date: January 9, 2018

Model Performance Period: October 1, 2018–December 31, 2025¹⁹

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

Number of Participants: in 2020, 1,707 participants; in 2021: 986 participants; in 2022: 749 participants

Geographic Scope: Participants located in Washington D.C. and 43 states (2020–2021); 39 states in 2020

Model Types: Episode-based Payment Initiatives

¹⁹ During the reporting period, the BPCI Advanced Model was set to end December 31, 2023. After the reporting period but prior to publication of this report, CMS announced the BPCI Advanced Model would be extended for two years. The model will now conclude on December 31, 2025.

Coronavirus Disease 2019 PHE Flexibilities: In response to concerns expressed by participants, the following flexibilities have been incorporated into the model via amendments to Participation Agreements for the Bundled Payments for Care Improvement (BPCI) Advanced Model:

- CMS offered participants the option to eliminate both upside and downside risk by excluding all Clinical Episodes (CEs) initiated on or after January 1, 2022, and end on or before December 31, 2022, from reconciliation (2020).
- For BPCI Advanced participants who chose to remain in two-sided risk, CMS offered participants the option to exclude from Reconciliation those CEs that included a COVID-19 diagnosis during the episode (2020).
- Beginning in 2021 and continuing through the remainder of the Model, CMS implemented the policy to exclude all COVID-19 CEs from reconciliation and did not offer the option to exclude all CEs from reconciliation.
- In alignment with other CMS programs and models, quality reporting was adjusted during 2020 and was also adjusted for 2021.

Model Description: Building on the lessons learned from the Bundled Payments for Care Improvement (BPCI) Model, BPCI Advanced is designed to align incentives for reducing costs while improving coordination and quality of care. BPCI Advanced is an Advanced APM, meaning that participating clinicians who meet certain participation thresholds may obtain Qualifying APM Participant (QP) status in the Quality Payment Program. BPCI Advanced broadly engages participants across geographic areas, with varying demographic attributes of their patient populations, organization size, and clinical types. BPCI Advanced also involves a broad range of Medicare-enrolled practitioners, including participating physicians and non-physician practitioners.

BPCI Advanced uses a bundled payment methodology that involves combining the payments for physician, hospital, and other health care provider services into a single payment amount. This amount is calculated based on the expected costs of all items and services furnished to a beneficiary during an episode of care, which is referred to as a Clinical Episode (CE). A single bundled payment will often cover services furnished by various health care providers in multiple care delivery settings. The goal of a single bundled payment to health care providers and suppliers is to motivate care redesign by adopting best practices, reducing deviation from standards of care, and providing a clinically appropriate level of services for patients throughout the CE. Entities receiving a bundled payment may realize a gain or loss, based on how successfully they manage resources and total costs throughout each CE. The length of the CE depends on the site of service. For inpatient CEs, the episode length is the start of the inpatient admission (Anchor Stay) plus 90 days beginning the day of discharge. For the outpatient CEs, the episode length is the start of the outpatient procedure (Anchor Procedure), plus 90 days beginning on the day of completion of the outpatient procedure.

BPCI Advanced includes two types of participants: Convener Participants and Non-Convener Participants. Convener Participants facilitate care coordination among downstream Episode Initiators (EIs) and bear (and apportion) financial risk under the model. A Non-Convener Participant is either an ACH or a PGP that is an EI and bears financial risk only for itself rather than on behalf of a downstream EI. EIs are limited to ACHs and PGPs.

In the first two years of the model, there were 1,295 episode initiators, including 715 acute care hospitals and 580 physician group practices. CMS offered an additional application opportunity to participate in the model beginning at the start of January 2020. At that time, participants who had signed participation agreements with CMS for the first two years of the model were offered an opportunity to add or drop CEs and episode initiators. Peak EI participation was achieved in model's third year with 2,041 EIs (1,010 ACHs and 1,031 PGPs). By the fourth and fifth years of the model, the volume of EIs began to decline with 1,205 EIs (682 ACHs and 523) and 831 EIs (435 ACHs and 396 PGPs), respectively.

In the first two years of the model, participants were held accountable for at least one CE category, and were able to choose from 29 inpatient and three outpatient CE categories, comprised of both medical and surgical categories. In the model's third year, additional CE categories were added, and 30 inpatient and three outpatient, and one multi-setting CE categories were offered. In year four, participants were required to be accountable for CE Service Line Groups, rather than individual CE categories. Participants were not able to modify their selections if continuing into the subsequent year. The eight CE Service Line Groups are inclusive of 30 inpatient, three outpatient, and one multi-setting CE categories. Participants are not permitted to drop active CE categories, nor add new CE categories, except when expressly permitted by CMS. The same limitation applies to the withdrawal or addition of downstream EIs by a Convener Participant.

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

Evaluation Status/Results: The third evaluation report from BPCI Advanced was released in February 2022 and covers the model from its beginning, October 1, 2018, through December 31, 2019 (Model Years 1 and 2).

BPCI Advanced reduced episode payments by 2.2 percent of the BPCI Advanced baseline mean for medical episodes (or \$564 per episode) and 4.5 percent for surgical episodes (or \$1,353 per episode). Reductions in episode payments were driven by changes in post-acute care (PAC) use. Results were similar when calculated by EI type, as both hospital and PGP EIs reduced payments in both episode categories.

BPCI Advanced reduced readmissions for surgical episodes during the 90 days following a discharge or procedure by 4.1 percent of the BPCI Advanced mean. Estimates were similar by

EI type, though only the PGP estimate was statistically significant. Neither EI type reduced readmissions for medical CEs. There was little to no impact on mortality overall or by medical and surgical groupings.

Though hospitals and PGPs EIs reduced episode payments, after accounting for reconciliation payments made to participants, Medicare experienced a small net loss of \$65.7 million, or 0.4 percent of what Medicare payments would have been absent the model for Model Years 1 and 2. The estimated loss was not statistically significantly different from zero.

BPCI Advanced generally resulted in estimated net losses for medical CEs and estimated net savings for surgical CEs. Target prices in the BPCI Advanced Model were designed to achieve three percent net savings compared to what Medicare payments would have been absent the model. For both hospitals and PGPs, evidence suggests target prices were too high for most medical CEs but were more accurate for surgical CEs. CMS made significant design changes for Model Year 4, beginning January 1, 2021) to improve target price accuracy for both CMS and model participants.²⁰

Webpage: Additional information is available at the [BPCI Advanced Model webpage](#).

Community Health Access and Rural Transformation Model (CHART)

Model Announcement Date: August 11, 2020

Model Performance Period: Community Transformation Track: October 1, 2021–December 31, 2028

Note: In February 2022, CMS announced the removal of an ACO Transformation Track from the CHART Model, given broader efforts underway by CMS to increase ACO adoption in rural areas.

Model Participants: Community Transformation Track: Lead Organizations (grant recipients; organization types include state Medicaid agencies and academic medical centers) and Participant Hospitals (acute care hospitals, critical access hospitals, and rural emergency hospitals)

Number of Participants: Community Transformation Track: Four Lead Organizations (South Dakota, Texas, and Washington’s State Medicaid agencies; University of Alabama at Birmingham [Academic Medical Center]). Number of Participant Hospitals will be known starting Calendar Year 2023.

²⁰ For details, see the [Communication about new pricing methodology](#) sent to BPCI Advanced participants.

Geographic Scope: Rural communities across Alabama, South Dakota, Texas, and Washington.

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: The CHART Model will give rural communities the flexibility necessary to design custom, innovative approaches to delivering high-quality care that best suit individual community needs. Specifically, the model will test whether upfront and annual funding coupled with aligned financial incentives increases operational flexibility, and whether robust technical support enables rural health care providers to transform care on a broad scale and increase uptake of Alternative Payment Models (APMs) in ways that improve access to high-quality care for rural beneficiaries while reducing Medicare and Medicaid expenditures.

The CHART Model awarded cooperative agreements to four rural communities to implement the Community Transformation Track. As part of the application process, each Lead Organization selected a set of rural counties and census tracts in their respective states to implement the Community Transformation Track. Collectively, these communities cover more than 300,000 Medicare fee-for-service (FFS) beneficiaries. Medicaid beneficiaries will also be included in the track beginning Calendar Year (CY) 2024. Hospitals will begin participating in the model in CY 2023.

Lead Organizations, Participant Hospitals, and additional community partners (for example, state Medicaid agencies, and commercial payers) will develop and implement a multi-year strategic plan for rural health care delivery under the Community Transformation Track. Continuation of cooperative agreement funding is contingent on implementation of and progress on the strategic plan. Under the Community Transformation Track, participating rural hospitals will receive financial flexibilities through a predictable capitated payment, operational flexibilities, and benefit enhancements. The capitated payment is a prospectively set total amount of revenue which provides Participant Hospitals with a stable revenue stream that creates incentives to reduce both fixed costs and avoidable utilization. The capitated payment creates a cost-containment incentive for participant hospitals to provide more efficient care to rural residents while providing predictable revenue for hospitals.

CMS will monitor the implementation of each community's strategic plan and provide robust technical assistance to the Lead Organizations. Communities and Participant Hospitals will be assessed on a set menu of quality measures. All communities and their Participant Hospitals will be measured on prevention of chronic disease, reducing all-cause readmissions, and patient engagement via the Hospital Care Consumer Assessment of Healthcare Providers and Systems (HCAHPS). In addition, each community will select a target population health domain (chronic disease prevention, maternal health, or substance use) that the community and participating hospital will be measured on for the duration of the Community Transformation Track.

Evaluation Status/Results: The evaluation of the CHART Model will assess whether providing rural communities and their Participant Hospitals with capitated payments with upfront funding leads to an impact on Medicare and Medicaid beneficiaries' access to care, total cost of care, and the quality of care received. The evaluation will use a claims-level analysis of Medicare and Medicaid data as well as site visits and annual surveys to examine whether the CHART Model leads to savings to the Medicare and Medicaid programs while maintaining or improving the quality of care provided to beneficiaries receiving care from participating entities.

Webpage: Additional information is available at the [CHART Model webpage](#).

Comprehensive Care for Joint Replacement Model (CJR)

Model Announcement Date: July 9, 2015

Model Performance Period: April 2016–December 2024

Model Participants: Acute Care Hospitals

Number of Participants: Approximately 324 hospitals in 34 MSAs as of November 2021

Geographic Scope: For the first two Performance Years (PYs) of the Comprehensive Care for Joint Replacement (CJR) Model, hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in 67 mandatory MSAs, with few exceptions, were required to participate. The 67 MSAs are located in the following states: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, and Wisconsin. As of February 1, 2018, IPPS hospitals in 34 of the original 67 MSAs were required to participate, except for participant hospitals categorized as low volume or rural hospitals. Participant hospitals in the other 33 original MSAs were given a one-time opportunity to voluntarily opt in to the model during January 2018 for PYs 3 through 5. As of October 1, 2021, only hospitals in one of the 34 required MSAs and not designated as low volume or rural are required to participate in the model's three-year extension. The IPPS hospitals required to participate are located in the following states: Alabama, Arkansas, California, Connecticut, Florida, Indiana, Kentucky, Louisiana, Mississippi, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Utah. The list of participant hospitals is available at <https://innovation.cms.gov/innovation-models/cjr>.

Model Types: Episode-based Payment Initiatives

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to concerns expressed by participants, the following flexibilities have been incorporated into the CJR model via amendments to CJR regulations:

- For episodes initiated between January 31, 2020 through March 31, 2021, actual episode payments were capped at the target price (removed downside risk) (86 FR 23496); and
- For episodes initiated after March 31, 2021, actual episode payments are capped at the target price determined for episodes that contain a COVID-19 Diagnosis Code as defined in 42 CFR§510.2 (86 FR 23496).

Model Description: The CJR Model is a Medicare Part A and B episode payment model that is designed to improve care for Medicare patients undergoing hip and knee replacements (also called lower extremity joint replacements, or LEJRs) performed in the inpatient or outpatient setting and for total ankle replacements performed in the inpatient setting. Hip and knee replacement are the most common surgeries for Medicare beneficiaries and by providing participating hospitals with bundled payments for these procedures, as well as ankle replacements, the CJR Model encourages hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization or outpatient procedure through recovery. The model was implemented through notice and comment rulemaking in a final rule published in the Federal Register on November 24, 2015. Certain model policies were modified in several subsequent final rules²¹, including addressing the removal of the Total Knee Arthroplasty (TKA) and Total Hip Arthroplasty (THA) from the inpatient-only (IPO) list in calendar year 2018 and calendar year 2020 respectively, by changing the definition of an ‘episode of care’, beginning in PY6, to include outpatient (OP) procedures for TKAs (OP TKAs) and THAs (OP THAs), in addition to inpatient procedures. The model began on April 1, 2016 and will run through December 31, 2024.

The CJR Model is a retrospective bundled payment model where CMS provides participant hospitals with a target price for each CJR MS-DRG, prior to the start of each performance year. All providers and suppliers furnishing LEJR episodes of care to patients throughout the year are paid under existing Medicare payment systems. The target price includes a discount over expected episode spending and initially incorporated a blend of historical hospital-specific spending and regional spending for LEJR episodes, with the regional component of the blend increasing over time and eventually being 100 percent regional for PYs 4 through 8. Following the end of a model performance year, actual total spending for the episode is compared to the target price for the participant hospital where the beneficiary had the initial LEJR surgery. Depending on the participant hospital’s quality and episode spending performance, the hospital

²¹ (82 FR 180); (82 FR 22899); (82 FR 57066); (83 FR 26604); (86 FR 23498)

may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.

The CJR Model is in its sixth performance year.

Evaluation Status/Results: The fourth evaluation report from the CJR Model was released in September 2021, and covers the first through fourth performance periods (April 2016–December 2019). The evaluation indicates that a range of hospitals, with a range of resources and circumstances, can and do successfully respond to the incentives under a mandatory episode-based payment approach for LEJR episodes to reduce per-episode payments while maintaining quality. LEJR episodes in the mandatory CJR Model areas had total episode payments 5.2 percent lower than control group episodes. On average across all LEJR episodes, total Medicare standardized (wage-adjusted) episode payments went down by \$1,511 more for CJR episodes between the baseline and the intervention periods than for control group episodes, which resulted in an estimated \$202.0 million reduction in Medicare payments. The report found that a variety of markets, hospitals, and patient types were able to significantly reduce episode payments. Reductions in total episode payments were driven by shifts to less intensive post-acute care settings and shorter lengths of stay. After accounting for the \$126.1 in reconciliation payments made to hospitals, the estimated savings to the Medicare program was \$76.0 million. While the CJR Model reduced average episode payments, due to the wide range around the estimated decrease CMS cannot conclude with statistical certainty that the CJR Model resulted in savings to Medicare in its first four performance years.

During the first four performance years, the unplanned readmission rate decreased more for CJR episodes than for control group episodes, representing a 3.5 percent decrease from the CJR baseline. For elective LEJR episodes, there was a relative reduction in the complication rate, representing a 7.9 percent decrease from the CJR baseline. There were no statistically significant changes in emergency department use or mortality. CJR Model and comparison group patient survey respondents reported making similar gains in functional status from before their hospitalization to after the end of the episode, and reported similar satisfaction with their overall recovery, care management, and care transitions experiences. While the majority of patients reported needing some level of caregiver support, CJR beneficiaries reported needing slightly more help than comparison beneficiaries. For the subset of survey respondents with a hip fracture, CJR respondents reported less improvement in functional status from before their LEJR to the end of their episode than control respondents. Hospitals reported making changes along the clinical care pathways with a heavy focus on provider and patient education. Additional hospital care redesign strategies include engaging caregivers in the process, same-day ambulation, coordinating with post-acute care facilities, and following up with patients after hospital discharge.

Webpage: Additional information is available at the [CJR Model webpage](#).

Comprehensive End-Stage Renal Disease Care Model (CEC)

Model Announcement Date: April 15, 2014

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

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

Number of Participants: 33 ESCOs, of which 29 were Large Dialysis Organizations (LDOs) owned dialysis facilities and four were non-Large Dialysis Organizations (non-LDOs) owned dialysis facilities with 65,472 ESRD beneficiaries as of March 2021.

Geographic Scope: ESCOs were located in Alabama, Arizona, California, Delaware, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Minnesota, Nevada, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington.

Model Types: Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities:

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

- Reduced 2020 downside risk for those months affected by the PHE;
- Capped ESCOs' gross savings upside potential at five percent gross savings;
- Removed COVID-19 inpatient episodes;
- Removed 2020 financial guarantee requirement;
- Made 2020 quality reporting optional and used the higher of 2019 or 2020 quality scores; and
- Extended the model until March 31, 2021.

Model Description: The Comprehensive End-Stage Renal Disease Care (CEC) Model is based on findings from the Pioneer Accountable Care Organization (ACO) Model, Next Generation ACO Model, and the Medicare Shared Savings Program. In the CEC Model, dialysis facilities, nephrologists, and other providers joined together to create ESCOs to coordinate care for aligned beneficiaries. ESCOs were accountable for clinical quality and cost of care provided to aligned ESRD beneficiaries as measured by Medicare Part A and B spending, including all spending on dialysis services. This model encouraged dialysis providers to think beyond their traditional roles in care delivery and created incentives for

them to provide patient-centered care that would address beneficiaries' health needs, both inside and outside of the dialysis facility.

The 29 ESCOs with LDOs were able to receive shared savings payments and were liable for shared losses (two-sided risk). ESCOs with participation by dialysis facilities owned by non-LDOs had the option to participate in either a two-sided risk track or a one-sided risk track where they would be able to receive shared savings and would not be liable for shared losses. All 29 ESCOs with LDOs participated in two-sided risk arrangements and qualified as Advanced Alternative Payment Models (APM) under the Quality Payment Program, while all four ESCOs with non-LDOs participated in one-sided financial risk.

Evaluation Status/Results: The fifth and final evaluation report from CEC was released in January 2022, and covers the life of the model (October 1, 2015–March 31, 2021). The report found that CEC reduced Medicare spending by \$217 million. This represents a 1.3 percent decrease. When Medicare shared savings payments to ESCOs are accounted for, Medicare experienced net losses of \$46 million. Lower spending was driven by reductions in hospitalizations and accompanying services such as readmission and institutional post-acute care. There was a three percent reduction in the number of hospitalizations and a five percent reduction in hospitalizations due to ESRD complications.

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

Webpage: Additional information is available at the [CEC Model webpage](#).

Comprehensive Primary Care Plus Model (CPC+)

Model Announcement Date: April 2016

Model Performance Period:

- First cohort: January 1, 2017–December 31, 2021
- Second cohort: January 1, 2018–December 31, 2021

Model Participants: Primary care practices

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to the Coronavirus Disease 2019 Public Health Emergency (PHE), the Comprehensive Primary

Care Plus (CPC+) Model made several adjustments related to financial methodologies and quality reporting for PY2020:

- Option for CPC+ practices to receive advanced prospective, non-claims based quarterly payments (care management fees and partial capitation payments) for 2020 Q3 in May 2020 (for instance, two months early);
- Adjusted PY2020 performance-based incentive payment (PBIP) benchmarks and scoring approach for quality and utilization measures (for example, higher of practices' 2019 CAHPS score or median CAHPS; higher of practices' 2019 or 2020 overall PBIP performance);
- Did not administer 2020 CAHPS;
- Made care delivery reporting optional for summer 2020; and
- Cancelled 2020 quality and financial audits (but conducted small number of ad hoc audits).

Number of Participants: 2,851

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

Model Types: Primary Care Transformation

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

The CPC+ Model included two primary care practice tracks (“Track 1” and “Track 2”) with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. CPC+ aimed to improve beneficiaries’ health and quality of care, and decrease total cost of care. Practices in both tracks made changes to the way providers delivered care, centered on key care delivery functions: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health.

To support the delivery of comprehensive primary care, CPC+ made upfront financial investments through quarterly care management fees and increased payment to Track 2 practices serving beneficiaries with complex needs. While Track 1 practices received payment from Medicare Fee-For-Service (FFS) as usual, CPC+ shifted a portion of Track 2 practices’ FFS payments into quarterly non-claims-based payments. Annual performance-based incentive payments reward practices based on their performance on patient experience measures, clinical quality measures, and utilization measures that drove total cost of care. The

care delivery redesign ensured practices in each track had the infrastructure to deliver better care, resulting in a healthier patient population.

The CPC+ Model's multi-payer design brought 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+ practices were supported by 52 payer partners who shared CMS' commitment to alignment on payment, data sharing, and quality metrics in the CPC+ Model. The multi-payer partnership gave practices additional financial resources and flexibility to make investments to improve the quality and efficiency of care and reduce unnecessary health care utilization. The CPC+ Model provided practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback to guide their decision-making.

Evaluation Status/Results: The fourth CPC+ evaluation report was released in May 2022, and covers the fourth year of the model for practices that started participation in January 2017. In the fourth year of the model, acute inpatient expenditures decreased, while other types of expenditures increased, resulting in no model impacts on total Medicare expenditures without accounting for the model payments and an increase in total Medicare expenditures when the model payments were included. After factoring in the model payments, Medicare expenditures increased by \$1 and \$2 per beneficiary per month (1.5 and 2.6 percent), respectively, in Track 1 and Track 2, relative to comparison practices outside of the model, during the first four years of the model. The report did find some modest favorable effects on service use and quality, including reductions in acute hospitalizations by one percent, emergency department visits by 1.8 percent, and primary care visits by 1.8 percent. Hospice use increased by 4.5 and 3.8 percent in Track 1 and Track 2, respectively, with larger effects in later years. While the evaluation did adjust for potential bias from the PHE, we still interpret these latest impact estimates with caution. The report also found that participating primary care practices continued to receive substantial support from CMS and partner payers, which helped them weather the pandemic and meet their patients' physical and mental health needs.

Webpage: Additional information is available at the [CPC+ Model webpage](#).

Emergency Triage, Treat, and Transport Model (ET3)

Model Announcement Date: February 14, 2019

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

Model Participants: Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers are participating in the payment model.

Number of Participants: A total of 184 participants entered into a Participation Agreement (PA) with CMS to participate in the Emergency Triage, Treat, and Transport (ET3) Model. A final list of ET3 Model participants is available on the ET3 Model website.

Geographic Scope: The ET3 Model is nationwide. Participants in the ET3 Model are Medicare-enrolled ambulance service suppliers or ambulance providers in 36 states.

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: For the duration of the PHE, CMS temporarily expanded the list of allowable destinations for ambulance transports. Participants in the model will be able to continue to access these flexibilities while participating in the model, for as long as they are available. Additionally, CMS decided to delay the start of the ET3 Model from May 1, 2020 until January 2021 in response to the PHE.

Model Description: The ET3 Model is a voluntary, five-year payment model that provides greater flexibility to ambulance care teams to address emergency health care needs of Medicare FFS beneficiaries following a 911 call. CMS will continue to pay to transport a Medicare FFS beneficiary to a hospital emergency department (ED) or other Medicare-covered destination. In addition, under the model, CMS pays participants to: (1) transport a beneficiary to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or (2) initiate and facilitate the treatment of a beneficiary in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. The model will allow beneficiaries to access the most appropriate services at the right time and place. As a result, the ET3 Model aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.

Evaluation Status/Results: Assuming sufficient volume to evaluate the model, the evaluation will assess savings, changes in quality and other outcomes to Medicare beneficiaries that result from substituting transports to alternative destinations and treatment in place for ED visits and transports to other Medicare-covered destinations. Potential savings may result from care provided in lower cost settings (such as urgent care centers, CMHCs, physician offices) and modalities (such as telehealth in treatment in place).

Webpage: Additional information is available at the [ET3 Model webpage](#).

End-Stage Renal Disease Treatment Choices (ETC) Model

Model Announcement Date: Model announced and Notice of Proposed Rulemaking issued July 10, 2019. Final rule appeared in the Federal Register on September 29, 2020.

Model Performance Period: Delayed start (relative to the start date proposed in the Notice of Proposed Rulemaking) as a result of the Coronavirus Disease 2019 Public Health Emergency (PHE). Start date: January 1, 2021. End date: June 30, 2027.

Model Participants: Managing clinicians (MCs) and end-stage renal disease (ESRD) facilities. A Managing Clinician is a Medicare-enrolled physician or non-physician practitioner who furnishes treatment and bills the Monthly Capitation Payment (MCP) for managing one or more adult ESRD beneficiaries.

Number of Participants: CMS required ESRD facilities and MCs to participate in the model according to their location in randomly selected geographic areas and in a manner that will account for approximately 30 percent of ESRD facilities and MCs in the 50 States and District of Columbia. In 2021, the ETC Model included 2,425 ESRD facilities and 3,056 MCs.

Geographic Scope: CMS required 30 percent of Hospital Referral Regions (HRR) across the country (excluding U.S. territories). ESRD facilities and MCs in HRRs with at least 20 percent of the component ZIP Codes located in Maryland are included in the model's interventions, unless otherwise excluded, in a manner consistent with the ongoing Maryland Total Cost of Care Model.

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Coronavirus Disease 19 Public Health Emergency (PHE) Flexibilities: In response to the COVID-19 Public Health Emergency (PHE), the CMS Innovation Center issued telehealth flexibilities for the ETC Model. Flexibilities active during the period covered in this report include:

- Clarifying waivers of select requirements for furnishing kidney disease patient education services, and issuing additional waivers to allow such services to be furnished via telehealth upon the expiration of the COVID-19 PHE.

Model Description: The ESRD ETC Model tests the use of payment adjustments to increase rates of home dialysis and transplantation in order to preserve or enhance the quality of care furnished to Medicare beneficiaries while reducing Medicare expenditures. Under the ETC Model, CMS will make certain payment adjustments to encourage participating ESRD facilities and MCs to ensure that ESRD beneficiaries have access to different treatment options and receive education about these options.

As finalized in September 2020 in the “Medicare Program; Specialty Care Models to Improve Quality of Care and Reduce Expenditures” final rule, certain ESRD facilities and Managing Clinicians selected for participation will be excluded from certain payment adjustments because they serve low volumes of adult ESRD beneficiaries.

The ETC Model includes two payment adjustments. The first is a uniformly positive adjustment on Medicare claims for home dialysis and home dialysis-related services during the initial three years of the model (January 1, 2021 through December 31, 2023), providing an additional payment to selected ESRD facilities and MCs for supporting beneficiaries dialyzing at home. The second adjustment is a positive or negative adjustment that is determined based on the ETC Participant's home dialysis rate and transplant rate among attributed beneficiaries. The magnitude of the positive or negative payment adjustments increases during the duration of the model. This adjustment applies to both home and in-center dialysis and dialysis-related claims from July 1, 2022 through June 30, 2027.

In the CY 2022 ESRD Prospective Payment System (PPS) final rule, which appeared in the Federal Register on November 8, 2021 and became effective January 1, 2022, CMS made changes to the ETC Model to address socioeconomic disparities in home dialysis and transplant rates. These changes include a two-tiered approach to address disparities by stratifying achievement benchmarks based on the proportion of attributed beneficiaries who are dually eligible for Medicare and Medicaid or Low Income Subsidy (LIS) recipients, and adding the Health Equity Incentive for ETC Participants who demonstrate significant improvement in the home dialysis rate or transplant rate among their attributed beneficiaries who are dually eligible or LIS recipients.

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

Webpage: Additional information is available at the [ETC Model webpage](#).

Enhancing Oncology Model (EOM)

Model Announcement Date: June 27, 2022

Model Performance Period: July 1, 2023–June 29, 2028

Model Participants: Physician group practices (PGPs)

Number of Participants: N/A; As of August 2022, participant selection has not occurred.

Geographic Scope: Nationwide

Model Types: Episode-based Payment Initiatives

Model Description: The Enhancing Oncology Model (EOM) aims to drive transformation and improve care coordination in oncology care by preserving and enhancing the quality of care furnished to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare fee-for-service (FFS). Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding systemic chemotherapy administration to patients with common cancer types. EOM is a five year voluntary model, beginning on July 1, 2023, that aims to improve quality and reduce costs through payment incentives and required participant redesign activities. CMS designed EOM to test how to improve health care providers' ability to deliver care centered around patients, consider patients' unique needs, and deliver cancer care in a way that will generate the best possible patient outcomes.

Under EOM, participating PGPs will take on accountability for their patients' health care quality and for total spending during 6-month episodes of care for beneficiaries with certain cancers.

- EOM will include a Monthly Enhanced Oncology Services (MEOS) payment for Enhanced Services provided to eligible beneficiaries. The MEOS payment will be higher for beneficiaries dually eligible for Medicare and Medicaid.
- EOM participants will have the opportunity to earn a retrospective performance-based payment (PBP) based on care quality and savings, or owe CMS a performance-based recoupment (PBR). Participants will be required to take on downside risk from the start of the model.
- EOM participants will be required to implement participant redesign activities, including 24/7 access to care, patient navigation, care planning, use of evidence-based guidelines, use of electronic Patient Reported Outcomes (ePROs), screening for health-related social needs, use of data for quality improvement, and use of certified electronic health record technology.
- EOM will focus on beneficiaries receiving systemic chemotherapy (that is, not beneficiaries receiving hormonal therapy only) for seven cancer types: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.

Evaluation Status/Results: N/A

Webpage: Additional information is available at the [EOM webpage](#).

Expanded Home Health Value-Based Purchasing Model (Expanded HHVBP)

Model Announcement Date: November 2021

Model Performance Period: Model began on January 1, 2022 and will continue indefinitely

Model Participants: Medicare-certified home health agencies (HHAs)

Number of Participants: As of 2020, approximately 11,000 Medicare certified HHAs nationwide

Geographic Scope: HHAs in the 50 states, territories and District of Columbia

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: CMS will continue to test whether higher payment incentives can significantly change health care providers' behavior to improve quality of care by shifting Medicare-certified HHAs from volume-based to value-based purchasing. The expanded HHVBP Model design largely mirrors the original Model design with modifications, including removing "new measure" data collection; revising the cohorts used to define benchmarks, achievement thresholds, and the payment adjustments from state-level to nationwide groupings; and updating the baseline year. The expanded model will apply the same financial and quality improvement incentives, quality reporting structure, and payment adjustment framework as the existing model.

Evaluation Status/Results: CMS will continue to monitor the performance data under expansion. The first monitoring report will examine CY 2023 performance.

Webpage: Additional information is available at the [Expanded HHVBP Model webpage](#).

Global and Professional Direct Contracting (GPDC) Model

Model Announcement Date: The Global and Professional Direct Contracting (GPDC) Model was announced on April 22, 2019. On February 24, 2022, the Centers for Medicare & Medicaid Services (CMS) announced the GPDC Model would be redesigned and renamed the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model starting January 1, 2023.

Model Performance Period: The six-year performance period that began on April 1, 2021 and ends on December 31, 2026. Three implementation periods, one leading up to each of the first three performance years were offered to new model participants prior to the start of their

beginning participation in the model performance period. The first such implementation period began on October 1, 2020.

Model Participants: Each organization currently participating in the GPDC Model pursuant to a Participation Agreement with CMS is a Direct Contracting Entity (DCE). A DCE is another name for an Accountable Care Organization (ACO). There are three types of DCEs, each with different characteristics and subject to different standards: (1) Standard DCEs comprised of health care providers that generally have experience serving Medicare FFS beneficiaries; (2) New Entrant DCEs comprised of health care providers that have not traditionally provided services to Medicare fee-for-service (FFS) beneficiaries; and (3) High Needs Population DCEs serving Medicare FFS beneficiaries with complex needs as defined by CMS. A variety of entities are eligible to participate in the model through contractual arrangements with a DCE, including health systems, physician practices, provider groups, payers, community-based organizations, and Programs of All-Inclusive Care for the Elderly organizations. Direct Contracting Participant Providers and Preferred Providers must be Medicare-enrolled providers or suppliers.

Beginning in 2023, model participants will be referred to as Medicare Accountable Care Organizations (ACOs) under the redesigned and renamed ACO REACH Model. The ACO REACH Model will continue to offer model participants the option to participate as a Standard ACO, New Entrant ACO, or High Needs Population ACO.

Number of Participants: In 2022, there were 99. For 2023, CMS offered a Request for Applications for new organizations interested in beginning participation in the ACO REACH Model. Out of 271 complete applications submitted, CMS offered provisional acceptance to 128 organizations. Additionally, current GPDC Model participants must maintain a strong compliance record and agree to meet requirements for the ACO REACH Model by January 1, 2023 in order to continue their participation.

Geographic Scope: Nationwide

Model Types: Primary Care Transformation, Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to feedback expressed by applicants regarding a January 2021 start date and the need to implement the model as close to its original design as possible, the CMS Innovation Center:

- Delayed start of the first performance year of the model to April 1, 2021;
- Planned for a 2021 performance year of fewer than 12 months (April 1, 2021–December 31, 2021);
- Adjusted the financial methodology for the model to reflect the altered duration of the 2021 performance year;

- Adjusted quality benchmarks to reflect the altered duration of the 2021 performance year; and
- Permitted accepted applicants to delay participation to January 1, 2022.

Model Description: The GPDC Model tests alternative approaches to risk-sharing arrangements and payment. The goal is to reduce expenditures and preserve or enhance quality of care for beneficiaries in Traditional Medicare. The GPDC Model builds on lessons learned from initiatives involving Medicare ACOs, such as the Medicare Shared Savings Program and the Next Generation ACO (NGACO) model test.

The GPDC Model provides new opportunities for a variety of organizations to participate in value-based care arrangements. In addition to organizations that have provided services to a Traditional Medicare population, the GPDC Model will provide new opportunities for organizations with less experience in Medicare fee-for-service (FFS) to enter into value-based care arrangements.

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

There are two risk-sharing options available: Professional and Global.

1. **The Professional Option** offers a lower risk-sharing arrangement—50 percent of savings and losses with risk corridors and optional stop-loss protection risk mitigation strategies—and provides Primary Care Capitation (PCC) Payment, a capitated, risk-adjusted monthly payment for enhanced primary care services provided by DC Participant Providers and those Preferred Providers participating in PCC.
2. **The Global Option** offers a higher risk-sharing arrangement—100 percent of savings and losses with broader risk corridors and optional stop-loss protection risk mitigation strategies—and provides two payment alternatives: either PCC Payment or Total Care Capitation (TCC) Payment, a capitated, risk-adjusted monthly payment for all services provided by DC Participant Providers and those Preferred Providers participating in TCC.

The risk-sharing options under the GPDC Model provide an opportunity to test novel methods for managing Medicare FFS expenditures. The GPDC Model seeks to improve quality of care and health outcomes for Medicare beneficiaries through the alignment of financial incentives, emphasis on patient choice, strong monitoring to ensure that beneficiaries, including patients with complex, chronic conditions and seriously ill populations, maintain access to care, and an emphasis on care delivery. To help ensure that care quality is improved and beneficiary choice and access are protected, CMS will withhold a meaningful percentage of the benchmark subject to performance on quality of care, while also monitoring model

participants to ensure that beneficiaries' access to care is not adversely affected as a result of the model.

On February 24, 2022, CMS announced that, effective January 1, 2023, the GPDC Model would be redesigned, in response to Administration priorities, including commitment to advancing health equity, stakeholder feedback, and participant experience. CMS also renamed the model the ACO REACH Model to better align the name with the purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved.

Changes in the model design for ACO REACH will better inform the Medicare Shared Savings Program and future models by testing approaches to:

- Advancing health equity to bring the benefits of accountable care to underserved communities;
- Promoting provider leadership and governance; and
- Protecting beneficiaries and the model with more participant vetting, monitoring, and transparency.

A separate model test—the Geographic Direct Contracting Model—was announced on December 3, 2020.²² However, CMS subsequently announced the cancellation of the Geographic Direct Contracting Model on February 24, 2022.

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

Webpage: Additional information is available at the [GPDC Model webpage](#) and the [ACO REACH Model webpage](#).

Home Health Value-Based Purchasing Model (HHVBP)

Model Announcement Date: November 2015

²² Information about this model is available at [Geographic Direct Contracting Model](#).

Model Performance Period: January 1, 2016–December 31, 2021²³

Model Participants: Medicare-certified Home Health Agencies (HHAs)

Number of Participants: Approximately 1,800

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

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: The HHVBP Model was designed to test whether higher payment incentives can significantly change health care providers' behavior to improve quality of care by shifting Medicare-certified HHAs from volume-based to value-based purchasing. The specific goals of the model were 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 public reporting process.

The original HHVBP Model was implemented in nine States representing each geographic area in the nation. Requiring all Medicare-certified HHAs in the selected states to participate in the Model ensured that competing HHAs were representative of HHAs nationally, and there was no selection bias and sufficient participation to generate meaningful results.

HHAs participating in the original model received annual payment adjustments based on their total performance score (TPS) for the applicable performance year. This score was based on National Quality Strategy (NQS) measures, claims-based and survey-based measures, as well as process measures developed by the CMS Innovation Center in an effort to address existing gaps in quality metrics.

HHAs in the nine states had their payments adjusted in the following manner:

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

²³ The CY 2022 HH PPS Final Rule ended the original HHVBP Model one year early for the HHAs in the nine original Model states, such that CY 2020 performance data will not be used to calculate a payment adjustment for HHAs in the nine states and will not have their payments impacted in CY 2022.

Nationwide Expansion: The evaluation findings from 2016–2018 achieved an average 4.6 percent improvement in quality scores as well as average annual savings of \$141 million to Medicare. These findings, coupled with the CMS Chief Actuary’s certification and determinations made by the Secretary designated the HHVBP Model as eligible for expansion nationwide through rulemaking. On January 8, 2021, CMS [announced](#) its intent to expand the original HHVBP Model. The HHVBP Model was expanded nationwide in the Calendar Year (CY) 2022 Home Health Prospective Payment System (HH PPS) Final Rule. All Medicare-certified HHAs in the 50 states, territories and District of Columbia will be required to participate beginning January 1, 2023. CY 2022 is a pre-implementation year during which CMS is providing learning opportunities to support HHAs in preparing for the CY 2023 performance year.

Evaluation Status/Results: The fifth evaluation report from the HHVBP Model was published in 2022 and covers five Performance Years of the model (CY 2016–2020). The evaluation found modest improvements in quality of care and a reduction in Medicare expenditures. Total Performance Scores (TPS), an aggregate quality score used to compute payment adjustments for home HHAs, were 7.4 percent higher among HHAs in HHVBP states than HHAs in non-HHVBP states in 2020. OASIS-based outcome measure scores (components of the TPS) for HHAs increased more in HHVBP states than in comparison states. Home health users in HHVBP states had greater decreases in Medicare spending compared to beneficiaries in non-HHVBP states. Among home health users in HHVBP states, average Medicare spending decreased \$2.17 per day, or 1.6 percent for the home health episode plus 30 days following the episode, for aggregate Total Medicare savings of \$949 million during the five years. Spending decreased primarily during the home health episode itself and was driven by reductions in hospitalization payments. Although two of five measures of patient experience with care declined slightly, the model significantly reduced unplanned hospitalizations and improved beneficiaries’ functional status on five of six OASIS measures.

Webpage: Additional information is available at the [HHVBP webpage](#).

Integrated Care for Kids (InCK) Model

Model Announcement Date: August 23, 2018

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

Model Participants: State Medicaid agencies, local health care providers, public health departments, and universities.

Number of Participants: Seven awardees, including two award recipients in Illinois

Geographic Scope: 17 rural and urban counties across six states: Connecticut, Illinois, New Jersey, New York, North Carolina, and Ohio

Model Types: Initiatives Focused on the Medicaid and CHIP Populations

Model Description: The Integrated Care for Kids (InCK) Model is a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children under 21 covered by Medicaid and the Children’s Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. Some programs also include pregnant women over age 21 who are covered by Medicaid. InCK awardees devoted 2020 to 2021 planning their programs in order to begin conducting enhanced care coordination activities and universal needs assessments for health, behavioral health and health-related social needs in children and youth on January 1, 2022.

The goals of the InCK Model are to improve child health, reduce avoidable inpatient stays and out-of-home placement, and create sustainable Alternative Payment Models (APMs). The InCK Model supports state and local providers in conducting early identification and treatment of children with general health, behavioral health, and health-related social needs across settings. Participants integrate care coordination and case management across physical and behavioral health and other local service providers to provide child- and family-centered care. APMs support the early identification, risk stratification, and service integration activities.

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

Webpage: Additional information is available at the [InCK Model webpage](#).

Kidney Care Choices Model (KCC)

Model Announcement Date: July 10, 2019

Model Performance Period: January 1, 2022–December 31, 2026

Model Participants: Kidney Contracting Entities (KCEs) and CMS Kidney Care First (KCF) Practices

Number of Participants: 85, 55 KCEs and 30 KCF Practices

Geographic Scope: Nationwide

Model Types: Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: To create necessary flexibilities for participants in the KCC Model, we:

- Delayed the start of the first Performance Period for the first cohort to January 1, 2022;
- Created an application cycle during 2022 for a second cohort to launch January 1, 2023; and
- KCC includes a telehealth benefit enhancement (BE), allowing for the provision of certain services via telehealth. This waiver was part of the original model design, and is not in response to the PHE.

Model Description: The Kidney Care Choices (KCC) Model builds upon lessons learned from the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model. The KCC Model enables nephrologists and non-physicians who provide nephrology care (nephrology professionals), transplant providers, dialysis facilities, and other healthcare providers to manage care for beneficiaries with chronic kidney disease (CKD) Stages 4 and 5, ESRD, and kidney transplants by adding strong financial incentives for health care providers to delay the onset of dialysis, achieve better starts on dialysis, coordinate care, and guide beneficiaries through the kidney transplantation process.

The model has four options for participation: (1) the KCF Option; (2) the Comprehensive Kidney Care Contracting (CKCC) Graduated Option; (3) the CKCC Professional Option; and (4) the CKCC Global Option. The KCF Option is open to participation by nephrology practices, and their nephrologists and nephrology professionals. KCEs participating in the CKCC Options are required to include nephrologists or other nephrology professionals and transplant providers, while dialysis facilities and other types of providers and suppliers are optional participants in KCEs.

The patient is a key component of the model design. The tendency now is for patients with kidney disease to undergo the most expensive treatment path, with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment. By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision-making for their care. Beneficiaries with CKD Stages 4 and 5 or ESRD are aligned to a model participant based on where the beneficiary receives the majority of their kidney care. When an aligned beneficiary receives a kidney transplant, they remain aligned to that model participant for up to three years following a successful kidney transplant or until a kidney transplant fails.

In both the KCF Option and CKCC Options, participating KCF Practices and KCEs receive a CKD Quarterly Capitation Payment (QCP) on a per-beneficiary basis for managing the care of aligned beneficiaries with late-stage chronic kidney disease. Participants also receive the Adjusted Monthly Capitation (AMCP) for aligned beneficiaries with ESRD, which includes the normal Medicare Monthly Capitation Payment (MCP) and the Home Dialysis True-Up, to remove the disincentive for prescribing home dialysis. In addition, participating entities who guide beneficiaries through the kidney transplantation process will receive a Kidney Transplant Bonus (KTB) payment for every aligned beneficiary who receives a successful kidney transplant. The KTB is paid in installments based on whether the transplant remains successful for up to three years after the surgery.

In the KCF Option, CMS adjusts the amount of the CKD QCP and MCP portion of the AMCP paid to each KCF Practice based on the KCF Practice's performance on quality and utilization measures compared to the participating practice's own experience and national benchmarks.

The CKCC Options include the Graduated, Professional, and Global Options. In these options, KCEs take responsibility for the total cost and quality of care for their patients, and in exchange, can receive a portion of the Medicare savings they achieve. The three CKCC Options have distinct accountability frameworks, as follows:

- CKCC Graduated Option: This option allows participating KCEs to begin under a lower-reward, one-sided risk model and incrementally phase into accepting greater risk and greater potential reward.
- CKCC Professional Option: This option gives participating KCEs the opportunity to earn 50 percent of savings or be liable for 50 percent of losses based on the total cost of care for Part A and B services.
- CKCC Global Option: This option gives participating KCEs risk for 100 percent of the total cost of care for all Parts A and B services for aligned beneficiaries.

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

Webpage: Additional information is available at the [KCC Model webpage](#).

Maryland Total Cost of Care Model (Maryland TCOC)

Model Announcement Date: May 14, 2018

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

Model Participants: Acute care hospitals, primary care practices, other non-hospital providers and suppliers, care transformation organizations

Number of Participants: More than 2,100 (number of participants in Maryland Primary Care Program: 2,108; number of Maryland acute care hospitals under a Global Budget: 47)

Geographic Scope: State of Maryland

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to the Coronavirus Disease 2019 PHE, in September 2021, the CMS Innovation Center announced flexibilities for Maryland Primary Care Program (MDPCP) participants. Specifically, the CMS Innovation Center:

- Modified its performance-based incentive payment (PBIP) quality and utilization evaluation for Performance Year (PY) 2020 as well as the process and timeline for the PBIP report issuance and recoupment process. CMS used the better of a practice's standard acute hospital utilization (AHU) score or Area Deprivation Index (ADI) adjusted AHU score with a 2020 Maryland benchmark to calculate the AHU component of the PBIP for PY2020. CMS replicated this approach for the Emergency Department Utilization (EDU) component of the PBIP for PY2020 as well. Using a concurrent benchmark represents a fair evaluation of the AHU and EDU measures for payment purposes, as no other year shares the utilization trends observed during the PHE.
- CMS used the better of the practice's 2020 performance score or the 2020 MDPCP program's median performance score when analyzing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey responses for the quality component of the PY2020 PBIP. CAHPS surveys cover the latter half of the performance year, wherein visit numbers and appointment availability recovered to near-normal rates despite the ongoing PHE.
- In determining the scoring for MDPCP eCQM quality measures, CMS noted the high likelihood of changes to care-seeking behavior as evidenced by CCSQ's determination that CMS122 and CMS165 are measures at high risk of PHE-related impact. It is possible that MDPCP beneficiaries did not have access to home monitoring equipment for blood pressure or hemoglobin A1C and, due to the PHE, may not have attended primary care office visits as they otherwise would have. It would be unfair to penalize

practices for their patients' decisions to stay home during the PHE, as recommended by state guidelines. Therefore, CMS maintained the 2018 MIPS benchmarks as planned and used the better of an MDPCP practice's performance score or the 2020 MDPCP program's median performance score when calculating each MDPCP Practice's performance on the electronic clinical quality measures for PY 2020. This approach guarded against the variations in COVID-19 incidence and prevalence by using 2018 MIPS benchmarks while also providing practices with a safeguard against changes to care-seeking behavior stemming from the PHE by guaranteeing practices at least a median score on each eCQM.

In addition, the Protecting Medicare and American Farmers from Sequester Cuts Act applies to the quarterly care management fees (CMF) and comprehensive primary care payments (CPCP) made by CMS to MDPCP participants in MDPCP. CMS will apply sequestration to the CMFs and CPCPs made during calendar year 2022, in accordance with the Protecting Medicare and American Farmers from Sequester Cuts Act. Sequestration was not applied to the annual prospective performance-based incentive payment (PBIP) paid to the practice in 2022; this is consistent with prior year approaches to the application of sequestration to MDPCP payments. CMS will retrospectively reconcile the PBIP based on the MDPCP participant's performance on quality and utilization measures.

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

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

The Maryland TCOC Model sets Maryland on course to achieve fixed amounts of per-capita total cost of care savings to Medicare during each model year between 2019 and 2023. The

model's financial targets are structured to obtain a total of more than \$1 billion in Medicare total cost of care savings by the fifth Performance Year of the model (2023).

The Maryland TCOC Model includes three programs:

- The Hospital Payment Program (HPP) tests population-based payments for Maryland hospitals. In Maryland's HPP, each hospital receives a population-based payment amount to cover all hospital services provided during the course of the year. The HPP creates a financial incentive for hospitals to provide value-based care and to reduce the number of unnecessary hospitalizations, including readmissions. Under the HPP, each hospital is accountable for similar categories of quality measures to those used for the programs established under section 1886(o) (Hospital Value Based Purchasing program), section 1886(p) (Hospital Acquired Condition Reduction program), and Section 1886(q) (Hospital Readmissions Reduction program) of the Act. Maryland hospital quality and value-based payment programs that incorporate quality measures under the Maryland TCOC Model include: the Quality-Based Reimbursement (QBR) program; the Maryland Hospital Acquired Conditions (MHAC) program; and, the Readmission Reduction Incentive Program (RRIP).
- The Care Redesign Program (CRP) allows hospitals to make incentive payments to physician group practices and other non-hospital health care providers and suppliers who partner and collaborate with the hospital and perform care redesign activities aimed at improving quality of care and reducing the total cost of care for Medicare beneficiaries. A participating hospital may make incentive payments only if it has attained certain savings under its fixed global budget, and the total amount of incentive payments made cannot exceed such savings. Thus, the CRP and distribution of incentive payments under the program does not increase overall Medicare expenditures. To participate in the CRP, a hospital must enter into a CRP participation agreement with CMS and the state.
- The Maryland Primary Care Program (MDPCP) is structured to incentivize primary care practitioners and practices in Maryland to offer advanced primary care services to their patients. All participating practices receive a risk-stratified per-beneficiary-per-month payment directly from CMS intended to cover care management services—the care management fee (CMF). To support the flexible delivery of even more comprehensive and coordinated care, CMS will pay Track 2 Participant Practices the Comprehensive Primary Care Payment (CPCP), which is part upfront per-beneficiary-per-month (paid quarterly) and part reduced FFS payment (paid based on claims submission). The MDPCP also offers a Performance-based Incentive Payment (PBIP) to participating practices intended to incentivize them to reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements. CMS calculates the portion of the PBIP payment amount that an MDPCP participant must repay to CMS for a performance year

based on the analysis of MDPCP participant performance on an array of quality and utilization-focused measures. In June 2022, CMS solicited applications from Maryland primary care practices, care transformation organizations, and Federally Qualified Health Centers (FQHCs) to participate in the MDPCP beginning January 1, 2023.

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

In March 2021, CMS and the state agreed upon a framework for Maryland's population health strategy entitled the Statewide Integrated Health Improvement Strategy (SIHIS). SIHIS maximizes the population health improvement opportunities made possible by the Maryland TCOC Model. The SIHIS focuses on improving Maryland's health care system and the health outcomes of Marylanders in three domains: hospital quality, care transformation across the system, and total population health. For additional information regarding SIHIS please refer to the HSCRC's webpage located [here](#).

Beginning in 2022, CMS also offered the Health Equity Advancement and Resource Transformation (HEART) Payment for MDPCP participants to identify health-related social needs for high-cost and socioeconomically disadvantaged Medicare beneficiaries, address the complex needs of these underserved Medicare beneficiaries, and improve their health outcomes as part of their care management activities.

In June 2022, CMS announced an additional MDPCP track in which participating primary care practices will be rewarded or penalized for their performance on the cost and quality of care furnished to Maryland Medicare beneficiaries. This new track – MDPCP Track 3 – will begin on January 1, 2023. In the new track, participating practices and partner Care Transformation Organizations (CTOs) will receive a flat visit fee for select primary care services and a prospective population-based payment that will be adjusted, either positively or negatively, by a Performance Based Adjustment. The Maryland TCOC Model also includes an Outcomes-Based Credits framework, which is intended to incentivize statewide investment in population health and alignment across care transformation under the model. Within this framework, the state is able to receive credit for savings from population health improvements, which is structured as a discount in the amount of the Outcomes-Based Credits that will be applied to the state's actual TCOC used in calculating the state's performance against the model's savings targets. The amount of these Outcomes-Based Credits will be based on the savings from the population health improvements. CMS has approved one Outcomes-Based Credit methodology related to reduction in diabetes incidence, and expects to approve at least two additional Outcomes-Based Credit methodologies.

During the final three years of the performance period of the Model (calendar years 2024 through 2026), CMS and the state will negotiate an expanded model test, a new model test, or a transition to the national prospective payment systems.

Evaluation Status/Results: The first MD TCOC evaluation report released in July 2021 covers the implementation experience of the first two model years (January 1, 2019–December 31, 2020). In its first two years, the MD TCOC Model engaged a wide range of providers to begin transforming care throughout the state. The model continues to include hospital global budgets that encourage reductions in avoidable acute care while extending incentives and supports beyond the hospital to include post-acute providers, primary care, and community organizations. Also, during the first two model years, 468 primary care practices joined MDPCP, reaching 29 percent of primary care physicians and 47 percent of Medicare FFS beneficiaries in the state. MDPCP practices reported substantial improvements in care delivery during the first model year. Future evaluations will assess whether care transformation continues, expands in reach, and succeeds in reducing Medicare total cost of care while improving quality of care and population health for all Marylanders.

Webpage: Additional information is available at the [Maryland TCOC Model webpage](#).

Maternal Opioid Misuse (MOM) Model

Model Announcement Date: October 23, 2018

Model Performance Period: January 1, 2020–December 31, 2024. Note: Implementation started on January 1, 2021, but was delayed six months due to the COVID-19 Public Health Emergency (PHE). In this case, the performance period includes pre-implementation.

Model Participants: State Medicaid agencies and care-delivery partners, which include health and hospital systems, academic hospitals, and managed care organizations

Number of Participants: Eight state Medicaid agencies are participating in the model, working with 24 care-delivery partners

Geographic Scope: The model has enrolled women across Indiana, Maine, Maryland, and West Virginia. In Colorado, New Hampshire, Tennessee, and Texas, sites of care are limited to specified areas.

Model Types: Initiatives Focused on the Medicaid and CHIP Population

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to the COVID-19 Public Health Emergency (PHE), certain reporting requirements were waived or combined to reduce awardee burden. Pre-implementation was extended by six or more months in recognition of COVID-related administrative priorities and workforce shortages.

Model Description: CMS created the Maternal Opioid Misuse (MOM) Model in response to the surge in substance use-related illness and death in recent years, particularly in pregnant women. The primary goals of the MOM Model are to: (1) improve quality of care and reduce costs for pregnant and postpartum women with opioid use disorder (OUD) as well as their infants; (2) expand access, service-delivery capacity, and infrastructure based on state-specific needs; and (3) create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

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

- Supporting the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services.
- Leveraging CMS Innovation Center authorities and existing Medicaid flexibility to pay for sustainable care for the model population.
- Strengthening capacity and infrastructure by investing in institutional and organizational capacity to address key challenges in providing coordinated and integrated care.

State Medicaid agencies will implement the model with one or more care-delivery partners in their communities. Funding will be available for state awardees during the course of the five-year model in three distinct model periods: Pre-implementation, Transition, and Full Implementation.

Care delivery began in Year 2 of the model, with the start of the Transition Period on July 1, 2021 for six of the eight awardees. West Virginia and Texas delayed the start of enrollment until January 2022 and April 2022, respectively. After 12 months of Transition, states must implement strategies to cover and pay for all model services that are not otherwise covered by Medicaid. The MOM Model design supports each awardee's ability to quickly begin delivering coordinated and integrated care to pregnant and postpartum women with OUD during the Transition Period, while supporting states in developing a long-term coverage and payment strategy that aligns with their state Medicaid program.

Evaluation Status/Results: The evaluation of the MOM Model pre-implementation period indicated that beneficiaries face many barriers to care access, including transportation, childcare, and stigma. Care delivery partners are working to address these barriers. Integrating data systems to aid in coordinated care has been challenging, but care delivery partners have adapted current systems, such as state health information exchanges and current electronic health records to meet data sharing needs. Two states, Louisiana and Missouri, withdrew from the model during the pre-implementation period. The model implementation period evaluation will assess whether offering medication-assisted treatment in combination with behavioral health services and care coordination for pregnant women with OUD improves care quality and reduces costs for this population of women and their infants. The evaluation

plans to use Medicaid claims from the Transformed-Medicaid Statistical Information System linked to vital records and participants' medical chart data to investigate costs and health outcomes for women within each state. The program will develop comparison groups within states or from other states to verify outcomes. Because the model population is small and because state contexts vary, the evaluation will also conduct robust qualitative investigations to assess local contexts, individual women's experiences, and care access and quality for model participants.

Webpage: Additional information is available at the [MOM Model webpage](#).

Medicare Accountable Care Organization Track 1+ Model (Track 1+ Model)

Model Announcement Date: December 20, 2016

Model Performance Period: January 2018–December 2021

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

Number of Participants: 55 ACOs as of January 2018, of which 17 ACOs were participating upon Track 1+ Model conclusion on December 31, 2021. As of January 1, 2022, 69 percent of the Track 1+ Model ACOs had renewed their participation in the Shared Savings Program in either the BASIC or ENHANCED Track.

Geographic Scope: Nationwide

Model Types: Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: The CMS Innovation Center worked with the Center for Medicare to develop necessary flexibilities for all ACOs participating in the Medicare Shared Savings Program, including ACOs participating in the Track 1+ Model. CMS mitigated impacts of the PHE on Track 1+ Model participants by removing inpatient episodes of care for treatment of COVID-19 from benchmarks and other financial calculations, and by providing several other COVID-19 adjustments and flexibilities. For further information, please reference “The [Shared Savings and Losses and Assignment Methodology, Specifications of Policies to Address the Public Health Emergency for COVID-19](#)”, which describes the changes to Shared Savings Program policies to address the impact of the COVID-19 Public Health Emergency (PHE), which were finalized in the [Calendar Year \(CY\) 2021 Physician Fee Schedule Final Rule](#).

Model Description: CMS developed the Track 1+ Model in 2016 and 2017 to test a payment design that incorporated more limited downside risk than was then available in Track 2 or Track 3 of the Medicare Shared Savings Program. The Track 1+ Model was designed to

encourage more practices, especially small practices, to advance toward performance-based risk, and allowed ACOs that include hospitals—from large institutions to small rural hospitals—to participate. The Track 1+ Model was an Advanced APM, and eligible clinicians participating in Track 1+ Model ACOs had the potential to earn an incentive payment through the Quality Payment Program.

Early experience with and initial evidence on the design of the Track 1+ Model demonstrated that the availability of a lower-risk, two-sided model, was an effective way to encourage ACOs to take on risk. The lower level of risk offered under the Track 1+ Model was positively received by the industry and much of the methodology was incorporated into Level E of the BASIC Track under the Medicare Shared Savings Program, which was finalized in the December 2018 “Pathways to Success” Final Rule. ACOs were able to apply to the Track 1+ Model in 2018. Starting July 1, 2019, existing Track 1+ ACOs were given the option to complete the remainder of their agreement period as Track 1+ ACOs or to terminate their current participation agreement and apply to enter a new Medicare Shared Savings Program agreement period under either the BASIC track (Level E) or the ENHANCED track. Additionally, in response to the COVID-19 Public Health Emergency, Track 1+ ACOs in the last performance year of their current agreement period were allowed to elect to extend their agreement period for an additional performance year in 2021.

The Track 1+ Model tested an innovative design for a two-sided risk model, offering a two-part structure for determining the maximum level of the ACO’s loss liability according to the composition of ACO participants; applying either a revenue-based loss-sharing limit—a percentage of the ACO participants’ Medicare FFS revenues—or a benchmark-based loss-sharing limit—a percentage of the ACO’s updated historical benchmark. The Track 1+ Model’s lower risk provided information to determine whether:

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

and

- A model that includes these features might encourage more rapid progression to performance-based risk.

Evaluation Status/Results: The Track 1+ Model provided the Medicare Shared Savings Program with a significant increase in participation under downside risk that provided an evidence base for the design of the BASIC track, which was added to the program for agreement periods starting on or after July 1, 2019. Prior to the Track 1+ Model, as of January 1, 2017 only nine percent of Shared Savings Program ACOs were in a two-sided track and as of January 1, 2022, 59 percent of Shared Savings Program ACOs are in a two-sided track. Twenty percent of the ACOs in a two-sided track are in BASIC Level E. The Track 1+ Model provided a benchmark against which varying higher levels of financial risk sharing can ultimately be compared, including the ENHANCED track and models tested by CMMI. The Track 1+ Model also offers a baseline against the similar risk sharing required in BASIC track Level E to isolate whether other program changes are effective.

Webpage: Additional information is available at the [Shared Savings Program webpage](#).

Medicare Advantage Value-Based Insurance Design Model (VBID)

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

Model Participants: Medicare Advantage Organizations (MAOs)

Number of Participants: 34 MAOs in 49 states, DC, and Puerto Rico through 1,014 plan benefit packages (PBPs) in Plan Year (PY) 2022, up from 30 states and Puerto Rico with 157 participating PBPs in 2020 and 45 states, DC, and Puerto Rico with 451 participating PBPs in 2021

Geographic Scope: Eligible Medicare Advantage (MA) plan types in all states and territories may apply to participate in the Medicare Advantage Value-Based Insurance Design (VBID) Model. In PY 2022, MAOs are offering VBID Plan Benefit Packages (PBPs) in 49 states, the District of Columbia and Puerto Rico.

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: Through the VBID Model, CMS is testing service delivery and payment models that include a broad array of complementary MA health plan innovations designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including those with low incomes such as dually eligible individuals, and improve the coordination and efficiency of health care service delivery. Overall, the VBID Model

contributes to the modernization of the MA program and tests whether these model components improve health outcomes and lower expenditures for MA enrollees.

The model began allowing MAOs the flexibility to vary their plan benefit designs for enrollees with a limited set of clinical conditions. Since then, the model has expanded the permissible clinical conditions and has allowed MAOs to include additional interventions representing a broad array of value-based approaches to service delivery in MA, including the targeting of enrollees by chronic condition(s), socioeconomic status, or both, and the use of more flexible rewards and incentives.

The model has seen growth during the past few years in the number of enrollees eligible to receive VBID Model interventions—from 280,000 enrollees in 2020 to more than 3.7 million projected enrollees in 2022. Enrollees will receive additional benefits such as healthy foods and meals, transportation support, reduced cost-sharing, and have the ability to participate in additional Part C and Part D rewards and incentives programs as part of this model test. Of the 34 MAOs participating in 2022, 13 are participating in the Hospice Benefit Component, four more than in 2021, the initial year of the Hospice Benefit Component. These 13 organizations will test the model component through 115 PBPs (up from 53 PBPs in 2021) in service areas that cover 461 counties (up from 206 counties in 2021).

Outline of VBID Model Components Offered between Calendar Year (CY) 2020 to 2022

Between CY 2020 and 2022, CMS is testing the following health plan innovations in Medicare Advantage through the VBID Model.

- **Wellness and Health Care Planning (WHP)**—requires MAOs to develop a strategy to increase and track delivery of WHP services, including advance care planning (ACP), to enrollees;
- **VBID Flexibilities**—permits participating MAOs to offer VBID benefits to targeted enrollees, such as additional primarily and non-primarily health related supplemental benefits and reduced or eliminated cost sharing (including in the Part D benefit);
- **Hospice Benefit Component**—since CY 2021, allows participating MAOs to incorporate the Medicare Part A hospice benefit into their MA benefit offering with the goal of creating a seamless care continuum for enrollees in the MA program for Part A and Part B services; also requires participating MAOs to cover comprehensive palliative care services for eligible enrollees prior to hospice election and, as aligned with their approved application, make transitional, concurrent care services as well as hospice-specific supplemental benefits available to enrollees who elect hospice through network hospice providers.

- **Part C and D Rewards and Incentives (RI) Programs**—authorizes participating MAOs to provide higher-value rewards and incentives and RI programs in connection with Part D prescription drug benefits;
- **Flexibility to Cover New and Existing Technologies or U.S. Food and Drug Administration (FDA) Approved Medical Devices**—since CY 2021, allows MAOs to propose to cover, for targeted populations, new and existing technologies and medical devices that are FDA approved and that do not fit into an existing Medicare benefit category; **and**
- **Flexibility to Share Beneficiary Rebates Savings More Directly with Beneficiaries in the Form of Cash or Monetary Rebates**—in CYs 2021 and 2022, tests the flexibility for participating MAOs to share rebates in the form of cash or monetary rebates (as opposed to additional benefits coverage) under section 1854 of the Social Security Act with all of their enrollees through a mandatory supplemental benefit.

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

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

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

Overall, the VBID Model is not yet generating savings, but also is not costing Medicare additional money.

Webpage: Additional information is available at the [VBID Model webpage](#).

Medicare Care Choices Model (MCCM)

Model Announcement Date: June 2014

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

Model Participants: Hospices

Number of Participants: In December 2020, 85 hospices were participating prior to the one-year model extension; 49 hospices participated thereafter

Geographic Scope: 32 states (as of December 2020), followed by 25 states during one-year model extension

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: Through the Medicare Care Choices Model (MCCM), the Centers for Medicare & Medicaid Services (CMS) tested a new option for Medicare beneficiaries to receive supported care services from selected hospice providers, while continuing to receive services provided by other Medicare providers, including care for their terminal condition. CMS evaluated whether providing these supportive services could improve the quality of life and care received by Medicare beneficiaries, increase patient satisfaction, and reduce Medicare expenditures. Under current payment rules, Medicare and Medicaid beneficiaries with Medicare coverage (dually eligible beneficiaries) are required to forgo Medicare payment for care related to their terminal condition in order to receive services under the Medicare or Medicaid hospice benefit.

Under MCCM, selected hospices furnished support services made available under the Medicare hospice benefit that could not be separately billed under Medicare Parts A and B. These services included nursing, social work, hospice aide, hospice homemaker, volunteer (direct services), chaplain, bereavement, nutritional support, and respite care services (in-home only).

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

Evaluation Status/Results: The fourth MCCM evaluation report was released in April 2022 and covered the effect of the model on beneficiaries' outcomes from January 2016 through March 2021. Outcomes generally aligned with the expectations of the model. Specifically, MCCM beneficiaries were 29 percent more likely to enroll in the Medicare hospice benefit than matched comparison beneficiaries, and 26 percent less likely to be admitted to the hospital. These changes led to a 14 percent reduction in net Medicare expenditures (\$7,254 net savings per beneficiary) from the date of MCCM enrollment through death. Gross

Medicare savings totaled \$41.5 million and net Medicare savings totaled \$33.2 million through March 2021. MCCM also improved the quality of end-of-life care. Beneficiaries in MCCM were 26 percent less likely to receive an aggressive life-prolonging treatment in the last 30 days of life and spent six more days at home in the period between MCCM enrollment and death. These findings might not generalize to other settings, however, given the small number of MCCM hospices and the small percentage of eligible beneficiaries that enrolled.

Webpage: Additional information is available at the [MCCM webpage](#).

Medicare Diabetes Prevention Program Expanded Model (MDPP)

Model Announcement Date: July 7, 2016

Model Performance Period: April 2018–September 30, 2023

Model Participants: Medicare Diabetes Prevention Program (MDPP) suppliers can be traditional health care providers, such as physicians and hospitals, as well as community-based organizations, gyms, state and local health departments, and other qualifying entities. Such organizations can qualify through the Centers for Disease Control & Prevention (CDC) Diabetes Prevention Recognition Program (DPRP) to enroll in Medicare as MDPP suppliers, furnish MDPP services, and submit MDPP-related claims on the patients' behalf.

Number of Participants: Approximately 1,065 participants represent the number of MDPP locations across the U.S. There are 318 approved suppliers, and approximately 4 locations per supplier.

Geographic Scope: Nationwide

Model Types: Initiatives to Speed the Adoption of Best Practices

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: To create necessary flexibility for participants in the Medicare Diabetes Prevention Program Expanded Model, CMS initially extended the deadline for submitting the quarterly Crosswalk file to July 15, 2020. As part of the Interim Final Rule With Comment (IFC-1),²⁴ CMS established regulatory flexibilities in response to the COVID-19PHE for MDPP suppliers and beneficiaries enrolled in MDPP on or before March 1, 2020, including: removed the limits on the number of both in-person and virtual make-up sessions; allowed virtual delivery of MDPP services for suppliers with capabilities to provide them virtually; waived the once per lifetime benefit for enrolled beneficiaries; and waived the five percent weight loss requirement for beneficiary eligibility in the ongoing maintenance sessions intervals. In the Calendar Year (CY) 2021

²⁴ <https://www.cms.gov/files/document/covid-final-ifc.pdf>

Physician Fee Schedule (PFS),²⁵ CMS established an Emergency Policy that applies more broadly than the flexibilities finalized in the March 31, 2020 COVID-19 IFC, and provides MDPP suppliers and MDPP beneficiaries with flexibilities to address any future applicable 1135 waiver event. The flexibilities apply effective January 1, 2021 to the remainder of the COVID-19 PHE and all future applicable 1135 waiver events.

Model Description: In March 2016, under delegation of authority by the Secretary, CMS determined that the MDPP model test, tested through a Round One Health Care Innovation Award, met the criteria for expansion. The MDPP Expanded Model was developed through two rounds of rulemaking in the CY 2017 PFS final rule and the CY 2018 PFS final rule. This initial rulemaking resulted in the creation of a new provider type, MDPP suppliers, and the establishment of MDPP as a new preventive service for all eligible beneficiaries with Part B coverage through Original Medicare or Medicare Advantage. The CY 2022 PFS²⁶ final rule and correction notice²⁷ included changes to MDPP to boost supplier and patient enrollment. The MDPP changes that went into effect January 1, 2022 include:

- Shortening the MDPP services period to one year for patients who enrolled on or after January 1; the first core session date is the enrollment date;
- Redistributing all ongoing maintenance session payments to the first year with a focus on increasing attendance-based performance payments;
- Removing the ongoing maintenance session payments for patients whose first core session occurs on or after January 1;
- Maintaining the 2021 payment amounts for ongoing maintenance sessions for patients who started MDPP in 2021 or earlier and maintain five percent weight loss and attendance requirements; the first core session date is the enrollment date; and
- Waiving the MDPP supplier enrollment fee.

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

²⁵ <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>

²⁶ <https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf>

²⁷ <https://www.govinfo.gov/content/pkg/FR-2021-12-27/pdf/2021-27853.pdf>

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

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

Virtual MDPP services do not qualify as telehealth services, and therefore, MDPP could not be added to the Medicare telehealth as a result of the PHE. Instead, CMS issued flexibilities through both the IFC-1 and the CY 2021 PFS to ensure that beneficiaries participating in the set of MDPP services during the PHE for COVID-19 or any future applicable 1135 waiver event can maintain consistent access to care via virtual delivery of services with minimal disruption throughout their entire set of MDPP services. The MDPP expanded model was actuarially certified for primarily in-person delivery. CMS is not allowing additional virtual delivery of the set of MDPP services beyond the Emergency Policy finalized in the CY 2021 PFS.

Evaluation Status/Results: The first evaluation report for the MDPP Expanded Model was released in March 2021, and describes how the program was implemented since it began serving Medicare beneficiaries in April 2018 through early 2020. The number of participating suppliers and beneficiaries has grown steadily, but slowly, since the start of the MDPP. As of March 2020, there were 196 MDPP suppliers providing services in 762 unique locations across the county, and more than 2,000 Medicare beneficiaries had participated in the program. MDPP beneficiaries have lost weight and are largely meeting physical activity goals, thereby meeting a key intermediary goal of the expanded model. On average, MDPP beneficiaries lost 5.1 percent of their starting weight. (This average includes beneficiaries who may be partway through the expanded model.) However, at this point, data are insufficient to determine whether the program lowers Medicare expenditures, reduces utilization, or prevents diabetes.

Webpage: Additional information is available at the [MDPP Expanded Model webpage](#).

Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Model

Model Announcement Date: May 22, 2014

Model Performance Period: December 1, 2014–December 1, 2020. While the model ended under CMS Innovation Center authority on December 1, 2020, it was expanded nationwide in accordance with section 1834(l)(16) of the Act, as added by section 515(b) of MACRA ([Pub. L. 114-10](#)).

Model Participants: Ambulance suppliers

Number of Participants: 257 ambulance suppliers serving 2,000 Medicare beneficiaries during the time period of October 1, 2020 through December 1, 2020.

Geographic Scope: The District of Columbia and eight states, including Delaware, Maryland, Pennsylvania, New Jersey, North Carolina, South Carolina, Virginia, and West Virginia while the model was under CMS Innovation Center authority.

Model Types: Initiatives to Speed the Adoption of Best Practices

Model Description: The Medicare Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT) Model, jointly operated by the CMS Innovation Center and the CMS Center for Program Integrity, tested whether prior authorization helped reduce improper payments and reduce Medicare costs while maintaining or improving quality of care. The model did not create additional documentation requirements. It required the same information that has always been necessary to support Medicare payment, but earlier in the process. This helped to confirm that all relevant coverage, coding, and clinical documentation requirements were met before the beneficiary was served and before the claim was submitted for payment.

The model was originally scheduled to end on December 1, 2017, and was extended as a CMS Innovation Center model through December 1, 2020.

Section 515(b) of MACRA ([Pub. L. 114-10](#)) added paragraph (16) to section 1834(l) of the Act, which requires that, beginning January 1, 2017, the Secretary expand the model nationally to all states if an expansion to all states meets certain statutory requirements for expansion of models tested under section 1115A of the Act. These requirements are described in paragraphs (1) through (3) of section 1115A(c) of the Act.

On March 28, 2018, the Chief Actuary of CMS certified that expansion of the model would reduce program spending under the Medicare program, stating that even under the most conservative assumptions, the projected savings from expansion would significantly outweigh the cost of administering the prior authorization policy.

On May 29, 2019, the Secretary of the Department of Health and Human Services determined that the model met the statutory criteria for expansion under sections 1115A(c)(1) and (c)(3) of the Act. CMS was therefore required under section 1834(l)(16) of the Act, as added by section 515(b) of MACRA ([Pub. L. 114-10](#)), to expand the model nationwide.

The Office of Management and Budget approved the information collection burden associated with the model (control number 0938-1380), per the Paperwork Reduction Act.

In September 2020, CMS publicly announced the nationwide expansion of the Medicare Prior Authorization Model. The states that participated in the model under the CMS Innovation

Center which included Delaware, the District of Columbia, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia, transitioned to the national model on December 2, 2020 under section 1834(1)(16) of the Act, as added by section 515(b) of MACRA (Pub. L. 114-10). After a delay to additional states due to the COVID-19 Public Health Emergency, the model was expanded on:

- December 1, 2021 to Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas;
- February 1, 2022 to Alabama, American Samoa, California, Georgia, Guam, Hawaii, Nevada, Northern Mariana Islands and Tennessee;
- April 1, 2022 to Florida, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, Puerto Rico, Wisconsin, and U.S. Virgin Islands;
- June 1, 2022 to Connecticut, Indiana, Maine, Massachusetts, Michigan, New Hampshire, New York, Rhode Island, and Vermont; and
- August 1, 2022 to Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, Wyoming, and nationwide to Railroad Medicare.

Prior Authorization Process: The ambulance supplier or beneficiary was 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 reviewed the request and provided a provisional affirmative or non-affirmative decision within a specified timeframe. If the request was non-affirmed, unlimited resubmissions were allowed

A claim submitted with an affirmative prior authorization was paid as long as all other requirements were met, and a claim submitted with a non-affirmative decision was denied (with appeal rights available). If an ambulance supplier chose to forego prior authorization and submitted a claim without a prior authorization decision, the claim was stopped for pre-payment review.

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

Evaluation Status/Results: The final RSNAT evaluation report was released in May 2021, and covers the first five years of model implementation. Findings indicate that prior authorization was successful in reducing RSNAT and total Medicare spending. The model reduced RSNAT service expenditures by 76 percent (approximately \$750 million over five

years) for the population examined: beneficiaries with end-stage renal disease and/or severe pressure ulcers in the model states, relative to a comparison group of similar states. This decrease in RSNAT service expenditures, in turn, caused total Medicare FFS expenditures to decrease by 2.4 percent (\$1 billion over five years) for the population examined. Overall, the model had few-to-no adverse effects on the quality of care or access to care.

Webpage: Additional information is available at the [Medicare Prior Authorization: RSNAT Model webpage](#).

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

Demonstration Announcement Date: July 1, 2011

Model Performance Period: Each state demonstration has a unique start date. The first was the Washington Managed Fee-for-Service (FFS) Model demonstration on July 1, 2013. CMS has offered states the opportunity to extend each demonstration. Current state demonstration end dates range from December 31, 2022 through December 31, 2023, with capitated states eligible to apply for extensions through December 31, 2025. Demonstrations in Colorado and Virginia ended on their originally scheduled end dates of December 31, 2017.

Model Participants: State Medicaid agencies and health plans

Geographic Scope: 11 active demonstrations in 11 states

Model Types: Initiatives Focused on the Medicare-Medicaid Enrollees

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

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

In 2021, CMS continued to partner with states and health plans under the initiative. Nine of these demonstrations were testing the capitated model, serving more than 430,000

beneficiaries as of December 1, 2021.²⁸ One of these demonstrations, in Washington, was testing the managed FFS demonstration, serving approximately 28,000 beneficiaries as of December 1, 2021. CMS was partnering with Minnesota to implement an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving approximately 42,000 dually eligible beneficiaries as of December 1, 2021.

Approved demonstrations are at different stages of implementation. Start dates range from July 2013 for the Washington managed FFS demonstration to July 2016 for the Rhode Island capitated demonstration. The Virginia and Colorado demonstrations concluded as scheduled on December 31, 2017. At the end of 2019, the New York Fully Integrated Duals Advantage (FIDA) transitioned from a capitated model demonstration, although CMS continues to partner with the state to test integrated grievances and appeals. In these states, enrollees continue to have access to care coordination and support services through integrated care initiatives that build upon demonstration experiences.

In the second quarter of 2022, CMS issued a final rule²⁹ establishing additional requirements to be incorporated into Dual Eligible Special Needs Plans (D-SNPs) based on experiences with the Financial Alignment Initiative. These requirements are intended to strengthen care delivery standards for dually eligible populations through mechanisms such as enrollee advisory committees and integrated member materials.

Evaluation Status/Results: Through the period of this report, CMS has released independent evaluation reports for Colorado and Virginia (the first and final report for each). A combined first and second evaluation report has been released for the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (preliminary) as well as Rhode Island. Additionally, the second evaluation reports have been released for California, Illinois, Michigan, Ohio, South Carolina, and Texas (preliminary). A combined second and third evaluation report for New York has also been released. The third evaluation report has been released for Minnesota; the fourth evaluation reports for Massachusetts (preliminary) and Washington; as well as the fifth evaluation report for Washington. Lastly, the first brief report for the New York Integrated Appeals and Grievances demonstration has been released. Performance data from demonstration reporting and other sources is also available on the Medicare-Medicaid Coordination Office [website](#).

Highlights from the evaluation reports of the Washington MFFS demonstration include statistically significant reductions in gross Medicare Parts A and B expenditures of \$385 million for the first six years of the demonstration, achieved by reducing inpatient, skilled nursing facility, and nursing facility use. Reductions in expenditures and changes in service

²⁸ California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas.

²⁹ Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefits Programs; Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-4192-F, CMS-1744-F, and CMS-3401-F)

utilization have been fairly consistent over time in Washington. Preliminary savings calculations from the actuarial analysis—used for performance payment purposes—through the first six demonstration years of the Washington demonstration also show reductions in gross Medicare Parts A and B expenditures of \$293 million.³⁰

Among the 10 capitated model demonstrations with reports that contain cost results, six have shown significant increases in Medicare Parts A and B expenditures. These expenditures range from \$35 to \$118 per member per month. The remaining four demonstrations show no impact.

Overall, six of seven capitated model demonstrations with reports that contain utilization results to date have shown significant increases in physician visits, consistent with the goals of the demonstration. An increasing portion of beneficiaries in the capitated demonstrations have rated their health plans a “9” or “10” (with “10” being the best). CMS has also observed increasing access to care coordination within the capitated model demonstrations, including a 36 percent increase in health risk assessment completion and a 66 percent increase in care plan completion from 2014 to 2019.

Webpage: Additional information is available at the [FAI Model webpage](#).

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

Model Announcement Date: May 2015

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

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

Number of Participants: 305 organizations

Geographic Scope: The model supports participant organizations in 47 states as well as the District of Columbia and Puerto Rico.

Model Types: Initiatives to Speed the Adoption of Best Practices

Model Description: The Million Hearts® Cardiovascular Disease Risk Reduction Model (MH Model) was a five-year model test of a performance-based payment model designed to prevent heart attacks and strokes. It was a randomized controlled trial that promoted improved cardiovascular disease (CVD) outcomes and reduced utilization through evidence-based care, including atherosclerotic disease risk calculation, stratification, and risk management. As of

³⁰ Washington can qualify to share in up to 50 percent of the gross savings.

2019, the model supported participant organizations in 47 states plus Washington D.C. and Puerto Rico.

The MH Model incentivized practices to calculate risk for all eligible Medicare beneficiaries by using the American College of Cardiology/American Heart Association Atherosclerotic Cardiovascular Disease (ASCVD) ten-year pooled cohort risk calculator, and to develop risk modification plans based on beneficiary risk profiles. Half of all selected applicants were randomly assigned to the intervention group, with the remaining selected applicants assigned to the control group.

Intervention Group participant organizations (POs) were paid a one-time \$10 per-beneficiary fee to calculate beneficiaries' ASCVD risk scores. Low- and medium-risk beneficiaries were excluded from further participation in the model, in favor of beneficiaries who received a score of 30 percent or greater and were considered high-risk. Providers were required to engage in shared decision-making with their high-risk beneficiaries and to re-assess their risk annually.

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

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

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

Evaluation Status/Results: The fourth evaluation report for the Million Hearts® Model was released in February 2022 and describes how the model was implemented during its first four years (2017–2020). The report includes estimates of the model's impact on heart attacks, strokes, survival, and spending. Overall, the Model has improved cardiovascular preventive care, but has not yet reduced observed heart attacks and strokes or lowered Medicare spending. Within the first four years, the model has not reduced the incidence of first-time heart attacks or strokes. Among both the intervention and control group, four percent of beneficiaries had a first-time heart attack or stroke within three years of enrollment. The model has also not measurably impacted Medicare spending.

However, providers in the Million Hearts® Model were more likely than control group providers to report measuring—and being aware of—their patients' cardiovascular risk. Beneficiaries enrolled by the intervention group were also more likely to initiate or intensify medications to lower blood pressure or cholesterol. These changes contributed to reductions in overall predicted risk of having a heart or attack or stroke. CVD risk scores among high-risk beneficiaries decreased by 1.3 percentage points (four percent) more in the intervention group than the control group within a year of enrollment, with larger reductions in blood pressure and cholesterol levels among model participants.

Webpage: Additional information is available at the [Million Hearts® Model webpage](#).

Next Generation Accountable Care Organization Model (NGACO)

Model Announcement Date: March 10, 2015

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

Model Participants: Medicare Accountable Care Organizations (ACOs)

Number of Participants: 35 ACOs participated in the last Performance Year (2021)

Geographic Scope: 29 states

Model Types: Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: To create necessary flexibilities for participants in the Next Generation Accountable Care Organization Model (NGACO) in 2020 we:

- Extended the period of performance by one year, from December 2020 to December 2021, and
- Offered an amendment to the Next Generation ACO Model Participation Agreement for Performance Year PY 2020 to:
 - Reduce downside risk for PY 2020 by reducing shared losses by the proportion of months during the Performance Year affected by the PHE and the percentage of Next Generation Beneficiaries who reside in an area affected by the PHE;
 - Cap the maximum allowable percentage of the ACO's Performance Year Benchmark that will be paid to the ACO as shared savings or paid by the ACO as shared losses at five percent;
 - Remove episodes of care for treatment of COVID-19 triggered by an inpatient

- service from the accrued expenditures used to calculate shared savings and shared losses for PY 2020;
- Remove all episodes of care for treatment of COVID-19 triggered by an inpatient service from the beneficiary experience accrued in calculating the Performance Year Benchmark;
 - Use a retrospective regional trend, rather than a prospective national trend, to calculate the Performance Year Benchmark for PY 2020; and
 - Remove the requirement for the ACO to maintain a financial guarantee for PY 2020.
- For ACOs that did not sign the PY 2020 Amendment, CMS used its authority under the Participation Agreement to modify the trend used to calculate the Performance Year Benchmark from a prospective national trend to a retrospective national trend. COVID-19 episodes were not removed from the trend used to calculate the Performance Year Benchmark or from the accrued expenditures used to calculate shared savings and shared losses.
 - CMS modified the NGACO financial methodology to provide financial protection to all NGACOs that continued in the model for PY 2021. These financial protections included:
 - Reducing downside risk for PY 2021 by reducing shared losses by the proportion of months during the Performance Year affected by the PHE and the percentage of Next Generation Beneficiaries who reside in an area affected by the PHE;
 - Removing episodes of care for treatment of COVID-19 triggered by an inpatient service from the accrued expenditures used to calculate shared savings and shared losses for PY 2021;
 - Removing all episodes of care for treatment of COVID-19 triggered by an inpatient service from the beneficiary experience accrued in calculating the Performance Year Benchmark;
 - Using a retrospective national trend, rather than a prospective national trend, to calculate the Performance Year Benchmark for PY 2021;
 - Removing the requirement for the ACO to maintain a financial guarantee for PY 2021; and
 - Updating the projected coding factor used to adjust risk scores (based on observed risk score growth in the NGACO reference population). This update is performed retrospectively.

Model Description: The Next Generation ACO (NGACO) Model built upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program. NGACO Model participants had the opportunity to take on greater levels of financial risk than ACOs in other current initiatives. While the ACOs in this model were at greater financial risk, they also had a greater opportunity to share in the model's savings.

The ACOs were able to select from flexible payment options that supported ACO investments in care improvement infrastructure and clinical process workflows by providing regular cash flow payments to allow ACOs to make those investments.

Like the Pioneer ACO Model, the NGACO Model allowed beneficiaries to choose to be aligned to the ACO, and tested beneficiary incentives for seeking care with Next Generation ACO providers and suppliers. The NGACO Model included benefit enhancements designed to provide ACOs with greater flexibility in care delivery, including a conditional waiver of the requirement for a three-day inpatient hospital stay prior to admission to a skilled nursing facility (SNF). The NGACO Model's benefit enhancements also included the option to use telehealth in circumstances not otherwise permitted under Medicare, including providing coverage for teledermatology and teleophthalmology services furnished using asynchronous store and forward technologies, and to use post-discharge home visit services for care coordination.

Beginning in 2019, the NGACO Model began using an updated financial methodology, and implemented new benefit enhancements and beneficiary engagement incentives including a waiver to permit certain cost-sharing support arrangements for Part B services; a waiver to allow the use of gift cards to incentivize certain beneficiaries to participate in chronic disease management programs; and a waiver increasing the availability of in-home care to beneficiaries at risk of hospitalization. The quality measures and reporting requirements used in the NGACO Model closely followed those used in the Medicare Shared Savings Program.

The NGACO Model ended on December 31, 2021, at the end of the sixth PY. There were 35 ACOs made up of approximately 49,000 health care providers participating in the NGACO Model for 2021. These ACOs served about 1.3 million beneficiaries across 29 states. The NGACO Model was an Advanced APM under the Quality Payment Program.

Evaluation Status/Results: The fourth evaluation report for the NGACO Model describes the effects of the model during its first four PY (2016–2019) across 62 ACOs that participated in the model in one of three ACO cohorts. Participation in the NGACO Model increased from 18 ACOs participating in the first Performance Year (2016) to 41 ACOs in the fourth year (2019). The proportion of participating ACOs electing full risk (100 percent) as opposed to partial risk (80 percent) declined from 56 percent of ACOs in 2018 to 32 percent of ACOs in 2019. During the four-year period examined, the evaluation found that participating ACOs invested in the following four areas in response to the model's incentives:

- Improved data analytic capacity to manage prospectively aligned populations;
- Engagement with beneficiaries through care management activities and annual wellness visits;
- Engagement with physicians using financial and non-financial incentives; and
- Cultivation of partnerships with skilled nursing facilities (SNFs) to improve delivery of post-acute care (PAC).

During 2016–2019, the NGACO Model successfully reduced total Medicare Part A and B spending, but was associated with an increase (loss) in net Medicare spending. Cumulative Medicare Parts A and B spending declined by a statistically significant \$667 million relative to similar non-NGACO beneficiaries in the same markets. Reductions in spending in post-acute care settings and for professional services contributed to this decline. However, once shared savings payments to participant ACOs and coordinated care reward (CCR) payments across the first four years are included (\$910 million), the model’s net spending increased. The cumulative net Medicare spending impact of the model totaled a statistically significant \$243 million increase (0.4 percent increase) in Medicare expenditures. Overall, the NGACO Model was not associated with notable changes in quality as measured by readmissions or ambulatory care sensitive inpatient admissions.

Webpage: Additional information is available at the [NGACO Model webpage](#).

Oncology Care Model (OCM)

Model Announcement Date: February 2015

Model Performance Period: July 1, 2016–June 30, 2022

Model Participants: Physician Group Practices

Number of Participants: As of February 2022, 126 physician group practices, representing approximately 25 percent Medicare fee-for-service (FFS) chemotherapy-related cancer care, and five third-party payers.

Geographic Scope: Nationwide

Model Types: Episode-based Payment Initiatives

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: The following flexibilities were made for participants in the Oncology Care Model (OCM):

- An option for OCM practices to elect to forgo both upside and downside risk for performance periods affected by the PHE;
- For OCM practices that remain in one or two-sided risk for the performance periods affected by the PHE, removal of COVID-19 episodes from reconciliation for those performance periods;
- Making the following reporting optional for PHE-affected performance periods: aggregate-level reporting of quality measures and beneficiary-level reporting of clinical and staging data;
- Making optional reporting cost and resource utilization and practice transformation survey in summer 2020 and 2021; and
- An extension of the model for one year, through June 2022.

Model Description: OCM aims to provide higher quality, more highly coordinated oncology care at lower cost to Medicare. OCM launched on July 1, 2016, and with the one-year extension described above, is anticipated to run for six performance years.

The CMS Innovation Center designed the Model in collaboration with stakeholders from the medical, consumer and business communities who believed an alternative model for oncology care would better support beneficiaries and clinicians' work with their patients. Under OCM, practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer. OCM incentivizes participating physician practices to comprehensively and appropriately address the complex care needs of Medicare beneficiaries receiving chemotherapy treatment, and heighten the focus on furnishing services that improve the patient experience and/or health outcomes. OCM episodes of care span six months following the initiation of chemotherapy treatment for cancer.

OCM incorporates a two-part payment system for participating practices. The first is a monthly per-beneficiary-per-month payment for the duration of the episode, referred to as the OCM Monthly Enhanced Oncology Services (MEOS) payment. The MEOS payment helps pay for 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. If practices and pools are participating in a two-sided risk arrangement, they may be responsible for a recoupment to CMS based on a comparison of their actual Medicare FFS expenditures for episodes of care compared to a target amount (for the original two-sided risk arrangement) or the benchmark amount (for the alternative two-sided risk arrangement).

To calculate the performance-based payment, all Medicare Part A and Part B expenditures as well as certain Part D expenditures during the episode are included in the total cost of care,

compared against a risk-adjusted target, and then adjusted by a quality score. Beginning in mid-2019, clinical data related to the stage of cancer at diagnosis have been used to inform the target prices.

As of February 2022, there were 126 physician practices and five third-party payers participating in OCM. These numbers have changed since the CMS Innovation Center launched the model. The model started with 17 participating payers, but ten of the third-party payers have since left the model, and three of the third-party payers consolidated their participation and now participate as one. The participating practices are heterogeneous in terms of practice size, ownership, and location. Both of the OCM two-sided Risk Arrangement tracks are considered to be an Advanced Alternative Payment Model under the Quality Payment Program.

Evaluation Status/Results: The evaluation report from OCM on Performance Periods 1 through 6 was released in December 2021, and covers six-month episodes during which a cohort of episodes terminated and were reconciled together. Episodes initiated for FFS Medicare beneficiaries who received chemotherapy for cancer care between July 1, 2016 and July 1, 2019, all of which ended by December 31, 2019. Episode payments for high-risk cancers (all eligible cancers except those designated as low-risk breast, low-intensity prostate, and low-risk bladder cancers) declined in the first six performance periods by \$487 per episode ($p < 0.05$, -1.2 percent), but these impacts were offset by increases in episode payments of \$130 per episode ($p < 0.01$, 1.8 percent) for low-risk cancers, leading to a gross reduction in spending of \$298 per episode. After accounting for the distribution of incentive payments in the first five performance periods, OCM resulted in net losses to Medicare of nearly \$377.1 million.

OCM had no impact on overall beneficiary cost-sharing or on patient-reported out-of-pocket spending for cancer-related expenses. There was no meaningful impact on emergency department visits or hospitalizations overall, or for chemotherapy-related toxicity. In an examination of utilization in the last 30 days of life for decedents, OCM led to a 1.1 percent relative decrease in inpatient hospitalizations through the first five performance periods. There was no impact on hospice care use or timing. From a quality perspective, OCM practices report helping patients address financial barriers and side-effects, and fill prescriptions on time. Most cancer patients responding to our survey rated their cancer care very highly at the start of the model, and there were no overall changes over time and no pattern indicating differences between OCM and comparison respondents. Patients continue to rate care experience very highly.

Webpage: Additional information is available at the [OCM webpage](#).

Part D Enhanced Medication Therapy Management Model (MTM)

Model Announcement Date: September 25, 2015

Model Performance Period: January 1, 2017–December 31, 2021

Model Participants: Part D standalone basic Prescription Drug Plans (PDPs)

Number of Participants: Six Part D Sponsors

Geographic Scope: The model was tested in five Part D Regions that comprise 11 states: 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).

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: The Part D Enhanced Medication Therapy Management (MTM) Model was an opportunity for Prescription Drug Plans (PDPs) in selected regions to offer innovative MTM programs aimed at improving the quality of care while also reducing costs.

The Enhanced MTM Model tested whether providing selected plans with regulatory flexibility to design and implement innovative programs and aligning financial incentives can more effectively achieve key goals for MTM programs, including:

- Improving compliance with medication protocols and protocols for high-cost drugs; ensuring that beneficiaries get the medications they need; and ensuring that those medications are used properly;
- Reducing medication-related problems, such as duplicative or harmful prescriptions, polypharmacy, or suboptimal treatments;
- Increasing patients' knowledge of their medications to achieve their own or their prescribers' therapy goals; and
- Improving communication among prescribers, pharmacists, caregivers, and patients.

CMS granted participating PDPs a waiver of existing MTM regulations that define both the target population and the MTM services that can be provided to enable plans to target barriers to optimal medication usage at an individual level. Services provided under the model were funded through a separate payment to plans, outside of the standard bid/premium structure. Plans that were successful at reducing their members' medical expenditures were eligible for a performance incentive in the form of a reduction in enrollee premiums for a future model year. In addition, the Part D Enhanced MTM Model provided participating plans with access

to Medicare Parts A and B claims data, in order to facilitate effective targeting of beneficiaries at high risk of medication-related issues.

In 2017 through 2021, six Part D Sponsors participated in the model, enrolling more than 1.7 million beneficiaries in 22 participating plan benefit packages. The Part D Enhanced MTM Model period of performance ended December 31, 2021.

Evaluation Status/Results: The fourth evaluation report for Enhanced MTM covers the first four model years (2017–2020). The report found that the model made no significant impact on Medicare’s Parts A and B Expenditures, in each model year and cumulatively across all four model years. Through the first four years, the model reduced Medicare Parts A and B expenditures by \$1.16 per member per month. After accounting for CMS’s Model payments, the model increased Medicare’s net expenditures by \$3.45 per member per month, resulting in a loss of \$270 million during the first four model years. These expenditure impacts, however, were not statistically significant. Beneficiaries who were more likely to be eligible for and benefit from Enhanced MTM services, such as those who qualified for the low-income subsidy or who had medically complex profiles, also did not experience significant impacts on their expenditures.

The report found that participating Part D sponsors used the model’s flexibilities to increase the number of beneficiaries receiving Enhanced MTM services, but this expansion did not clearly improve select quality and utilization measures. The model was associated with reduced expenditures in inpatient and post-acute care, including for ambulatory-care sensitive conditions, but these expenditures were partially offset by increases in expenditures in outpatient settings. There was limited or no impact on most medication adherence measures examined in the report.

Webpage: Additional information is available at the [MTM Model webpage](#).

Part D Payment Modernization Model (PDM)

Model Announcement Date: January 18, 2019

Model Performance Period: January 1, 2020–December 31, 2021

Model Participants: The Model was open to eligible standalone Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug Plans (MA-PDs).

Number of Participants: Two

Geographic Scope: N/A

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: The Part D Payment Modernization Model was created to test how changes in Part D benefit design and incentives would affect overall Part D prescription drug spending and beneficiary out-of-pocket costs. The model aimed to reduce Medicare expenditures while preserving or enhancing beneficiary quality of care. The model tested whether changes to the Part D payment structure created new incentives for plans, patients, and providers to choose drugs with lower list prices, as a way to address rising Federal reinsurance Part D subsidy and beneficiary out-of-pocket costs. By taking increased risk for CMS's federal reinsurance subsidy (80 percent of catastrophic phase liability), plans participating in the model were eligible to receive performance-based payments, or sent payments to CMS, based on spending.

After careful consideration and assessing preliminary data from CMS' Calendar Year (CY) 2022 Request for Applications, the Centers for Medicare & Medicaid Services (CMS) announced the termination of the PDM Model as of December 31, 2021, due to limited participation as required under section 1115(A)(b)(4).

Evaluation Status/Results: An internal evaluation is currently in progress. The evaluation primarily focuses on implementation and descriptive comparisons of several measures, including but not limited to gross drug costs above the out of pocket threshold, between Model participants and nonparticipants. The evaluation will focus on descriptive comparisons due to the low confidence we could place in estimates of the impact of the Model due to limited participation.

Webpage: Additional information is available at the [PDM Model webpage](#).

Part D Senior Savings Model (PDSS)

Model Announcement Date: March 11, 2020

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

Model Participants: Pharmaceutical manufacturers who manufacture and market applicable drugs; Part D Sponsors

Number of Participants: 106 Part D Sponsors and five pharmaceutical manufacturers for Plan Year (PY) 2022

Geographic Scope: National

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description: Beginning in January 2023 the Inflation Reduction Act (IRA) will cap cost-sharing for each insulin product covered under a Medicare prescription drug plan at \$35 for a month's supply. Also, Part D deductibles will not apply to these covered insulin products. The Part D Senior Savings Model, which first tested a similar benefit in Model-participating plans, will continue in 2023.

The Part D Senior Savings Model tests the impact of offering beneficiaries enhanced alternative Part D plan options that offer lower out-of-pocket costs for insulin as supplemental benefits. The model aims to reduce Medicare expenditures while preserving or enhancing quality of care for beneficiaries.

Under the Model, CMS is testing a change where Part D sponsors that participate in the Model offer beneficiaries prescription drug plans that provide supplemental benefits for a broad range of insulins. Participating pharmaceutical manufacturers will pay the 70 percent discount in the coverage gap for the Part D insulins they market, but those manufacturer discount payments would now be calculated before the application of supplemental benefits under the Model.

Through the model, CMS is also testing how participating Part D sponsors may best encourage healthy behaviors and medication adherence through Part D Rewards and Incentives Programs.

Evaluation Status/Results: The introduction of the IRA will be used as a natural experiment to strengthen the evaluation design and increase confidence in our impact estimates. For the first two Model performance years, including Calendar Year (CY) 2021 and CY 2022, CMS will assess whether the Model's maximum \$35 copay for a month's supply for select Model insulins offered by participating Part D plans has an impact on costs to Part D beneficiaries, Part D plans, Medicare, beneficiary health outcomes, and quality of care. In CY 2023, CMS will continue to examine the same research questions that focus on the Model's impact on relevant outcome measures, including, but not limited to, insulin use and Part D out-of-pocket costs. The estimated effects of the Model's impact in CY 2023 will be interpreted within the context that the maximum \$35 copay for a month's supply will now be available as a basic plan benefit among non-participating plans. The evaluation will employ a mixed-methods approach, using qualitative and quantitative data such as interviews with plan sponsors and focus groups with prescribers and beneficiaries, and existing data such as Medicare Part D claims-based data, plan bids, and plan characteristics files to assess the impacts of the model.

Webpage: Additional information is available at the [Part D Senior Savings Model webpage](#).

Pennsylvania Rural Health Model (PARHM)

Model Announcement Date: January 12, 2017

Model Performance Period: January 1, 2019–December 31, 2024

Model Participants: Acute care hospitals and critical access hospitals (CAHs) in rural Pennsylvania

Number of Participants: 18 hospitals participating as of Performance Year 4 (2022)

Geographic Scope: Commonwealth of Pennsylvania, with a particular focus on rural areas

Model Types: Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In response to the COVID-19 Public Health Emergency (PHE), certain flexibilities were put in place:

- Modified the Rural Hospital Participation Scale Target to require just 13 rural hospital participants for Performance Year (PY) 3 (2021). Waived enforcement of and modified the Rural Hospital Participation Scale Target for Performance Years 4–6 (2022–2024) to require 18 rural hospital participants, as the PHE impacted hospital recruitment;
- Provided Pennsylvania and participating hospitals an extension for their annual transformation plan submission; and
- Added a telehealth benefit enhancement waiver to temporarily waive geographic location requirements and expand the availability of telehealth services; and
- Delayed reconciliation of PY 2 (2020) hospital global budgets by a year to allow more time to assess COVID-19 impact, with the goal of applying COVID-19 adjustments and reconciliation amounts of both PY 2 and 3 (2020 and 2021) together in prospective PY 5 (2023) global budgets.

Model Description: The Pennsylvania Rural Health Model (PARHM) seeks to increase rural Pennsylvanians’ access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare and Medicaid, and improving the financial state of acute care hospitals and CAHs in rural Pennsylvania to ensure continued access to care. Pennsylvania, through the Pennsylvania Department of Health (PA-DOH), is the state partner working with CMS to jointly administer this model. The state continues to play a central role in designing and operationalizing the model.

The two key components of this model are hospital global budgets and deliberate hospital care delivery transformation. Under this model, participating rural hospitals are paid based on all-payer global budgets—a fixed amount that is set in advance for inpatient and outpatient hospital-based services, and paid throughout the year by Medicare fee-for-service (FFS) and other participating payers. In addition, participating rural hospitals will thoughtfully redesign

care delivery in accordance with their CMS and State-approved Rural Hospital Transformation Plans to improve quality of care and meet the needs of their local communities. By doing so, the model tests whether the predictable nature of the global budgets will enable participating hospitals to invest in quality and preventive care and to tailor services to rural beneficiaries. In addition, other payers in Pennsylvania, including Medicaid and commercial plans, may participate in the model.

In the model design, CMS planned to provide up to \$25 million in funding, via two separate awards, to help Pennsylvania begin its implementation of the model. As of PY 4 (2022), the final year in which funding is available, CMS has awarded about \$17.7 million. The remaining funds have been restricted for the remainder of the model performance period. Pennsylvania is expected to sustain the model beyond PY 4 (2022).

The first cooperative agreement of \$10 million was awarded to the PA-DOH in fiscal year (FY) 2017 for the purpose of accelerating setup, supporting technical assistance for hospitals, and planning for the Rural Health Redesign Center (RHRC). On November 27, 2019, the Pennsylvania state legislature created the RHRC. The goal was for the RHRC to administer the model during the six-year implementation period, and to be the award recipient of the second cooperative agreement, but legislative delays made this challenging. Because the RHRC was not operational until May 2020, the second cooperative agreement was awarded to the PA-DOH in FY 2019.

The second cooperative agreement awarded an additional \$7.7 million to Pennsylvania, out of the up to \$15 million available, to support several activities, including model operations, global budget administration, data analytics, technical assistance, and quality assurance. CMS did not award the full amount of available funds due to Pennsylvania not meeting the Rural Hospital Participation Scale Targets for PYs 1–3 (2019–2021). In drafting the terms and conditions for this award, CMS developed specific milestones and contingent funding in recognition of the importance of meeting the hospital participation scale targets to achieving the model’s overall goals.

The Payer Participation Scale Target for PY 1 (2019) is defined as having 75 percent or more of the eligible net patient revenue for each of the participating rural hospitals come from participating payers under a global budget. The scale target rises to 90 percent for PYs 2–6 (2020–2024). CMS does not anticipate Pennsylvania meeting the Payer Participation Scale Targets for each PY 1–3 (2019–2021) for a variety of reasons, including payer recruitment impacted by the COVID-19 PHE and managed care contract bid changes, and some commercial payers excluding tiered networks from global budgets. Compliance will be assessed in Q1 2023 following reconciliation of PY 2 (2020) and PY 3 (2021) hospital global budget payments and CMS validation of calculations. Program level data is considered preliminary until global budgets are reconciled for applicable PYs.

In addition to Medicare FFS, five payers (Geisinger, Highmark, UPMC, Gateway, Aetna) voluntarily participate in the model, including their Medicare Advantage, Medicaid Managed

Care, and Commercial plan lines of business. All payers joined the model in Performance Year 1 (2019), except Aetna, which joined in PY 2 (2020).

Under this model, Pennsylvania is responsible for attaining and maintaining the following three population health and access goals: (1) increase access to primary and specialty services; (2) reduce deaths related to substance use disorder (SUD) and improve access to treatment for opioid abuse; and (3) reduce rural health disparities through improved chronic disease management and preventive screenings. To address these goals, participating rural hospitals have identified strategies in their Rural Hospital Transformation Plans for PYs 1 and 2. Strategies range from enhanced care management, telehealth, improving emergency department utilization, enhancing operational efficiency and creating increased access to services such as substance use, behavioral health, and palliative care. Participating rural hospitals are required to engage local stakeholders in designing and implementing these activities to meet the needs of their community.

Evaluation Status/Results: The first annual report for PARHM was released in August 2021 and the second report was released in June 2022. The first report covers the first performance year (2019) and provides baseline information for the first cohort of participating hospitals which includes five participants. The first report documented that Cohort 1 participating hospitals had negative average total margins and declining inpatient volume prior to the model's start. This potentially was a motivating factor for joining the model. Participants spoke positively of the global budgets that were provided to hospitals. The payments were particularly helpful for reducing volatility during the COVID pandemic. However, the pandemic did make it difficult for participating hospitals to make progress on hospital transformation plans that they had developed under the model.

The second report covered the second performance year (2020). During the second performance year, eight additional hospitals joined the model as part of Cohort 2. Hospitals continued to face challenges with hospital transformation activities due to the ongoing pandemic. Global budget payments were once again highlighted by participants as being helpful in reducing reimbursement volatility as the pandemic continued. The average baseline financial performance of Cohort 2 hospitals was better than their Cohort 1 counterparts. Both cohorts of hospitals experienced declines in inpatient utilization across multiple diagnostic categories during the second performance year.

Webpage: Additional information is available at the [PARHM webpage](#).

Primary Care First Model Options (PCF)

Model Announcement Date: April 22, 2019

Model Performance Period: Six performance years (PYs), with two staggered cohorts of practices each participating for a five-year performance period: one cohort from January 1, 2021 through December 31, 2025; and the second cohort from January 1, 2022 through December 31, 2026.

Model Participants: Primary care practices and physician practices

Number of Participants: 3,007 practices and 24 payer partners as of January 1, 2022

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

Model Types: Primary Care Transformation

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: In addition to the flexibilities offered to providers under the Medicare Physician Fee Schedule, the CMS Innovation Center created additional flexibilities for participants in Primary Care First, including:

- Delayed the implementation of the Performance Based Adjustment until the second quarter of the second PY;
- Waived the geographic location requirements for select primary care telehealth services for the duration of a practice's participation in Primary Care First;
- Updated the benchmarking approach for measuring practice performance on health care utilization measures to ensure a comparable reference point for performance during and after the PHE; and
- Utilized 2019 as the base performance period for the first cohort of practices' continuous improvement bonus calculation until the second quarter of 2023 to ensure practices are not penalized for utilization trends affected by the PHE.

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

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

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

Webpage: Additional information is available at the [PCF Model Options webpage](#).

Radiation Oncology Model (RO Model)

Model Announcement Date: July 10, 2019

Earliest Possible Model Performance Period: To be determined. CMS issued a final rule that appeared in the August 28, 2022 Federal Register, CMS-5527-F2, that finalized delaying the current start date of the RO Model to a date to be determined through future rulemaking.³¹

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

Number of Participants: 400 HOPDs and 600 PGPs

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

Model Types: Episode-based Payment Initiatives

Model Description: The RO Model addresses several long-standing challenges with respect to payment for radiotherapy (RT) services in Medicare, including (1) the lack of site neutrality for payments, (2) incentives that encourage volume of services over the value of services, and (3) coding and payment challenges.

The RO Model aims to improve quality of care and reduce expenditures for Medicare beneficiaries by encouraging use of evidence-based guidelines for RT to treat cancer and by using a predictable, site-neutral, prospective episode-based payment. The RO Model was

³¹ Please reference the final rule: CMS-5527-F2: <https://www.federalregister.gov/public-inspection/2022-18541/radiation-oncology-model>.

designed to qualify as a Merit-based Incentive Payment System (MIPS) Alternative Payment Model (APM) and an Advanced APM.

The RO Model is designed to test whether replacing fee-for-service (FFS) payments for RT services with prospective episode-based payments will reduce costs while continuing to deliver high-value RT care, by reducing the financial incentive to provide more services in the current payment systems.

The RO Model provides prospective payments for most RT services furnished during a 90-day episode of care for 15 cancer types. Episodes are split into two parts: a Professional Component (PC) and a Technical Component (TC), as these services are sometimes furnished by separate RT providers and RT suppliers, and paid for under Medicare FFS through different payment systems. Episode payments are based on a site-neutral, trended national base rate that is adjusted for each participant's historical expenditures, case mix, and geographic location. Both the PC and TC prospective payment amounts are subject to a CMS discount, a quality withhold, and an incorrect payment withhold. Beginning in Performance Year (PY) 3, the prospective payment amount will also be subject to a patient experience withhold.

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

To be included in the RO Model, a Medicare beneficiary must receive included RT services in a ZIP Code linked to a selected CBSA from a RO participant during the model's performance period for a cancer type that meets the criteria for inclusion in the RO Model. Beneficiaries also must have traditional Medicare FFS as their primary payer, be eligible for Medicare Part A, be enrolled in Medicare Part B, and not be in a Medicare hospice benefit period. Individuals who meet these requirements and are enrolled in a clinical trial for RT services for which Medicare pays routine costs are also included the RO Model.

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

Webpage: Additional information is available at the [RO Model webpage](#).

Vermont All-Payer Accountable Care Organization Model (VT APM)

Model Announcement Date: October 26, 2016

Model Performance Period: January 1, 2017–December 31, 2022³²

Model Participants: Medicare Accountable Care Organizations (ACOs) in Vermont

Number of Participants: One (1) Accountable Care Organization: OneCare Vermont

Geographic Scope: State of Vermont

Model Types: Accountable Care

Coronavirus Disease 2019 Public Health Emergency (PHE) Flexibilities: To create necessary flexibilities for participants in the Vermont All-Payer ACO Model, CMS amended the Vermont Medicare ACO Initiative Participation Agreement to:

- Remove episodes of care for treatment of COVID-19 triggered by an inpatient service from the performance year expenditures used to calculate shared savings and shared losses for Performance Year (PY) 2020 and 2021;
- Use retrospective regional trend, rather than a prospective base-year trend for PY 2020 and PY 2021;
- Reduce downside risk for PY 2020 and 2021 in an amount determined by multiplying the shared losses by the percentage of total months during the PY affected by an extreme and uncontrollable circumstance such as the PHE, as defined in 42 C.F.R. § 400.200, and the percentage of Initiative Beneficiaries who reside in an area affected by the PHE; and
- Modify PY 2020 and PY 2021 quality measures to pay-for-reporting.

These flexibilities are intentionally similar to those created in response to the PHE for the Next Generation ACO Model and the Medicare Shared Savings Program.

Model Description: The VT APM offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state. The model aims for broad ACO participation throughout the state, across all the significant payers and the majority of the care delivery

³² A maximum of two voluntary, 12-month extensions under consideration for the Model. If implemented, the Model performance period could operate through December 31, 2024.

system, to make redesigning the entire care delivery system an effective business strategy for Vermont providers and payers.

By establishing state and ACO-level accountability for health outcomes for the state's entire population, VT APM incentivizes collaboration between the care delivery and public health systems necessary to achieve these outcomes. Vermont will focus on achieving health outcomes and quality of care targets in four areas prioritized by Vermont: (1) substance use disorder, (2) suicides, (3) chronic conditions, and (4) access to care. Vermont is accountable for three categories of measures for each of the four priority areas: population-level health outcomes targets, health care delivery system quality targets, and process milestones.

VT APM limits the annualized per-capita health care expenditure growth for all major payers to 3.5 percent and limits Medicare per-capita health care expenditure growth for Vermont Medicare beneficiaries to at least 0.2 percentage points less than that of projected national Medicare growth.

Under the VT APM, Vermont encourages Vermont payers and health care providers to participate in ACO arrangements. ACO initiatives continue to have payer-specific benchmarks and financial settlement calculations, but the design of a scale target ACO initiative (for example, payment based on quality measures, risk arrangement, payment mechanisms, and beneficiary alignment methodology) is closely aligned across payers.

The Vermont Medicare ACO Initiative is a Medicare fee-for-service (FFS) ACO initiative tailored to Vermont, offered by CMS to ACOs in Vermont under VT APM. The Vermont Medicare ACO Initiative is largely based on the Next Generation ACO Model, and supports ACO design alignment with other Vermont payers' ACO initiatives. The Green Mountain Care Board, Vermont's health care regulatory body, has a significant role in setting the Vermont Medicare ACO Initiative Performance Year benchmarks in accordance with standards specified by CMS and subject to CMS approval.

Medicaid is a critical health care payer in the VT APM. In 2016, CMS approved a five-year extension of Vermont's section 1115(a) Medicaid demonstration, which enables Medicaid to participate in VT APM. Specifically, the 1115(a) Medicaid demonstration promotes delivery system and payment reform by allowing Vermont Medicaid to enter into ACO arrangements that align with other health care payers' ACOs. CMS recently approved a five-year extension of the state's section 1115(a) Medicaid demonstration. The demonstration will now expire December 31, 2027.

The Vermont Medicare ACO Initiative qualifies as an Advanced Alternative Payment Model under CMS' Quality Payment Program, allowing physicians and other clinicians to potentially qualify for Advanced Alternative Payment Model incentive payments.

Evaluation Status/Results: The first evaluation report from VT APM was released in August 2021. The first evaluation report covers PY 1 and 2 (2018-2019), and focuses on the Medicare population. The report found that the VT APM reduced annual Medicare spending per

beneficiary by \$607 among those VT beneficiaries attributed to the VT Medicare ACO Initiative across the first two PYs, and a higher \$783 reduction in the statewide population. Annual Medicare net savings, which considers CMS incentive payments to providers, was \$522 per beneficiary in the VT Medicare ACO Initiative population and \$748 in the statewide population. Reductions in Medicare spending were driven by reductions in the use of acute care stays, especially 30-day readmissions.

Model stakeholders that were interviewed reported that the Model provides an important, unifying forum for providers, payers, and state-level stakeholders and is strengthening relationships between providers. The report also found OneCare Vermont, the sole ACO operating in the state and participating in the Model, introduced a focus on care coordination for high-and very high-risk patients in particular. Hospitals, now assuming downside financial risk, are investing in additional population health initiatives.

Webpage: Additional information is available at the [VT APM webpage](#).

IV. CMS Innovation Center Demonstrations

In addition to managing its portfolio of model tests, the CMS Innovation Center also conducts certain Congressionally mandated demonstrations. Between October 1, 2020 and September 30, 2022, the following six demonstrations were active:

- The Frontier Community Health Integration Project Demonstration (FCHIP)³³;
- The Independence at Home Demonstration (IAH)³⁴;
- The Intravenous Immune Globulin Demonstration (IVIG)³⁵;
- The Medicare Pilot Program for Asbestos Related Disease (Libby, Montana)³⁶;
- The Rural Community Hospital Demonstration (RCHD)³⁷; and
- The Value in Opioid Use Disorder Treatment Demonstration (Value in Treatment)³⁸.

³³ Authorized under section 123 of the Medicare Improvements for Patients and Providers Act. The FCHIP Demonstration was recently extended for five years by the Consolidated Appropriations Act of 2021.

³⁴ Authorized under section 1866E of the Social Security Act.

³⁵ Authorized under P.L. 112-242 Title I - Medicare IVIG Access Sec. 101.

³⁶ Authorized under section 1881A of the Social Security Act (section 10323 of the Affordable Care Act).

³⁷ Authorized under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

³⁸ Authorized under section 1866F of the Social Security Act (Act), as added by section 6042 of the Substance Abuse Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

V. Beneficiaries and Individuals Included in CMS Innovation Center Activities

CMS estimates that during the period of report more than 41,500,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care, or will soon be receiving care from more than 314,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives described in Sections 3 and 4 of this Report to Congress.

The number of beneficiaries and individuals estimated to be included in CMS Innovation Center model tests and initiatives is listed in Table One below. The table also breaks down the aggregate number of beneficiaries and individuals specifically covered by Medicare fee-for-service (FFS), Medicare Advantage, Medicaid and the Children’s Health Insurance Program (CHIP), Medicare and Medicaid dually eligible beneficiaries, private insurance, and those either uninsured or not covered by any of the aforementioned payers.

Table One: *Estimated number of beneficiaries and individuals currently or previously included in models or other initiatives implemented under section 1115A of the Social Security Act between October 1, 2020 and September 30, 2022.*

Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives (Estimate as of September 30, 2022)	
TOTALS³⁹	TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED⁴⁰
Medicare FFS, including Medicare and Medicaid dually eligible enrollees	10,793,669
Medicare Advantage, including Medicare and Medicaid dually eligible enrollees	10,339,966

³⁹ Certain exclusions to beneficiary eligibility for inclusion in these models may apply. Specific information can be obtained by visiting respective CMS Innovation Center web pages.

⁴⁰ Values represent estimated unique counts between October 1, 2020 and September 30, 2022, unless otherwise specified.

Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives (Estimate as of September 30, 2022)	
TOTALS ³⁹	TOTAL BENEFICIARIES AND INDIVIDUALS IMPACTED ⁴⁰
Non-dually eligible Medicaid enrollees	1,562,523
Medicare Part D Prescription Drug Plan and Medicare Advantage Prescription Drug Plan beneficiaries, including Medicare and Medicaid dually eligible enrollees	17,210,072
Individuals with Private Insurance and Those Who were Either Uninsured or Not Covered by Any of the Aforementioned Payers	1,608,040
Medicare and Medicaid dually eligible enrollees	6,609,773 ⁴¹
ESTIMATED TOTAL FOR ALL BENEFICIARIES & INDIVIDUALS	41,514,270 ⁴²

⁴¹ This estimated Medicare and Medicaid dually eligible enrollee count is not included in the total. These counts are already included within the other categories.

⁴² The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these “overlaps,” see Section 2, Part A: Accounting for Model Test and Alternative Payment Model Overlaps of this report.

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

Table Two is an account of the estimated payments made from October 1, 2020 to September 30, 2022 on behalf of beneficiaries included in model tests and initiatives authorized under section 1115A of the Act.

In addition to payments made to model and initiative participants under section 1115A of the Act, the table includes payments under Title XVIII or XIX of the Act, and CMS Innovation Center funds obligated to support the design, implementation, and evaluation of model tests and initiatives developed under section 1115A of the Act.

The table represents obligations less any recoveries of obligated funds during the Fiscal Year (FY) 2021–2022 period for the following: current model tests and initiatives; those that were originally housed in the CMS Innovation Center but are now funded under different authorities and implemented by different CMS components; those that have ended; and those that have been announced but not implemented.

Not included in the table are payments made for services on behalf of beneficiaries in accordance with existing payment provisions, except as waived solely for purposes of testing a model.

Table Two: *As of September 30, 2022, estimates of payments made to model participants (including health care providers, states, conveners, ACOs, and others), including payments under Title XVIII or XIX of the Act and CMS Innovation Center funds obligated to support activities initiated under section 1115A of the Act.*

Please note: *this table does not include Medicare, Medicaid, and CHIP payment amounts that health care providers or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred in the absence of the models.*

Estimated Payments for 1115A Model Tests and Initiatives⁴³

Fiscal Year 2022 (Estimate as of September 30, 2022)

INITIATIVE	CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars ⁴⁴	Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars ⁴⁵	Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars ⁴⁶
Accountable Health Communities Model	\$19,296,941	Not Applicable	\$6,246,001
Artificial Intelligence Health Outcomes Challenge ⁴⁷	\$1,010,000	Not Applicable	Not Applicable
Bundled Payments for Care Improvement Advanced Model	Not Applicable	Data Not Yet Available	\$26,824,067
Community Health and Rural Transformation Model	\$9,953,853	Payments Not Yet Made	\$11,132,386

⁴³ This table excludes administrative costs that are not associated with specific models or initiatives.

⁴⁴ The column titled “CMS Innovation Center payments made to model participants under section 1115A of the Act in United States Dollars” reflects payments made to participants in the testing of models, such as health care providers, states, conveners, ACOs, and others. These payments are paid through CMS Innovation Center funds as provided under section 1115A of the Act. These payments were made by September 30, 2020.

⁴⁵ The column titled “Payments under Title XVIII or XIX made for services on behalf of beneficiaries in United States Dollars” reflects payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. For example, certain models (such as the Next Generation ACO Model) include opportunities to share in the savings that health care providers generate for Medicare through reductions in payments under Title XVIII. This column does not include Medicare, Medicaid, and CHIP payment amounts that health care providers or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.

⁴⁶ The column titled “Other CMS Innovation Center funds under section 1115A obligated to support model design, implementation, and evaluation in United States Dollars” reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2020, September 30, 2020, such as contract awards for administrative and evaluation obligations, but excluding payments listed in the column titled “CMS Innovation Center payments made to model participants under section 1115A of the Act.”

⁴⁷ The Artificial Intelligence Health Care Outcomes Challenge is an infrastructure improvement challenge initiative, and does not directly serve beneficiaries.

Estimated Payments for 1115A Model Tests and Initiatives⁴³

Fiscal Year 2022 (Estimate as of September 30, 2022)

INITIATIVE	CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars ⁴⁴	Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars ⁴⁵	Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars ⁴⁶
Comprehensive Care for Joint Replacement Model	Not Applicable	\$226,017,183	\$10,952,176
Comprehensive ESRD Care Model	Not Applicable	\$116,363,183	\$1,465,707
Comprehensive Primary Care Plus Model ⁴⁸	Not Applicable	\$736,731,304	\$55,912,255
Emergency Triage, Treat, and Transport Model	Payments Not Yet Made	Payments Not Yet Made	\$15,242,434
End-Stage Renal Disease Treatment Choices Model	Not Applicable	Payments Not Yet Made	\$17,713,618
Enhancing Oncology Model	Not Applicable	Payments Not Yet Made	Payments Not Yet Made
Global and Professional Direct Contracting Model	Not Applicable	\$1,205,153,175	\$53,931,290
Health Care Payment Learning and Action Network ⁴⁹	Not Applicable	Not Applicable	\$11,068,520

⁴⁸ The CMS Office of Financial Management has advised that providing separate numbers for CPC+ Track 3 (now PCF) and CPC+ Tracks 1 & 2 is impossible, as all three tracks of the CPC+ model use the same ICIP; all funding apportioned by OMB and the related model program-specific OFM accounting structures treat all CPC+ tracks as one CPC+ model test.

⁴⁹ The Health Care Payment Learning and Action Network is a learning collaborative, and does not directly serve beneficiaries.

Estimated Payments for 1115A Model Tests and Initiatives⁴³

Fiscal Year 2022 (Estimate as of September 30, 2022)

INITIATIVE	CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars ⁴⁴	Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars ⁴⁵	Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars ⁴⁶
Home Health Value-Based Purchasing Model	Not Applicable	Not Applicable	\$6,181,705
Integrated Care for Kids Model	\$35,035,757	Not Applicable	\$19,077,429
Kidney Care Choices Model	Payments Not Yet Made	\$34,615,272	\$37,273,021
Maryland Total Cost of Care Model	Not Applicable	\$389,357,897	\$28,633,607
Maternal Opioid Misuse Model	\$13,654,512	Not Applicable	\$4,893,293
Medicare ACO Track 1+ Model	Not Applicable	\$147,478,342	\$8,025,253
Medicare Advantage Value-Based Insurance Design Model	Not Applicable	Not Applicable ⁵⁰	\$7,432,070
Medicare Care Choices Model	Not Applicable	Data Not Yet Available	\$1,176,106
Medicare Diabetes Prevention Program Expanded Model	Not Applicable	Not Applicable	\$7,995,355
Medicare-Medicaid Financial Alignment	\$11,282,756	\$29,300,000	\$26,067,895

⁵⁰ With the exception of capitation payments made to participating MAOs for the hospice benefit, the Medicare Advantage Value-Based Insurance Design Model is not designed to provide any payments to MAOs in addition to those provided under statute for the Medicare Advantage program, but is based on the expectation that MAOs will incorporate the model flexibilities into their supplemental benefits and use existing means (the rebate or enrollee premiums) to pay for those supplemental the benefits.

Estimated Payments for 1115A Model Tests and Initiatives⁴³

Fiscal Year 2022 (Estimate as of September 30, 2022)

INITIATIVE	CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars ⁴⁴	Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars ⁴⁵	Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars ⁴⁶
Initiative and State Demonstration to Integrate Care for Dually Eligible Individuals			
Million Hearts®: Cardiovascular Disease Risk Reduction Model	\$0	Data Not Yet Available	\$3,656,579
Next Generation ACO Model	\$25,653	\$856,457,094	\$5,953,570
Oncology Care Model	Not Applicable	\$237,372,566	\$22,145,630
Part D Enhanced Medication Therapy Management Model	Not Applicable	\$71,536,719	\$6,421,833
Part D Payment Modernization Model	Not Applicable	Payments Not Yet Made	\$1,032,561
Part D Senior Savings Model	Not Applicable	Not Applicable	\$5,019,726
Pennsylvania Rural Health Model	\$4,000,000	\$213,858,745 ⁵¹	\$5,973,209
Primary Care First Model Options ⁵²	Data Not Yet Available	\$726,498,004	\$64,209,868

⁵¹ This is an unreconciled PARHM global budget figure for FY 2021 and is subject to change. At the time of this report's composition, a reconciled figure was not available.

⁵² The CMS Office of Financial Management has advised that providing separate numbers for CPC+ Track 3 (now PCF) and CPC+ Tracks 1 & 2 is impossible, as all three tracks of the CPC+ Model use the same ICIP; all

Estimated Payments for 1115A Model Tests and Initiatives⁴³

Fiscal Year 2022 (Estimate as of September 30, 2022)

INITIATIVE	CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars ⁴⁴	Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars ⁴⁵	Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars ⁴⁶
Radiation Oncology Model	Not Applicable	Data Not Yet Available	\$627,872
Vermont All-Payer ACO Model	\$0	\$536,695,665	\$3,073,250
ESTIMATED TOTALS:	\$93,249,472	\$5,313,576,403	\$475,358,286

VII. Evaluation Reports

The table below lists all publicly released evaluation reports from CMS Innovation Center models with activity during the period of this report. Links to the posted reports are embedded in the table.

Publicly Released Evaluation Reports

INITIATIVE	REPORT
Accountable Health Communities Model	First evaluation report
ACO Investment Model	First , Second , and Final evaluation reports

⁴³ funding apportioned by OMB and the related model program-specific OFM accounting structures treat all CPC+ tracks as one CPC+ Model.

Publicly Released Evaluation Reports	
INITIATIVE	REPORT
Bundled Payments for Care Improvement (Four Models) ⁵³	Model One: First and Final evaluation reports Models 2-4: First , Second , Third , Fourth , Fifth , Sixth , and Seventh evaluation reports
Bundled Payments for Care Improvement Advanced Model	First , Second , and Third evaluation reports
Comprehensive ESRD Care Model	First , Second , Third , Fourth , and Final evaluation reports
Comprehensive Care for Joint Replacement Model	First , Second , Third , and Fourth evaluation reports
Comprehensive Primary Care Plus Model	First , Second , Third , and Fourth evaluation reports
Financial Alignment Initiative for Medicare-Medicaid Enrollees	Michigan demonstration: Second evaluation report New York demonstration: First brief report Ohio demonstration: Second evaluation report
Home Health Value-Based Purchasing Model	First , Second , Third , Fourth , and Fifth evaluation reports
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents (Two Phases Counted as Two Models) ⁵⁴	Phase One: Year Three , Year Four , and Final evaluation reports Phase Two: First , Second , Third , Fourth , and Final evaluation reports
Integrated Care for Kids Model	Pre-Implementation Evaluation Report

⁵³ The period of performance for the Bundled Payments for Care Improvement Models 1-4 ended prior to the period of report; however, the seventh evaluation report was released in April 2021.

⁵⁴ The period of performance for the Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents ended prior to the period of report; however, the fourth and final evaluation reports were released in March 2021 and January 2022 respectively.

Publicly Released Evaluation Reports	
INITIATIVE	REPORT
Maryland Total Cost of Care Model	<u>Implementation Evaluation Report</u>
Maternal Opioid Misuse Model	<u>Pre-Implementation Evaluation Report</u>
Medicaid Innovation Accelerator Program ⁵⁵	<u>Interim</u> and <u>Final</u> evaluation reports
Medicare Advantage Value-Based Insurance Design Model	<u>Evaluation Report of the First Three Years</u>
Medicare Care Choices Model	<u>First</u> , <u>Second</u> , <u>Third</u> , and <u>Fourth</u> evaluation reports
Medicare Diabetes Prevention Program	<u>First</u> evaluation report
Medicare-Medicaid Financial Alignment Initiative and State Demonstrations to Integrate Care for Dually Eligible Individuals	<p><u>Addressing Social Determinants of Health in Demonstrations Under the Financial Alignment Initiative</u></p> <p>Colorado demonstration: <u>Preliminary Year One Savings Report</u>, <u>Preliminary Year Two Savings Report</u>, <u>Evaluation Report</u>, and <u>Concluding Year Two and Year Three Savings Report</u></p> <p>California demonstration: <u>First Evaluation Report</u> and <u>Preliminary Second Evaluation Report</u></p> <p>Illinois demonstration: <u>First Evaluation Report</u> and <u>Second Evaluation Report</u></p> <p>Ohio demonstration: <u>First Evaluation Report</u></p> <p>Massachusetts demonstration: <u>First Evaluation Report</u>, <u>Second Evaluation Report</u>, <u>Third Evaluation Report</u>, and <u>Fourth Evaluation Report</u></p> <p>Michigan demonstration: <u>First Evaluation Report</u></p>

⁵⁵ The period of performance for the Medicaid Innovation Accelerator Program ended prior to the period of report; however, the final evaluation report was released in December 2020.

Publicly Released Evaluation Reports

INITIATIVE	REPORT
	<p>Minnesota demonstration: First Evaluation Report, Second Evaluation Report, and Third Evaluation Report</p> <p>New York demonstration: First Evaluation Report, Combined Second and Third Evaluation Report, and Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities Preliminary Combined First and Second Evaluation Report</p> <p>Rhode Island demonstration: Combined First and Second Evaluation Report</p> <p>South Carolina demonstration: First Evaluation Report and Second Evaluation Report</p> <p>Texas demonstration: First Evaluation Report and Preliminary Second Evaluation Report</p> <p>Virginia demonstration: Evaluation Report</p> <p>Washington demonstration: Final Year One and Preliminary Year Two Savings Report, First Evaluation Report, Final Year Two and Preliminary Year Three Savings Report, Second Evaluation Report, Final Year Three and Preliminary Year Four Savings Report, Third Evaluation Report, Fourth Evaluation Report, Final Year Four and Preliminary Year Five Savings Report, Final Year Five and Preliminary Year 6 Savings Report, and Fifth Evaluation Report</p> <p>These reports, as well as additional cross-state reports, can be found on the model webpage.</p>
Medicare Prior Authorization Models	<p>Repetitive Scheduled Non-Emergent Ambulance Transport Model: First Interim Report, Second Interim Report, and Final Evaluation Report</p>

Publicly Released Evaluation Reports	
INITIATIVE	REPORT
	Non-Emergent Hyperbaric Oxygen Therapy Model: <u>Interim Report</u> and <u>Final Report</u>
Million Hearts®: Cardiovascular Disease Risk Reduction Model	<u>First</u> , <u>Second</u> , <u>Third</u> , and <u>Fourth</u> evaluation reports
Next Generation ACO Model	<u>First</u> , <u>Second</u> , <u>Third</u> and <u>Fourth</u> evaluation reports
Oncology Care Model	<u>Baseline Period Report</u> , <u>Second</u> , <u>Third</u> , <u>Fourth</u> , and <u>Fifth</u> evaluation reports, and <u>Participants’ Perspectives Report</u>
Part D Enhanced Medication Therapy Management Model	<u>First</u> , <u>Second</u> , <u>Third</u> , and <u>Fourth</u> evaluation reports
Pennsylvania Rural Health Model	<u>First</u> and <u>Second</u> evaluation reports
Pioneer ACO Model ⁵⁶	<u>Year One</u> , <u>Year Two</u> , <u>Three-Day SNF Waiver</u> , and <u>Final</u> evaluation reports
State Innovation Models Initiative (Two Rounds Counted as Two Models)	Model Design and Pre-Test States, Round One: <u>Final Report</u> Model Test, Round One: <u>First</u> , <u>Second</u> , <u>Third</u> , <u>Fourth</u> , and <u>Final</u> evaluation reports Model Design States, Round Two: <u>Final Report</u> Model Test, Round Two: <u>First</u> , <u>Second</u> , <u>Third</u> and <u>Final</u> ⁵⁷ evaluation reports
Vermont All-Payer ACO Model	<u>First</u> Evaluation Report

⁵⁶ Though the period of performance for the Pioneer ACO Model ended prior to the period of report, the model is discussed in this report because the model, as tested in its first two years, was certified for expansion under section 1115A(c), and certain features of the model have since been incorporated into the Medicare Shared Savings Program through notice and comment rulemaking.

⁵⁷ The period of performance for the State Innovation Models Initiative ended prior to the period of report; however, the final evaluation report from the SIM Round Two Model Test was released in October 2021.

VIII. Recommendations for Legislative Action

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

IX. Conclusion

Since the last Report to Congress, the CMS Innovation Center, in accordance with the statute, has continued to develop and test a broad range of new payment and service delivery models expected to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Plan (CHIP) beneficiaries. From October 1, 2020 to September 30, 2022, the CMS Innovation Center has announced, tested, or issued Notices of Proposed Rulemaking for 32 models and initiatives intended to achieve better care, improve health outcomes, and reduce expenditures for Medicare, Medicaid, and CHIP beneficiaries.

The CMS Innovation Center has been protecting taxpayer dollars and innovating in payment models by designing and redesigning model tests and initiatives in ways that increase the proportion of health care paid for through value-based arrangements. Consistent with the Innovation Center Strategy Refresh discussed above, further model development and testing continue to focus on innovative payment and service delivery models designed to reduce program expenditures while preserving or enhancing the quality of care furnished and strive to advance the following strategic objectives

- Ensuring health equity is embedded in every model test;
- Streamlining the model test portfolio and reducing complexity and overlap to help scale what works;
- Providing tools to support transformation in care delivery that will assist providers in assuming financial risk;
- Designing model tests to ensure broad provider participation in model tests; and
- Redesigning financial benchmarks and risk adjustment to improve model test effectiveness.

The CMS Innovation Center's portfolio of models and initiatives has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves

Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico.

CMS estimates that during the period of this report more than 41,500,000 Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 314,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.^{58,59,60} For purposes of this report, CMS beneficiaries include individuals with coverage through Medicare fee-for-service (FFS), Medicaid, dually eligible beneficiaries, CHIP, and Medicare Advantage.

In addition, value-based health care is delivered to beneficiaries through the Medicare Shared Savings Program, a statutorily mandated ACO program that incorporates lessons learned from CMS Innovation Center model testing and that serves more than 11.0 million beneficiaries across 483 Medicare ACOs. In total, more than 37.9 million Americans are served by CMS Innovation Center model tests and initiatives and the Medicare Shared Savings Program.⁶¹

Because a number of these programs, models, and initiatives involve multiple payers or focus on broad areas of quality improvement, millions of other Americans are benefiting from the CMS Innovation Center's activities. Model tests and initiatives driven by the CMS Innovation Center materially contribute to ongoing improvements in the health care system. Models under way and in development at the CMS Innovation Center will help transform health care delivery and payment, moving the country towards a system in which beneficiaries—and eventually all Americans—receive equitable, value-based care driven by evidence, performance, reduced cost, and increasing quality.

⁵⁸ The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests. For an explanation of how the CMS Innovation Center deals with these “overlaps,” see Section 2, Part A of this report, Accounting for Model Test and Alternative Payment Model Overlaps.

⁵⁹ The CMS Innovation Center counts beneficiaries and individuals by model test. In specific circumstances, it is possible that an individual might participate or a beneficiary might be included in multiple model tests.

⁶⁰ This does not include the number of beneficiaries indirectly affected by the CMS Artificial Intelligence Health Outcomes Challenge, Health Care Payment Learning and Action Network, the Home Health Value-Based Purchasing Model, the Medicaid Innovation Accelerator Program, and the Transforming Clinical Practice Initiative. Nor does it include beneficiaries served by demonstrations, which are not part of the mandated focus of this Report to Congress.

⁶¹ The Medicare Shared Savings Program is a statutorily mandated ACO program administered by CMS, and is not a CMS Innovation Center model authorized under section 1115A of the Act. This number combines the number of beneficiaries assigned to ACOs participating in the Medicare Shared Savings Program with the number of beneficiaries and other individuals aligned with or attributed to entities participating in CMS Innovation Center models and other initiatives. Additional data is available in this [fact sheet](#).