



## Catalog of Value-Based Initiatives for Rural Providers

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## Introduction

The following catalog summarizes rural-relevant, value-based programs currently or recently implemented by the Department of Health and Human Services (HHS), primarily by the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicare & Medicaid Innovation (CMMI).

### **Purpose**

To help rural leaders and communities identify HHS value-based programs appropriate for rural participation.

### **Inclusion Criteria**

HHS value-based programs appropriate for rural clinicians or health care delivery organizations. (The programs may not be exclusively for rural clinicians or health care delivery organizations but are appropriate for and inclusive of rural clinicians or health care delivery organizations.)

### **Program Descriptions**

- Program name (and any aliases)
- Summary
- Eligibility and rural-relevant requirements
- Timeline and key dates
- Payment model/funding
- Current rural participation/impact
- Website information

Each program description is accurate as of the date noted. Users should access the link(s) in the descriptions for the most current program information.

The catalog also includes three appendices:

- HHS Initiatives which Support Value-Based Care – programs that provide technical assistance and support for implementation of activities that advance value-based care which include rural assistance although may not be limited to rural assistance
- Inactive Program Archive – Descriptions of value-based care models that are no longer active
- Acronym List

# Accountable Health Communities (AHC) Model

**Aliases:** AHC Model

## **Summary**

The AHC model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries has an impact on total health care costs and improves health and quality of care. The foundation of the AHC Model is universal, comprehensive screening for health-related social needs of community-dwelling Medicare and Medicaid beneficiaries accessing health care at participating clinical delivery sites. The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation. Over a five-year period, CMS will test a two-track model featuring interventions of varying intensity that link beneficiaries with community services:

- **Assistance Track** – Provide community service navigation services to **assist** high-risk beneficiaries with accessing services.
- **Alignment Track** – Encourage partner **alignment** to ensure that community services are available and responsive to the needs of the beneficiaries.

## **Eligibility and rural-relevant requirements**

- Eligible applicants included community-based organizations, health care provider practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers.
- To be eligible for participation, the minimum number of beneficiaries that applicants are required to screen annually is 75,000

## **Timeline/key dates**

- There are currently 30 organizations participating in the Accountable Health Communities Model and all are participating in the awareness and alignment tracks. The list is available here: [Awardees](#).
- CMS developed and released its [Health-Related Social Needs Screening Tool](#) in January 2018.
- Anticipated participant performance period end date is April 30, 2022.

## **Payment model/funding**

Funding goes to consortiums led by bridge organizations, or to bridge organizations to form consortiums responsible for implementing the model.

- Up to \$2.57 million to each of 12 Assistance Intervention award recipients
- Up to \$4.51 million to each of 20 Alignment Intervention award recipients

## **Current rural participation/impact**

Below is the current list of participants who have organizations from rural counties involved. (Counties that are rural)

- Delta Health Alliance, Inc., Stoneville, MS (1 out of 7)
- Partners in Health, Inc., Charleston, WV (32 out of 55)
- Nevada Primary Care Association, Carson City, NV (1 city out of 4 are rural)
- Danbury Hospital, Danbury, CT (1 out of 6)
- University of Kentucky Research Foundation, Lexington, KY (All are rural)
- St. Josephs Hosp. Health Ctr., Syracuse, NY (2 out of 5)
- Oregon Health & Science University, Portland, OR (5 out of 8)
- Tift County Hosp. Authority, Tifton, GA (6 out of 8)
- The Health Collaborative, Cincinnati, OH (3 out of 8)
- Mountain States Health Alliance, Johnson City, TN (9 out of 11)
- Rocky Mountain, HMO Grand Junction, CO (20 out of 21)

**Website:** <https://innovation.cms.gov/initiatives/AHCM>

# Bundled Payments for Care Improvement (BPCI) Advanced

**Aliases:** BPCI Advanced

## **Summary**

Bundled Payments for Care Improvement (BPCI) Advanced is a voluntary episode-based payment model that combines physician, hospital, and other service reimbursements into a single bundled payment to reduce expenditures and improve quality of care. BPCI Advanced builds on past bundled payment initiatives to include payments for 37 Clinical Episodes and 7 quality measures. BPCI Advanced will operate under a total-cost-of-care concept, in which the total Medicare fee for services (FFS) spending on all items and services furnished to a BPCI Advanced Beneficiary during the Clinical Episode, including outlier payments, will be part of the Clinical Episode expenditures for purposes of the Target Price and reconciliation calculations, unless specifically excluded.

## **Eligibility and rural-relevant requirements**

For purposes of BPCI Advanced, a “Participant” is defined as an entity that enters into a Participation Agreement with CMS to participate in the Model. BPCI Advanced will require downside financial risk of all Participants from the outset of the Model Performance Period.

*Convener Participant:* brings together multiple downstream entities, referred to as “Episode Initiators (EIs).” A Convener Participant facilitates coordination among its EIs and bears and apportions financial risk under the Model.

- Eligible entities that are Medicare-enrolled providers or suppliers
- Eligible entities that are not enrolled in Medicare
- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)

*Non-Convener Participant:* is in itself an EI and does not bear risk on behalf of multiple downstream Episode Initiators.

- Acute Care Hospitals (ACHs)
- Physician Group Practices (PGPs)

## **Timeline/key dates**

- Application period for Cohort 1 closed March 12, 2018. Cohort 1 launched October 1, 2018
- Application period for Cohort 2 closed June 24, 2019. Cohort 2 launches January 1, 2020
- Program End Date December 31, 2023

## **Payment model/funding**

BPCI Advanced is a voluntary payment model that provides single retrospective bundled payment with one risk track for a 90-day Clinical Episode duration. There are 33 Inpatient and 4 Outpatient Clinical Episodes that are included in the payment model. Inpatient Clinical Episodes will begin with an inpatient admission to an acute care hospital and is called the Anchor Stay. Outpatient Clinical Episodes will begin at the start of an outpatient procedure and is called the Anchor Procedure. Medicare Severity-Diagnosis Related Group (MS-DRGs) used for identifying the Anchor stay and Healthcare Common Procedure Coding System (HCPCS) codes will be used for identifying the Anchor Procedure. Total duration of one Clinical Episode is 90 days of the Anchor Stay or the Anchor Procedure. This model qualifies as an Advanced APM as it requires the participant to bear downside risk from the outset. Payment is based on total-cost-of-care concept that involves total Medicare fee for services (FFS) payment, for all services and items provided during the Clinical Episode, plus outlier payments that are reconciled semi-annually against prospectively determined clinical episode-specific target prices.

**Current rural participation/impact:** CMS is not placing limitations on applicants based on geographic region (e.g., Applicants are not limited to a specific MAC jurisdiction), geographic type (e.g., urban, rural), or facility size. Participants in other current and past CMS Innovation Center models and Medicare demonstrations are eligible to apply. CAHs, hospitals participating in the Rural Community Hospital demonstration, and rural hospitals participating in the Pennsylvania Rural Health Model, are excluded from the definition of an ACH for purposes of BPCI Advanced.

**Website:** <https://innovation.cms.gov/initiatives/bpci-advanced/>

# Comprehensive Care for Joint Replacement (CJR) Model

**Aliases:** Bundled Joints, Joint Bundles

## **Summary**

The CJR model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements (also called lower extremity joint replacements or LEJR). This model tests bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

## **Eligibility and rural-relevant requirements**

- For the first 2 performance years of the model, participation in the CJR model was mandatory for all IPPS providers located within the 67 MSAs. MSAs are counties associated with a core urban area and have a population of at least 50,000.
- Starting February 1, 2018, the CJR Model continues on a mandatory basis in 34 of the 67 selected geographic areas, with an exception for low volume and rural hospitals, and will continue on a voluntary basis in 33 of the 67 selected geographic areas. Of the approximately 323 providers eligible for voluntary participation, 86 providers opted to elect to continue to participate in CJR for the remaining performance years. See [final rule](#) for list of voluntary and mandatory geographic areas.
- Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection.

## **Timeline/Key Dates**

- The program had an April 1, 2016 start date.
- The five performance years for the model are 2016 – 2020.
- As of February 2018, CMS reduced the number of geographic areas for mandatory participation from 67 to 34.

## **Payment model/funding**

- The CJR attempts to hold hospitals more financially accountable through cost and quality mechanisms by using an episode-based payment approach to incent care coordination throughout the continuum (hospital-based care, physician practices, and post-acute care providers).
- Episode of care starts at admission (DRG 469 or 470) and ends 90-days post-discharge from the hospital to cover the “complete period of recovering for beneficiaries.”
- Participating organizations will receive episode target prices. At the end of a model performance year, actual spending for the episode (total expenditures for related services under Medicare Parts A and B) is compared to the Medicare target episode price for the responsible hospital. Depending on the participant hospital’s quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending. Part A and Part B expenditures are price standardized (per the CMS price standardization methodology) and total expenditures are risk adjusted.

## **Current rural participation/impact**

- There is an exception to mandatory participation for low volume and rural hospitals in the 34 geographic areas where IPPS participation is required.
- CMS will conditionally waive the 3-day stay requirement for covered SNF services for beneficiaries in CJR episodes in performance years 2 through 5 of the CJR model (i.e., on or after January 1, 2017). The waiver is not valid for CAH or swing beds stays (details [here.](#))

**Website:** <https://innovation.cms.gov/initiatives/cjr>

# Comprehensive Primary Care Plus (CPC+)

**Aliases:** CPC+

## **Summary**

CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally based multi-payer payment reform and delivery transformation. The program includes two practice tracks with incrementally advanced delivery requirements and various payment options. The two tracks will center on five primary care functions:

- Access and Continuity of Care
- Care Management
- Comprehensiveness and Coordination of Care
- Patient and Caregiver Engagement
- Planned Care and Population Health

## **Eligibility and rural-relevant requirements**

- 14 regions were selected for participation for Round 1 based on sufficient interest from multiple payers (measured by covered lives and alignment of proposals). Four additional regions (Louisiana, Nebraska, North Dakota, and the Greater Buffalo Region of New York) for Round 2 [were announced](#) to participate from 2018 to 2022.
- On May 27, 2016, CMS opened practice eligibility to allow participation in both MSSP and CPC+. Initial requirements had stated those participating in an MSSP were not eligible.
- CMS has indicated that CPC+ meets the criteria for an Advanced Payment Model (APM) under the [Quality Payment Program \(QPP\)](#).

## **Timeline/key dates**

- CPC+ is a five-year model that begins performance year in 2017.
- Round 1 regions were announced and practice applications were opened on August 1, 2016.
- Round 2 regions were announced May 17, 2017.

## **Payment model/funding**

CPC+ includes three payment elements:

1. **Care Management Fee (CMF):** Both tracks provide a non-visit-based CMF paid per-beneficiary-per month (PBPM), paid on a quarterly basis, with the amount risk-adjusted for each practice's specific population.
  - \$15 Per Beneficiary Per Month (PBPM) across four risk tiers in Track 1.
  - \$28 PBPM Medicare CMFs across five risk tiers in Track 2; \$100 CMF for medically complex.
2. **Performance-Based Incentive Payment:** CPC+ prospectively pays and retrospectively reconciles a performance-based incentive based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.
  - Performance-Based Incentives: Track 1 receives \$2.50 PBPM; Track 2 receives \$4 PBPM.
3. **Payment under the Medicare Physician Fee Schedule:**
  - Track 1 continues to bill and receive payment from Medicare FFS as usual.
  - Track 2 practices also continue to bill as usual, but the FFS payment are reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which are paid in a lump sum on a quarterly basis absent a claim.

## **Current rural participation/impact**

There are [2,851 primary care practices](#) currently participating in Comprehensive Primary Care Plus (CPC+) in 18 regions, supported by 56 aligned payers.

- No specific rural focus, but Round one participation regions include many rural areas including the states of AR, CO, HI, MI, MT, OH, OK, OR, OH, (and northern KY). Round 2 participation regions include LA, NE, ND, and Erie and Niagara Counties of NY.
- Since the model focuses on primary care payments from Medicare Part B, RHCs and FQHCs are ineligible because they are paid on a fee schedule.

**Website:** <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus>



# Diabetes Prevention Program (MDPP) Expanded Model

**Aliases:** MDPP

## **Summary**

The Medicare Diabetes Prevention Program (MDPP) expanded model is a structured intervention aimed at people with prediabetes symptoms and consists of structured evidence-based intervention for preventing Type 2 diabetes. The intervention provides a minimum of 16 intensive core sessions using a curriculum approved by the Centers for Disease Control and Prevention (CDC). The core sessions are group-based and classroom-style sessions with practical training in long-term dietary changes, physical activities and life-style changes for weight management. These core sessions are followed by monthly meetings for ensuring maintenance of these healthy lifestyle behaviors. The model covers 12 months of core sessions (6 months of core sessions and 6 months of core maintenance sessions) and an additional 12 months of ongoing maintenance sessions. The primary goal of this model is to achieve at least 5% weight loss by participants.

## **Eligibility and rural-relevant requirements**

To become a MDPP supplier, the provider must:

- Possess MDPP preliminary recognition or full CDC DPRP recognition, a valid Taxpayer Identification Number (TIN) or National Provider Identification (NPI), and pass high categorical risk level enrollment screening
- Submit an MDPP enrollment application with a list of MDPP coaches and their information including full name, date of birth, Social Security Number (SSN), active and valid NPI, and coach eligibility end date (when applicable)
- Satisfy MDPP supplier standards and requirements as well as other existing Medicare providers or suppliers' requirements, and revalidate enrollment every 5 years
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FDHCs) must re-enroll as MDPP supplier and use the CMS-1500 claim form while filing for reimbursement. MDPP services should be included as non-reimbursable costs on the case report to avoid any possible duplications.

MDPP Enrollment Checklist available here: <https://innovation.cms.gov/Files/x/mdpp-enrollmentcl.pdf>. MDPP Supplier Requirement Checklist is available here: <https://innovation.cms.gov/Files/x/mdpp-supplierreq-checklist.pdf>.

**Timeline/key dates:** Enrollment start date: January 2018; Service Start date: April 2018

## **Payment model/funding**

- Performance-based Payment Model paid by CMS claims system. The Payment Code is Healthcare Common Procedure Coding System (HCPCS) G-codes.
- Payment Structure:
  - **Core Sessions:** MDPP services initiated after the first visit. Suppliers paid based on the beneficiary attendance, regardless of the beneficiary's weight loss.
  - **Core Maintenance Sessions:** Paid in 2 installments with 3-month intervals, based on beneficiary attendance goals. Payment is increased if 5% weight loss goal is achieved during the interval.
  - **Ongoing Maintenance Sessions:** Paid in 4 installments with 3 months intervals only when two ongoing maintenance sessions and 5% weight loss goal is achieved during the interval.

## **Current rural participation/impact**

Any supplier (rural or other) meeting the requirements may participate. MDPP services do not need to be furnished in a traditional health care setting, but must follow the requirements for MDPP locations, which makes them more accessible to rural communities via virtual make-up sessions. Virtual make-up sessions can be furnished for any sessions other than core sessions and are only allowed as make-up sessions when requested by the MDPP beneficiary. Virtual make-up sessions are reimbursed only if they are not virtual only models. Moreover, weight measured during virtual sessions are not considered for payment or continued beneficiary eligibility.

**Website:** <https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/>

A table outlining the differences between Diabetes Self-Management Training ([DSMT](#)) and MDPP can be found [here](#).



# Diabetes Self-Management Training (DSMT)

**Aliases:** DSMT, Diabetes Self-Management

## **Summary**

CMS provides reimbursement for Medicare beneficiaries for diabetes self-management training (DSMT), under certain conditions. The program aims to educate diabetic patients on how to cope and self-manage their diabetes. The program provides individuals with knowledge and skills necessary for adoption of diabetes self-care behaviors and lifestyle changes required for improving health outcomes. The training includes instructions on self-monitoring of blood glucose, diet and exercise, insulin treatment plan, and self-management skills. A total of 10 hours of initial training which includes 1 hour of individual training and 9 hours of group training in a calendar year is covered by the program. Beneficiaries are qualified for 2 hours of follow-up training per calendar year after 12 months of the initial training.

## **Eligibility and rural-relevant requirements**

Medicare Part B beneficiaries with risk of diabetes complications are eligible for the program coverage. A written order is required from the physician or qualified non-physician practitioner involved in management of beneficiary's diabetic condition. People in rural areas can receive services from a practitioner in a different location through telehealth. DSMT services should be ordered by Medicare-enrolled physicians and provided by a DME supplier certified by CMS-approved national accreditation organizations (i.e. American Diabetes Association (ADA) and American Association of Diabetic Educators (AADE)). Information about DSMT accreditation program is available [here](#).

## **Timeline/key dates**

Medicare reimbursement for DMST services started in 1997. DMST payment guidelines were revised on May 29, 2007; August 24, 2012; December 21, 2015.

## **Payment model/funding**

The Part B deductible is applicable. Beneficiaries are required to pay 20% of the Medicare-approved amount. The Medicare Physician Fee Schedule (MPFS) is utilized for reimbursement of physician and non-physician providers, and skilled nursing facilities. Indian Health Service and Critical-Access Hospitals are paid at 101% of reasonable cost payment rate. RHCs and FQHCs are not paid under MPFS payment model but instead are paid using all-inclusive reimbursement rates based on the DSMT cost as reported in the facility's cost report. Home Health Agencies are reimbursed based on MPFS non-facility rate. This program doesn't follow any performance or value-based reimbursement payment model. Medicare pays the DSMT services provided through telehealth given that at least 1 hour of in-person instruction is provided to participants in the initial year of training period.

Information about Medicare covered services and supplies for diabetes is available here: [Covered items](#)

## **Current rural participation/impact**

Rural providers approved for in-person DSMT (not telehealth DSMT) include:

- Critical access hospitals
- Federally qualified health centers (FQHCs)
- Home health agencies
- Hospital outpatient departments
- Independent clinics (Freestanding FQHCs and Independent Rural Health Clinics)
- Private physician practices
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs)

For RHCs: Only individual DSMT is payable by Medicare Part B.

- If there is a solo diabetes instructor, this person must be an RD and CDE.
- The RHC may be able to include the cost of furnishing group DSMT on its annual cost report. It is best to first verify this with the regional MAC.

## **Websites:**

For beneficiaries: <https://www.medicare.gov/coverage/diabetes-self-mgmt-training.html>

For providers: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5433.pdf>

# Emergency Triage, Treat, and Transport (ET3) Model

**Aliases:** ET3

**Summary:** Medicare currently only allows for reimbursement for emergency ground ambulance services when beneficiaries are transported to hospitals, CAHs, SNFs, or dialysis centers, (most often hospital emergency departments) even when lower-acuity care providers may be more appropriate. The ET3 model is a voluntary, five-year payment model providing increased flexibility to ambulance care teams to address emergency health needs for FFS benefits in Medicare, after they call 911. Through the model, Local governments, designees, or other entities operating or overseeing 911 dispatches can apply for funding to develop and operate a triage line for low-acuity emergency calls. The expected result is improved quality and lower costs through reducing avoidable transports to ED and subsequent unnecessary hospitalizations.

## **Eligibility and rural-relevant requirements**

- Medicare-enrolled ambulance suppliers and hospital-based ambulance providers are eligible to respond to the RFA to participate in the payment model.
- Local governments, designees, and other operators controlling 911 dispatch entering into cooperative agreements with CMS are eligible to respond to a Notice of Funding Opportunity (NOFO) for funding to develop a low-acuity triage line if they operate in a geographic area with at least one ambulance supplier is participating in ET3.
- Rural and frontier areas without current medical dispatch and/or telehealth services are eligible to participate. Applicants are required to propose an intervention design for alternative destination transport at a minimum. Applicants able to demonstrate capacity to implement treatment in place –through telehealth, in-person care, or both can earn additional points in the application process.

**Timeline/key dates:** ET3 will run for a five-year performance period. CMS anticipates a phased approach with up to three rounds of RFAs, two NOFOs, and staggered performance dates. Because the performance period for all participants will end at the same time, only those applicants selected through the first RFA are able to participate throughout the full five-year period.

- October 5, 2019 – RFA deadline for Medicare-enrolled ambulance suppliers and providers
- NOFO application date is TBD
- January 1, 2020 – Performance year 1 begins
- December 31, 2024 – Performance period ends

## **Payment model/Funding**

- In addition to reimbursement for transport to a hospital or ED, CMS will pay participating ambulance suppliers and providers for transport to an alternative destination (such as a primary care doctors office or urgent care clinic), or to provide treatment in place with a qualified health care practitioner at the scene or via telehealth.
- Model participants will not receive additional funding beyond model payments for eligible services.
- NOFO awardees may receive funding through the two-year cooperative agreements with CMS to establish or expand a medical triage line.

**Website:** <https://innovation.cms.gov/initiatives/et3/>

# Home Health Value-Based Purchasing (HHVBP) Model

**Aliases:** HHVBP Model

## **Summary**

The HHVBP Model requires participating Medicare-certified home health agencies (HHAs) to compete for payment adjustments based on quality performance, in contrast to their current prospective payment system (PPS) reimbursements. The goals of this model are to 1) incentivize HHAs to increase both quality and efficiency of provided care, 2) identify and study the use of new potential quality and efficiency measures in the home health setting, and 3) improve current public reporting processes. HHAs are scored based on a total of six process measures, 15 outcome measures from Outcome and Assessment Information Set (OASIS) and Home Health Care Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data, and three new measures, submitted by HHAs. These scores are compared to previous performance on these measures in addition to the performance of other home health agencies on these measures within each HHA's respective state. Payments will be adjusted by up to an eight percent increase or decrease of current Medicare reimbursable payments based upon the HHA's performance in the identified measures.

## **Eligibility and rural-relevant requirements**

The model includes all Medicare-certified HHAs within the states of Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee.

## **Timeline/key dates**

The HHVBP Model was implemented on January 1, 2016 and will be terminated December 31, 2022.

The CY 2018 HHPPS was announced July 28, 2017.

- Final rule in effect January 1, 2018.

## **Payment model/funding**

This model will adjust (either increase or decrease) payments based on the following timetable:

- A maximum payment adjustment of 3 percent in 2018.
- A maximum payment adjustment of 5 percent in 2019.
- A maximum payment adjustment of 6 percent in 2020.
- A maximum payment adjustment of 7 percent in 2021.
- A maximum payment adjustment of 8 percent in 2022.

## **Current rural participation/impact**

All HHAs in the following states are participating: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee.

- Rural beneficiaries make up 4.9% of home health beneficiaries across all participating HHVBP states.
- Although they have more significant rural participation, the three HHVBP states with the most pronounced rural populations (Iowa, Nebraska, and Tennessee) together account for only 17% of agencies and 14% of beneficiaries overall in the HHVBP states. Of the participating states, Iowa has the largest percentage of rural home health beneficiaries (24.6%).

**Website:** <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>

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# Hospital Acquired Conditions Reduction Program (HACRP)

**Aliases:** HAC, HAC penalty program, HAC Reduction Program

## **Summary**

Established by the ACA, the HAC Reduction Program encourages hospitals to improve patient safety and reduce the number of hospital-acquired conditions, such as hospital-acquired infections, pressure ulcers, and hip fractures or hemorrhages after surgery

For FY 2019, hospital scores are based on six quality measures in two domains:

- CMS Recalibrated Patient Safety Indicator (PSI) 90 (CMS PSI 90)
- Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy) (SSI)
  - Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteremia
  - Clostridium Difficile Infection (CDI)

Hospitals that rank in the bottom 25 percent have payment reduced by one percent for the associated fiscal year.

## **Eligibility and rural-relevant requirements**

- All IPPS hospitals are eligible.
- CAHs and acute care hospitals in Maryland are exempt.

## **Timeline/key dates**

- Program was effective beginning Fiscal Year (FY) 2015 (discharges beginning on October 1, 2014).
- Program criteria and scoring are updated annually through the IPPS rule making process.

## **Payment model/funding**

- Hospitals that rank in the worst performing quartile with respect to risk-adjusted HAC quality measures have their payments reduced to 99 percent of what would otherwise have been paid.

## **Current rural participation/impact**

- CAHs are exempt, but rural IPPS hospitals are included.
- In 2019, 800 hospitals were impacted by safety penalties

**Website:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html>

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# Hospital Readmissions Reduction Program (HRRP)

**Aliases:** HRRP, Readmission penalty program

## **Summary**

Established by the ACA, the HRRP requires CMS to reduce payments to IPPS hospitals with excess readmissions effective for discharges beginning on October 1, 2012.

Excess readmission ratio (EER) is calculated by dividing a hospital's number of "predicted" 30-day readmissions for certain conditions by the number that would be "expected," based on an average hospital with similar patients.

The FY 2019 HRRP calculates excess readmission ratios for six conditions: Acute Myocardial Infarction (AMI), Heart Failure, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Bypass Graft (CABG), and Elective primary total hip and/or total knee arthroplasty (THA/TKA).

## **Eligibility and rural-relevant requirements**

- All IPPS hospitals are eligible.
- CAHs and acute care hospitals in Maryland are exempt.
- Hospitals must have a minimum of 25 cases per applicable condition to have an excess readmission ratio calculated.
- Applies only to Medicare Part A payments under IPPS.

## **Timeline/key dates**

- CMS uses a three-year performance period for calculations. Payment adjustments for FY 2019, were based on the 3-year performance period of July 1, 2014 through June 30, 2017.
- Program criteria and methodology are updated annually through the IPPS rulemaking process.

## **Payment model/funding**

- Payments are adjusted by multiplying the base operating DRG payment amount by the adjustment factor.
- The penalty is capped at a maximum of 3 percent.
- Beginning in FY 2019, CMS updated the methodology to calculate the payment adjustment factor using a stratified methodology to assess a hospital performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid:
  - Hospitals are assigned to one of five peer groups based on the hospitals portion of dual eligible (beneficiaries that are eligible for Medicare and Medicaid).
  - The stratified methodology calculates the median ERR for each measure and peer group (peer group median ERR). The peer group median ERR is the threshold used to assess hospital performance relative to other hospitals within the same peer group. Hospitals whose ERR is greater than the peer group median are considered to have excess readmissions.

## **Current rural participation/impact**

- No specific rural focus, though eligible rural PPS hospitals are included to participate if they meet specified case volume thresholds.
- Studies indicate that rural PPS hospitals will experience lower penalties starting 2019 due to the shift to a stratified methodology.

**Website:** <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>

# Hospital Value-Based Purchasing (VBP) Program

**Aliases:** Hospital VBP, Inpatient VBP

**Summary:** The Hospital VBP Program is part of CMS' long-standing effort to link Medicare's prospective payment system for hospitals to a value-based system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting. The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Congress authorized Inpatient Hospital VBP as part of the ACA. The program uses the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**Eligibility and rural-relevant requirements:**

- All IPPS hospitals are eligible.
- CAHs and acute care hospitals in Maryland are exempt.

**Timeline/key dates:**

- There is a two-year lag between the reporting year and the payment year (i.e., quality scores from 2018 will affect payment in 2020).
- Program criteria and scoring are updated annually through the IPPS rule making process.

**Payment model/funding:**

- The Hospital VBP Program is funded by a reduction from participating hospitals' base operating DRG payments (2%). Resulting funds are redistributed to hospitals based on their Total Performance Scores (TPS). The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that program year. The adjustment factor is applied to the base DRG rate, and affects payment for each discharge in the relevant fiscal year (October 1 – September 30).
- Total Performance Scores are calculated using baseline to performance period comparisons in four domains: Person and Community Engagement, Clinical Care, Safety, and Efficiency and Cost Reduction. The four domains are weighted equally at 25 percent each. The metrics included and weighting of the domains is adjusted annually through the IPPS rule making process.
- Hospitals must have a domain score for at least three out of the four domains to have a TPS.

**Current rural participation/impact**

- CAHs are exempt, but rural IPPS hospitals are included.
- In FY 2019, rural hospitals had a higher average total performance score relative to urban hospitals which translated to a higher than average payment adjustment (Average Total Performance Score of 42.4 for rural hospitals compared to 38.1 for all participating hospitals).

**Website:** <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html>

# Independence at Home Demonstration

**Aliases:** None

## **Summary**

Under the Independence at Home Demonstration, the CMS Innovation Center works with medical practices to test the effectiveness of delivering comprehensive primary care services at home and if doing so improves care for Medicare beneficiaries with multiple chronic conditions. Additionally, the Demonstration will reward health care providers that provide high quality care while reducing costs.

## **Eligibility and rural-relevant requirements**

- The 14 participating Primary Care practices provided documentation in their application regarding experience in providing home-based primary care to beneficiaries who are high-cost and have multiple chronic conditions; in addition, they must serve at least 200 eligible beneficiaries.
- Beneficiaries are eligible to participate if they have two or more chronic conditions, enrolled in Medicare FFS, need help with two or more functional activities, had a non-elective inpatient admission within the past year, and have received acute or subacute rehabilitation within the past year.

## **Timeline/key dates**

- Two separate cohorts for implementation between 2012 – 2015
- Initial extension authorized through 2017
- A second extension through the BBA 2-year extension authorized in 2018.
- Anticipated performance period end date December 31,2020

## **Payment model/funding**

- The participating practices will be eligible for financial incentives if they succeed in offering high quality care that reduces costs for the Medicare program. To qualify for an incentive payment, the practice's expenditures for participating beneficiaries must be lower than the calculated target expenditure, which represents the expected Medicare FFS expenditures of participating beneficiaries in the absence of the Demonstration. Practices are required to meet stringent quality standards and ensure that financial targets are met.
- Nine participating practices received incentive payments in Year 1. Seven practices received incentive payments in Year 2. In Year 2, CMS modified the shared savings methodology to improve the comparability between the demonstration and matched comparison group beneficiaries. Seven practices received incentive payments in Year 3
- In Performance Year 4, Independence at Home practices saved \$32,900,000 in aggregate, an average of \$2,819 per beneficiary. Seven participating practices earned incentive payments in the amount of \$8,095,0009.

## **Current rural participation/impact**

- All 14 of the originally participating primary care practices are in urban areas. However, seven are Health Professional Shortage Areas and/or Medically Underserved Areas.
- 12 of the participants continued in the demonstration as part of the 2-year extension authorized as part of the BBA in 2018.

**Website:** <https://innovation.cms.gov/initiatives/independence-at-home/>

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PAGE UPDATED: 10/2019



# Maryland Total Cost of Care Model

**Aliases:** TCOC Model

## **Summary**

The new Maryland Total Cost of Care Model (TCOC) will leverage the foundation already developed by Maryland for hospitals and build upon investments from the [Maryland All-Payer Model](#). This model sets a per capita limit on Medicare total cost of care in Maryland, holding the state fully at risk for Medicare beneficiaries. It is expected to save Medicare over \$1 billion by the end of 2023 across the entire state. Care will be coordinated across both hospital and non-hospital settings. This model encourages person-centered care redesign and provides new tools and resources for primary care providers to better meet the needs of patients with complex conditions to increase the health of its citizens. The model includes Outcomes-Based Credits, which enables CMS to grant the State credits for performance on targets. The amount of the credits will be based on ROI calculations.

Model performance requirements include:

- Hospital cost growth per capita for all payers must not exceed 3.58% per years
- Maryland commits to save \$300 million in annual Medicare spending for Part A and B by 2023
- Federal resources will be invested in primary care and delivery innovation to improve population health
- Providers will leverage initiatives and federal programs to align participation in efforts on improving care and care coordination
- Maryland will set aggressive quality of care and population health goals

## **Eligibility and rural relevant requirements**

All Maryland hospitals, both rural and urban, are included. Under the expansion, to the TCOC model starting Jan. 1, 2019, the program will also apply to some doctors' visits and other outpatient services, such as long-term care. Community health care providers will be able to choose whether they want to participate in the model.

## **Timeline/Key Dates**

Maryland TCOC will run for an eight-year performance period starting in January 1, 2019 and concluding on December 31, 2026. During the final 3 years, CMS and the State will negotiate expanding the model, adopting a new model, or returning to the national prospective payment system.

## **Payment model/Funding**

The TCOC Model includes three programs:

- Hospital Payment Program: Each hospital receives a population-based payment amount to cover all hospital services provided during the year
- Care Redesign Program: Allows hospitals to make incentive payments to nonhospital providers who partner and collaborate with the hospital and perform care redesign to improve quality of care
- Maryland Primary Care Program: Incentivizes primary care providers to offer advanced primary care services to their patients, where practices will receive an additional per beneficiary per month payment directly from CMS to cover care management services and utilization improvements

## **Rural Participation/Impact**

All Maryland hospitals, both rural and urban, are included. FQHCs and RHCs are not eligible to participate in the Maryland Primary Care Program.

**Websites:** <https://innovation.cms.gov/initiatives/md-tccm/>; <https://hscrc.state.md.us/Pages/tcocmodel.aspx>

# Medicare Care Choices Model

**Aliases:** MCCM

## **Summary**

The Medicare Care Choices Model (MCCM) provides Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit the option to receive hospice like services while continuing to receive curative services. Beneficiaries who are dually eligible for Medicare and Medicaid are also included. The goal of the MCCM is to determine whether access to this type of service will improve quality of care, and patient quality of life and family satisfaction, and offer new payment systems for the Medicare and Medicaid programs.

## **Eligibility and Rural-relevant Requirements**

The program's target population is dual eligible beneficiaries, who are eligible for Medicare or Medicaid hospice benefits. Participation in the model is limited to Medicare beneficiaries with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). Eligible beneficiaries must have had Medicare parts A and B for the preceding 12 months and must not have elected the Medicare or Medicaid hospice benefit within the last 30 days prior to their participation in the MCCM. These beneficiaries must be living in a traditional home and does not cover institutional care.

## **Timeline/key dates**

CMS originally planned to select at least 30 Medicare-certified hospices to participate in the Model. Due to robust interest, CMS invited over 140 Medicare-certified hospices to participate in the Model and increased the duration of the Model to 5 years.

- Cohort 1 began furnishing MCCM services on January 1, 2016
- Cohort 2 began MCCM services on January 1, 2018
- Beneficiary enrollment continues through June 30, 2020
- Anticipated end date for both cohorts is December 31, 2020

## **Funding**

Participating hospices will receive payment under the MCCM through the standard Medicare claims process. Hospices will be paid a per-beneficiary-per-month (PBPM) fee that is dependent on the number of calendar days that services are provided under the model. Hospices will be paid \$400 PBPM if services are provided under the model for 15 or more calendar days per month, and \$200 PBPM if services are provided under the model for fewer than 15 calendar days per month.

## **Current rural participation/impact**

About 140 Medicare-certified hospices from both urban and rural geographic areas initially participated in the model. 37 withdrew from participation by the end of 2017. Due to low enrollment, it is too early to measure impact. As of early 2018, 1,325 beneficiaries have been enrolled. Ten percent of beneficiaries approached about the Model have elected hospice immediately and nearly 80 percent of those who enroll in MCCM elect hospice when they leave the Model.

**Website/contact Info:** <https://innovation.cms.gov/initiatives/Medicare-Care-Choices/>

# Medicare Shared Savings Program (MSSP): Updated Fall 2019

**Aliases:** MSSP, Shared Savings Program, ACOs (note: several ACO models are part of MSSP), MSSP ACO

## **Summary**

The MSSP was established by the ACA and is a key component of Medicare delivery system reform initiatives. MSSP facilitates coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in MSSP by creating or participating in an ACO. The Shared Savings Program rewards ACOs that lower health care cost growth while meeting performance standards on quality of care. Participation in an ACO is voluntary.

## **Eligibility and rural-relevant requirements**

- Eligible providers and suppliers must form a Medicare ACO, and the ACO must apply to CMS.
- To be accepted, ACOs must have at least 5,000 attributed Medicare FFS patients, meet all other eligibility and program requirements, and agree to participate in the program for at least 5 years.
- Statute and individual program regulations specify the eligibility and program requirements.

## **Timeline/key dates**

- For standard MSSP ACO participation there is an annual application cycle. Updates to program requirements and methodology are made through the Federal rule making process. Significant changes were made during the 2019 rule making process. For a description of program structure prior to July 2019 see the archived description in Appendix B [here](#).
- July 1, 2019 MSSP Agreement Start date application period closed February 2019, MSSP agreements were signed June 2019.
- January 1, 2020 MSSP applications were due July 29, 2019

## **Payment model/funding**

- CMS and ACO's establish budget targets for the total health spending of attributed ACO FFS Medicare beneficiaries. CMS continues to make payments on a fee-for-service basis. At the end of the year, the actual and target spending are reconciled. If actual spending is less than the target and is above the minimum savings rate, *and* if the ACO has performed adequately on access and quality metrics, the ACO and CMS share the difference.
- Currently, an ACO enters a five-year agreement period under two tracks:
  - **Basic Track:** glide-track with 5 levels that gives the option of starting with one-sided shared savings model
    - **Level A and B:** one-sided shared savings, 40 percent of savings, no shared loss, annual election to enter higher risk. Available only for the first two years of participation
    - **Level C:** two-sided shared savings/shared losses model, 50 percent split of savings, loss sharing limit is 1%, annual election to enter higher risk
    - **Level D:** two-sided shared savings/shared losses model, 50 percent split of savings, loss sharing limit is 2%
    - **Level E:** two-sided shared savings/shared losses model, 50 percent split of savings, loss sharing limit not to exceed 1 percent higher than the benchmark nominal risk amount
  - **Enhanced Track:** two-sided shared savings/share loss model, 75 percent split of savings, loss sharing limit is 15%
  - In return for greater risk, the Basic Levels C-D, and Enhanced tracks allow for prospective beneficiary assignment, waiver of the Skilled Nursing Facility (SNF) 3-day rule, and potential flexibility around telehealth requirements for billing and reimbursement.)

## **Current rural participation/impact**

- RHCs, FQHCs, and CAHs are eligible to participate in ACOs if they meet specific requirements.
- As of July 2019:
  - 435 Critical Access Hospitals were participating in an MSSP ACO.
  - 71% of all participating ACOs were under one-sided risk.

**Website:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>

# The Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model

**Aliases:** Million Hearts®

## **Summary**

The Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model is a randomized controlled trial that seeks to bridge a gap in cardiovascular care by providing targeted incentives for health care practitioners to engage in beneficiary CVD risk calculation and population-level risk management. Model uses data-driven, widely accepted predictive modeling approaches to generate individualized risk scores, and mitigation plans for eligible Medicare FFS beneficiaries.

This model will use a randomized controlled design to identify successful prevention and population health interventions for CVD implemented within the following framework for the intervention group:

- Universal risk stratification of all Medicare eligible beneficiaries who meet the cardiovascular disease risk factor inclusion criteria.
- Evidenced-based risk modification using shared decision making between beneficiaries and care teams.
- Prevention and population health management strategies based on beneficiary risk stratification.
- Reporting of continuous risk calculator variables and CVD 10-year risk score through a Data Registry (QCDR) that will be provided as part of the model test.

## **Eligibility and rural-relevant requirements**

- The types of providers participating in the model include but are not limited to: general/family medicine, internal medicine, geriatric medicine, multi-specialty, nephrology or cardiovascular care.
- The types of practices participating in the model include, but are not limited to, private practices, community health centers and other community-based clinics, academic/university health centers, hospital-owned physician practices, and hospital/physician organizations.
- Participating practices are randomly assigned to be part of a control group or intervention group.

## **Timeline/key dates**

- the CVD Risk Reduction Model spans over a 5-year period, beginning in January 2017 and ending by December 2021.
- Participants were announced in July 2016, and the model is currently closed to additional applications.

## **Payment Model/funding**

- Control Group: One-time payment of \$20/beneficiary to off-set costs of data collection and submission
- Intervention group – two payments:
  - Cardiovascular Disease Risk Stratification payment: participants receive a one-time \$10 per-beneficiary payment for each eligible beneficiary that is assessed for CVD risk.
  - Cardiovascular Care Management (CVD CM) payment: ongoing monthly CVD CM payments will be available for beneficiaries that were categorized as high-risk in the initial risk assessment and for whom data elements have been reported. In the first year of the model, participants will receive a monthly \$10 CVD CM payment for each high-risk FFS. For years 2–5 of the model, participants may receive up to a \$10/month CVD CM payment for those beneficiaries identified as high risk, contingent on the participant’s performance in CVD risk reduction of the high-risk beneficiaries reflected in the longitudinal treatment benefit tool.

## **Current rural participation/impact**

No specific rural focus. However, with over 500 participating organizations in all but one state (SD), rural providers are participating in the model.

**Website:** <http://millionhearts.hhs.gov/> and <https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/>

## Next Generation ACO (NGACO) Model

**Aliases:** All Inclusive Population-Based Payment (AIPBP), Next Gen ACO

### **Summary**

NGACO aims to encourage experienced ACOs to assume higher levels of financial risk and rewards than are currently available under other MSSP and the [Pioneer ACO Model](#). Provider participation in ACOs is purely voluntary, and participating patients see no change in their Medicare benefits and keep their freedom to see any Medicare provider. The model allows these provider groups to assume higher levels of financial risk and reward than are available under their previous ACO model. The goal is to test whether strong incentives coupled with patient engagement and case management support tools improve outcomes and increase savings over traditional fee-for-service reimbursement.

### **Eligibility and rural-relevant requirements**

- Participation is open to previous participants of MSSP and Pioneer, along with other qualifying organizations
- ACOs may not simultaneously participate in NGACO and the MSSP models

### **Timeline/key dates**

- Launched in January 2016 with 18 ACOs
- 41 ACOs participating in 2019 – 2020 performance period

### **Payment model/funding**

- In performance year 2 (2017), participating ACOs began a capitation style mechanism called, All Inclusive Population-Based Payments (AIPBP), which will be one of four payment mechanisms:
  - FFS
  - FFS plus a Per-Beneficiary Per-Month (PBPM) infrastructure payment
  - Population-Based Payment (same as [Pioneer Model](#))
  - Capitation (PBPM)
- AIPBP will function by estimating total annual care expenditures and paying the ACO per-beneficiary/per-month payment
- If the projected trend is substantially different from the experienced trend, CMS will adjust the payment to shield participants against external price shifts

### **Current rural participation/impact**

- Telehealth and other benefit enhancement waivers allow beneficiaries to seek out better, more-cost effective care, necessary services
- Regional efficiency trend adjustments ensure participating providers receive adequate compensation for services provided in regions that are experiencing major payment changes beyond their control
- No specific rural focus. However, ACOs with a rural presence are among participants

**Website:** <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

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PAGE UPDATED: 10/2019

# Part D Enhanced Medication Therapy Management Model

**Aliases:** Enhanced MTM Model

## **Summary**

The Part D Enhanced Medication Therapy Management (Enhanced MTM) model tests whether providing Part D sponsors with additional payment incentives and allowing for regulatory flexibilities will improve therapeutic outcomes and reduce net Medicare expenditures. Payment incentives include a prospective payment for more extensive MTM interventions outside of the plan's annual Part D bid and an increased direct premium subsidy for plans that successfully reduce fee-for-service expenditures and fulfill quality reporting requirements. Additional regulatory flexibilities are intended to allow for more individualized and risk-stratified interventions.

## **Eligibility and Rural-relevant Requirements**

To participate in the Enhanced MTM model, a plan must be an individual market standalone basic plan, have a minimum enrollment of 2,000, have existed as a basic plan for at least three years prior to the first year of the model test, and not be under sanction by CMS or other law enforcement entities.

## **Timeline/key dates**

- The Enhanced MTM five-year performance period began January 1, 2017 and continues through December 31, 2021.
- Participants for the model were chosen in August 2016 and the model is not currently accepting new applicants.

## **Funding**

CMS will offer participating plans a per-member-per-month prospective payment to provide funding for enhanced items and services, improved system linkages, and other pharmacy, prescriber or beneficiary incentives.

## **Current rural participation/impact**

- There are six Part D sponsors participating in the MTM program: Blue Cross and Blue Shield of Florida, Jacksonville, FL; Blue Cross and Blue Shield Northern Plains Alliance, Eagan, MN; CVS Health, Woonsocket, RI; Humana, Louisville, KY; UnitedHealthcare, Minneapolis, MN; and WellCare Prescription Insurance, Tampa Bay, FL. Part D sponsors are responsible for designing the eligibility requirements for beneficiaries to participate in the MTM program, as well as specific intervention activities. No specific rural focus is included, though Model Participants include highly rural states in their covered regions.
- Eleven out of 22 participating plans are eligible to receive the performance-based payment because their medical spending was reduced by 2 percent or more;
- Seven participating plans show reductions in medical spending, but the reductions are less than 2 percent and therefore the plans are ineligible to receive the performance-based payment;
- Four plans have shown increases in spending and are therefore ineligible to receive the performance-based payment. Estimated Enrollment across all participating plans in 2017: 1.7 million beneficiaries

## **Website/contact Info:**

- <https://innovation.cms.gov/initiatives/enhancedmtm/>
- Questions: [EnhancedMTM@cms.hhs.gov](mailto:EnhancedMTM@cms.hhs.gov)

# Pennsylvania Rural Health Model

**Aliases:** PA Rural Health Model

## **Summary**

Established as a joint effort between the Pennsylvania Department of Health and the Centers for Medicare & Medicaid Services (CMS), the Pennsylvania Rural Health Model aims to improve health outcomes, while reducing the growth of hospital expenditures and promoting sustainability of rural Pennsylvania hospitals. Payment under the model is based on all-payer global budgets, where maximum payment rates are pre-established for hospital payments and paid monthly by fee-for-service (FFS) Medicare and other payers. Pennsylvania's rural hospitals, who must volunteer to participate, are expected to redesign their care delivery to increase quality of care and meet the needs of their local communities

The model is testing whether predictable global budgeting, for both inpatient and outpatient hospital-based services, allows rural providers to further invest in improved quality and preventive care for their populations.

## **Eligibility and rural-relevant requirements**

- Both critical access hospitals and acute care hospitals in rural Pennsylvania are eligible, as well as, other payers including Medicaid and commercial plans.
  - For this model, Pennsylvania and CMS are defining 'rural' as a county with less than 284 people per square mile, which is the definition used by the Pennsylvania General Assembly.
  - Participation will be phased in over the seven performance years with at least 30 hospitals participating in the final years.
- Participating hospitals must develop and submit a Rural Hospital Transformation Plan to the Pennsylvania Department of Health and CMS.

## **Timeline/key dates**

- The Model will run for seven performance years (PYs), between January 12, 2017 and December 31, 2023.
- During PY0 (2017- 2018) CMS will provide funding to the state, the state will establish participation agreements, and rural hospitals will develop their Rural Hospital Transformation Plans.
- Prospectively set, all-payer global budgeting payments will occur in PY1-PY5 (2019-2023).

## **Payment model/funding**

- CMS has committed to providing \$25 million to Pennsylvania over four years to implement the model.
- The State will calculate the global budgets and submit them to CMS for review and approval.
- Pennsylvania aims to have 75 percent of participating hospital revenues coming from global budgeting by PY1 (2018).
- Pennsylvania will encourage commercial payers to participate in the Model, and will work to achieve Medicaid participation, which is necessary for the Model to be implemented.
- Pennsylvania agrees to an all-payer financial target of no more than 3.38 percent in annual hospital spending growth on inpatient and outpatient hospital-based services per resident of Pennsylvania's rural areas served by participating rural hospitals. 3.38 percent represents the compound annual growth rate for Pennsylvania's gross state product from 1997 to 2015.
- Pennsylvania commits to achieving \$35 million in Medicare hospital savings from the rural participants over the course of the model.

## **Current rural participation/impact**

- The Rural Health Model seeks to increase the financial viability of rural Pennsylvania hospitals to ensure continued access to care. The model is developed for rural hospital participation specifically.

**Website:** <https://innovation.cms.gov/initiatives/pa-rural-health-model/>



## Primary Cares Initiative

**Aliases:** Primary Care First (PCF) and Direct Contracting (DC) Models

### **Summary**

Administered through CMMI, the Primary Cares Initiative will provide primary care providers with new payment models under two distinct paths: Primary Care First and Direct Contracting. PCF offers two payment models: PCF General and PCF High Need Populations; while Direct Contracting offers three payment model options: DC Global, DC Professional, and DC Geographic.

### **Primary Care First (PCF)**

The PCF models build on the underlying principles of the CPC+ model emphasizing the priority of the doctor-patient relationship, enhanced care for seriously-ill patients with complex and chronic health needs and reduced administrative burden through quality-based incentives. The model implements a set of voluntary five-year payment structure to support delivery of advanced primary care. The goal is to establish a seamless continuum of care, supported by a large network of supportive providers. PCF tests whether delivery of advanced primary care can reduce total cost of care, accommodating practices at multiple stages of readiness to assume accountability for patient outcomes, while assuming financial risk in exchange for reduced administrative burdens and performance-based payment. The PCF High Needs Population, also referred to as the Seriously Ill Population (SIP) model, encourages advanced primary care practices and previously enrolled Medicare clinicians who provide hospice and palliative care to take responsibility for seriously ill beneficiaries lacking a PCP and/or effective care coordination.

### **Direct Contracting (DC)**

The DC Models build on the success of the CMS ACO initiatives, including Medicare Shared Savings Program and Next Generation ACO Model, and similarly leverages innovative approaches from Medicare Advantage and the private sector risk-sharing agreements. DC establishes three model options for participants (Direct Contract Entities or DCEs) to engage in risk-sharing payment approaches with population-based payment (PBP), beneficiary alignment, and enhanced benefits. The three model options include: DC Professional, DC Global, and DC Geographic. Under DC Professional, DCEs will receive Primary Care Capitation, a capitated, risk-adjusted monthly payment for enhanced primary care services equal to seven percent of the total cost of care for enhanced primary care services. Under DC Global, DCEs may choose between Primary Care Capitation and Total Care Capitation, a risk-adjusted monthly payment for all services provided. DC Geographic will similarly run on a Total Care Capitation model.

### **Timeline/key Dates**

- Application period for practices to begin Primary Care First participation in January 2021 will be open between October 24, 2019 and close on January 22, 2020.
- The solicitation period for payers will formally begin six weeks after the start of the practice application period, on December 9, 2019, and will close on March 13, 2020.
- Letters of Intent for the DC Professional and Global PBP were due August 5, 2019. Subject to response, CMS expects to initiate application process for the Geographic option in Fall 2019.

### **Payment model/Funding**

PCF includes a simple population/performance-based payment with 50% upside risk sharing of revenue and 10% downside. DC Professional operates with DCEs bearing 50% of shared savings/losses on the total cost of care. The Primary Care Capitation risk-adjusted monthly payment is equal to seven percent of the total cost of care for the enhanced primary care services. Under DC Global Total Care Capitation, and DC Geographic, DCEs bear risk for 100% of shared saving/losses for the total cost of care.

### **Current rural participation/impact**

PCF will be offered in 26 regions for a 2020 start date, several regions are statewide and would include rural areas. CMS is currently accepting public input on refining DC Geographic design parameters. RHCs and FQHCs are generally ineligible because they are paid by Medicare under separate systems.

**Websites:** <https://innovation.cms.gov/initiatives/primary-care-first-model-options/>;  
<https://innovation.cms.gov/initiatives/direct-contracting-model-options/>

# Quality Payment Program (QPP)

**Aliases:** QPP, MACRA/MIPS

## **Summary**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for Medicare Part B clinician payment and created the QPP, which links clinician payment to quality. QPP replaces the Physician Quality Reporting System, the Medicare EHR Incentive Program, and the Value Based Modifier. The QPP has two tracks:

- Advanced Alternative Payment Models (APMs): Clinicians that opt to participate in a qualified Advanced APM, through Medicare Part B will earn an incentive payment.
- Merit-based Incentive Payment System (MIPS): Clinicians that participate in traditional Medicare Part B will participate in MIPS and earn a performance-based payment adjustment.

## **Eligibility and rural-relevant requirements**

- For MIPS, eligible clinicians are those who bill Medicare Part B more than \$90,000/year for Part B and see more than 200 Part B patients and provide 200 or more covered professional services Medicare Part B patients/year.
  - Eligible clinicians include physicians, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, physical therapists, occupational therapists, clinical psychologists, audiologists, speech-language pathologists, dietitians, and certified registered nurse anesthetists.
- In 2020, for APMs, eligible clinicians must receive 50 percent of their Medicare payments or see 35 percent of their Medicare patients through an Advanced APM. Programs qualifying as Advanced APMs can be found [here](#).
- RHCs and FQHCs are generally ineligible because they are paid by Medicare under separate systems.
- Under MACRA, CMS has designated \$20 million dollars for technical assistance over five years (\$100 million total) to support small practices in rural and underserved areas ([SURS Technical Assistance](#)).
- MIPS adjustments apply to the provider portion of payment for eligible clinicians practicing in Method I CAHs and in Method II CAHs if they have not assigned their billing rights to the CAH.

## **Timeline/Key Dates**

- There is a lag between performance and payment adjustment. For example, performance in 2019 will impact payment in 2021.
- The QPP Performance Year begins every January 1 and ends on December 31.
- Participants must report data by March 31 of the following calendar year.

## **Payment model/funding**

### **MIPS:**

- Positive or negative payment adjustment will be made based on evidence-based and practice-specific quality data in four areas: Quality, Improvement Activities, Promoting Interoperability, and Cost. Future years will bring increasing positive or negative performance adjustments plateauing at +/- 9 percent in 2022.
- During the first six payment years of the program (2019-2024), MACRA allows for up to \$500 million each year in additional positive adjustments for exceptional performance.
- In 2021, the program will transition to a new [MIPS Value Pathways Framework](#) that is anticipated to streamline program requirements.

### **APM:**

- Clinicians participating as an Advanced APM will earn a 5 percent incentive payment and are exempt from MIPS payment adjustments.
- Starting in PY 2019, eligible clinicians may become Qualifying Alternative Payment Model Participants (QP) through an All-Payer option. Learn more [here](#).

**Website:** <https://qpp.cms.gov/>

# Section 223 Demonstration Program for Certified Community Behavioral Health Clinics (CCBHC)

**Aliases:** Certified Community Behavioral Health Clinics, CCBHCs, Section 223

## **Summary**

Authorized under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA 223), this program is a combined effort by HHS agencies including Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and the Office of the Assistant Secretary of Planning and Evaluation. It supports state-level efforts to increase access and improve the quality of community-based mental health and substance abuse disorder treatment delivery. In 2015, 24 states received \$22.9 million in planning grants to plan for the demonstration project. The grants helped states prepare to participate in the two-year demonstration program. The funding supported states' efforts to:

- Certify CBHCs based on federally developed criteria – emphasizing accessible and high-quality care.
- Establish a Medicaid PPS payment system for CCBHCs
- Improve data collection and reporting systems
- Engage stakeholders in how the state will implement the program

Eight states were selected for the two-year program based on application and geographic distribution, including rural and underserved areas. In participating states, CCBHCs will be reimbursed through Medicaid for behavioral health treatment, services, and supports to Medicaid-eligible beneficiaries using an approved prospective payment system

## **Eligibility and rural-relevant requirements**

- Only clinics certified during the planning grant phase and submitted in the demonstration program application are eligible to participate as official CCBHCs. Participating states may continue to certify clinics, though they will not be part of the program evaluation.
- CCBHCs must be non-profit organizations, state operated clinics, Indian Health Service, or tribal organizations.
- CCBHCs have care coordination requirements which include partnerships or formal contracts between the CCBHC and a variety of organizations including FQHCs, and as applicable, RHCs, to the extent such services are not provided directly through the certified community behavioral health clinic.

## **Timeline/key dates**

- Selected states announced on December 31, 2016: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania.
- Two-year demonstration programs began July 1, 2017.
- Congress extended this program to November 2019, and states can request to continue under CMS waiver 1115.

## **Payment model/funding**

- The program requires states develop a Medicaid prospective payment system for CCBHC services.
- The match rate for CCBHCs is either the Enhanced FMAP/CHIP rate or the current FMAP for eligible beneficiaries under Medicaid expansion, and down to 90 percent by 2020.

## **Current rural participation/impact**

1. Rural providers may become a CCBHC if they meet Statute eligibility requirements and listed eligibility.
2. A requirement of the 24 planning grants was to certify at least two CBHCs in diverse areas, including rural and underserved communities.
3. Telehealth/telemedicine and online services are eligible for inclusion.

**Website:** <http://www.samhsa.gov/section-223>

# Skilled Nursing Facility Value-Based Purchasing Program

**Aliases:** SNF VBP

## **Summary**

The SNF VBP Program aims to reward quality and improve quality of healthcare in Skilled Nursing Facilities (SNFs). It establishes incentive payments based on performance scores on quality measures. The current measure utilized is the Skilled Nursing Facility 30-Day All Cause Readmission Measure (SN FRM), which assesses the risk-standardized rate of all-cause, all-condition unplanned inpatient hospital readmissions of Medicare fee-for-service beneficiaries within 30 days of discharge from a prior hospitalization.

## **Eligibility and rural-relevant requirements**

All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program.

- Timeline/key dates
- Starting October 1, 2018, SNFs began receiving value-based incentive payments for the quality of care they give to people with Medicare
- For FY 2019, of the nearly 15,000 participating SNFs, 73% were penalized. 3% of the participating SNFs will receive the maximum bonus of 1.6%, and 20% will receive the maximum penalty of 2%.
- For FY 2019, SNFs serving African-American or black residents, Hispanic or Latino residents, and Medicaid-eligible residents were more likely to experience losses under the program, and less likely to see gains.

## **Payment model/funding**

CMS withholds 2% of SNFs' fee-for-service (FFS) Part A Medicare payments to fund the program. This 2% is referred to as the "withhold". CMS redistributes 60% of the withhold to SNFs as incentive payments

## **Current rural participation/impact**

- All SNFs paid under the prospective payment system will receive incentive payments under the SNF VBP Program as directed by the Social Security Act
- Eligible SNFs include freestanding SNFs, SNFs associated with acute care facilities, and all non-critical access hospital (CAH) swing bed rural facilities.
- The SNF VBP Program is not optional and does not require any action by SNFs to participate.

**Website:** <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page.html>

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PAGE UPDATED: 10/2019

# Vermont All-Payer ACO Model

## **Summary**

Established as a joint effort between CMS and the state of Vermont, the all-payer ACO model is a test of the State's alternative payment model where the most dominant payers in the State (Medicare, Medicaid, and commercial health plans) incentivize quality and value in healthcare. This program test will specifically focus on outcomes, operating under the same payment structure for the majority of providers throughout the State, in an effort to transform the State's delivery system.

The State of Vermont and CMS envision the ACO model as a means to improve care delivery and promote the model as a rational business strategy. Additionally, CMS provided a five-year extension for the State's 1115(a) Medicaid demonstration waiver, which allowed Medicaid to operate as a full-partner in the ACO Model approach. By establishing State-level standards for ACO-level health outcomes, the Model aims to incentivize coordination to achieve the following targets:

- ACO Scale Targets – where the State encourages payers and providers to participate in ACO programs, with the goal of 70 percent participation rate for residents, and 90 percent of Medicare beneficiaries by 2022.
- All-Payer and Medicare Financial Targets – the State will limit annualized per capita healthcare expenditure growth to 3.5 percent, and Medicare per capita healthcare growth rate to at least 0.1 percentage point below the national average Medicare growth rate.
- Health Outcomes and Quality of Care Targets – the State will seek improvements in four prioritized areas: substance use disorder, suicides, chronic conditions, and access to care.

## **Eligibility and rural-relevant requirements**

Participation is voluntary for both providers and other payers, including rural providers. As of 2019, 12 of Vermont's 14 hospitals were participating in OneCare Vermont, 6 of which are critical access hospitals.

## **Timeline/key dates**

- The Vermont All-Payer ACO Model began on January 1, 2017 and will conclude on December 31, 2022.
- There will be six performance years (PY0-PY5), each spanning a full calendar year.

## **Payment model/funding**

- In 2017 CMS provided \$9.5 million in initial investment to facilitate care coordination among providers in the State and improve collaboration with stakeholders.
- CMS expects at least a portion of funds to be used by Vermont to achieve its existing Blueprint for Health and Supports and Services at Home programs.

## **Current rural participation/impact**

- In addition to the six participating CAHs, several rural FQHC and Community Health Centers are involved.
- The goal is that at least 50 percent of Vermont All-Payer beneficiaries are aligned with an ACO by the end of 2019, thus far the state has been running below originally identified targets.

**Website:** <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>

## Appendix 1: Initiatives which Support Value-Based Care

### Health Care Payment and Learning Action Network

#### **Summary**

The Health Care Payment and Learning Action Network (HCP LAN) was established to provide a forum that brings together private payers, providers, employers, state partners, consumer groups, individual consumers, and many others to accelerate the transition from a fee-for-service payment model to value-based and alternative payment models. HCP LAN adopted the goal of transitioning 30% of U.S. healthcare payments to alternative payment models (APMs) by 2016 and 50% by 2018. In 2017, almost 34% of total U.S. health care payments were tied to APMs. Participants are expected to actively engage in the network by contributing to workgroups, sharing best practices, and learning from peers. A variety of work products have been developed with the intent of supporting implementation and alignment of value-based reimbursement and APMs. Some examples include [APM Framework](#), and [Patient Attribution](#), [Financial Benchmarking](#), and [Performance Measurement](#) models for Population Based Payments. While there is no rural focus, rural payers, providers, state agencies etc. are encouraged to participate in the network and utilize HCP LAN resources

**Website:** <https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/>  
or <https://hcp-lan.org/>

### Hospital Innovation Improvement Network (HIIN)

#### **Summary**

A part of the Partnership for Patients (PfP), HIINs work at the regional, state, national or hospital system level to sustain and accelerate national progress and momentum towards continued harm reduction in the Medicare program, and help identify solutions already working and disseminate them to other hospitals and providers through the following activities:

- Support learning collaboratives for hospitals.
- Provide a wide array of initiatives and activities to improve patient safety.
- Conduct intensive training programs to help hospitals make patient care safer.
- Provide technical assistance to help hospitals achieve quality measurement goals.
- Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
- Identify high performing hospitals and their leaders to coach and serve as national faculty to other hospitals committed to achieving the Partnership goals.

While there is no specific rural focus, a significant number of rural hospitals and CAHs have participated in HIIN activities in the past, and continued rural participation is anticipated.

**Website:** <https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html>

### Quality Payment Program - Small Practice, Underserved, and Rural Support (QPP-SURS)

#### **Summary**

The Medicare Access and CHIP Reauthorization Act (MACRA) established the Medicare Quality Payment Program (QPP), which includes funding to provide technical assistance for eligible practices and providers. To enable small practices to maximize participation in the QPP, CMS established Small Practice, Underserved, and Rural Support (QPP-SURS), to provide free technical assistance to eligible clinicians across the country. This assistance provided clinicians the necessary guidance for successful participation in the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).

As part of the initiative, QPP-SURS includes assistance in:

- Selecting quality measures and activities for each MIPS performance category
- MIPS reporting
- Strategic planning

- Adjusting to new payment methodologies
- Health IT optimization, including Certified Electronic Health Record Technology (CEHRT)
- Evaluating benefits and costs of joining APMs
- Technical assistance is available to MIPS-eligible practices (15 or fewer clinicians)
- Priority eligibility is available for clinicians operating in:
  - Rural areas
  - Health Professional Shortage Areas (HPSAs)
  - Medically Underserved Areas (MUAs)

CMS contracted with regional organizations to provide technical assistance at no cost to eligible clinicians. This initiative directly targeted small size practices for greater participation in QPP, especially those in rural settings.

**Website:** <https://qpp.cms.gov/about/small-underserved-rural-practices>



## Appendix 2 – Inactive Program Archive

### ACO Investment Model (AIM)

**Aliases:** AIM Model

**Stage:** Closed

#### **Summary**

The ACO Investment Model built on the previous experience of the Advance Payment Model, which tests the use of pre-paid shared savings to encourage new Accountable Care Organizations (ACOs) to form in rural and underserved areas. The model encouraged current MSSP ACOs to transition to models with greater risk sharing.

#### **Eligibility and rural-relevant requirements**

Limited to two groups:

- *New Shared Savings Program ACOs (2015 & 2016)* – AIM specifically encouraged uptake of coordinated, accountable care in rural and other areas underserved.
- *Previously participating ACOs under the MSSP starting from 2012-2014* – AIM helped engaged ACOs transition to higher levels of financial risk, with the goal of improving care and increasing savings.

Other requirements:

- Previously participating ACOs must have reported quality measures to MSSP for previous year.
- Previously participating ACOs must have had a beneficiary assignment less than 10,000 for the most recent quarter. ACOs with a 2015 or 2016 start date must have beneficiary assignment of 10,000 or fewer unless they are serving a rural area.
- The ACO was not be owned by a health plan and did not participate in the [Advance Payment ACO Model](#).
- The ACO did not include a hospital as a participant as defined by MSSP, unless the hospital is a Critical Access Hospital or an inpatient prospective payment system (IPPS) hospitals with 100 or fewer beds.

#### **Timeline/key dates**

- AIM was an evolution of the [Advance Payment Model ACO](#) that closed to new participants in 2013.
- ACOs had to join by January 1, 2016

#### **Funding model**

Only available for ACOs that started in 2015 or 2016:

- Upfront, Fixed Payment – \$250,000 payment in the first month of participation
- Upfront, Variable Payment – number of prospectively-assigned beneficiaries multiplied by \$36
- Monthly Variable Payment – monthly payment based on the number of prospectively-assigned beneficiaries multiplied by \$8, for up to 24 months

ACOs that participated in Medicare Shared Savings Program from 2012-2014:

- Upfront, Variable Payment – payment based on the number of prospectively-assigned beneficiaries
- Monthly, variable payment – monthly payment based on the number of prospectively-assigned beneficiaries and the size of the ACO

#### **Rural participation/impact**

AIM ACOs decreased total Medicare spending and had greater reduction in Medicare spending compared to similar Non-AIM ACOs, and reduced spending and utilization compared to Medicare FFS beneficiaries.

Of the 45 AIM ACO participants across 37 states:

- 68% were mostly rural
- 53% included critical access hospitals

**Website:** <https://innovation.cms.gov/initiatives/ACO-investment-Model>

**Report:** <https://innovation.cms.gov/Files/reports/aim-second-annrpt-fg.pdf>

## Community Based Care Transitions Program (CCTP)

**Aliases:** Section 3026, Care Transitions Program, CCTP was a component of the Partnership for Patients

**Stage:** No longer active

### **Summary**

CCTP, created by Section 3026 of the Affordable Care Act (ACA), tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP were to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

### **Eligibility and rural-relevant requirements**

Community Based Organizations (CBOs) and IPPS hospitals partnering with CBOs:

- Must have provided care transition services across the continuum of care and have had a formal organizational and governance structure:
  - Care transition services that begin no later than 24 hours prior to discharge.
  - Timely, culturally and linguistically competent post-discharge education to patients so they understand potential additional health problems or a deteriorating condition.
  - Timely interactions between patients and post-acute and outpatient providers.
  - Patient-centered self-management support and information of beneficiary's condition.
  - Comprehensive medication review including, counseling and self-management support.
  - Formal relationships with hospitals, other providers, and consumer representatives.

### **Timeline/key dates**

- Five rounds of participants were announced between 2011 and 2015.
- Final evaluation reports released November 2017.

### **Payment model/funding**

\$300 million between 2011-2015:

- CCTP did not pay for administrative overhead and infrastructure costs.
- CBOs were paid an all-inclusive rate per eligible discharge, determined based on the cost of care transition services provided at the patient level and systemic changes at the hospital level. However, the CBO was paid only once per eligible discharge in a 180-day period for any given beneficiary. Payments from CCTP were only for Medicare Fee-for-Service (FFS) beneficiaries.

### **Rural participation/impact**

- CBOs were only paid care transition fees for beneficiaries intervened upon immediately following discharge from a partnering IPPS hospital (not a CAH).
- Preference was given to Administration on Aging (AoA) grantees or entities that provide services to medically underserved populations, small communities, and rural areas.

**Website:** <https://innovation.cms.gov/initiatives/CCTP/>

**Report:** <https://downloads.cms.gov/files/cmml/cctp-final-eval-rpt.pdf>

## Comprehensive Primary Care (CPC) Initiative

**Aliases:** Comprehensive Primary Care (CPC)

**Stage:** No longer active

### **Summary**

The CPC initiative was a four-year multi-payer initiative designed to strengthen primary care. CMS collaborated with commercial and State health insurance plans in seven regions to offer population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five “comprehensive” primary care functions. The initiative tested whether provision of those functions at each practice site – supported by multi-payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology – could achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy. The next evolution of this program is [Comprehensive Primary Care Plus \(CPC+\)](#).

### **Eligibility and Rural-Relevant Requirements**

- Seven CPC regions were chosen with the highest market penetration by payers who would align their payment models to support the five functions of CPC.
- Practices were selected in 2012 by an application process based on utilization of health information technology (HIT), ability to demonstrate advanced primary care delivery by appropriate accreditation bodies, service to patients covered by participating payers, participation in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure
- CPC practice eligibility excluded Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and practices that participate in an MSSP ACO or other CMS programs that included shared savings.

### **Timeline/key dates**

- Program began in 2013 and ended in 2016

### **Payment model/funding**

CPC integrated a defined payment model and practice redesign focus:

- Payment: Practices received two payments in support of their Medicare/Medicaid FFS patients
  - Practices are paid a monthly, non-visit-based care management fee (averages \$20 per beneficiary in PY 1 – 2, then decreases to \$15 for PY 3 – 4).
  - Annually after PY 1, CPC practices could share in net savings, calculated at the regional level and distributed to participating practices based on their performance on quality metrics.
- Practice Redesign:
  - CPC aimed to help practices support their patients with the following: Access and Continuity, Planned Care for Chronic Conditions and Preventative Care, Risk-Stratified Care Management, Patients and Caregiver Engagement, and Care Coordination across the Medical Neighborhood.
  - Participating CPC practices must have reported progress through a CMS web portal.

### **Rural participation/impact**

- The percent rural population for CPC regions ranged from 5-44 percent; some of the areas had significant rural populations despite being metropolitan areas (example: Greater Tulsa had 36% rural beneficiaries).
- Since the model focuses on primary care payments from Medicare Part B, RHCs and FQHCs were ineligible because they are paid on a fee schedule.

**Website:** <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>

**Reports:** <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>

# Frontier Community Health Integration Project (FCHIP) Demonstration

**Aliases:** FCHIP

**Stage:** No longer active

## **Summary**

Ten Critical Access Hospitals (CAHs) participated in the FCHIP Demonstration, which aimed to test new models of health care delivery in the most sparsely populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. The demonstration tested whether enhanced payments for certain services will enhance access to care for patients, increase the integration and coordination of care among providers within the community, and reduce avoidable hospitalizations, admissions, and transfers, therefore improving the quality of care for Medicare beneficiaries and lowering costs. A specific objective was to support the CAH and local delivery system in keeping patients within the community who might otherwise be transferred to distant providers.

## **Eligibility and rural-relevant requirements**

Eligible entities were:

- Located in a state with at least 65 percent of the counties have six or fewer residents per square mile.
- Limited to CAHs in Montana, Nevada, North Dakota, Wyoming, and Alaska

## **Timeline/key dates**

Began on August 1, 2016

Ended on July 31, 2019

## **Payment model/funding**

Provided financial incentives and Medicare payment changes for:

- Ambulance Services – participants were reimbursed 101 percent of reasonable cost for ambulance services they provide, regardless of any other ambulance services that may be available nearby - waiving the thirty-five-mile limit currently imposed by Medicare.
- Skilled Nursing Facility (SNF)/Nursing Facility (NF) Beds – participants would maintain up to 35 inpatient beds in contrast to the 25 currently allowed under Medicare. The 10 additional inpatient beds may only be used to provide SNF/NF level of care.
- Telehealth Services – As originating sites for telehealth services, participants were paid at 101 percent of cost for overhead, salaries, fringe benefits, and the depreciation value of the telehealth equipment instead of the physician fee schedule fixed fee currently allowed under Medicare. The distant site practitioner was paid an amount equal to the amount that such practitioner would have been paid had such services been furnished without the use of a telecommunications system.

## **Rural participation/impact**

Ten CAHs in three states (North Dakota, 3; Montana, 3; and Nevada, 4) began participating in this demonstration in August 2016. CMS found that ambulance and SNF/NF bed interventions were easily implemented and beneficial. The quality reported was on par with other CAHs and telehealth interventions faced administrative and operational challenges as stated in the [interim report](#). A final report is due within one year of the end of the demonstration and has not yet been filed.

**Website:** <https://innovation.cms.gov/initiatives/Frontier-Community-Health-Integration-Project-Demonstration/>

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INACTIVE PROGRAM ARCHIVE

## Maryland All-Payer Model

**Aliases:** None

**Stage:** Closed; Maryland now operating [Total Cost of Care Model \(TCOC\)](#)

### **Summary**

Established as a joint effort between CMS and the state of Maryland, the all-payer model was a modernization effort of the State's all-payer rate-setting system for hospital services. The model tested the effectiveness of an all-payer system for hospital payments that holds hospitals accountable for the total per-capita cost of care. The goal of the initiative was reduced costs and improved health outcomes.

Operating under the auspices of an existing 1814(b) Medicaid waiver, originally granted in 1978, Maryland is exempt from the Inpatient Prospective Payment System and the Outpatient Prospective Payment System, allowing the State to establish global payment rates. Under the All-Payer Model, Maryland adopted an approach based on per capita total hospital cost growth. Over five years, Maryland shifted all hospital revenue into global payment models. Improvements in quality of care for Maryland residents are evaluated through both hospital quality and population health measures, including:

- Readmissions – the State was committed to reducing all-cause, all-site hospital readmissions
- Hospital Acquired Conditions – Maryland committed to reaching an annual aggregate reduction of 6.89 percent in 3M's 65 potentially preventable conditions over a five-year period, for a total cumulative reduction of 30 percent.
- Population Health – Maryland submitted annual performance measure improvement reports.

### **Eligibility and rural-relevant requirements**

All Maryland hospitals were brought into the all-payer model, including the 10 rural hospitals. The state does not have any CAHs.

### **Timeline/key dates**

- January 1, 2014, Maryland launched the all-payer modernization effort.
- January 9, 2019 performance period end date.

### **Payment model/funding**

Maryland was required to generate \$330 million in Medicare savings and limit its annual all-payer per capita total hospital cost growth to 3.58 percent over a five-year performance period,

- First annual report found total savings of \$116 million to Medicare, and per capita cost growth rate was held at 1.47%, which is below the national average.
- Third annual report found that Maryland saved Medicare an aggregate of \$679 million during the first 3 years of the model and this reduced expenditures for hospital services without shifting costs to other parts of the health care system.

### **Rural participation/impact**

All hospitals in the state operated under global budgeting, and all but one rural hospital in TRP remained within 0.5 percent budget corridor. Preliminary findings demonstrated meaningful reductions in utilization, expenditures, or both in all categories of hospital service.

**Website:** <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>

**Report:** <https://downloads.cms.gov/files/cmimi/md-all-payer-thirdannrpt.pdf>

# Medicaid Incentives for the Prevention of Chronic Disease Program

**Aliases:** MIPCD program

**Stage:** Ended

**Summary:** The Affordable Care Act established the Medicaid Incentives for Prevention of Chronic Disease Model (MIPCD) program. It tested the effectiveness of providing incentives to encourage healthy behaviors directly to Medicaid beneficiaries of all ages who participated in MIPCD prevention programs. State initiatives used relevant evidence-based research and resources and made the program widely available and easily accessible. State initiatives addressed either tobacco cessation, controlling weight, lowering cholesterol, lowering blood pressure, preventing or controlling diabetes, or a combination of these goals.

## **Eligibility and Rural-relevant Requirements**

Any single State Medicaid Agency was eligible as long as the state committed to operating the program for at least three years, conducted a state-level evaluation, and fulfilled reporting requirements specified by the legislation and CMS.

## **Timeline/key dates**

- MIPCD applications were due on May 2, 2011.
- Participating states received their grants on September 11, 2011.
- Program ended December 31, 2016. The Final Evaluation Report was published on August 9, 2017 [here](#).

## **Funding**

Each participating state was awarded a 5-year grant to implement, conduct, and evaluate its MIPCD program. The original funding amount was \$100 million over 5 years. Participating Medicaid enrollees earned incentive payments through December 31, 2015. 100% reimbursement was provided through grant funding for incentives and services that would only be available through the MIPCD program.

## **Rural participation/impact**

Ten states (California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin) were recipients of the grant awards. All ten states successfully implemented incentive programs. During the MIPCD program, participants used more preventive services but there was not a significant change in total, inpatient, or ED Medicaid expenditures associated with receiving financial incentives. Montana, Nevada, and California specifically targeted participants in rural or remote locations. Montana's diabetes program used telehealth to reach participants living in rural areas. Nevada also utilized telehealth to reach participants in rural locations. California partnered with its Indian and Rural Health Office to provide program services to Native American clinic patients.

The health outcomes were somewhat favorable. Compared to the control group, incentivized participants had greater reductions in weight, and HbA1c and blood pressure levels; more minutes of physical activity; improvements in self-reported health status; and greater likelihood of reporting a smoking cessation quit attempt or having ceased smoking.

**Website:** <https://innovation.cms.gov/initiatives/mipcd/>

**Report:** <https://downloads.cms.gov/files/cmimi/mipcd-finalevalrpt.pdf>

## Medicare Shared Savings Program (MSSP): Program Summary Prior to July 2019

**Aliases:** MSSP, Shared Savings Program, ACOs (note: several ACO models were part of MSSP), MSSP ACO

*Note: CMS made substantial programmatic changes to the MSSP program in 2019. This archived program summary includes details about the MSSP program prior to that time. A current MSSP program description is [here](#).*

### **Summary**

The MSSP was established by the ACA and was a key component of Medicare delivery system reform initiatives. MSSP facilitated coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers could participate in MSSP by creating or participating in an ACO. The Shared Savings Program rewards ACOs that lower health care cost growth while meeting performance standards on quality of care. Participation in an ACO was voluntary.

### **Eligibility and rural-relevant requirements**

- Eligible providers and suppliers must have formed a Medicare ACO, and the ACO must have applied to CMS.
- To be accepted, ACOs must have had at least 5,000 attributed Medicare FFS patients, meet all other eligibility and program requirements, and agree to participate in the program for at least 3 years.

**Timeline/key dates:** MSSP ACOs began in 2012. There was an annual application cycle that resulted in 3-year contract cycles. ACOs were allowed to participate in two-contract cycles (6 years) before taking on risk. As of 2019, all new ACO contracts fall under the new program guidelines, but ACOs that were under contract prior to 2019 had the option to continue under their existing agreement through the end of their original 3-year contract period.

### **Payment model/funding**

- CMS and ACO's establish budget targets for the total health spending of attributed ACO FFS Medicare beneficiaries. CMS continues to make payments on a fee-for-service basis. At the end of the year, the actual and target spending were reconciled. If actual spending was less than the target and above the minimum savings rate, *and* if the ACO had performed adequately on access and quality metrics, the ACO and CMS shared the difference.
- ACOs entered a three-year agreement period under three tracks:
  - **Track One:** one-sided shared savings model, 50 percent of savings, no shared loss
  - **Track Two:** two-sided shared savings/shared losses model, 60 percent split of savings, limit on the amount of losses to be shared in phases in over 3-years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3 and any subsequent year
  - **Track Three:** two-sided shared savings/shared loss model, 75 percent split of savings, loss sharing limit is 15 percent. In return for greater risk, it allowed for prospective beneficiary assignment, waiver of the Skilled Nursing Facility (SNF) 3-day rule, and potential flexibility around telehealth requirements for billing and reimbursement.)
- **Track One Plus** was also offered for a limited time, which gave participants an option that included some of the flexibility of Track Three but limited potential downside risk.

### **Rural participation/impact**

- RHCs, FQHCs, and CAHs are eligible to participate in ACOs.
- The following findings are based on activity through 2018:
  - Medicare ACOs operated in 60.3 percent of all non-metropolitan counties.
  - Non-metropolitan provider participation in ACOs increased considerably since 2013, especially in the South, West, and Northeast census regions.
  - No non-metropolitan ACOs participated in models that included downside risk.
  - 1,210 rural health centers and 421 critical access hospitals were participating in ACOs.

**Website:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>



## Multi-Payer Advanced Primary Care Practice

**Aliases:** State-based infrastructure may have used different names, (e.g., in MN called the Health Care Home Model)

**Stage:** No longer active

### **Summary**

The demonstration evaluated whether advanced primary care practice reduced unjustified utilization and expenditures, improved the safety, effectiveness, timeliness, and efficiency of health care. The following states participated: ME, MI, MN, NY, NC, PA, RI, VT. Each state coordinated with Medicaid and private payers for involvement. The purpose of this project was to:

1. Decrease variation in utilization and expenditures, particularly that variation that was not justified,
2. Condense variation in utilization and expenditures for Medicare beneficiaries,
3. Enhance the safety, effectiveness, timeliness, and efficiency of care,
4. Increase patient autonomy in decision making, and
5. Increase the availability and delivery of evidence-based care in historically underserved areas.

### **Eligibility and rural-relevant requirements**

- Practices must have met medical home guidelines to participate; states identified and enrolled practices.

### **Timeline/Key Dates**

- Vermont, New York, and Rhode Island began June 1, 2011.
- North Carolina and Michigan began October 1, 2011.
- Maine, Minnesota, and Pennsylvania began January 1, 2012.

Initial demonstration was slated to end in 2014. CMS offered an extension through 2016 to states where some of the payment was distributed to community-based organizations that could not bill independently under the Chronic Care Management (CCM) codes that took effect in January 2015. Five states continued to participate under that extension (ME, MI, NY, RI, VT) through 2016.

### **Payment model/funding**

- Under the demonstration, states paid participating practices additional amounts for transforming their practices into medical homes and for providing services that are not otherwise covered under the traditional Medicare.
- Paid a monthly care management fee for beneficiaries who received care from Advanced Primary Care practice (APC), intended to cover care coordination, enhanced access, education, and other services.

### **Current rural participation/impact**

- All states had rural practice participation, ranging from 3 percent in MI to 68 percent in NC.

### **Evaluation**

- Participating rural practices were able to sustainably transform to a PCMH as long as they were given the resources, technical assistance, aligned incentives and expectations across payers, and payment for a critical mass of their patients.
- Not all patients were eligible for care management due to a lack of all-payer participation.
- Medicare expenditures varied greatly between states, with some states saving money and others seeing greater expenditures than comparison practices.
- Analyses indicate MAPCP did not show a statistically significant impact on rural populations consistently across all states. North Carolina, which primarily served rural areas, had the lowest access score.

**Website:** <https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/>

## Pioneer ACO Model

**Aliases:** Pioneer Accountable Care Organization

**Stage:** No longer active

### **Summary**

The Model was designed for health care organizations and providers experienced in coordinating care for patients across care settings. These providers could move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP. It worked in coordination with private payers by aligning provider incentives to improve quality and health outcomes for patients and achieve cost savings.

### **Eligibility and Rural-Relevant Requirements**

- Organizations were required to be structured as: ACO professionals in group practice arrangements, networks of individual practices of ACO professionals, partnerships or joint venture arrangements between hospitals and ACO professionals, hospitals employing ACO professionals, or FQHCs.
- Health IT requirement: at least 50 percent of the PCPs in the Pioneer ACO must have met the requirements for Meaningful Use for the receipt of payments from the EHR Incentive Programs.
- CMS prospectively assigned beneficiaries to Pioneer ACOs, which allowed providers to know in advance the beneficiaries for whom they were held accountable.
- ACOs must have had a minimum of 15,000 assigned Medicare FFS beneficiaries, unless they were in a rural area, then the minimum requirement was 5,000.

### **Timeline/Key Dates**

- Performance Years 1 – 3 (2012 – 2014): initial three-year contract period. Performance Year 4 (2015), Performance Year 5 (2016).

### **Payment model/funding**

- Performance years 1 and 2 tested shared savings and losses using a payment arrangement with higher risk and reward, when compared to the MSSP.
- In performance year 3, those Pioneer ACOs who were successful with shared savings could move to a new population-based payment model. This payment was a per member per month (PMPM) prospective payment used to replace the FFS ACO payments. There was also an option for partial-population based payment that limited the risk and reward

### **Rural participation/impact**

- There were nine ACOs participating in the Pioneer ACO Model. None were predominately rural although some participating systems included a small number of rural providers.

### **Evaluation**

- Many ACOs that chose to either exit the model or choose the lower risk options rather than population-based payment, but most still participate in some form of Medicare ACO.
- While the management of utilization and patient visits outside of the ACO was more difficult than anticipated, participating ACOs indicated some improvement in certain measures of patient experience and quality of care.

**Website:** <https://innovation.cms.gov/initiatives/Pioneer-aco-model/>

## Appendix 3 – Commonly Used Acronym List

ACA	Affordable Care Act
ACO	Accountable Care Organization
APM	Alternative Payment Model
CAH	Critical Access Hospital
CMMI	Center for Medicare & Medicaid Innovation
CMS	Center for Medicare & Medicaid Services
DRG	Diagnosis Related Group
EHR	Electronic Health Record
FFS	Fee-for-Service
FQHC	Federally Qualified Health Clinic
FY	Fiscal Year
HHS	Department of Health and Human Services
HIT	Health Information Technology
IPPS	Inpatient Prospective Payment System
MSSP	Medicare Shared Savings Program
PCP	Primary Care Provider/Physician
PMPM	Per Member per Month
PBPM	Per Beneficiary Per Month
RHC	Rural Health Clinic