



Rural

HEALTH VALUE



Catalog of Value-Based Initiatives for Rural Providers

Updated February 2026

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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 Center for Medicare & Medicaid Innovation Center (CMS Innovation Center).

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 table on page 1 classifies active models and programs in three areas:

- Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Payment Category (<https://hcp-lan.org/apm-refresh-white-paper/>),
- If participation for those eligible is mandatory or voluntary, including clarification where participation is restricted to geographic areas,
- For models run by the CMS Innovation Center, the stage of program implementation.

The catalog also includes three appendices:

- HHS Initiatives which Support Value-Based Care – These include 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- Inactive Program Archive – These include brief descriptions of value-based care models that are no longer active.
- Acronym List

Models and Programs by Category, Participation Requirement, and CMS Innovation Center Stage

Active Model or Program	HCP LAN Category*	Participation Requirement	CMS Innovation Center Stage [§]
ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model	2C	Voluntary	Announced
Accountable Care Organization Primary Care Flex Model	2A, 3A/B, 4B	Voluntary	Active
ACO REACH Model	4B	Voluntary	Active
Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model	4B	Voluntary [†]	Active
ASM (Ambulatory Specialty Model)	3B	Mandatory [†]	Announced
Bundled Payments for Care Improvement Advanced	4A	Voluntary	Active
Certified Community Behavioral Health Clinics	2A/C	Voluntary	N/A
Comprehensive Care for Joint Replacement Model	2C, 3B, 4A	Mandatory [†]	Active
Diabetes Prevention Program Expanded Model	1, 2C	Voluntary	Active
Diabetes Self-Management Training	1	Voluntary	N/A
Expanded Home Health Value-Based Purchasing Model	2C	Mandatory	Active
Frontier Community Health Integration Project Demonstration	1	Voluntary	Demonstration Extended
Guiding an Improved Dementia Experience	2A	Voluntary	Active
Hospital Acquired Conditions Reduction Program	2C	Mandatory	N/A
Hospital Readmissions Reduction Program	2C	Mandatory	N/A
Hospital Value-Based Purchasing Program	2C	Mandatory	N/A
Innovation in Behavioral Health (IBH)	2A/C	Voluntary [†]	Active
LEAD (Long-term Enhanced ACO Design) Model	4B	Voluntary	Announced
MAHA ELEVATE (Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) Model	2C, 4A	Voluntary	Announced
Maryland Total Cost of Care Model	4B	Mandatory (hospitals) [†] Voluntary (practices) [†]	Active
Medicare Promoting Interoperability Program	2B	Mandatory	N/A
Medicare Shared Savings Program	3A/3B ⁺	Voluntary	N/A
Quality Payment Program	2A/B/C	Mandatory	N/A
Radiation Oncology Model	4A	Mandatory [†]	Announced/Delayed
Skilled Nursing Facility Value-Based Purchasing Program	2A/C	Mandatory	N/A
Transforming Episode Accountability Model (TEAM)	3B	Mandatory [†]	Announced – Applications Under Review
Transforming Maternal Health (TMaH)	2A	Voluntary [†]	Active
Vermont All-Payer ACO Model	3B	Voluntary [†]	Active
WISeR (Wasteful and Inappropriate Service Reduction) Model	N/A	Voluntary [†]	Announced

* Health Care Payment Learning & Action Network (<https://hcp-lan.org/>) health care *payment categories*:

1. Fee-for-service – no link to quality and value
2. Fee-for-service – link to quality and value
 - A. Foundation payments for infrastructure and operations
 - B. Pay-for-reporting
 - C. Pay-for-performance
3. APMs built on fee-for-service architecture
 - A. Upside rewards for appropriate care
 - B. Upside and downside for appropriate care
4. Population-based payment
 - A. Condition-specific population-based payment
 - B. Comprehensive population-based payment
 - C. Integrated finance and delivery systems

⁺ Multiple payment categories included within one model

[†] Participation restricted to limited geographic areas

[§] CMS Innovation Center Stage Not Applicable (N/A) for programs run by the Center for Medicare & Medicaid Services (CMS)

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

Aliases: ACCESS

Summary

The ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model tests an outcome-aligned payment approach in Original Medicare to expand access to new technology-supported care options that help people improve their health and prevent and manage chronic disease. The voluntary model focuses on conditions affecting more than two-thirds of people with Medicare, including high blood pressure, diabetes, chronic musculoskeletal pain, and depression. ACCESS is designed to complement traditional care. PCPs and referring clinicians can refer patients to ACCESS organizations and will receive regular electronic updates on patient progress, patients can also self-refer. PCPs and referring clinicians may also bill a new co-management payment for documented review of patient updates and associated coordination activities, such as medication adjustments or problem list updates, strengthening collaboration between ACCESS organizations and traditional providers. ACCESS care organizations are expected to offer integrated, technology supported care that may include telehealth software, wearable devices, or online applications that coach individuals to make lifestyle changes.

Eligibility and rural-relevant requirements

- Organizations that are Medicare Part B as providers or suppliers (excluding DME and laboratory suppliers) are eligible to participate. They must have an active Taxpayer Identification Number (TIN) and comply with applicable state licensure requirements and Health Insurance Portability and Accountability Act of 1996 (HIPAA) and FDA requirements.
- Organizations must designate a physician Clinical Director responsible for clinical oversight and compliance. CMS will monitor clinical performance and publicly report aggregated, risk-adjusted results to help patients make informed choices.

To promote access in underserved areas, a fixed adjustment will be applied to rural patients in qualifying tracks

Timeline/key dates

- Applications for the first performance period must be submitted by April 1, 2026. Applications after that date will be considered for a January 2027 start.
- Applications will continue to be accepted on a rolling basis until April 1, 2033.
- The program will begin July 2026 and run for 10 years

Payment model/funding

- The ACCESS model will test Outcome-Aligned Payments (OAPs), a payment option for Medicare-enrolled care organizations. Participating organizations will receive recurring payments for managing patients' qualifying conditions, with full payment tied to achieving measurable health outcomes.
- To balance accountability with model accessibility, CMS will base payment on the overall share of an organization's patients who meet their outcome targets, allowing organizations to earn full payment through strong overall performance even if some individual patients do not meet their target.
- Patients can voluntarily sign up directly with participating ACCESS care organizations, on their own or upon referral from their provider. CMS will maintain a directory of all ACCESS participants to help patients and PCPs select the most appropriate ACCESS organization for their condition(s).

Current rural participation/impact

- TBD, program not yet active

Website: <https://www.cms.gov/priorities/innovation/innovation-models/access>

Accountable Care Organization (ACO) Primary Care Flex Model

Aliases: ACO PC Flex, PC Flex, PC Flex ACO

Summary

ACO Primary Care Flex is a voluntary five-year model test within the Medicare Shared Savings Program (SSP). It will test how prospective payments and increased funding for primary care in ACOs impact health outcomes, quality, and costs of care. The flexible payment design will empower participating ACOs and their primary care providers to use more innovative, team-based, person-centered, and proactive approaches to care.

The goals of the ACO PC Flex Model are to:

- Expand access to high-quality, accountable care and improve patient experience.
- Enhance primary care payment and spur innovative approaches to care delivery, such as team-based care, that are proactive and person-centered and drive quality improvement.
- Narrow disparities in health care outcomes.
- Reduce program expenditures while preserving or enhancing quality of care.
- Strengthen participation incentives for new and low-revenue ACOs in the Shared Savings Program.

Eligibility and rural-relevant requirements

- Option to join SSP as a low-revenue ACO (ACO-based revenue to participating providers is less than 35 percent of all ACO expenditures for attributed beneficiaries).
- The model includes adjustments in the primary care per-beneficiary per month (PBPM) adjustment to encourage FQHC and RHC participation.
- ACOs may not participate in the ACO PC Flex Model and also receive SSP Advance Investment Payments.

The model has no relation to HRSA's Medicare Rural Hospital Flexibility (Flex) program which provides funds to states for technical assistance to Critical Access Hospitals (CAHs).

Timeline/key dates

- Model announced: March 19, 2024
- Model Start Date: January 1, 2025

Payment model/funding

The model's new Prospective Primary Care Payment (PPCP) option will shift payment for primary care away from fee-for-service, visit-based payment to enhance the predictability and amount of primary care funding. The model also includes a one-time Advanced Shared Savings Payment (\$250,000) to help cover costs associated with forming an ACO and administrative costs for model activities. Specific policies will ensure PPCP funds are used to support primary care.

ACOs participating in the model will receive monthly PPCPs that replace FFS reimbursement for most primary care services. The PPCP is paid to the ACO, and the ACO establishes payment contracts with the providers. The PPCP will be regionally consistent and is made up of two parts:

- PPCP County Base Rate: based on a county's average primary care spending (before social and clinical risk factors are applied). County base rate will not be reconciled against claims expenditures, so will not be impacted by the amount of primary care claims submitted by providers.
- PPCP Payment Enhancements: based on characteristics of the ACO and assigned patient population. For most ACO participants, CMS anticipates this will increase primary care funding. Enhanced payments will not be put at risk, meaning they will not be recouped by CMS.

Current rural participation/impact

- 24 ACOs are participating in PY 2025, serving Medicare beneficiaries in all 50 states and the District of Columbia
- Participants include 8 CAHs and 58 RHCs.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model>

ACO REACH Model

Aliases: REACH, REACH ACO

Summary

In 2022, CMS redesigned the [Global and Professional Direct Contracting \(GPDC\) Model](#) to encourage health care providers to coordinate care to improve the care offered to people with Medicare. The ACO REACH model made key changes to the GPDC model in key areas: 1) Promoting provider leadership and governance through increased board representation requirements for providers, and protecting beneficiaries with more participant vetting, monitoring, and greater transparency. ACO REACH provides opportunities for different health care organizations to participate in Medicare FFS value-based care arrangements. Types of ACOs include:

- Standard ACOs – organizations that have substantial experience serving Original Medicare beneficiaries.
- New Entrant ACOs – organizations with less experience serving an Original Medicare population.
- High Needs Population ACOs – Organizations that serve Original Medicare beneficiaries with complex needs.

In PY 2026 a coordinated set of changes have been made to adjust the financial methodology and improve model sustainability. A summary of PY 2026 model changes can be found [here](#).

Eligibility and rural-relevant requirements

- Eligible providers include providers in group practice, networks of individual practices of providers, hospitals employing providers, FQHCs, RHCs, and CAHs. Providers must be Medicare-enrolled.
- A Nurse Practitioner (NP) Services Benefit Enhancement allows flexibility for NPs to certify need for a variety of services such as hospice, cardiac rehab, diabetic shoes, home infusion, and medical nutrition therapy.
- At least 75% control of the ACO's governing body must be held by participating providers or their designated representatives, and there must be at least two beneficiary advocates with voting rights on the governing board.

Timeline/key dates

- Participants Announced: August 15, 2022
- Model will run from 2023 – 2026

Payment model/funding

Two voluntary risk-sharing options:

- *Professional* offers a lower risk-sharing arrangement of 50% savings/losses with one payment option: Primary Care Capitation, a risk-adjusted monthly payment for primary care services provided by the ACO's participating providers.
- *Global* offers a higher risk-sharing arrangement of 100% savings/losses with two payment options: Primary Care Capitation (described above) or Total Care Capitation, a risk-adjusted monthly payment for all covered services, including specialty care, provided by the ACO's participating providers.

Current rural participation/impact

RHCs and CAHs are on the list of potentially eligible participants and may be included in REACH ACO networks. In 2023, of the 103 participating REACH ACOs, provider location data could not be found for 19 (14.4%). Half of the remaining ACOs had no nonmetropolitan providers, while the other half had providers (2%-83%) in nonmetropolitan locations.

Website: <https://innovation.cms.gov/innovation-models/aco-reach>

Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model

Aliases: AHEAD, AHEAD Model

Summary

The Achieving Healthcare Efficiency through Accountable Design (AHEAD) model is a state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs. Under this approach, a participating state uses its authority to assume responsibility for managing health care quality and costs across all payers, including Medicare, Medicaid, and private coverage. Through the AHEAD Model, participating states can increase investments in primary care while constraining total health care cost growth. AHEAD encourages a state level, multi-sector approach to care, thereby improving population health outcomes.

Eligibility and rural-relevant requirements

- Eligible entities are state agencies and sub-state regions with the authority and capacity to enter into an agreement with the Secretary on behalf of their state and accept funding.
- FQHCs, RHCs, and safety net providers are eligible for participation in the program.
- States will be required to establish a model governance structure to guide implementation of the model.

Timeline/key dates

- States applying to participate in AHEAD were selected in cohorts depending on their readiness to implement the model.
 - **Cohort 1 (Maryland):** 18-month pre-implementation period: July 2024 – December 2025. Cohort 1's first performance year will begin in January 2026, with nine total performance years.
 - **Cohort 2 (Connecticut, Hawaii, Vermont):** 42-month pre-implementation period: July 2024 - December 2027. Cohort 2's first performance year will begin in January 2028, with a total of seven performance years.
 - **Cohort 3 (Rhode Island and 5 downstate counties of New York):** 36-month pre-implementation period, January 2025 - December 2027. Cohort 3's first performance year will begin in January 2027, with a total of seven performance years.
- CMS will offer the opportunity for up to 2 new states to join AHEAD in July 2026 with performance beginning in 2028 or 2029.
- The model will conclude for all cohorts of state participants in December 2035.

Payment model/funding

- CMS will provide cooperative agreement funding to selected states for up to 6 years to support their participation in this Model. A maximum of \$12 million may be awarded to each participating state.
- Global budgets will provide hospitals with a fixed amount of revenue for the upcoming year for a specific patient population or program, such as Medicare fee-for-service beneficiaries.
- Participating primary care practices will receive a Medicare care management fee to meet requirements for person-centered care.
- In each state or region, CMS will select at least two Geo Entities in a competitive bidding process. The Geo Entities will be responsible for coordinating care, managing cost and quality for previously unattributed Medicare FFS beneficiaries.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/ahead>

Ambulatory Specialty Model

Aliases: ASM

Summary

The proposed Ambulatory Specialty Model (ASM) aims to improve prevention and upstream management of chronic disease, which would lead to reductions in avoidable hospitalizations and unnecessary procedures. ASM would promote preventive care and more upstream chronic disease management by rewarding specialists for improving patient health outcomes and coordination with primary care providers. Participation in ASM will be mandatory for specialists who commonly treat people with Original Medicare for heart failure or low back pain in an outpatient setting across selected regions.

The goals of ASM are to:

- Increase active collaboration between specialists and primary care providers to support better outcomes for patients at risk for and living with heart disease or low back pain
- Improve management of chronic disease and prevent development of additional disease through better risk assessment
- Reduce avoidable hospitalizations and unnecessary procedures that provide little benefit or could lead to harm
- Offer greater transparency in performance among participants and their peers
- Measure outcomes that center on the patient's priorities
- Empower participating specialists by aligning performance measures with factors they are better able to control

Eligibility and rural-relevant requirements

- Initially, ASM will include specialists in one-quarter of core-based statistical areas (CBSAs) and metropolitan divisions who treat heart failure or low back pain.
 - Heart Failure: physicians who specialize in general cardiology.
 - Low Back Pain: physicians who specialize in anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, or physician medicine and rehabilitation.
- The model will only include physicians who have historically treated at least 20 heart failure or low back episodes per year as identified by the episode-based cost measure methodology.

Timeline/key dates

- Model announced: July 14, 2025
- Model will start on January 1, 2027 and run for 5 performance years, through December 31, 2031

Payment model/funding

ASM will leverage the CMS Merit-based Incentive Payment System (MIPS) Value Pathways (MVP) framework.

Participants' performance would be assessed across four categories:

- Quality – for instance controlling the blood pressure of patients with heart failure or improving functional status for patients with low back pain
- Cost – especially from reductions in avoidable, unnecessary care
- Improvement activities – focusing on clinical care processes and patient engagement and ensuring that all patients are screened for health-related social needs
- Improving interoperability – by encouraging the adoption of technology, including certified electronic health record technology (CEHRT), that allows specialists to communicate and share data electronically

Participants' scores across the four performance categories will determine payment adjustments on future Medicare Part B claims for covered services. In the first payment year, these adjustments will range from -9% to +9%, all participants will be subject to this risk.

Current rural participation/impact

Participation would be mandatory for specialists who commonly treat people with Original Medicare for heart failure or low back pain in an outpatient setting across selected regions (regions for participation have not yet been announced)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/asm>

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 34 Clinical Episodes. Payment is tied to performance on 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 requires downside financial risk of all participants from the outset of the Model Performance Period. There are two different types of participants. A *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. These include both eligible entities that are enrolled in Medicare and those that are not as well as Acute Care Hospitals (ACHs) and Physician Group Practices (PGPs). A *Non-Convener Participant* is Episode Initiator and does not bear risk on behalf of multiple downstream Episode Initiators. These include ACHs and PGPs.

Timeline/key dates

- Cohort 1 launched October 1, 2018
- Cohort 2 launched January 1, 2020
- Cohort 3 launched January 1, 2024
- On Oct. 13, 2022, CMS announced that the BPCI Advanced Model will be extended for two years. The BPCI Advanced Model will now conclude on December 31, 2025.

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 8 Clinical Episode Service Line Groups with 29 Inpatient, 3 Outpatient, and 2 multi-setting Clinical Episode Catalog 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.

Latest evaluation information: [At-a-glance-2-pager Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced>

Certified Community Behavioral Health Clinics (CCBHCs)

Aliases: CCBHCs

Summary

The Certified Community Behavioral Health Clinics (CCBHCs) model is designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs must serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including developmentally appropriate care for children and youth. CCBHCs have standards for the range of services they provide and are required to get people into care quickly. CCBHCs must have crisis services available 24 hours a day, 7 days a week.

Eligibility and rural-relevant requirements

A CCBHC must be one of the following entities:

- A nonprofit organization
- Part of a local government behavioral health authority
- An entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS.

SAMHSA released [updated criteria](#) for CCBHCs in March of 2023. Clinics and states are on different schedules for implementation, with most being required to come into compliance by July 1, 2024. The criteria establish a basic level of service at which a CCBHC should operate and focuses on 6 key areas:

- Staffing
- Availability and Accessibility of Services
- Care Coordination
- Scope of Services
- Quality and Other Reporting
- Organizational Authority and Governance

Timeline/key dates

- Eight states participated in a [demonstration program](#) from 2017 – 2019 which was extended. Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. Kentucky and Michigan were added to the demonstration in 2020.
- In June 2022, the Bipartisan Safer Communities Act expanded CCBHCs nationwide allowing any state or territory to participate in the demonstration and allocating additional resources for states, and funding for planning, development, and certification of new CCBHCs.
- In September 2021, SAMSHA funded the [National Training and Technical Assistance Center for Certified Community Behavioral Health Clinics-Expansion \(TTA-CCBHC\)](#) to provide support for expansion of the model.
- In March 2023, [updated criteria for certification](#) were released.
- On June 4, 2024, ten new states joined the CCBHC Program: Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island and Vermont.

Payment model/funding

- CCBHCs can be supported through the Section 223 CCBHC Medicaid Demonstration, through SAMHSA administered CCBHC Expansion (CCBHC-E) Grants, or through independent state programs separate from the Section 223 CCBHC Medicaid Demonstration.
- CCBHCs receive Medicaid payment based on a prospective payment system with a Medicaid per-encounter rate. Rates vary by state, but the structure encourages alignment with value-based purchasing through monthly PPS and/or stratified payment rates for patient subgroups based on need.

Current rural participation/impact

- There are 495 CCBHCs in operation, including sites in rural areas.

Latest evaluation information: [2024 CCBHC Impact Report](#)

Website: <https://www.samhsa.gov/certified-community-behavioral-health-clinics>

Comprehensive Care for Joint Replacement (CJR) Model

Aliases: Bundled Joints, Joint Bundles

Summary

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

- The model adopts a quality first principle, meaning hospitals must achieve a minimum level of episode quality, as determined by a hospital's composite quality score, before receiving reconciliation payments.
- The model incentivizes hospitals to avoid expensive and harmful events, which increases episode spending and reduces the opportunity for reconciliation payments.
- CMS provides additional tools to improve care coordination by participant hospitals in selected MSAs.

Eligibility and rural-relevant requirements

- For the first 2 performance years (PY) of the model, participation in the CJR model was mandatory for all hospitals paid under IPPS and located within 67 metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area and have a population of at least 50,000.
- Starting February 1, 2018, 34 of the original 67 MSAs were required to participate, with an exception for low volume and rural hospitals. Participant hospitals in the other 33 original MSAs were given a one-time opportunity to voluntarily opt in to the CJR model during January 2018 for PY 3 - 5.
- Hospitals in one of the 34 required MSAs that are not designated as low volume or rural are required to participate in the CJR model 3-year extension. Non-MSA counties are not eligible for selection.

Timeline/Key Dates

- The program began in April 2016 and ran through December 2024, representing eight PYs.
- Originally scheduled for 5 years, in June 2020, CMS announced a three-year extension of the program and changed the episode definition to include outpatient knee and hip replacements.

Payment model/funding

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

Current rural participation/impact

- There are approximately 324 participant hospitals actively participating in the CJR model for PYs 6 through 8. The list of CJR participant hospitals is available [here](#)

Latest evaluation information: [At-a-glance-2-pager](#) , [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/cjr>

Medicare Diabetes Prevention Program Expanded Model

Aliases: MDPP

Summary

The Medicare Diabetes Prevention Program (MDPP) Expanded Model is a structured behavior change intervention aimed at preventing the onset of type 2 diabetes among Medicare beneficiaries. It consists of a CDC structured evidence-based intervention including a minimum of 16 intensive core sessions. The core sessions are group-based in classroom-style settings providing practical training in long-term dietary changes, increased physical activity, and behavior 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, hold 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 (FQHCs) 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](#). MDPP Supplier Requirement Checklist is available [here](#).

Timeline/key dates:

- Service Start Date: April 2018; Provider enrollment is ongoing.
- The 2025 Medicare Physician Fee Schedule included changes to align with a [simplified billing structure finalized in CY 2024](#), the option to deliver some or all of the MDPP sessions via distance learning (which had been allowed under the COVID-19 PHE). Additional information [here](#).

Payment model/funding

- Performance-based Payment Model paid by CMS claims system.
- November 2023: CMS simplifies the performance-based payment structure for MDPP by allowing fee-for-service payments for beneficiary attendance, while keeping the performance-based payments for beneficiary weight loss.
- Performance-based 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

The number of MDPP suppliers increased from 322 suppliers in 2022 to 905 suppliers in 2025. Vermont still has no MDPP supplier locations as of January 2025. Nevada, Rhode Island and South Dakota lacked an MDPP supplier location in 2022 but have since gained at least one supplier.

Latest evaluation information: [At-a-glance 2-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/Medicare-diabetes-prevention-program>

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 life-style 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 Durable Medical Equipment (DME) supplier certified by CMS-approved national accreditation organizations (i.e., American Diabetes Association (ADA) and American Association of Diabetic Educators (AADE)). Becoming a CMS-approved DSMT accreditation organization is voluntary. Only a nonprofit or not-for-profit organization with demonstrated experience in working with individuals with diabetes can apply for accreditation. Information about the 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 the training period. Information about [Medicare Diabetes Coverage](#).

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
- Freestanding FQHCs
- Independent Rural Health Clinics
- Private physician practices
- 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: [Medicare Diabetes Prevention & Diabetes Self-Management Training \(cms.gov\)](#)

Expanded Home Health Value-Based Purchasing (HHVBP) Model

Aliases: Expanded HHVBP, HHVBP

Summary

Under the Expanded Home Health Value-Based Purchasing (HHVBP) Model, Home Health Agencies (HHAs) receive adjustments to their Medicare fee-for-service payments based on their performance against a set of quality measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year). The goals remain the same as in the [original model](#) 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.

Eligibility and rural-relevant requirements

The model includes all Medicare-certified HHAs in all fifty states, District of Columbia, and the U.S. territories.

Timeline/key dates

- January 1, 2022 – December 31, 2022: Pre-implementation year., CMS provided resources and training allowing HHAs time to prepare and learn about the expectations and requirements of the model without risk to payments.
- January 1, 2023: Start date for performance Year 1, CMS begins to assess HHA performance.
- CY 2025 was the first payment year, with payment adjustment amounts determined on CY 2023 performance.

Payment model/funding

Data from Outcome and Assessment Information Set (OASIS), completed Home Health Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys and claims-based measures are used to calculate HHAs' performance. In a payment year, an applicable percent ranging from –5 to 5 percent is applied toward Medicare fee-for-service payments.

Current rural participation/impact

All Medicare-certified HHAs in all states are included. Comparison cohorts will be determined based on each HHA's unique beneficiary count in the prior Calendar Year. HHAs are assigned to either a nationwide larger-volume cohort or a nationwide smaller-volume cohort to group HHAs that are of similar size and are more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments.

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

Frontier Community Health Integration Project (FCHIP) Demonstration

Aliases: FCHIP

Summary

Five Critical Access Hospitals (CAHs) are participating in the extension of the Frontier Community Health Integration Project (FCHIP) Demonstration, which aimed to test models of integrated, coordinated health care in the most sparsely populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. The initial Demonstration began August 1, 2016 and ran through July 31, 2019. A specific objective of FCHIP is to support the CAHs 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 must:

- Adhere to the requirements of the Rural Hospital Flexibility Program of the Social Security Act.
- Describe intent in meeting community health needs in areas of telehealth, nursing facility care, and ambulance services.
- Be located in a state where at least 65 percent of the counties have six or fewer residents per square mile.
- Limited to CAHs in Montana, Nevada, and North Dakota.

Timeline/key dates

- Initial Demonstration ran from August 1, 2016. - July 31, 2019.
- A Five-Year Extension was announced in August 2021. FCHIP resumed on the next cost report period beginning on or after January 1, 2022.

Payment model/funding

Financial incentives and Medicare payment changes are provided for:

- Ambulance Services – participants are reimbursed 101 percent of reasonable costs of furnishing Medicare Part B ambulance services instead of being paid under the Medicare ambulance fee schedule.
- Skilled Nursing Facility (SNF)/Nursing Facility (NF) Care – CAHs can 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 levels of care. CAHs continue to receive cost-based reimbursement for inpatient and skilled nursing care delivered in the extra beds.
- Telehealth Services – As originating sites for telehealth services, participants are 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 practitioners are paid an amount equal to the amount that such practitioners would be 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, suggesting that telehealth would have proliferated without the demonstration. Five CAHs in Montana (2) and North Dakota (3) continue to participate.

Latest evaluation information: [At-a-glance 2 pager](#), [Full report](#).

Website: <https://www.cms.gov/priorities/innovation/innovation-models/frontier-community-health-integration-project-demonstration>

Guiding an Improved Dementia Experience (GUIDE)

Aliases: GUIDE

Summary

Participants in the Guiding an Improved Dementia Experience (GUIDE) model will establish dementia care programs (DCPs) that provide ongoing, longitudinal care and support to people with dementia and their unpaid caregivers through an interdisciplinary team. Participant providers will connect patients and their caregivers to care navigators who will help them access medical and non-medical resources. The GUIDE Model will focus on dementia care management and aims to improve quality of life for people with dementia, help them remain in their homes and communities, and reduce strain on their unpaid care givers. Participants will bill for the service through the Medicare Physician-Fee Schedule.

Eligibility and rural-relevant requirements

Providers eligible to be GUIDE participants are Medicare Part B-enrolled providers/suppliers, excluding durable medical equipment (DME) and laboratory suppliers, who are eligible to bill under the Medicare Physician Fee Schedule and agree to meet the care delivery requirements of the model. GUIDE Participants must maintain an interdisciplinary care team to meet the care delivery requirements of the GUIDE Model. At a minimum, the interdisciplinary care team must include a “care navigator” and a clinician with “dementia proficiency”. If a participant cannot meet the GUIDE Model care delivery requirements alone, they can contract with other organizations, including both Medicare-enrolled and non-Medicare enrolled entities, to meet the care delivery requirements.

Separate tracks are established for established and new DCPs:

- **Established programs** have an established interdisciplinary care team, including a care navigator, use an electronic health record platform that meets the standards for Certified Electronic Health Record Technology, and meet other care delivery requirements.
- **New programs** must not be operating a comprehensive community-based DCP at the time of model announcement and will have a one-year pre-implementation period to establish their programs.

The model aims to address unpaid caregiver needs through supportive services and respite care, and requires participating providers to implement Health-Related Social Needs screenings/referrals.

Timeline/key dates

- Model announced: July 31, 2023.
- At Model launch in July 2024, CMS announced 327 organizations are participating, 90 under the Established Track and 240 under the New Program Track
- The Model will continue eight years from launch.

Payment model/funding

- New program track safety net providers will receive one-time, lump sum infrastructure payments to support their program development activities before the start of the performance year.
- Providers receive a per month per beneficiary payment for providing GUIDE model required care management and care coordination services to beneficiaries and caregivers.
- Participants in the GUIDE model will also be able to bill for the respite services they provide to caregivers of beneficiaries with dementia, per an annual respite cap amount.

Current rural participation/impact

Any providers with an established DCP were eligible to participate in GUIDE. CMMI is offering financial and technical support for development of new dementia care programs targeted to areas such as rural communities with less access to specialty dementia care. A list of participating organizations can be found [here](#).

Website: <https://www.cms.gov/priorities/innovation/innovation-models/guide>. [GUIDE Fact Sheet](#).

Hospital Acquired Conditions Reduction Program (HACRP)

Aliases: HAC, HAC penalty program, HAC Reduction Program

Summary

Established by the ACA, the Hospital Acquired Conditions Reduction Program (HACRP) 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 2025, 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. Each year, CMS sends hospitals confidential Hospital-Specific Reports (HSRs) that contain detailed program information and calculations for them to review. CMS gives hospitals 30 days to review their HAC Reduction Program data, submit questions about the calculation of their results, and request corrections to the scoring.

Eligibility and rural-relevant requirements

- IPPS hospitals are eligible
- CAHs 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.
- FY 2025 HAC reduction Program Key Dates Matrix available [here](#).

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.
- The FY 2025 HAC Reduction Program Fact Sheet available [here](#).
- Scoring methodology infographic located [here](#).
- Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores will receive a payment reduction of 1 percent on overall Medicare fee-for-service (FFS) payments

Current rural participation/impact

- CAHs are exempt, but rural IPPS hospitals are included.
- Penalties were waived from 2020 - 2023 due to the COVID PHE).

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

Hospital Readmissions Reduction Program (HRRP)

Aliases: HRRP, Readmission penalty program

Summary

Established by the ACA, the Hospital Readmissions Reduction Program (HRRP) required CMS to reduce payments to IPPS hospitals with excess readmissions effective for discharges starting October 1, 2012. Excess admission ratio (ERR) 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 HRRP calculates excess admission 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 admission ratio calculated.
- Applies only to Medicare Part A payments under IPPS.

Timeline/key dates

- CMS uses a three-year performance period for calculations. For example, payment adjustments for FY 2025 will be based on the 3-year performance period of July 1, 2020 through June 30, 2023.
- Program criteria and methodology are updated annually through the IPPS rulemaking process.
- FY2026 HRRP Fact Sheet available [here](#)

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 if they meet specified case volume thresholds.
- In FY 2023 1,220 hospitals were penalized under the existing methodology, with urban hospitals accounting for 83% of that figure.

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 Value-Based Purchasing (VBP) Program is part of CMS's 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 2026 affect payment in 2028).
- Program criteria and scoring are updated annually through the IPPS rule making process.
- Criteria for FY 2028 payment adjustments can be found [here](#)

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 (Oct 1 – Sept 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.

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

Innovation in Behavioral Health (IBH) Model

Aliases: IBH

Summary

The Innovation in Behavioral Health (IBH) Model is focused on improving quality of care and behavioral and physical health outcomes for Medicaid and Medicare populations with moderate to severe mental health conditions and substance use disorder (SUD). The IBH Model seeks to bridge the gap between behavioral and physical health. Practices participating in the IBH Model will screen and assess patients for select health conditions, as well as mental health conditions and/or SUD, in community-based behavioral health practices. IBH is a state-based model, led by state Medicaid Agencies, with a goal of aligning payment between Medicaid and Medicare for integrated services. State Medicaid Agencies in Michigan, New York, Oklahoma, and South Carolina were selected to participate in the model. Oklahoma will implement the IBH model statewide, and Michigan, New York, and South Carolina will implement the model in designated sub-state geographic service areas, including rural parts of the state.

Eligibility and rural-relevant requirements

States, including U.S. territories and the District of Columbia, had the option to apply as a whole state, or a specified sub-state region. Participating state are required to select practice participants – community-based behavioral health organizations or settings that, at the time of application, met all the following criteria:

- Licensed by the state awardee to deliver behavioral services, for mental health and/or substance use disorder
- Meet all state-specific Medicaid provider enrollment requirements and are eligible for Medicaid reimbursement
- Serve adult Medicaid beneficiaries (age 18 or older) with moderate to severe behavioral health conditions
- Provide mental health and/or substance use disorder services at the outpatient level of care

Medicare and Medicaid beneficiaries, including those dually eligible, who receive behavioral health care from a participating practice, are eligible to receive services as part of the model.

Timeline/key dates

- January 18, 2024: CMS Announced the IBH Model
- January 1, 2025: Model launch date (Michigan, New York, Oklahoma, and South Carolina)
- Pre-Implementation Period: Model Years 1-3
- Implementation Period: Model Years 4-8

Payment model/funding

- The selected state Medicaid Agencies will receive cooperative agreement funding to partner with their state’s agencies for mental health and/or SUD to ensure alignment in clinical policies, as well as work with at least one partnering Medicaid Managed Care Organization (MCO) or another intermediary partner, where applicable, to develop and implement the IBH Model in their state.
- Community-based behavioral health practices (“practice participants”) will be responsible for conducting screenings and assessments of behavioral and physical health and health-related social needs, offering treatment as appropriate within their scope of practice, providing “closed loop” referrals to other primary care providers, specialists, and community-based resources, and monitoring ongoing conditions. This approach uses the behavioral health setting as a point of entry to identify and secure further care and facilitate close collaboration with primary and specialty care providers.
- Medicare payments for practice participants will include:
 - Infrastructure funding to support health IT investments and practice transformation.
 - Integration Support Payment (ISP), a prospective risk adjusted PMPM for screening, assessment, coordination, and HRSN screening and referral.
 - Performance-based payments to incentivize quality outcomes.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model>

Long-term Enhanced ACO Design (LEAD) Model

Aliases: LEAD ACO

Summary

The intent of LEAD is to address financial and administrative obstacles for established and newly created ACOs, including smaller, independent, or rural-based practices. The model will have a 10-year performance period that offers a predictable window without rebasing and a pathway toward sustainable long-term benchmarks and savings. LEAD will focus on better serving coordinated care for high-needs patients, such as those who are homebound or home limited. The model also includes design features that put more focus on preventative care and gives providers expanded flexibility to check in with patients regularly, reach out before problems escalate, and coordinate care that happens between visits. LEAD will also support the integration of Medicare and Medicaid services for dually-eligible patients receiving Medicare benefits through Original Medicare. During initial planning phases from March 2026 to March 2027, CMS will identify two states to develop a framework for ACO-Medicaid partnership arrangements. This will define how ACOs and Medicaid organizations work together to share data and coordinate care to improve outcomes, including preventing avoidable hospitalizations and helping patients remain engaged in their communities.

Eligibility and rural-relevant requirements

Applications will be submitted at the ACO level, participating providers may include:

- Current [ACO REACH Model](#) participants and other ACOs.
- Current Medicare fee-for-service health care providers that have historically not participated in ACOs.
- Health care providers serving underserved populations, such as those with a high proportion of dually eligible individuals, Federally Qualified Health Centers, and Rural Health Clinics.

LEAD will support rural participation by offering an add-on payment that will not be reconciled to support infrastructure development and allowing lower beneficiary alignment minimums for ACOs with providers that are new to ACO participation.

Timeline/key dates

- Model applications will open in March 2026.
- The 10-year performance period will run from January 1, 2027, through December 31, 2036.

Payment model/funding

LEAD will be based on flexible, capitated population-based payments to support team-based care and downstream value-based care arrangements.

- Integration of high-needs patients: A more accurate risk adjustment and benchmarking model will be integrated across all ACOs, creating an incentive to develop the capabilities to care for patients with complex needs.
- Two voluntary risk-sharing options:
 - Global Risk: Eligible to receive up to 100% of their savings and liable for up to 100% of total losses relative to their established performance benchmark
 - Professional Risk: Eligible to receive up to 50% of total savings and liable for up to 50% of total losses relative to their established performance year benchmark.
- Healthy living flexibilities: Benefit Enhancements and Beneficiary Engagement Incentives that support the delivery of coordinated, proactive, and preventative care. This includes Part B cost sharing support and, by 2029, a Part D premium buy down.
- CMS Administered Risk Arrangements (CARA): Will provide CMS support to ACOs to enable episode-based risk arrangements between ACOs and specialist and provider organizations to facilitate stronger preferred provider relationships, will also feature an episode-based falls prevention program.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/lead>

[Make America Healthy Again: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence \(ELEVATE\)](#)

Aliases: MAHA ELEVATE

Summary

The MAHA ELEVATE Model is designed to address the chronic disease epidemic. The proposals will utilize evidence-based, whole-person care approaches — including functional or lifestyle medicine interventions which are currently not covered by Original Medicare. These approaches are intended to support, not replace, the medical care currently received by people with Medicare. The model will also gather and evaluate new data on cost and quality to inform future interventions promoting healthy lifestyle behaviors and ultimately reduce spending in Original Medicare. By testing whole person approaches to care, MAHA ELEVATE aims to help transform the U.S. health care system to one that proactively addresses the root causes of chronic disease rather than reactively addressing symptoms. MAHA ELEVATE aims to:

- Establish in Original Medicare an evidence base featuring cost and quality data on the effectiveness of whole-person functional or lifestyle medicine approaches to care, including psychological, nutritional, and physical interventions.
- Empower patients to take control of their health through lifestyle changes.
- Prevent illness and promote wellness through novel approaches to supporting people in behavior changes aimed at improving health or slowing and/or reversing disease progression.

Eligibility and rural-relevant requirements

- Proposals should include services not already covered by Original Medicare but with documented evidence of the intervention’s efficacy. Cooperative agreements will be awarded to organizations with experience integrating and measuring the impact of such approaches to health and wellness, with scientifically documented improvements in health. All proposals must incorporate nutrition or physical activity as part of the design. Three awards will be reserved for interventions that address dementia. There are no specific rural-relevant requirements.

Timeline/key dates

- CMS will release a Notice of Funding Opportunity (NOFO) in early 2026 for the first cohort, and the voluntary model will launch on September 1, 2026.
- Cooperative agreements will be awarded in two rounds for two separate cohorts — one starting in 2026 and the second in 2027.

Payment model/funding

- The model will provide approximately \$100 million to fund 3-year cooperative agreements for up to 30 proposals that promote health and prevention for Original Medicare beneficiaries.
- MAHA ELEVATE cooperative agreement funding can be used to cover whole-person care services, including functional or lifestyle medicine, that Original Medicare doesn’t cover. It can only be used for Original Medicare patients. It can also be used to cover costs for administration and data collection and reporting.

Current rural participation/impact

A variety of organizations, including health systems, ACOs, FQHCs, and RHCs will be eligible to apply.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/maha-elevate>

Maryland Total Cost of Care (TCOC) Model

Aliases: TCOC Model

Summary

The Maryland Total Cost of Care (TCOC) model leveraged the foundation already developed by Maryland for hospitals and built upon investments from the [Maryland All-Payer Model](#). This model set a per capita limit on Medicare total cost of care in Maryland, and held the state fully at risk for Medicare beneficiaries. The model encouraged a person-centered care redesign and provided 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 included Outcomes-Based Credits, which enabled CMS to grant the State credits for performance on targets. Model performance requirements included:

- Hospital cost growth per capita for all payers must not have exceeded 3.58% per year
- Federal resources were invested in primary care and delivery innovation to improve population health
- Providers leveraged initiatives and federal programs to align participation in efforts on improving care and care coordination

Eligibility and rural-relevant requirements

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

Timeline/Key Dates

- Maryland TCOC started January 1, 2019, and concluded on December 31, 2025. In Spring 2025, it was announced that Maryland would be transitioning to the [States Advancing All-Payer Health Equity Approaches and Development \(AHEAD\) Model](#) starting in 2026.
- A new track, Track 3, began January 1, 2023, for primary care practices. Track 3 increased the total cost of care accountability of participating primary care practices by introducing upside and downside risk based on practice performance on cost and quality metrics. Track 3 was largely modeled after the [Primary Care First \(PCF\) Model](#).

Payment Model/Funding

The TCOC Model included three programs:

- **Hospital Payment Program:** Each hospital received a population-based payment amount to cover all hospital services provided during the year, creating a financial incentive for hospitals to provide value-based care and to reduce unnecessary hospitalizations.
- **Care Redesign Program:** Allowed hospitals to provide incentive payments to nonhospital providers who partnered and collaborated with the hospital and perform care redesign activities to improve quality of care. A participating hospital may only make incentive payments if it had attained certain savings under its fixed global budget, and the total amount of incentive payments made could not exceed such savings.
- **Maryland Primary Care Program:** Incentivized primary care practices and FQHCs in Maryland to offer advanced primary care services to their patients. Participating practices and FQHCs received an additional per beneficiary per month payment directly from CMS to cover care management services.

Rural Participation/Impact

- All Maryland hospitals, both rural and urban were included.
- FQHCs were eligible to participate in the Maryland Primary Care Program.

Latest evaluation information: [At-a-glance 2 pager](#), [Full Report](#)

Websites: <https://www.cms.gov/priorities/innovation/innovation-models/md-tccm>;
<https://hsrc.state.md.us/Pages/tcocmodel.aspx>

Medicare Promoting Interoperability Program

Aliases: Medicare PI (PI), Formerly known as the Medicare EHR Incentive Program or “Meaningful Use”

Summary

In 2011, CMS established the Medicare and Medicaid Electronic Health Record Incentive Programs (now known as the Medicare Promoting Interoperability Program) to encourage eligible professionals (EPs), eligible hospitals, and CAHs to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT). Starting in 2018, the PI requirements for EPs were incorporated into the [Quality Payment Program](#) (QPP).

Eligible hospitals and CAHs attesting to CMS are currently required to report on four scored objectives: Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. Participants are also required to report (yes/no) on the Protect Patient Health Information objective: Security Risk Analysis measure and Safety Assurance Factors for EHR Resilience (SAFER) Guides measure. Eligible Hospitals and CAHs must also attest to a variety of security and safety factors and submit electronic clinical quality measures (eCQMs) as part of the program.

Eligibility and rural-relevant requirements

- All eligible hospitals and Critical Access Hospitals (CAHs) that receive federal funds from Medicare are included in the program. Those that do not participate are subject to a negative payment adjustment.
- To be considered a meaningful user and avoid a downward payment adjustment, eligible hospitals and CAHs attesting to the Medicare Promoting Interoperability Program will be required to use CEHRT that has been updated to meet [2015 Edition Cures Update](#) criteria.

Timeline/key dates

- Program criteria and scoring are updated annually through the IPPS rule making process.
- CMS has indicated they will begin public reporting of the total PI score starting with CY 2023 results.
- The calendar year 2025 EHR reporting period began on January 1, 2025, and will end on December 31, 2025.
- The reporting deadline for the prior CY is typically at the end of February, the reporting deadline for CY 2025 is Monday, March 2, 2026.

Payment model/funding

- CMS implements a performance-based scoring methodology. Eligible hospitals and CAHs are required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Each measure will contribute to the eligible hospital or CAHs total Medicare Promoting Interoperability Program score. A minimum of 70 points is required to satisfy the scoring requirements in 2025, and 80 points in 2026.
- If an eligible hospital does not meet requirements, the payment adjustment is applied as a reduction to the applicable percentage increase to the Inpatient Perspective Payment System payment rate. If a CAH does not demonstrate meaningful use, its Medicare reimbursement will be reduced from 101 percent of its reasonable costs to 100 percent for that year.
- [CY 2025 Program Requirements Infographic](#)

Current rural participation/impact

- CAHs that do not participate or meet the minimum threshold of points are subject to a negative payment adjustment. Eligible hospitals and CAHs may apply for hardship exceptions, if applicable, to avoid downward payment adjustments. Hardship exceptions are granted on a case-by-case basis and only if CMS determines that requiring an eligible hospital or CAH to be a meaningful EHR user would result in a significant hardship.
- 994 CAHs met the scoring requirements in the most recent program year (CY 2024).

Website: <https://www.cms.gov/medicare/regulations-guidance/promoting-interoperability-programs>

Medicare Shared Savings Program (SSP)

Aliases: MSSP, Shared Savings Program, Medicare ACO, MSSP ACO.

Summary

The Medicare Shared Savings Program (SSP) was established by the ACA and is a key component of Medicare delivery system reform initiatives. It 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 SSP by creating or participating in an ACO. The SSP aims to reward ACOs that lower health care cost growth while meeting performance standards on quality of care. Provider 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.
- ACOs must have at least 5,000 attributed Medicare FFS patients, meet all other eligibility and program requirements and agree to participate in the SSP for at least 5 years.
- Statute and individual program regulations specify eligibility and program requirements.

Timeline/key dates

- For standard SSP ACO participation there is an [annual application](#) cycle, with the first stage of applications usually occurring in June of the year prior to the agreement start date.
- Updates to program requirements and methodology are made through the annual Federal rule making process.
- Significant rule changes to the SSP were implemented in January 2023 and 2024 that allowed greater flexibility to performance-based risk, adjusted benchmarking methodology, and include advance investment payments (AIPs) to new low revenue ACOs.

Payment model/funding

- CMS establishes expenditure targets based on prior year paid claims for care provided to FFS Medicare beneficiaries not attributed to ACOs. CMS continues to make payments on a fee-for-service basis. At the end of the year, actual and targeted 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.
- Modifications took effect for applicants that start as an ACO in January 2024. The modifications affect inexperienced ACOs, which could include rural ACOs, as they enter five-year agreements under one of two tracks:
 - **BASIC Track:** Standard ACOs move annually along a glide-track with 5 levels that gives the option of starting with one-sided shared savings model (Inexperienced ACOs may remain in level A for all 5 years of the initial agreement period, then move along the glide path in their second 5 year agreement period). ACOs may choose to remain at Level E indefinitely or move to the ENHANCED Track after the initial agreement period.
 - Level A and B: one-sided shared savings, up to 40 percent share of savings, no shared loss.
 - Level C: two-sided shared savings/shared losses, up to 50% share of savings, loss sharing limit is 30%. Not to exceed 2 percent of ACO revenue capped at 1 percent of benchmark.
 - Level D: two-sided shared savings/shared losses, up to 50% share of savings, loss sharing limit is 30%. Not to exceed 4 percent of ACO revenue capped at 2 percent of benchmark.
 - Level E: two-sided shared savings/shared losses, up to 50% share of savings, loss sharing limit is 30%. Not to exceed 8 percent of ACO revenue capped at 4 percent of benchmark.
 - **ENHANCED Track:** two-sided shared savings/share loss, up to 75% share of savings, loss sharing limit is 40-75%

Current rural participation/impact

- RHCs, FQHCs, and CAHs are eligible to participate in ACOs if they meet specific requirements.
- As of January 2025: 547 CAHs and 2,872 RHCs were participating in an MSSP ACO, 29% of all participating ACOs were under one-sided risk.
- PY 2024 Performance Results available [here](#).

Website: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharesavingsprogram>

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 Quality Payment Program (QPP), which links clinician payment to quality. QPP replaced 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 for Medicare Part B covered professional services.

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, clinical social workers, nurse midwives, dietitians, and certified registered nurse anesthetists.
- RHCs and FQHCs are generally ineligible because they are paid by Medicare under separate systems.
- 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.
- Virtual groups are a participation option for solo practitioners and practices with 10 or fewer providers allowing them to submit aggregated data.

Timeline/Key Dates

- There is a lag between performance and payment adjustment (ex. performance in 2023 impacts payment in 2025).
- The QPP Performance Year begins January 1 and ends on December 31, with reporting due by March 31 of the following calendar year.
- The Quality Payment Program Exception Application Window opens in the Spring/Summer.
- Virtual Group Election is due to CMS by December 31 each year. [Virtual Group Participation Toolkit](#).

Payment model/funding

MIPS: Positive or negative payment adjustments made based on evidence-based and practice-specific quality data in four areas: Quality, Improvement Activities, Promoting Interoperability, and Cost.

- During the first six payment years of the program (2019-2024), MACRA allowed for up to \$500 million each year in additional positive adjustments for exceptional performance.
- In 2021, the program transitioned to a new [MIPS Value Pathways Framework](#) to streamline program requirements.

APM: Clinicians participating in a Qualifying Advanced APM (QP) are excluded from MIPS reporting and payment adjustments and were eligible for an incentive payment for performance years 2017 – 2023. For performance year 2024 and beyond, they will receive a higher Medicare Physician Fee Schedule update than clinicians than non-QPs.

- Starting in PY 2019, eligible clinicians may become Qualifying Alternative Payment Model Participants (QP) through an [All-Payer option](#).

Current rural participation/impact

- 89,107 rural clinicians were eligible for MIPS in 2023 and all but 5.81% actively submitted data for participation.
- For CY 2022 scores (CY 2024 payment), the median payment adjustment for rural clinicians that were engaged in the program was 0.90%

Latest evaluation information: [2023 Quality Payment Program Experience Report](#)

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

Radiation Oncology (RO) Model

Aliases: RO Model

Summary

The Radiation Oncology (RO) Model aims to improve the quality of care for cancer patients receiving radiotherapy (RT) and move toward a simplified payment system. The RO Model tests whether bundled, prospective, site neutral, modality agnostic, episode-based payments to physician group practices (PGPs), hospital outpatient departments (HOPD), and freestanding radiation therapy centers for radiotherapy (RT) episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

Eligibility and rural-relevant requirements

RT providers that operate solely in Maryland and/or Vermont are excluded from participation in this model. Outside of this exclusion, RO participants can be any of the following entities: 1) a physician group practice (PGP), including freestanding radiation therapy centers or 2) a Hospital Outpatient Department (HOPD).

- **A Professional participant** is a Medicare-enrolled PGP, identified by a single Taxpayer Identification Number (TIN) that furnishes only the professional component (PC) of RT services at a freestanding radiation therapy center or a HOPD.
- **A Technical participant** is an HOPD or freestanding radiation therapy center, identified by a single CMS Certification Number (CCN) or TIN, which furnishes only the technical component (TC) of RT services during an RO episode.
- **A Dual participant** furnishes both the PC and TC of an RO episode for RT services through a freestanding radiation therapy center, identified by a single TIN.

Timeline/key dates

- December 2021: Congress prohibits implementation prior to January 1, 2023
- August 2022: Final rule posted delaying model start to a date to be determined through future rulemaking (TBD).

Payment model/funding

The design of the RO Model includes several key programmatic elements:

- **Episode Payments**: CMS makes prospective, episode-based (i.e., bundled) payments, based on a patient's cancer diagnosis, that cover RT services furnished in a 90-day episode for the 16 cancer types meeting the included cancer type criteria described in the final rule.
- **Site-neutrality**: The Model uses site-neutral payment by establishing a common, adjusted national base payment amount for the episode, regardless of the setting where it is furnished.
- **Professional and Technical Payment Components**: Episode payments are split into professional and technical components to allow the current claims systems for PFS and OPFS to be used to adjudicate RO Model claims and for consistency with existing business relationships.
- **Linking Payment to Quality**: The Model links payment to quality using reporting and performance on quality measures, clinical data reporting, and patient experience as factors when determining payment to RO participants. The Model meets the requirements to qualify as an Advanced APM and a MIPS APM under QPP starting in Performance Year (PY) 1. Quality Guide can be found [here](#).
- **Mandatory Model**: The RO Model is a mandatory model that requires participation from RT providers and suppliers that furnish RT services within randomly selected CBSAs to participate.

Current rural participation/impact

- The Model operates in defined, randomly selected, Core-Based Statistical Areas with a population of at least 10,000. Generally, CBSAs do not include extremely rural regions, but they do contain rural RT providers and RT suppliers. If a RO participant has less than 20 episodes, then they are eligible for the low volume opt-out
- Hospital outpatient departments (HOPD) that are part of a CAH will be excluded. HOPDs that are part of a hospital participating in the Pennsylvania Rural Health model are excluded. RT providers and suppliers that only furnish RT in Maryland and Vermont are excluded.

Website: <https://innovation.cms.gov/innovation-models/radiation-oncology-model>

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Aliases: SNF VBP

Summary

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP) aims to reward quality and improve quality of health care in Skilled Nursing Facilities (SNFs) by establishing incentive payments based on performance on quality measures. For FY 2025, the measure utilized is the Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM), 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. Starting in Program Year 2026, CMS has adopted [additional measures](#) for inclusion in the program.

Eligibility and rural-relevant requirements

All SNFs paid under Medicare's SNF Prospective Payment System (PPS) are included in the SNF VBP Program. The SNF VBP Program is not optional and does not require any action by SNFs to participate. CMS has adopted some exceptions for SNFs with fewer than 25 eligible stays allowing them to be held harmless from penalties. Under the SNF VBP Program, SNFs:

- Are evaluated by their performance on specified measures;
- Are assessed on both improvement and achievement, and scored on the higher of the two;
- Receive quarterly confidential feedback reports containing information about their performance; and
- Earn incentive payments based on their performance.

If a SNF can demonstrate that an extraordinary circumstance affected the care that it provided to its patients, and thus affected its subsequent measure performance, CMS will exclude extraordinary circumstance performance from calculations.

Timeline/key dates

- October 1, 2018: SNFs began receiving value-based incentive payments for the quality of care they gave to people with Medicare.
- There is a two-year lag between performance period and payment impact. For example, FY 2025 Medicare FFS payments will be based upon FY 2023 performance period in comparison to FY 2021 baseline period.
- FY 2026 key dates timeline available here: [Skilled Nursing Facility Value-Based Purchasing Program FY 2026 Timeline](#)

Payment model/funding

- CMS withholds 2% of SNFs' Medicare FFS Part A payments
- CMS redistributes 60% of the withhold to SNFs as incentive payments, and the remaining 40% of the withhold is retained in the Medicare Trust Fund.
- CMS calculates an incentive payment multiplier that accounts for both the 2% payment withhold and any incentive payments earned through performance on the SNFRM. This incentive payment multiplier is applied to the SNF's adjusted federal per diem rate for services provided during the applicable SNF VBP Program year.

Current rural participation/impact

All SNFs paid under the prospective payment system. Eligible SNFs include freestanding SNFs, SNFs associated with acute care facilities, and all non-Critical Access Hospital (CAH) swing bed rural facilities.

- For FY 2024, of the roughly 10,278 SNFs, 71.7% were penalized (received less than the full 2% back), of these 33.1% received a full 2% rate cut penalty. 2413 SNFs (15.9%) had a neutral rate adjustment.
- SNFs that were not for profit, government owned, located in rural areas, and larger were significantly more likely to earn positive incentive payments.

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

Transforming Episode Accountability Model (TEAM)

Aliases: TEAM Model

Summary

The Transforming Episode Accountability Model (TEAM) is a mandatory episode-based alternative payment model in which selected acute care hospitals coordinate care for people with Fee-for-Service (FFS) Medicare who undergo one of the surgical procedures (initiate an episode) included in the model and assume responsibility for the cost and quality of care from surgery through the first 30 days after the Medicare beneficiary leaves the hospital. As part of taking responsibility for cost and quality during the episode, hospitals would connect patients to primary care services to help establish accountable care relationships and support optimal, long-term health outcomes. Episodes of care for five different surgical procedures will be included in TEAM: lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure.

Eligibility and rural-relevant requirements

CMS used Core-Based Statistical Areas (CBSAs) to identify selected geographic regions for the model test. Hospitals paid under the Inpatient Prospective Payment System (IPPS) and located in the selected CBSAs are required to participate in TEAM. Hospitals that participated in the [Bundled Payments for Care Improvement \(BCPI\) Advanced model](#) or [Comprehensive Care for Joint Replacement \(CJR\) model](#) through the end of the last performance period(s) will be eligible for a one-time opportunity to voluntarily opt-in to TEAM. The model's target pricing methodology will include a social risk adjustment to ensure target prices properly reflect the additional resources needed to care for those with additional needs.

Timeline/key dates

- January 1, 2026: Model Starts
- December 31, 2030 – Model Ends

Payment model/funding

Hospitals will continue to bill FFS Medicare as usual for included episodes but will receive target prices which are set prior to each performance year. Target prices will be based on all non-excluded Medicare Parts A and B items and services included in an episode and would be risk-adjusted based on beneficiary-level factors. Performance in the model will be assessed by comparing the hospitals' actual Medicare FFS spending for the episode to their target price, as well as through an assessment of performance on three quality measures: hospital readmission, patient safety, and patient-reported outcomes. Hospitals may earn a payment from CMS, subject to a quality performance adjustment, if the total Medicare costs for the episode are below the target price. Hospitals may owe CMS a repayment amount, subject to a quality performance adjustment if the total Medicare costs for the episode are above the target price. The TEAM design includes a one-year glide path available to all participants. There are three participation Tracks:

Track 1 – no downside risk and lower levels of reward for the first year (or up to three years for safety net hospitals).

Track 2 – Lower levels of risk and reward for certain participants (such as safety net hospitals), for years 2 – 5.

Track 3 – Higher levels of risk and reward for years 1 – 5.

Current rural participation/impact

Of the 741 hospitals identified for mandatory participation, 124 (16.7%) are located in non-metro counties (CBSAs do not include extremely rural regions, but they do contain some non-metropolitan counties). CAHs were not eligible for participation. There are no participating hospitals in Alaska, Delaware, Hawaii, Maryland, Montana, North Dakota, or Wyoming. Safety net hospitals for TEAM are identified based on the proportion of low-income Medicare patients, additional details available here. Selected hospital types for Track two include Medicare Dependent Hospitals, rural hospitals, Sole Community Hospitals, and Essential Access Community hospitals

Website: <https://www.cms.gov/priorities/innovation/innovation-models/team-model>

Transforming Maternal Health (TMaH) Model

Aliases: TMaH

Summary

TMaH is a CMS model designed to focus exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP). The model will support participating state Medicaid agencies (SMAs) in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The goal of the model is to reduce disparities in access and treatment. The model aims to improve outcomes and experiences for mothers and their newborns, while also reducing overall program expenditures.

Eligibility and rural-relevant requirements

- TMaH is a state-based model, in which state Medicaid agencies serve as model awardees. Managed Care Organizations (MCOs), Perinatal Quality Collaboratives, hospitals, birth centers, health centers and Rural Health Clinics, maternity care providers and community-based organizations are critical collaborators to model success.
- Participating states: Alabama, Arkansas, California, the District of Columbia, Illinois, Kansas, Louisiana, Maine, Minnesota, Mississippi, New Jersey, Oklahoma, South Carolina, West Virginia, and Wisconsin
- Part of TMaH's approach to promoting person-centered care includes expanded access to diverse types of maternity care providers, such as midwives as well as doulas, who provide non-clinical support and guidance.

Timeline/key dates

- December 15, 2023: Model Announcement
- January 2025: Participating States announced
- January 2025 - December 2027: Pre-implementation Period
- January 2028 - December 2034: Implementation Period

Payment model/funding

- SMAs were the only eligible applicants and could receive up to \$17 million in funding over the course of ten years.
- TMaH's initiatives center on three main pillars:
 - Access to care, infrastructure, and workforce capacity: TMaH will support relationship building and education to help participating states address barriers that limit access to valuable resources, such as midwives, doulas, and perinatal Community Health Workers.
 - Quality improvement and safety: Participating SMAs will implement quality initiatives and protocols with a goal of making childbirth safer and improving both the mother and baby's overall experience.
 - Whole-person care delivery: Pregnancy and birth are deeply personal experiences, and every person's journey is unique. Under the TMaH Model, participating SMAs will strive to ensure that every mother receives care that is customized to meet their specific needs by supporting the development of a unique birth plan.

Website: <https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model>

Vermont All-Payer ACO Model

Aliases: None

Summary

Established as a joint effort between CMS and the state of Vermont, Vermont's All-Payer ACO Model is exploring new ways of paying for health care services that keep the state's health care spending in check and improve the health of Vermonters. The state's dominant payers (Medicare, Medicaid, and commercial health plans) have joined together to test an alternative payment model for providers across the state that incentivizes quality and value in health care. By working with providers and payers to align payment models, care models, quality measures, and more, the Model seeks to transform the state's delivery system and improve care for all Vermonters.

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. By establishing State-level standards for statewide and ACO-level health outcomes, the Model aims to incentivize coordination to achieve the following targets:

- ACO Scale Targets – Scale – the percentage of Vermonters included in the model – is critical to transforming care delivery and achieving financial savings. Vermont's goal, by 2022, was for the Model to include 90 percent of Medicare beneficiaries and 70 percent of "Vermont all-payer beneficiaries" (most Vermonters).
- All-Payer and Medicare Financial Targets – the State will limit annualized per capita health care expenditure growth to 3.5 percent (and no more than 4.3 percent), and Medicare per capita health care 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 three prioritized areas: access to primary care, deaths from substance use disorder and suicide, and prevalence of chronic conditions.

Additionally, CMS provided five-year extensions for the State's 1115(a) Medicaid demonstration waiver in 2018 and 2022, which allows Medicaid to operate as a full partner in the ACO Model approach.

Eligibility and rural-relevant requirements

Participation is voluntary for hospitals and health care practitioners and providers, including rural providers.

Timeline/key dates

- The Vermont All-Payer ACO Model began on January 1, 2017 and will conclude on December 31, 2025.
- There are eight performance years (PY0-PY8), each spanning a full calendar year.
- The program was originally slated to end December 31, 2022, but the state of Vermont and CMMI agreed to extend the program until the end of 2025. In July 2024 it was announced that Vermont will be transitioning to the [Achieving Healthcare Efficiency through Accountable Design \(AHEAD\) Model](#).

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 provide continued support for Vermont's statewide multi-payer patient-centered medical home program, the Blueprint for Health, and the Support and Services at Home (SASH) program, which provides care coordination and social services to Medicare beneficiaries.

Current rural participation/impact

- In 2021, 14 of Vermont's 15 eligible hospitals participated in one or more ACO payer initiatives, 7 of which are Critical Access Hospitals. Rural FQHCs and RHCs are eligible, but participation among small practices is limited. 9 FQHCs participated in 2021.

Latest evaluation information: [At-a-glance Two-pager](#), [Full Report](#)

Websites: <https://gmcboard.vermont.gov/payment-reform/APM>;
<https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model>

Wasteful and Inappropriate Service Reduction (WISeR) Model

Aliases: WISeR

Summary

The Wasteful and Inappropriate Service Reduction (WISeR) Model aims to protect taxpayers by using Artificial Intelligence (AI) and Machine Learning (ML), along with clinical review, to ensure timely and appropriate Original Medicare payments for select items and services. Participating technology companies will streamline early medical necessity reviews in the claims process to 1) reduce inappropriate utilization, 2) lower spending in Original Medicare, 3) expedite decision making and 4) ease provider administrative burden. CMS has selected a set of services for inclusion that 1) pose concerns related to patient safety if delivered inappropriately; 2) have existing publicly available coverage criteria; and 3) may involve prior reports of fraud, waste, and abuse. Example services include skin and tissue substitutes, electrical nerve stimulators, and knee arthroscopy for knee osteoarthritis. A full list of services included for the first performance year can be found [here](#). WISeR will run for six years in six states: New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington.

Eligibility and rural-relevant requirements

Model participants are technology companies that will interface with Medicare Administrative Contractors (MACs). CMS identified one model participant per each MAC jurisdiction. Eligibility requirements for model participants included:

- Ability to interpret and apply clinical coverage criteria derived from National and Local Coverage Determinations (NCDs and LCDs), experience in working with payers on improving prior authorization processes, including the incorporation of enhanced technologies
- Established processes for ensuring appropriate clinical expertise is incorporated into determinations and for ensuring that providers and suppliers have the ability to resubmit requests after non-affirmative decisions
- Compliance with all applicable Federal data protection and security requirements
- Participating companies must have clinicians with relevant experience for the selected services to conduct medical reviews as appropriate
- Capability to offer back up options to advanced technologies, including processing requests through phone, fax, electronic portals, and mail

Timeline/key dates

- June 27, 2025: CMS announced WISeR Model and RFA opened (applications due July 25, 2025)
- Fall 2025: Selection, announcement, and onboarding. Operations Guide and Provider Education Materials released
- January 1, 2026 – December 31, 2026: Model Launch and six-year performance period begins

Payment model/funding

- There will be no change in provider/supplier payments for services selected for prior authorization under the model
- Participants are compensated based on a share of averted expenditures rather than on a fixed fee or per claim basis
- Model payments are calculated from requests that did not result in a paid claim

Rural participation/Impact:

- All providers and suppliers for Original Medicare in selected states will have the choice of submitting a prior authorization request for the model's selected items and services or go through a post-service/pre-payment review
- Those that choose the prior authorization route may either submit the prior authorization request (a) directly to the model participant or (b) to their Medicare Administrative Contractor (MAC) that will forward the request to the model participant. For those that do not submit a request for an included service, claims will be subject to medical review by the model participant to ensure the delivered service met Medicare coverage, coding, and payment criteria prior to payment
- WISeR does not change Medicare coverage or payment policy or provider's/supplier's appeal rights

Website: <https://www.cms.gov/priorities/innovation/innovation-models/wiser>

Appendix 1: Value-Based Care Support Initiatives

Health Care Payment and Learning Action Network (HCP LAN)

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. The HCP LAN goal statement is to accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models, and they have set target percentages to be reached by 2025 in the following markets: Medicaid (30%), Commercial (30%), Medicare Advantage (65%), Traditional Medicare (60%). Additionally, goals were set for 2030, and are as follows: Medicaid (50%), Commercial (50%), Medicare Advantage (100%), Traditional Medicare (100%). 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 such as the [APM Framework](#), which provides a standard classification for APMs. 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://www.cms.gov/priorities/innovation/health-care-payment-learning-and-action-network>

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO)

The Quality Improvement Organization (QIO) Program is one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

The QIO Program's Regional Quality Innovation Network-QIOs (QIN-QIOs) bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. QIN-QIOs are staffed by health care quality experts and serve regions, to help implement and spread best and innovative practices for better care while accommodating local conditions and cultural factors. Rural health care organizations are a focus for inclusion in the QIN-QIO improvement initiatives.

Websites: <https://www.cms.gov/medicare/quality/quality-improvement-organizations>;
<https://www.cms.gov/medicare/quality/quality-improvement-organizations/current-work> (lists which organizations are serving as the regional QIN-QIO in each state)

Appendix 2 – Inactive Program Archive

[ACO Investment Model \(AIM\)](#)

Aliases: AIM Model

Stage: No Longer Active

Summary

The ACO Investment Model (AIM) built on previous experience with the [Advance Payment Model](#), testing the use of pre-paid shared savings to encourage new Accountable Care Organizations (ACOs) to form in rural 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 encouraged uptake of coordinated, accountable care in rural areas.
- *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 owned by a health plan and did not participate in the [Advanced 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

- ACOs had to join by January 1, 2016
- AIM ended in 2018.

Payment model/funding

Only available for new 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

Of the 45 AIM ACO participants across 38 states:

36 had at least 65% of their delivery sites in rural areas 27 ACOs reported having a Critical Access Hospital (CAH) or Inpatient Prospective Payment System (IPPS) hospital with fewer than 100 beds as part of their ACO structure.

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.

Evaluation: [At-A-Glance Report](#), [Final report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/aco-investment-model>

[Accountable Health Communities Model](#)

Aliases: AHC Model

Summary

The Accountable Health Communities (AHC) model addressed 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 was 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 aimed 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 tested a two-track model that linked 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 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.
- The minimum number of beneficiaries that applicants are required to screen annually is 75,000.
- Twenty-eight organizations participated in the Accountable Health Communities Model and all participated in the assistance and alignment tracks. [List of participating organizations](#).
- CMS developed and released its [Health-Related Social Needs Screening Tool](#) in January 2018.

Timeline/key dates

- Participant performance period launched May 1, 2017 and ended April 30, 2022. There was an optional no cost extension performance period that ended April 30, 2023

Payment model/funding

- The model provided support to community bridge organizations to test service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs).
- Funds for this model supported the infrastructure and staffing needs of bridge organizations, and do not pay directly or indirectly for any community services.

Rural participation/impact

- A majority of bridge organizations (17) had geographic target areas (GTAs) with no rural counties. The remaining 12 bridge organizations served at least two rural counties, and rural counties made up 50% or more of the GTAs of six of those bridge organizations.
- Among Medicaid beneficiaries and depending on the track, between 12% and 16% lived in rural regions.
- Among FFS Medicare beneficiaries and depending on the track, 17% to 24% lived in rural regions.
- The Assistance track saw higher rates of beneficiaries living in rural regions compared to the Alignment track. Medicaid beneficiaries in the Alignment Track in rural regions had a larger reduction in avoidable ED visits compared to urban regions ($p = 0.01$)

Latest evaluation information: [At-a-glance 2 pager](#), [Third Evaluation Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/ahcm>

[Advance Payment Accountable Care Organization \(ACO\) Model](#)

Aliases: Advance Payment ACO Model

Stage: No Longer Active

Summary

The Advance Payment Accountable Care Organization (ACO) model was an initiative to provide advance payments to entities like smaller practices and rural providers with limited financial capacity. The intent was to help these organizations participate in the Shared Savings Program (SSP) with financial support to build resources needed to improve care delivery. The model was active from 2012 to 2015.

Eligibility and rural-relevant requirements

To be eligible for the Advance Payment ACO Model, ACOs were required to:

- Participate in the Shared Savings Program,
- Assign at least 5,000 beneficiaries,
- Not include any inpatient facilities (and have total annual revenue less than \$50 million), or include Critical Access Hospitals and/or Medicare low-volume rural hospitals (and have total annual revenue less than \$80 million), and
- Not be co-owned by a health plan or insurer.

Timeline/key dates

Performance period start dates:

- First cohort on April 1, 2012
- Second cohort on July 1, 2012
- Third Cohort on January 1, 2013

Model concluded December 31, 2015

Payment model/funding

The Advance Payment ACO Model was funded by CMMI. Advanced payments were designed to provide both fixed and variable start-up costs. Each selected ACO participants received three types of payments:

- An upfront, fixed payment of \$250,000
- An upfront, variable payment of \$36 per historically assigned beneficiary
- A monthly payment of \$8 per historically assigned beneficiary for 24 months

ACOs receiving the advance payment had a repayment obligation to the Centers for Medicare & Medicare Services through generated shared savings in first and subsequent performance years, and any future agreement periods. Advance Payment ACO providers received Medicare fee-for-service payments and were eligible for shared savings.

Rural participation/impact

The model targeted organizations like small rural and physician-based organizations facing financial barriers to SSP participation. ACO applicants serving rural populations and a higher number of Medicare beneficiaries, and applicants with lower financial capacity, were favored in the application score criteria. The model had 35 participants.

Evaluation: [Final report](#)

Website: <https://innovation.cms.gov/innovation-models/advance-payment-aco-model>

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

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

Stage: No longer active; expanded nationally in 2021;

Summary

Authorized under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA 223), this program was 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 supported 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 prepare for a two-year demonstration program. The funding supported states' efforts to:

- Certify CCBHCs 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 areas. In participating states, CCBHCs were 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 were eligible to participate as official CCBHCs. Participating states could continue to certify clinics, though they would not be part of the program evaluation.
- CCBHCs had to be non-profit organizations, state operated clinics, Indian Health Service, or tribal organizations.
- CCBHCs had care coordination requirements which included partnerships with a variety of organizations including FQHCs, and some RHCs, to the extent such services were not provided directly through the CCBHC.

Timeline/key dates

- Selected states announced on December 31, 2016: Minnesota, Missouri, New Jersey, New York, Nevada, Oklahoma, Oregon, and Pennsylvania.
- Two-year demonstration programs began July 1, 2017.
- Congress extended this program to November 2019.
- All original participants were extended through November 30, 2020 under CMS waiver 1115.
- July 10, 2024: Participants in CCBHC state demonstration were permitted to add new CCBHCs using this [guidance](#).

Payment model/funding

- The program required states develop a Medicaid prospective payment system for CCBHC services.
- The match rate for CCBHCs was 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

- Rural providers could become a CCBHC if they met statute eligibility requirements and listed eligibility.
- A requirement of the 24 planning grants was to certify at least two CCBHCs in diverse areas, including rural communities.
- Telehealth/telemedicine and online services were eligible for inclusion.

Evaluation: [Fourth CCBHC Program Report to Congress, 2020](#)

Website: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/section-223>

Community Health Access and Rural Transformation (CHART) Model – Community Transformation Track

Aliases: CHART- Community Track, CHART

Summary

Community Health Access and Rural Transformation (CHART) Model was designed to allow rural communities to use innovative financial arrangements and leverage their operational and regulatory flexibility to better address health disparities. The CHART Community Transformation Track attempted to:

- Increase financial stability for rural providers through the use of new ways of reimbursing providers that provided up-front investments and predictable, capitated payments that paid for quality and patient outcomes;
- Remove regulatory burden by providing waivers that increased operational and regulatory flexibility for rural providers; and
- Enhance access to health care services by ensuring rural providers remained financially sustainable and offer additional services that address social determinants of health including food and housing.

January 2024 Update: Based on feedback received from Model stakeholders, as well as a lack of hospital participation, the CHART Model ended early on September 30, 2023. CMS believes that the lessons learned from the CHART Model will continue to aid in the development of a potential future rural health care model at the CMS Innovation Center. Supporting rural health remains a key priority, and CMS is actively examining additional ways to expand access to high-quality health care and address the unique needs and challenges in rural areas.

Eligibility and rural-relevant requirements

CMS awarded cooperative agreement funding to four entities who served as Lead Organizations: University of Alabama Birmingham, State of South Dakota Department of Social Services, Texas Health and Human Services Commission, and Washington State Healthcare Authority.

Timeline/key dates

- September 2021: Announced four cooperative agreements among four states and organizations
- Pre-Implementation Period: October 2021 – December 2022
- February 2022, CMMI removed a planned Accountable Care Organization (ACO) Track from the CHART model
- November 2022: Announced insufficient participation to proceed with the first Implementation year
- September 30, 2023: Model ended

Payment model/funding

- Lead Organizations received cooperative agreement funding to recruit Participant Hospitals, develop a community Transformation Plan, engage the state Medicaid agency and other aligned payers, convene an Advisory Council, and ensure compliance with Model requirements.
- Participant Hospitals would have received a predictable capitated payment amount (CPA) and opportunities for operational and regulatory flexibilities. CMS would have replaced Participant Hospitals' Fee for Service (FFS) claim reimbursement with biweekly payments that equal the annual CPA.
- The CHART CPA combined concepts from a global budget and from an ACO into a single hospital payment methodology with the CPA for Participant Hospitals calculated based on Medicare FFS revenue using historical expenditures for Eligible Hospital Services.
- By Performance Period 2 (CY 2024), each Lead Organization had to secure multi-payer alignment from the State Medicaid Agency. Multi-payer alignment from commercial payers was recommended but not required.

Rural participation/impact

CHART specifically targeted rural communities.

Website: <https://innovation.cms.gov/innovation-models/chart-model>

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

Community-Based Care Transitions Program (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 CCTP were to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, improve quality of care, reduce readmissions for high-risk beneficiaries, and document measurable savings to the Medicare program.

Eligibility and rural-relevant requirements

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

- There were 18 participating sites involved in the Community-Based Care Transitions Program.
- 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.

Evaluation: [Final report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/CCTP>

Comprehensive Primary Care (CPC) Initiative

Aliases: Comprehensive Primary Care (CPC)

Stage: No longer active

Summary

The Comprehensive Primary Care (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 was [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, range 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 October 2012 and ended in December 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 were 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 percentage of rural populations for CPC regions ranged from 5-44%; some of the areas had significant rural populations despite being metropolitan areas (example: Greater Tulsa had 36% rural beneficiaries).
- Since the model focused on primary care payments from Medicare Part B, RHCs and FQHCs were ineligible because they are paid on a fee schedule.
- There were 442 CPC practice sites distributed across seven CPC regions.
- 2,188 participating providers served approximately 2,700,000 patients, of which approximately 410,177 were Medicare & Medicaid beneficiaries.

Evaluation: [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-initiative>

Comprehensive Primary Care Plus (CPC+)

Aliases: CPC+

Stage: No Longer Active

Summary

The Comprehensive Primary Care Plus (CPC+) was a national advanced primary care medical home model that aimed to strengthen primary care through regionally based multi-payer payment reform and delivery transformation. The program included two practice tracks with incrementally advanced delivery requirements and various payment options.

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) were selected for Round 2.
- 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.
- CPC+ met the criteria for an Advanced Payment Model (APM) under the [Quality Payment Program \(QPP\)](#).

Timeline/key dates

- CPC+ was a five-year model that began in 2017.
- Round 1 performance period was January 1, 2017 – December 31, 2021.
- Round 2 performance period was originally slated January 1, 2018 – December 31, 2022, but in spring 2021 it was announced that both cohorts would end December 31, 2021.

Payment model/funding

CPC+ included three payment elements:

1. **Care Management Fee (CMF):** Both tracks provided 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 paid and retrospectively reconciled a performance-based incentive based on how well a practice performed on patient experience measures, clinical quality measures, and utilization measures that drove total cost of care.
 - Performance-Based Incentives: Track 1 received \$2.50 PBPM; Track 2 received \$4 PBPM.
3. **Payment under the Medicare Physician Fee Schedule:**
 - Track 1 continued to bill and receive payment from Medicare FFS as usual.
 - Track 2 practices also continued to bill as usual, but the FFS payment was reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which were paid in a lump sum on a quarterly basis absent a claim.

Rural participation/impact

In 2021 there were [2,610 primary care practices](#) participating in Comprehensive Primary Care Plus (CPC+) in 18 regions, supported by 52 aligned payers.

- No specific rural focus, but Round 1 participation regions encompassed many rural areas including the states of AR, CO, HI, MI, MT, OH, OK, OR, OH, (and northern KY). Round 2 participation regions included LA, NE, ND, and Erie and Niagara Counties of NY.
- Since the model focused on primary care payments from Medicare Part B, RHCs and FQHCs were ineligible because they were paid on a fee schedule.

Evaluation (most recent): [At-a-glance 2-pager](#), [Full report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus>

Emergency Triage, Treat, and Transport (ET3) Model

Aliases: ET3

Summary

Emergency Triage, Treat, and Transport (ET3) was a voluntary, five-year payment model that provided greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service (FFS) beneficiaries following a 911 call. CMS continued to pay to transport a Medicare FFS beneficiary to a hospital emergency department or other covered destination. In addition, under the model, CMS paid participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. The ET3 Model ended early on December 31, 2023, two years prior to the performance period end date. This decision was made due to lower than expected participation and lower than projected interventions. Emergency Medical Services remain an area of focus for CMS, they believe that the lessons learned from the ET3 Model can aid in the development of potential future initiatives.

Eligibility and rural-relevant requirements

The Participants of the ET3 Model were Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers. Upon arriving on the scene of a 911 response, participating ambulance suppliers and providers triaged Medicare FFS beneficiaries to one of the model's interventions. As part of a multi-payer alignment strategy, the Innovation Center encouraged ET3 Model participants to partner with additional payers, including state Medicaid agencies, to provide similar interventions to all people in their geographic areas.

Timeline/key dates

- The selection of applicants was announced on February 27, 2020.
- In response to the COVID-19 PHE, on April 8, 2020, CMS delayed the start of the ET3 Model.
- The model launched on January 1, 2021
- The program closed early on December 31, 2023.

Payment model/funding

- In addition to reimbursement for transport to a hospital or ED, CMS paid 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 did not receive additional funding beyond model payments for eligible services.
- For the duration of COVID-19 PHE, CMS temporarily expanded the list of allowable destinations for ambulance transports. Participants in the model were able to continue to access these flexibilities while participating in the model, for as long as they were available.

Rural participation/impact

There were 31 participants that included at least one non-metropolitan county in their service area. Organizations from 36 different states participated in the ET3 Model.

Evaluation Report (most recent): [At-a-glance two-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/et3>

Frontier Extended Stay Clinic (FESC) Demonstration

Aliases: FESC Demonstration

Stage: No Longer Active

Summary

Frontier Extended Stay Clinic (FESC) demonstration allowed remote clinics to provide extended-stay care, including overnight stays, for patients who required monitoring and observation but did not require hospitalization, or for patients that could not be transferred to acute care hospitals due to adverse weather conditions or other reasons. The demonstration targeted remote clinics that provided brief day-time outpatient patient visits with diagnosis and treatment services. The program was mandated by Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act for three years and had five participants.

Eligibility and rural-relevant requirements

Clinics located at least 75 miles from the closest short-term acute care hospital or Critical Access Hospital, or clinics that were inaccessible by public road were eligible. Conditions of participation included:

- **Staffing requirements:** A physician, a nonphysician provider, or a registered nurse must be on call or onsite 24 hours a day, seven days a week. The on-call clinician must arrive on site within 30 minutes of a patient's after-hours arrival. When the clinic has one or more extended stay patients, there must be a clinical staff on site. No more than four extended stay patients could be treated at one time in a clinic.
- **Facilities and Services:** Extended stay facilities were required to follow ambulatory health care occupancy life safety codes suitable for operating as observation and emergency facilities for up to 48 hours.
- **Administrative Procedures:** Extended stay facilities were required to have either formal agreements or transfer arrangements with acute care hospitals. Clinics were required to have a clinical records system and patient medical report transfer mechanism in place. They were also required to develop a quality assessment and performance improvement program.

Timeline/key dates:

- The first site began Demonstration on April 15, 2010.
- Demonstration ended on April 15, 2013.
- The Report to Congress was posted on November 24, 2014.

Payment model/funding

The Consolidated Appropriations Act of 2004 provided annual capacity-building grant funding, which was administered by FORHP, to support eligible outpatient clinics for establishing infrastructure, administrative and staffing resources. The Public Health Service Act from HRSA provided additional grant funding to Federally Qualified Health Clinics. HRSA administered the funds through a cooperative agreement with Alaska FESC Consortium.

The Centers for Medicare and Medicaid Services (CMS) established a wage-adjusted FESC bundled payment rate per 4-hour unit of time for stays longer than 4 hours with maximum stay of 48 hours. The payment rate was based on Medicare's wage-adjusted hospital outpatient prospective payment rates for observation bed stays. The Alaska Medicaid program also implemented higher payment rates for extended stay services based on all-inclusive ambulatory visit payment rates. Extended stays were qualified for payment if:

- Adverse weather conditions or other factors prevented transfer of patients to an acute care hospital.
- Patients needed extended monitoring and observation for a limited time period that did not require hospitalization.

The FESC legislation required the demonstration to be budgeted neutral to the Medicare program.

Rural participation/impact

The demonstration was designed for rural remote clinics.

Evaluation: [Final report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/frontier-extended-stay-clinic>

Global and Professional Direct Contracting (GPDC) Model

Aliases: GPDC, Direct Contracting Model, DCEs, DC Global, DC Professional

Summary

CMS redesigned the GPDC Model renamed the [ACO REACH Model](#).

The Global and Professional Direct Contracting (GPDC) model was a voluntary, Accountable Care Organization (ACO) model designed to put patients at the center of their care. It built on the previous CMS ACO initiatives, including the [MSSP](#) and [NexGen](#) Models, and individualized attention to a beneficiary's specific health care needs within Original Medicare while changing financial incentives to reward high quality care. GPDC established 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. A key aspect of the GPDC Model was providing new opportunities for a variety of different health care organizations to participate in value-based care arrangements in Medicare FFS. The GPDC Model benefited participating organizations by reducing practices' administrative burden, allowing health care providers greater flexibility in how they delivered care, and rewarding them for improving quality. Types of DCEs included:

- Standard DCEs – DCEs composed of organizations that generally had experience serving Medicare FFS beneficiaries.
- New Entrant DCE – DCEs composed of organizations that had not traditionally provided services to a Medicare FFS population.
- High Needs Population DCEs – DCEs that served Medicare FFS beneficiaries with complex needs.

In February 2022, CMS announced cancelation of the [Geographic Direct Contracting Model](#), which had been on hold since March 2021.

Eligibility and rural-relevant requirements

- Eligible providers included providers in group practice, networks of individual practices of providers, hospitals employing providers, FQHCs, RHCs, and CAHs.
- Must have had an identifiable governing body with the authority to execute functions and make final decisions for the DCE, with at least 25% of control being held by participating providers or their designated representatives.
- Current GPDC Model participants that maintained a strong compliance record and agreed to meet all the ACO REACH Model requirements by January 1, 2023 could continue participating in the ACO REACH Model.

Timeline/key dates

- The GPDC Model began in 2020 with an initial implementation period for organizations that wanted to align beneficiaries to meet the minimum beneficiary requirements prior to the start of the first performance year, which began April 1, 2021. The performance period ended December 31, 2022.
- The GPDC Model transitioned to the new ACO REACH Model on January 1, 2023.

Payment model/funding

Two voluntary risk-sharing options:

- *Professional* offered a lower risk-sharing arrangement of 50% savings/losses. It provided Primary Care Capitation, a risk-adjusted monthly payment for primary care services provided by DCE's participating providers.
- *Global* offered a higher risk sharing arrangement of 100% savings/losses. It provided two payment options: Primary Care Capitation (described above) or Total Care Capitation, a risk-adjusted monthly payment for all covered services, including specialty care, provided by DCE's participating providers.

Current rural participation/impact

RHCs and CAHs were included on the lists of potentially eligible participants and may have been included in DCE provider networks. In PY 2022, 5.9% of Standard DCE, 2.0% of New Entrant DCE, and 3.8% of High Needs DCE beneficiaries resided in rural ZIP codes.

Evaluation Report (most recent): [At-a-glance two-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model>

[Home Health Value-Based Purchasing \(HHVBP\) Model](#)

Aliases: HHVBP Model

Stage: No Longer Active, expanded nationally under the [Expanded Home Health VBC Model](#)

Summary

The Home Health Value-Based Purchasing (HHVBP) model was one of the Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models in Section 3021 of the Affordable Care Act. It required 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 were 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 were 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 were compared to previous performance on these measures and to the performance of other home health agencies on these measures within each HHA's respective state. Payments were adjusted by up to a seven 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 included 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 effective on January 1, 2016 and terminated December 31, 2021.
- On January 8, 2021, [CMS announced intent to expand](#) the HHVBP model nationally.
- In November 2021, CMS published the CY 2022 Home Health Proposed Payment System Final Rule which expanded the HHVBP nationally, and ended the HHVBP Model one year early for the HHAs in the nine original Model states.
- The [Expanded HHVBP model](#) begins in CY 2022 with a pre-implementation year. The first performance period will be CY 2023.

Payment model/funding

This model adjusted (either upward or downward) 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.

Rural participation/impact

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

- Rural beneficiaries made up 6.4% of home health beneficiaries across all participating HHVBP states.
- Smaller HHAs, which are more common in rural areas, were shown to demonstrate greater quality improvement.
- 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 had the largest percentage of rural home health beneficiaries (24.6%).
- 1,907 home health agencies were in operation, 2,077,228 home health episodes were provided, and 734,951 Medicare FFS beneficiaries were covered across all participating HHVBP states.

Evaluation (most recent): [At-a-glance-2-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/home-health-value-based-purchasing-model>

Independence at Home

Aliases: IAH

Summary

Through the Independence at Home (IAH) Demonstration CMMI worked 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.

Selected primary care practices provided home-based primary care to targeted chronically ill beneficiaries for a three year period. Participating practices made in-home visits tailored to an individual patient's needs and coordinated their care. CMS tracked the beneficiary's care experience through quality measures. Practices that succeed in meeting these quality measures while generating Medicare savings had an opportunity to receive incentive payments after meeting a minimum savings requirement.

Eligibility and rural-relevant requirements

Participation in the home-based care demonstration was voluntary for Medicare beneficiaries. As part of their application, the participating practices were required to demonstrate experience providing home-based primary care to high-cost chronically ill beneficiaries. Participating practices included primary care practices and other multidisciplinary teams that were:

- Led by physicians or nurse practitioners
- Had experience providing home-based primary care to patients with multiple chronic conditions
- Served at least 200 eligible beneficiaries.

Beneficiaries were eligible to participate if they have two or more chronic conditions, required human assistance with at least two activities of daily living, had been hospitalized and received acute or subacute rehabilitation services in the prior 12 months, were enrolled in Medicare FFS, and were not in long-term care or hospice at the time of enrollment in the demonstration.

Timeline/key dates

- Two separate cohorts selected for implementation between 2012 – 2015.
- An initial extension was authorized through 2017. A second, 2-year extension authorized in 2018, and a third extension in 2020 authorized the program through December 31, 2023
- Program ended December 31, 2023.

Payment model/funding

- Participating practices were eligible for financial incentives if they succeed in offering high quality care that reduced costs for the Medicare program. To qualify for an incentive payment, the expenditures for participating beneficiaries needed to be lower than the calculated target expenditure, which represented the expected Medicare FFS expenditures of participating beneficiaries in the absence of the Demonstration. Practices were required to meet stringent quality standards and ensure that financial targets were met.
- In Year 2, CMS modified the shared savings methodology to improve the comparability between the demonstration and matched comparison beneficiaries.

Rural participation/impact

- All 14 of the originally participating primary care practices were in urban areas. Seven were in Health Professional Shortage Areas and.
- Nine sites continued to participate in the original extension periods.
- As of January 2023, there was just one participating site involved in the Independence at Home Demonstration.

Evaluation (most recent): [At-a-glance-2-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/independence-at-home>

Making Care Primary Model

Aliases: MCP

Summary

The Making Care Primary (MCP) Model was a voluntary primary care model launched in July 2024 in eight states: Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington. It was designed as a multi-payer model with three participation tracks that build upon previous primary care models, such as the Comprehensive Primary Care (CPC), CPC+, Primary Care First (PCF), and the Maryland Primary Care Program (MDPCP). It was intended to provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration, address patient's health related-social needs. The MCP included three domains: 1) Care Management, 2) Care Integration, and 3) Community Connection.

Eligibility and rural-relevant requirements

- Be a legal entity formed under applicable state, federal, or Tribal law authorized to conduct business in each state in which it operates.
- Be Medicare-enrolled, and bill for health services for a minimum of 125 attributed Medicare beneficiaries.
- Have the majority (at least 51%) of their primary care sites located in an MCP state.
- Federally Qualified Health Centers (FQHCs) are eligible to participate
- Rural Health Clinics (RHCs), current Primary Care First (PCF) practices, current ACO REACH Participant Providers, and Grandfathered Tribal FQHCs were **not** eligible to participate.
- Organizations could not concurrently participate in the Medicare Shared Savings Program (SSP) and MCP after the first six months of the model. Organizations can apply to rejoin an SSP ACO after participation in MCP.

Timeline/key dates

- July 1, 2024 – Program starts
- In March 2025, CMS announced that MCP will end early – at the end of 2025 – rather than run the originally planned 10.5 years.

Payment model/funding

MCP was a multi-payer model where participants choose from three progressive tracks based on their experience in value-based care. Track 1 was reserved for organizations with no prior value-based care experience.

- **Track 1 –Building Infrastructure:** Participants develop the foundation to implement advanced primary care services. Payment for primary care is fee-for-service (FFS). CMS provides additional financial support to help develop care transformation infrastructure and advanced care delivery capabilities.
- **Track 2 – Implementing Advanced Primary Care:** Participants build upon track 1 requirements by partnering with social service providers and specialists, implementing care management services, and systematically screening for behavioral health conditions. Payment for primary care shifts to a 50/50 blend of prospective, population-based payments and FFS payments. CMS provides additional financial support at a lower level than Track 1 to support building advanced care delivery capabilities.
- **Track 3 – Optimizing Care and Partnerships:** Participants expand upon the requirements of Tracks 1 and 2 by using quality improvement frameworks to optimize and improve workflows, address silos to improve care integration, develop social services and specialty care partnerships, and deepen connections to community resources. Payment for primary care shifts to fully prospective, population-based payment. CMS provides financial support at a lower level than Track 2 to sustain care delivery activities.

Participants could also earn financial rewards for improving patient health outcomes in each track.

Website: <https://innovation.cms.gov/innovation-models/making-care-primary>

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 to reduce costs and improve 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.
- Total per beneficiary per month (PBPM) expenditures for Medicare beneficiaries declined by \$16.60 more in Maryland than in the comparison group, resulting in an aggregate \$293 million savings to Medicare during the first 2 years of the model.
- 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.

Evaluation: [At-a-glance 2 pager](#), [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model>

Medicare Care Choices Model

Aliases: MCCM

Stage: No Longer Active

Summary

The Medicare Care Choices Model (MCCM) provided Medicare beneficiaries who qualified for coverage under the Medicare hospice benefit the option to receive hospice like services while continuing to receive curative services. Beneficiaries who were dually eligible for Medicare and Medicaid were also included. The goal of the MCCM was to determine whether access to this type of service would improve quality of care, 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 was dual eligible beneficiaries, who were eligible for Medicare or Medicaid hospice benefits. Participation in the model was 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 have been 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 continued until June 30, 2020
- June 25, 2020 – Announced that Model extended an additional year, through 2021
- Model concluded for Cohorts 1 and 2 on December 31, 2021.

Payment model/funding

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

Rural participation/impact

- 141 Medicare-certified hospices from both urban and rural geographic areas initially participated in the model. 37 withdrew from participation by the end of 2017. There were 43 hospices active in 2019 for Cohort 1 and 42 active for Cohort 2.
- 7,263 Medicare beneficiaries enrolled in MCCM, all qualifying for hospice. Lengths of enrollment varied widely, with a median of about 2 months. About 89% of enrollees died before the model ended.
- MCCM reduced Medicare expenditures and use of acute care services. Enrollees had 26 percent fewer inpatient hospital admissions and 12 percent fewer outpatient emergency department visits and observation stays than beneficiaries in the comparison group. Further, net expenditures decreased by \$7,604 per MCCM enrollee (13%).
- MCCM enrollees were more likely to receive better quality of end-of-life care in the period between enrollment and death. For example, deceased MCCM enrollees were less likely than comparison beneficiaries to receive an aggressive life-prolonging treatment in the last 30 days of life (61% versus 76%).

Evaluation (most recent): [At-a-glance-2-pager](#) [Full Report](#)

Website/contact Info: <https://www.cms.gov/priorities/innovation/innovation-models/medicare-care-choices>

Medicaid Incentives for the Prevention of Chronic Diseases Model (MIPCD)

Aliases: MIPCD program

Stage: No Longer Active

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.

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 and Nevada used telehealth to reach participants living in rural areas.

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.

- About three-quarters of survey respondents strongly agreed that they were happy with the incentives overall and most strongly agreed that the incentives were fair (73 percent) and that they liked getting incentives for taking good care of their health (78 percent).
- Because chronic diseases develop slowly and our evaluation only lasted 5 years, we were not able to directly measure whether the MIPCD programs prevented chronic diseases. However, we can infer whether long-term effects on chronic diseases are possible based on the short-term health outcomes (e.g., smoking cessation, weight loss) reported in State evaluation reports.

Evaluation: [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/mipcd>

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 Medicare Shared Savings Program (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. 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 3years 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 Clinics and 421 Critical Access Hospitals were participating in ACOs.

Website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram>

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

Aliases: Million Hearts®

Stage: No Longer Active

Summary

The Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model was a randomized controlled trial that sought 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. The Model used data-driven, widely accepted predictive modeling approaches to generate individualized risk scores, and mitigation plans for eligible Medicare FFS beneficiaries. The model used 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 met the cardiovascular disease risk factor inclusion criteria.
- Evidenced-based risk modification that used 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 was provided as part of the model test.

Eligibility and rural-relevant requirements

- The types of providers participating in the model included but were 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 were 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 were randomly assigned to be part of a control group or intervention group.

Timeline/key dates

- The CVD Risk Reduction Model took place over 5 years, from January 2017 to December 2021.

Payment model/funding

The control group had a one-time payment of \$20/beneficiary to off-set costs of data collection and submission while the intervention group had two payments:

- Cardiovascular Disease Risk Stratification payment: participants received a one-time \$10 per-beneficiary payment for each eligible beneficiary that was assessed for CVD risk.
- Cardiovascular Care Management (CVD CM) payment: ongoing monthly CVD CM payments were 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 received a monthly \$10 CVD CM payment for each high-risk FFS. For years 2–5 of the model, participants received 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 were participating in the model. Key findings include:

- Over five years, the model reduced the incidence of first-time heart attacks and strokes by 3 to 4 percent, preventing one or more events per 400 high- and medium-risk beneficiaries enrolled, and reduced the all-cause death rate.
- The model improved CVD risk factors, such as blood pressure and cholesterol levels, and decreased CVD risk scores for high-risk beneficiaries within one year of enrollment.

Evaluation (most recent): [At-a-glance-2-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/million-hearts-cvdrmm>

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 Multi-payer Advanced Primary Care Practice demonstration evaluated whether advanced primary care practice reduced unjustified utilization and expenditures, improved the safety, effectiveness, timeliness, and efficiency of health care in participating states: 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.

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 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.

Rural participation/impact

- All states had rural practice participation, ranging from 3 percent in MI to 68 percent in NC.
- 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.
- Among rural Medicare beneficiaries, ER visits not leading to hospitalization increased by 3,969 visits among Blueprint for Health beneficiaries compared to rural beneficiaries in non-PCMH practices.

Evaluation: [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/multi-payer-advanced-primary-care-practice>

Next Generation ACO (NGACO) Model

Aliases: NGACO, Next Gen ACO

Stage: No longer active

Summary

Next Generation ACO (NGACO) aimed to encourage experienced ACOs to assume higher levels of financial risk and rewards than were available under other [MSSP](#) and the [Pioneer ACO Model](#). Provider participation in ACOs was purely voluntary, and participating patients saw no change in their Medicare benefits and kept their freedom to see any Medicare provider. The model allowed these provider groups to assume higher levels of financial risk and reward than were available under their previous ACO model. The goal was to test whether strong incentives coupled with patient engagement and case management support tools improved outcomes and increased savings over traditional fee-for-service reimbursement. The Model was associated with larger spending reductions for beneficiaries with multiple chronic conditions and those with prior hospitalizations.

Eligibility and rural-relevant requirements

- Participation was open to previous participants of MSSP and Pioneer, along with other qualifying organizations.

Timeline/key dates

- Launched in January 2016 with 18 ACOs, 41 ACOs currently participating
- Originally scheduled to end in 2020, was extended through 2021

Payment model/funding

- Participating ACOs assumed 80 or 100 percent upside and downside risk.
- ACOs selected a payment mechanism on an annual basis from the following options:
 - FFS
 - FFS plus a Per-Beneficiary Per-Month (PBPM) infrastructure payment
 - Population-Based Payment (same as [Pioneer Model](#))
 - All Inclusive Population-Based Payments (AIPBP) a capitation style mechanism called All Inclusive Population-Based Payments (AIPBP), which functioned by estimating total annual care expenditures and paid the ACO per-beneficiary/per-month payment
- If the projected trend was substantially different from the experienced trend, CMS would adjust the payment to shield participants against external price shifts.
- A variety of benefit enhancements were available for beneficiaries including:
 - Post Discharge Home Visits
 - Care Management Home visits
 - Telemedicine
 - Skilled Nursing Facility Three-Day Rule Waiver
 - Part-B cost sharing (allows waiver of co-pay and deductible for specific services)
 - Gift Card incentives for chronic care management

Rural participation/impact

- Regional efficiency trend adjustments ensured participating providers received adequate compensation for services provided in regions that were experiencing major payment changes beyond their control.
- No specific rural focus. However, ACOs with a rural presence were among participants.
- The NGACO Model reduced gross, but not net Medicare Parts A and B spending for its aligned beneficiaries.
- Spending reductions grew larger almost every year, reflecting NGACOs' improvements in infrastructure and clinical processes, exit by poorer-performing NGACOs, and the COVID-19 pandemic.

Evaluation (most recent): [At a glance 2-pager](#), [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/next-generation-aco-model>

Part D Enhanced Medication Therapy Management Model

Aliases: Enhanced MTM Model

Stage: No Longer Active

Summary

The Part D Enhanced Medication Therapy Management (Enhanced MTM) model tested whether providing Part D sponsors with additional payment incentives and allowing for regulatory flexibilities would improve therapeutic outcomes and reduce net Medicare expenditures. Payment incentives included 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 flexibility was intended to allow for more individualized and risk-stratified interventions. Beneficiary enrollment across participating sponsors' Enhanced MTM PBPs remained stable at about 1.9 million through the first three Model Years and decreased to about 1.7 million in Model Year 4.

Eligibility and Rural-relevant Requirements

To participate in the Enhanced MTM model, a plan had to be an individual market standalone basic plan, had a minimum enrollment of 2,000, had 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 concluded December 31, 2021.
- Participants for the model were chosen in August 2016.

Payment model/funding

CMS offered 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.

Rural participation/impact

- There were 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 were responsible for designing the eligibility requirements for beneficiaries to participate in the MTM program, as well as specific intervention activities. No specific rural focus was included, though Model Participants included highly rural states in their covered regions.
- Eleven out of 22 participating plans were eligible to receive the performance-based payment because their medical spending was reduced by 2 percent or more.
- Seven participating plans showed reductions in medical spending, but the reductions were less than 2 percent and therefore the plans are ineligible to receive the performance-based payment.
- Four plans showed increases in spending and were therefore ineligible to receive the performance-based payment. Estimated Enrollment across all participating plans in 2017 was 1.7 million beneficiaries.
- There were no statistically significant impacts on Medicare Parts A and B expenditures for the overall enrollee population in Model-participating plans.

Evaluation (most recent): [At-a-glance 2-pager](#), [Final Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/enhancedmtm>

[Pennsylvania Rural Health Model](#)

Aliases: PA Rural Health Model, PA RHM

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 aimed to improve health outcomes, while reducing the growth of hospital expenditures and promoting sustainability of rural Pennsylvania hospitals. Payment under the model was based on all-payer global budgets, where payment amounts were pre-established for hospital payments and paid monthly by Medicare and other payers. Pennsylvania's rural hospitals, who had to volunteer to participate, were expected to redesign their care delivery to increase quality of care and meet the needs of their local communities. The model tested whether predictable global budgeting, for both inpatient and outpatient hospital-based services, allowed 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 were eligible, as well as other payers including Medicare, Medicaid and commercial plans.
- For this model, Pennsylvania and CMS defined 'rural' as a county with less than 284 people per square mile, which is the definition used by the Pennsylvania General Assembly.
- Participation was phased in over the first four performance years with an initial goal of 30 hospitals participating by year four of the seven-year program.
- Participating hospitals had to develop and submit a Rural Hospital Transformation Plan to the Pennsylvania Department of Health and CMMI.

Timeline/key dates

- The Model ran for seven performance years (PYs), between January 12, 2018 and December 31, 2024, with the first performance year (PY0) being a pre-implementation period.
- During PY0 – PY4 (2018- 2022) CMS provided funding to the state, the state recruited the participant hospitals and established participation agreements, and rural hospitals developed their Rural Hospital Transformation Plans.
- For PY5 and PY6, activities included continued transformation planning and global budget administration for the participant hospitals.
- Prospectively set, all-payer global budgeting payments occurred in PY1-PY6 (2019-2024).

Payment model/funding

- CMS committed to providing up to \$25 million to Pennsylvania over five years to implement the model.
- The State calculated the global budgets and submitted them to CMS for review and approval.
- The model included commercial and Medicaid participation. Pennsylvania aimed to have 75 percent of participating hospital eligible revenues coming from global budgeting by PY1 (2019) and 90 percent for later performance years.
- Pennsylvania agreed 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 represented the compound annual growth rate for Pennsylvania's gross state product from 1997 to 2015.
- Pennsylvania committed to achieving \$35 million in Medicare hospital savings from the rural participants over the course of the model.

Rural participation/impact

The model was developed specifically for rural hospital participation and 18 rural hospitals participated

Evaluation (most recent): [At-a-glance 2-pager](#), [Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model>

Pioneer Accountable Care Organization (ACO) Model

Aliases: Pioneer Accountable Care Organization

Stage: No Longer Active

Summary

The Pioneer Accountable Care Organization (Pioneer ACO) 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). Model concluded after performance year 5.

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.
- 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.

Evaluation: [Final Report At-a-Glance 2-pager](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/pioneer-aco-model>

[Primary Care First](#)

Aliases: CMS Primary Care Initiative, PCF

Summary

Primary Care First (PCF) was a voluntary payment model designed to support delivery of advanced primary care. Built on the underlying principles of the [CPC+ model](#), PCF emphasized the priority of the doctor-patient relationship, enhanced care for patients with complex chronic health needs, and financial incentives to improve health outcomes. The model implemented a set of voluntary payment structures to support delivery of advanced primary care. In Primary Care First, CMS used a focused set of clinical quality and patient experience measures to assess quality of care delivered at the practice. A PCF practice was required to meet standards that reflect quality care to be eligible for a positive performance-based adjustment to their primary care model payments.

To amplify the impact of the model, PCF was designed as a multi-payer model. Payer partners committed to aligning with the model's payment methodology, quality measurement strategy, and data sharing approach to align resources and incentives across a participating practice's entire patient population.

Eligibility and rural-relevant requirements

Participation was open to primary care practices with advanced primary care capabilities that meet the following:

- Located in one of the 26 selected regions
- Include primary care practitioners certified in internal medicine, general medicine, geriatric medicine, family medicine, hospice, and palliative medicine
- Provide primary care health services to at least 125 attributed Medicare beneficiaries at a particular location
- At least 50% of collective billing based on revenue is accounted for by primary care services
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance
- Use 2015 Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE)
- Demonstrate a set of advanced primary care delivery capabilities via questions in the Practice Application

Timeline/Key Dates

- Primary Care First included two cohorts of participating practices: Cohort 1 began in January 2021, and Cohort 2 began in January 2022. In March 2025, CMS announced that PCF will end as of December 31, 2025 (one-year early)
- November 2021 – CMS announced the proposed Seriously Ill Population (SIP) component for PCF will not be implemented.

Payment model/Funding

- PCF included a hybrid total primary care payment that included a population based PMPM payment for attributed beneficiaries (adjusted by risk based on HCC scores), a flat per visit fee, and a performance-based adjustment providing an upside of up to 50% of model payments as well as a small downside (negative 10% of model payments) incentive, which applied to the entire practice, as well as to multi-specialty practices.
- A PCF practice was required to meet standards that reflect quality care in order to have been eligible for a positive performance-based adjustment to their primary care model payments.

Current rural participation/impact

- [PCF participation](#) was available in 26 regions; several regions are statewide and include rural areas. There are approximately 1,717 practices participating in Primary Care First across both cohorts, and 20 payer partners.
- Federally Qualified Health Centers and Rural Health Clinics are excluded from participating in PCF.

Latest evaluation information: [At-a-glance-2-pager Full Report](#)

Website: <https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options>

Value in Opioid Use Disorder Treatment Demonstration Program

Aliases: Value in Treatment

Summary

Value in Opioid Use Disorder Treatment Demonstration Program (Value in Treatment) is a 4-year demonstration program authorized under section 1866F of the Social Security Act (Act). The purpose of the demonstration is to increase access of Medicare beneficiaries to opioid use disorder (OUD) treatment services, improve physical and mental health outcomes, and reduce expenditures.

Value in Treatment will test whether the demonstration: reduces hospitalizations and emergency department (ED) visits; increases use of medication assisted treatment (MAT) for OUD; improves health outcomes for individuals with OUD, including reducing the incidence of infectious diseases such as Human Immunodeficiency Virus (HIV) and hepatitis C (HCV); reduces deaths from opioid overdose; reduces utilization of inpatient residential treatment; and reduces Medicare program expenditures to the extent possible.

Eligibility and rural-relevant requirements

Entities and individuals enrolled in Medicare, who applied for and were selected to participate in the demonstration program, who established an OUD care team and used such team to furnish or arrange for OUD treatment services in the outpatient setting under the demonstration, and who were one of the following types of individuals or entities:

- Physician
- Group practice comprised of at least one physician
- Hospital outpatient department
- Federally Qualified Health Center
- Rural Health Clinic
- Community mental health center
- Opioid treatment program
- Critical Access Hospital
- Certified Community Behavioral Health Clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014

Timeline/key dates

- April 2021 – Selected participants announced, and first performance period began
- December 31, 2024 – End of performance period

Payment model/funding

The demonstration made \$10,000,000 available from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act each of fiscal years 2021-2024 for demonstration payments.

Value in Treatment created two new payments for OUD treatment services furnished to applicable beneficiaries:

1. **A per beneficiary per month care management fee (CMF)**, which the participant used to “deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under [Title XVIII];” and
2. **A performance-based incentive**, which was payable based on the participant’s performance with respect to criteria specified by CMS, including evidence-based medication-assisted treatment (MAT), as well as patient engagement and retention in treatment.

Services had to be based on an applicable beneficiary’s individualized OUD treatment plan. Applicable beneficiaries had a current diagnosis for OUD, were enrolled under Medicare Part A and Part B, and were not enrolled in a Medicare Advantage plan. Applicable beneficiaries included those dually eligible for Medicare and Medicaid if the criteria above were also met.

Current rural participation/impact

The demonstration was open to providers (FQHCs, RHCs, CAHs, and others) that met eligibility requirements. Participants were in 36 states and District of Columbia and included FQHCs, behavioral health clinics, group practices, one Rural Health Clinic, and opioid treatment programs. Selected participants can be found [here](#).

Evaluation (most recent): [At a Glance report](#) ; [Full Report](#)

Website: <https://innovation.cms.gov/innovation-models/value-in-treatment-demonstration>

Appendix 3 – Commonly Used Acronym List

ACA	Affordable Care Act
ACO	Accountable Care Organization
APM	Alternative Payment Model
CAH	Critical Access Hospital
CDC	Centers for Disease Control and Prevention
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis Related Group
EHR	Electronic Health Record
ECE	Extraordinary Circumstance Exception
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HHS	Department of Health and Human Services
HIT	Health Information Technology
IPPS	Inpatient Prospective Payment System
MSAs	Metropolitan Statistical Areas
MSSP	Medicare Shared Savings Program (also known as SSP)
PCP	Primary Care Provider/Physician
PHE	Public Health Emergency
PMPM	Per Member per Month
PBPM	Per Beneficiary Per Month
PY	Performance Year
RHC	Rural Health Clinic
SSP	Medicare Shared Savings Program (also known as MSSP)