Catalog of Value-Based Initiatives for Rural Providers

UPDATED 03/2022

For more information about the Rural Health Value project, contact:
University of Iowa | College of Public Health | Department of Health Management and Policy
www.RuralHealthValue.org | cph-rupri-inquiries@uiowa.edu | (319) 384-3831

This resource was developed with funding from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $500,000 with 0% financed with non-governmental sources. The contents are those of the authors(s) do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.
# Table of Contents

Introduction .......................................................................................................................... 1  
Models and Programs by Category, Participation Requirement, and CMMI Stage ........................ 2  
Accountable Health Communities (AHC) Model .................................................................. 3  
Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model .......................................................... 4  
Bundled Payments for Care Improvement (BPCI) Advanced .................................................. 5  
Community Health Access and Rural Transformation (CHART) Model - Community Transformation Track .......................................................... 6  
Comprehensive Care for Joint Replacement (CJR) Model ...................................................... 7  
Diabetes Prevention Program (MDPP) Expanded Model ....................................................... 8  
Diabetes Self-Management Training (DSMT) ...................................................................... 9  
Emergency Triage, Treat, and Transport (ET3) .................................................................. 10  
Expanded Home Health Value-Based Purchasing (HHVBP) Model .......................................... 11  
Frontier Community Health Integration Project (FCHIP) Demonstration .............................. 12  
Global and Professional Direct Contracting (GPDC) Model .................................................. 13  
Hospital Acquired Conditions Reduction Program (HACRP) ................................................ 14  
Hospital Readmissions Reduction Program (HRRP) ............................................................ 15  
Hospital Value-Based Purchasing (VBP) Program ................................................................. 16  
Maryland Total Cost of Care (TCOC) Model ...................................................................... 17  
Medicare Shared Savings Program (Shared Savings Program) ................................................. 18  
Pennsylvania Rural Health Model ...................................................................................... 19  
Primary Care First ............................................................................................................. 20  
Quality Payment Program (QPP) ....................................................................................... 21  
Radiation Oncology Model .................................................................................................. 22  
Skilled Nursing Facility Value-Based Purchasing Program ................................................... 23  
Value in Opioid Use Disorder Treatment Demonstration Program ........................................ 24  
Vermont All-Payer ACO Model .......................................................................................... 25  

## Appendix 1: Value-Based Care Support Initiatives

- Health Care Payment and Learning Action Network (HCP LAN) ........................................ 26  
- Hospital Quality Improvement Contractor (HQIC) ............................................................ 26  
- Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) .................. 26  
- Quality Payment Program - Small Practice, Underserved, and Rural Support (QPP-SURS) ........................................................................ 27  

## Appendix 2 – Inactive Program Archive

- ACO Investment Model (AIM) ........................................................................................ 28  
- Advance Payment Accountable Care Organization (ACO) Model .................................... 29  
- Section 223 Demonstration Program for Certified Community Behavioral Health Clinics ........................................................................................................ 30  
- Community Based Care Transitions Program (CCTP) .................................................... 31  
- Comprehensive Primary Care (CPC) Initiative .................................................................. 32  
- Comprehensive Primary Care Plus (CPC+) ...................................................................... 33  
- Frontier Extended Stay Clinic (FESC) Demonstration ....................................................... 34  
- Home Health Value-Based Purchasing (HHVBP) Model ................................................... 35  
- Independence at Home Demonstration ............................................................................ 36  
- Maryland All-Payer Model ............................................................................................ 37  
- Medicare Care Choices Model ........................................................................................ 38  
- Medicaid Incentives for the Prevention of Chronic Disease Program (MIPCD) .................. 39
Introduction

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

Purpose

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

Inclusion Criteria

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

Program Descriptions

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

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

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

- If participation for those eligible is mandatory or voluntary, including clarification where participation is restricted to geographic areas,
- For models run by the Center for Medicare & Medicaid Innovation (CMMI), 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 CMMI Stage

<table>
<thead>
<tr>
<th>Active Model or Program</th>
<th>HCP LAN Category</th>
<th>Participation Requirement</th>
<th>CMMI Stage§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable Health Communities Model</td>
<td>2A</td>
<td>Voluntary</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model</td>
<td>4B</td>
<td>Voluntary</td>
<td>Accepting applications through April 22, 2022</td>
</tr>
<tr>
<td>Bundled Payments for Care Improvement Advanced</td>
<td>4A</td>
<td>Voluntary</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Community Health Access and Rural Transformation Model – Community Transformation Track</td>
<td>4B</td>
<td>Voluntary</td>
<td>Pre-Implementation</td>
</tr>
<tr>
<td>Comprehensive Care for Joint Replacement Model</td>
<td>4A</td>
<td>Mandatory</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Diabetes Prevention Program Expanded Model</td>
<td>1</td>
<td>Voluntary</td>
<td>Accepting applications, Ongoing</td>
</tr>
<tr>
<td>Diabetes Self-Management Training</td>
<td>1</td>
<td>Voluntary</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency Triage, Treat, and Transport</td>
<td>1</td>
<td>Voluntary</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Frontier Community Health Integration Project Demonstration</td>
<td>1</td>
<td>Voluntary</td>
<td>Demonstration Extended</td>
</tr>
<tr>
<td>Expanded Home Health Value-Based Purchasing Model</td>
<td>2C</td>
<td>Mandatory</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Global and Professional Direct Contracting Model</td>
<td>4B</td>
<td>Voluntary</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Hospital Acquired Conditions Reduction Program</td>
<td>2C</td>
<td>Mandatory</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospital Readmissions Reduction Program</td>
<td>2C</td>
<td>Mandatory</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospital Value-Based Purchasing Program</td>
<td>2C</td>
<td>Mandatory</td>
<td>N/A</td>
</tr>
</tbody>
</table>
| Maryland Total Cost of Care Model                                                       | 4B              | Mandatory (hospitals)
Voluntary (practices)¶                    | Accepting applications, Ongoing |
| Medicare Shared Savings Program                                                         | 3A/3B*          | Voluntary                 | N/A                          |
| Pennsylvania Rural Health Model                                                         | 4B              | Voluntary                 | Ongoing                      |
| Primary Care First                                                                     | 1/3A/4B*        | Voluntary                 | Ongoing                      |
| Quality Payment Program                                                                | 2A/2B/2C*       | Mandatory                 | N/A                          |
| Radiation Oncology Model                                                                | 4A              | Mandatory                 | On hold                      |
| Skilled Nursing Facility Value-Based Purchasing Program                                 | 2A              | Mandatory                 | N/A                          |
| Value in Opioid Use Disorder Treatment Demonstration Program                            | 2C/4A*          | Voluntary                 | Ongoing                      |
| Vermont All-Payer ACO Model                                                             | 3B              | Voluntary                 | Ongoing                      |

* 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
§ CMMI Stage Not Applicable (N/A) for programs run by the Center for Medicare & Medicaid Services (CMS)
Accountable Health Communities (AHC) Model

Aliases: AHC Model

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

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

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

**Timeline/key dates**
- As of October 2021, 28 organizations are participating in the Accountable Health Communities Model and all are participating in the assistance and alignment tracks. The list is available here: Awardees.
- CMS developed and released its Health-Related Social Needs Screening Tool in January 2018.
- Participant performance period launched May 1, 2017 and anticipated end date is April 30, 2022.

**Payment model/funding**
- The model provides 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 support the infrastructure and staffing needs of bridge organizations, and do not pay directly or indirectly for any community services.

**Current rural participation/impact**
Below is the current list of participants who have organizations from counties that are rural.

- Allina Health System, MN (1 out of 10)
- Partners in Health, Inc., Charleston, WV (34 out of 55)
- Danbury Hospital, Danbury, CT (1 out of 6)
- University of Kentucky Research Foundation, Lexington, KY (All are rural – 27 out of 27)
- St. Josephs Hosp. Health Ctr., Syracuse, NY (2 out of 5)
- Oregon Health & Science University, Portland, OR (5 out of 15)
- The Health Collaborative, Cincinnati, OH (3 out of 8)
- Mountain States Health Alliance, Johnson City, TN (10 out of 13)
- Rocky Mountain, HMO Grand Junction, CO (20 out of 21)
- MyHealth Access Network, Inc., OK (throughout the state)

**Latest evaluation information:** At-a-glance 2-pager, Full Report

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

PAGE UPDATED 12/2021
Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model

Aliases: REACH, REACH ACO

Summary
CMS has redesigned the Global and Professional Direct Contracting Model (GPDC) Model to advance health equity and encourage health care providers to coordinate care to improve the care offered to people with Medicare. The ACO REACH model makes changes to the GDPC model in three key areas: 1) Advancing health equity by testing an innovative payment approach to better support care delivery and coordination for patients in underserved communities including a focus on reducing health disparities, 2) Promoting provider leadership and governance through increased board representation requirements for providers and beneficiary advocates, and 3) 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 Medicare FFS beneficiaries.
- New Entrant ACOs – organizations with less experience serving a Medicare FFS population.
- High Needs Population ACOs – Organizations that serve Medicare FFS beneficiaries with complex needs.

Current GPDC Model participants that maintain a strong compliance record and agree to meet all the REACH ACO Model requirements by January 1, 2023 may continue participating as a REACH ACO.

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.
- 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.
- Participants must develop and implement a health equity plan to identify underserved communities and implement initiatives to reduce health disparities. Collection of beneficiary-reported demographic and social needs data is required.
- 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
- Application Period: March 7, 2022 – April 22, 2022
- REACH ACO Selection: June 2022
- Model will run from PY 2023 - 2026

Payment model/funding
Two voluntary risk-sharing options:
- Professional offers lower risk-sharing arrangement of 50% savings/losses. Provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for primary care services equal to 7% of the PY benchmark.
- Global offers highest risk sharing arrangement of 100% savings/losses. Provides two payment options: Primary Care Capitation (described above) or Total Care Capitation, a capitated, risk-adjusted monthly payment for 100% of total cost of care provided by Participant Providers and participating Preferred Providers.

The Model also includes a beneficiary-level Health Equity Benchmark Adjustment applied to ACOs serving higher proportions of underserved beneficiaries in order to mitigate the disincentive for ACOs to serve underserved patients by accounting for historically suppressed spending levels for these populations.

Current rural participation/impact
RHCs and CAHs are on the list of potentially eligible participants and may be included in REACH ACO networks.

Website: https://innovation.cms.gov/innovation-models/aco-reach
**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 will require downside financial risk of all Participants from the outset of the Model Performance Period.

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

- Eligible entities enrolled in Medicare
- Eligible entities not enrolled in Medicare

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

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

**Timeline/key dates**
- Cohort 1 launched October 1, 2018
- Cohort 2 launched January 1, 2020
- Program End Date December 31, 2023
- CMS has enacted specific COVID-19 related flexibilities for this demonstration. Read more [here](https://innovation.cms.gov/initiatives/bpci-advanced/).

**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 30 Inpatient, 3 Outpatient, and 1 multi-setting Clinical Episodes that are included in the payment model. Inpatient Clinical Episodes will begin with an inpatient admission to an acute care hospital and is called the Anchor Stay. Outpatient Clinical Episodes will begin at the start of an outpatient procedure and is called the Anchor Procedure. Medicare Severity-Diagnosis Related Group (MS-DRGs) used for identifying the Anchor stay and Healthcare Common Procedure Coding System (HCPCS) codes will be used for identifying the Anchor Procedure. Total duration of one Clinical Episode is 90 days of the Anchor Stay or the Anchor Procedure. This model qualifies as an Advanced APM as it requires the participant to bear downside risk from the outset. Payment is based on total-cost-of-care concept that involves total Medicare fee for services (FFS) payment, for all services and items provided during the Clinical Episode, plus outlier payments that are reconciled semi-annually against prospectively determined clinical episode-specific target prices.

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

**Latest evaluation information:** [At-a-glance 2-pager](https://innovation.cms.gov/initiatives/bpci-advanced/), [Full Report](https://innovation.cms.gov/initiatives/bpci-advanced/)

**Website:** [https://innovation.cms.gov/initiatives/bpci-advanced/](https://innovation.cms.gov/initiatives/bpci-advanced/)
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 allows rural communities to use innovative financial arrangements and leverage their operational and regulatory flexibility to transform their delivery systems to better address health disparities. The CHART Community Transformation Track aims to:

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

*Note: In February 2022, CMMI announced the anticipated Accountable Care Organization (ACO) Track is being removed from the CHART model.*

**Eligibility and rural-relevant requirements**
CMS awarded cooperative agreement funding to four entities who will serve 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.

A Lead Organization is a single entity that represents a rural Community, comprised of either (a) a single county or census tract or (b) a set of contiguous or non-contiguous counties or census tracts. Each county or census tract must be classified as rural, as defined by the Federal Office of Rural Health Policy’s list of eligible counties and census tracts used for its grant programs.

Community Lead Organizations will coordinate efforts across the community to ensure that access to care is maintained and ensure the needs of stakeholders are accounted for through development and implementation of a Transformation Plan that outlines a community health care delivery redesign strategy. Lead Organizations are responsible recruiting Participant Hospitals. CAHs and PPS hospitals that serve the identified community are eligible to be Participant Hospitals.

**Timeline/key dates**
- September 2021: Announced four cooperative agreements among four states and organizations
- Pre-Implementation Period: August 1, 2021 – December 31, 2022
- Performance Periods 1 – 6: January 1 – December 31, 2023 - 2028

**Payment model/funding**
- Lead Organizations will receive 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 will receive a predictable capitated payment amount (CPA) and opportunities for operational and regulatory flexibilities. CMS will replace Participant Hospitals’ Fee for Service (FFS) claim reimbursement with biweekly payments that equal the annual CPA.
- The CHART CPA combines concepts from a global budget and from an ACO into a single hospital payment methodology. The CPA for Participant Hospitals is calculated based on Medicare FFS revenue using historical expenditures for Eligible Hospital Services.
- By Performance Period 2 (CY 2024), each Lead Organization must secure multi-payer alignment from the State Medicaid Agency. Multi-payer alignment from commercial payers is recommended but not required.

**Current rural participation/impact**
CHART is specifically targeting rural communities.

**Website:** [https://innovation.cms.gov/innovation-models/chart-model](https://innovation.cms.gov/innovation-models/chart-model)
**Comprehensive Care for Joint Replacement (CJR) Model**

**Aliases:** Bundled Joints, Joint Bundles

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

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

**Timeline/Key Dates**
- The program had an April 1, 2016 start date and was originally scheduled to go for 5 years (through 2020)
- In February 2020, CMS announced a three-year extension of the program.
- As of February 2018, CMS reduced the number of geographic areas for mandatory participation from 67 to 34.
- CMS has enacted specific COVID-19 related flexibilities for this demonstration. Read more here.

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

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

**Latest evaluation information:** At-a-glance 2-pager, Full Report

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

PAGE UPDATED 12/2021
Diabetes Prevention Program (MDPP) Expanded Model

Aliases: MDPP

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

Eligibility and rural-relevant requirements
To become a MDPP supplier, the provider must:
- Possess MDPP preliminary recognition or full CDC DPRP recognition, 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.

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

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

Current rural participation/impact
Any supplier (rural or other) meeting the requirements may participate. MDPP services do not need to be furnished in a traditional health care setting, but must follow the requirements for MDPP locations, which makes them more accessible to rural communities via virtual make-up sessions. Although the number of MDPP suppliers continues to increase, the first evaluation report (March 2021) indicated that many MDPP supplier locations are clustered around large urban areas (e.g., Boston, Denver, Detroit, Seattle, New York City), with far fewer supplier locations in rural areas. Seven states (Alabama, Nevada, New Mexico, Rhode Island, South Dakota, Vermont, and Wyoming) have no MDPP supplier locations.

Latest evaluation information: [At-a-glance 2-pager](https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/), [Full report](https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/)


PAGE UPDATED 12/2021
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 DME supplier certified by CMS-approved national accreditation organizations (i.e. American Diabetes Association (ADA) and American Association of Diabetic Educators (AADE)). Information about DSMT accreditation program is available here.

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

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

Information about Medicare covered services and supplies for diabetes is available here: Covered items

**Current rural participation/impact**
Rural providers approved for in-person DSMT (not telehealth DSMT) include:
- Critical access hospitals
- Federally qualified health centers (FQHCs)
- Home health agencies
- Hospital outpatient departments
- Independent clinics (Freestanding FQHCs and Independent Rural Health Clinics)
- Private physician practices
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs) For RHCs: Only individual DSMT is payable by Medicare Part B.
- If there is a solo diabetes instructor, this person must be an RD and CDE.
- The RHC may be able to include the cost of furnishing group DSMT on its annual cost report. It is best to first verify this with the regional MAC.

**Websites:**
For beneficiaries: https://www.medicare.gov/coverage/diabetes-self-mgmt-training.html
For providers: Medicare Diabetes Prevention & Diabetes Self-Management Training (cms.gov)
**Emergency Triage, Treat, and Transport (ET3)**

**Aliases:** ET3

**Summary**
Medicare currently only pays for emergency ground ambulance services when beneficiaries are transported to hospitals, CAHs, SNFs, or dialysis centers (most often, hospital emergency departments), even when lower-acuity care providers may be more appropriate. The ET3 model is a voluntary, five-year payment model providing increased flexibility to ambulance care teams to address emergency health needs for FFS Medicare beneficiaries following a 911 call including transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC). The ET3 Model also allows initiating and facilitating treatment-in-place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth. The expected result is improved quality and lower costs through reducing avoidable transports to an ED and subsequent hospitalizations. As a component of the ET3 Model, CMMI offered a Medical Triage Line NOFO for local governments, designees, or other entities operating or overseeing 911 dispatches to develop and operate a triage line for low-acuity emergency calls. The NOFO was subsequently withdrawn due to insufficient applications.

**Eligibility and rural-relevant requirements**
All Medicare-enrolled ambulance suppliers and hospital-based ambulance providers were eligible to apply for the ET3 Model.

**Timeline/key dates**
- In response to the COVID-19 PHE, CMS delayed the start of the ET3 Model.
- The model launched on January 1, 2021 and is scheduled to go for 5 years (through 2025).

**Payment model/funding**
- In addition to reimbursement for transport to a hospital or ED, CMS will pay participating ambulance suppliers and providers for transport to an alternative destination (such as a primary care doctors office or urgent care clinic), or to provide treatment in place with a qualified health care practitioner at the scene or via telehealth.
- Model participants will not receive additional funding beyond model payments for eligible services.
- For the duration of COVID-19 PHE, CMS temporarily expanded the list of allowable destinations for ambulance transports. Participants in the model will be able to continue to access these flexibilities while participating in the Model. The flexibilities offered specifically to ambulances can be found [here](#).

**Current rural participation/impact**
There are 31 participants that include at least one non-metropolitan county in their service area. Organizations from 36 different states are participating in the ET3 Model.

**Website:** [https://innovation.cms.gov/initiatives/et3/](https://innovation.cms.gov/initiatives/et3/)
**Expanded Home Health Value-Based Purchasing (HHVBP) Model**

**Aliases:** Expanded HHVBP, HHVBP

**Summary**
Under the expanded HHVBP Model, 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. The goals are to 1) incentivize HHAs to increase both quality and efficiency of provided care, 2) identify and study the use of new potential quality and efficiency measures in the home health setting, and 3) improve current public reporting processes. During CY 2022, CMS will provide HHAs with resources and training. This will allow HHAs time to prepare and learn about the expectations and requirements of the expanded HHVBP Model without risk to payments.

**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: Anticipated start of the pre-implementation year. HHAs will not be assessed on their performance in CY 2022. CMS will begin to assess HHA performance in CY 2023.
- January 1, 2023: Anticipated start date for performance Year 1.

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

**Current rural participation/impact**
All Medicare-certified HHAs in all states will be 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.

Frontier Community Health Integration Project (FCHIP) Demonstration

**Aliases:** FCHIP

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

**Eligibility and rural-relevant requirements**
Eligible entities were:
- Located in a state with at least 65 percent of the counties have six or fewer residents per square mile.
- Limited to CAHs in Montana, Nevada, North Dakota, Wyoming, and Alaska

**Timeline/key dates**
- Began on August 1, 2016
- Ended on July 31, 2019
- Five Year Extension launched July 1, 2021

**Payment model/funding**
Provides financial incentives and Medicare payment changes for:
- Ambulance Services – participants are reimbursed 101 percent of reasonable cost for ambulance services they provide, regardless of any other ambulance services that may be available nearby - waiving the thirty-five-mile limit currently imposed by Medicare.
- Skilled Nursing Facility (SNF)/Nursing Facility (NF) Beds – participants 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 level of care.
- 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 practitioner was paid an amount equal to the amount that such practitioner would have been paid had such services been furnished without the use of a telecommunications system.

**Rural participation/impact**
Ten CAHs in three states (North Dakota, 3; Montana, 3; and Nevada, 4) began participating in this demonstration in August 2016. CMS found that ambulance and SNF/NF bed interventions were easily implemented and beneficial. The quality reported was on par with other CAHs, but telehealth interventions faced administrative and operational challenges.

**Latest evaluation information:** At-a-glance 2 pager, Full report.

**Website:** https://innovation.cms.gov/initiatives/Frontier-Community-Health-Integration-Project-Demonstration/
Global and Professional Direct Contracting (GPDC) Model

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

**Summary**
*CMS has redesigned the GDPC Model and is renaming it as the ACO REACH Model.* Current participants that maintain a strong compliance record, and agree to meet ACO REACH requirements by January 1, 2023 to continue participating as a REACH ACO.

The GPDC Model builds on the previous CMS ACO initiatives, including the MSSP and NexGen Models, and leverages innovative approaches from Medicare Advantage and the private sector risk-sharing agreements. GPDC establishes 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 is providing new opportunities for a variety of different health care organizations to participate in value-based care arrangements in Medicare FFS. Types of DCEs include:

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

CMS has also announced they are permanently cancelling the Geographic Direct Contracting Model, which has been on hold since March 2021.

**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.
- Must have 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.

**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 started April 1, 2021.
- In February 2022, CMS announced the GDPC Model will transition to the new ACO REACH Model on January 1, 2023.

**Payment model/funding**
Two voluntary risk-sharing options:
- **Professional** offers lower risk-sharing arrangement of 50% savings/losses. Provides Primary Care Capitation, a capitated, risk-adjusted monthly payment for primary care services provided by DC Participant Providers and those Preferred Providers that have agreed to participate in capitation (by accepting FFS claims reductions and agreeing to receive compensation from the DCE).
- **Global** offers highest risk sharing arrangement of 100% savings/losses. Provides two payment options: Primary Care Capitation (described above) or Total Care Capitation, a capitated, risk-adjusted monthly payment for all covered services provided by DC Participant Providers and Preferred Providers that have agreed to participate in capitation (by accepting FFS claims reductions and agreeing to receive compensation from the DCE).

**Current rural participation/impact**
RHCs and CAHs are included on the lists of potentially eligible participants, and may be included in DCE provider networks.

**Website:** [https://innovation.cms.gov/innovation-models/gpdc-model](https://innovation.cms.gov/innovation-models/gpdc-model)
Hospital Acquired Conditions Reduction Program (HACRP)

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

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

For FY 2022, hospital scores are based on six quality measures in two domains:
- CMS Recalibrated Patient Safety Indicator (PSI) 90 (CMS PSI 90)
- Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures:
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy) (SSI)
  - Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteremia
  - Clostridium Difficile Infection (CDI)

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

**Eligibility and rural-relevant requirements**
- All IPPS hospitals are eligible.
- CAHs and acute care hospitals in Maryland are exempt.

**Timeline/key dates**
- Program was effective beginning Fiscal Year (FY) 2015 (discharges beginning on October 1, 2014).
- Program criteria and scoring are updated annually through the IPPS rule making process.
- FY 2022 HAC reduction Program Key Dates Matrix available [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html).

**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 2022 HAC Reduction Program Fact Sheet available [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html).

**Current rural participation/impact**
- CAHs are exempt, but rural IPPS hospitals are included.
- In 2019, 800 hospitals were impacted by safety penalties

**Website:** [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html](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 HRRP requires CMS to reduce payments to IPPS hospitals with excess readmissions effective for discharges beginning on October 1, 2012.

Excess readmission 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 FY 2021 HRRP calculates excess readmission ratios for six conditions: Acute Myocardial Infarction (AMI), Heart Failure, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Bypass Graff (CABG), and Elective primary total hip and/or total knee arthroplasty (THA/TKA).

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

**Timeline/key dates**
- CMS uses a three-year performance period for calculations. For example, payment adjustments for FY 2020 were based on the 3-year performance period of July 1, 2015 through June 30, 2018.
- Program criteria and methodology are updated annually through the IPPS rulemaking process.

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

**Current rural participation/impact**
- No specific rural focus, though eligible rural PPS hospitals are included to participate if they meet specified case volume thresholds.
- Due to the shift to a stratified methodology 43.7% of rural hospitals experienced a lower penalty in 2019 compared with 2018 from the readmissions program.

**Website:** [https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html](https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html)
Hospital Value-Based Purchasing (VBP) Program

**Aliases:** Hospital VBP, Inpatient VBP

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

**Eligibility and rural-relevant requirements**
- All IPPS hospitals are eligible.
- CAHs and acute care hospitals in Maryland are exempt.

**Timeline/key dates**
- There is a two-year lag between the reporting year and the payment year (i.e., quality scores from 2020 affect payment in 2022).
- Program criteria and scoring are updated annually through the IPPS rule making process.
- For FY 2023, performance periods for mortality, complications, the patient safety composite measure are impacted by the ECE granted by CMS due to COVID-19. Claims from Q1 2020 and Q2 2020 will not be used in the claims based measure calculations. Details available [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 (October 1 – September 30).
- Total Performance Scores are calculated using baseline to performance period comparisons in four domains: Person and Community Engagement, Clinical Care, Safety, and Efficiency and Cost Reduction. The four domains are weighted equally at 25 percent each. The metrics included and weighting of the domains is adjusted annually through the IPPS rule making process.
- Hospitals must have a domain score for at least three out of the four domains to have a TPS.

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

**Website:** [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html)
Maryland Total Cost of Care (TCOC) Model

Aliases: TCOC Model

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

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

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

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

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

Rural Participation/Impact
- All Maryland hospitals, both rural and urban, are included. FQHCs are eligible to participate in the Maryland Primary Care Program.

Latest evaluation information: At-a-glance 2 pager, Full report

Websites: https://innovation.cms.gov/initiatives/md-tccm/; https://hscrc.state.md.us/Pages/tcocmodel.aspx
Medicare Shared Savings Program (Shared Savings Program)

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

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

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

Timeline/key dates
- For standard MSSP ACO participation there is an annual application cycle.
- CMS has enacted specific COVID-19 related flexibilities for this program, including forgoing an application cycle in 2020. Details available here.
- Updates to program requirements and methodology are made through the annual Federal rule making process. Significant changes, referred to as “Pathways to Success” were made during the 2019 rule making process. For a description of program structure prior to July 2019 see the archived description in Appendix B here.

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

Current rural participation/impact
- RHCs, FQHCs, and CAHs are eligible to participate in ACOs if they meet specific requirements.
- As of January 2022: 430 Critical Access Hospitals and 1,643 RHCs were participating in an MSSP ACO, 41% of all participating ACOs were under one-sided risk.
- PY 2020 Performance Results available here.

Website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram
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 aims to improve health outcomes, while reducing the growth of hospital expenditures and promoting sustainability of rural Pennsylvania hospitals. Payment under the model is based on all-payer global budgets, where payment amounts are pre-established for hospital payments and paid monthly by Medicare and other payers. Pennsylvania’s rural hospitals, who must volunteer to participate, are expected to redesign their care delivery to increase quality of care and meet the needs of their local communities. The model is testing whether predictable global budgeting, for both inpatient and outpatient hospital-based services, allows rural providers to further invest in improved quality and preventive care for their populations.

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

Timeline/key dates
- The Model will run 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 will provide funding to the state, the state will recruit the participant hospitals and establish participation agreements, and rural hospitals will develop their Rural Hospital Transformation Plans.
- For PY5 and PY6, activities will include continued transformation planning and global budget administration for the participant hospitals
- Prospectively set, all-payer global budgeting payments will occur in PY1-PY6 (2019-2024).

Payment model/funding
- CMS has committed to providing up to $25 million to Pennsylvania over five years to implement the model.
- The State will calculate the global budgets and submit them to CMS for review and approval.
- Pennsylvania aims to have 75 percent of participating hospital eligible revenues coming from global budgeting by PY1 (2019) and 90 percent for later performance years.
- Pennsylvania will encourage commercial payers to participate in the Model, and will work to achieve Medicaid participation, which is necessary for the Model to be implemented.
- Pennsylvania agrees to an all-payer financial target of no more than 3.38 percent in annual hospital spending growth on inpatient and outpatient hospital-based services per resident of Pennsylvania’s rural areas served by participating rural hospitals. 3.38 percent represents the compound annual growth rate for Pennsylvania’s gross state product from 1997 to 2015.
- Pennsylvania commits to achieving $35 million in Medicare hospital savings from the rural participants over the course of the model.

Current rural participation/impact
- The model is developed specifically for rural hospital participation.
- As of January 2021, 18 hospitals are participating.

Latest evaluation information: At-a-glance 2-pager, Full Report
Website: https://innovation.cms.gov/initiatives/pa-rural-health-model/

PAGE UPDATED 11/2021
Primary Care First

Aliases: CMS Primary Cares Initiative, PCF

Summary
PCF is a voluntary five-year payment model designed to support delivery of advanced primary care. Built on the underlying principles of the CPC+ model, PCF emphasizes 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 implements a set of voluntary five-year payment structure to support delivery of advanced primary care.

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

Eligibility and rural-relevant requirements
Participation is open to primary care practices with advanced primary care capabilities that meet the following:

- Location 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 Programing 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

- January 1, 2021 – First performance period for PCF begins.
- January 2022- 2nd PCF cohort begins
- November 2021 – CMS announced the Seriously Ill Population (SIP) component for PCF will not move forward
- CMS has enacted specific COVID-19 related flexibilities for this demonstration. Read more here.

Payment model/Funding

- PCF includes a hybrid total primary care payment that includes 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.
- A PCF practice must meet standards that reflect quality care in order to be 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 3,000 practices participating in Primary Care First across both cohorts, and 24 payer partners. Lists of participating practices and payer partners are available on the website below.

Website: https://innovation.cms.gov/innovation-models/primary-care-first
**Quality Payment Program (QPP)**

**Aliases:** QPP, MACRA/MIPS

**Summary**
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for Medicare Part B clinician payment and created the QPP, which links clinician payment to quality. QPP 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.

**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, dieticians, and certified registered nurse anesthetists.
- For the 2021 performance year, CMS will apply an automatic MIPS extreme and uncontrollable circumstances policy to individual MIPS eligible clinicians in response to the ongoing COVID-19 public health emergency. Individual MIPS eligible clinicians will have all 4 performance categories reweighted to 0% and receive a neutral payment adjustment in 2023 unless they submit data.
- RHCs and FQHCs are generally ineligible because they are paid by Medicare under separate systems.
- Under MACRA, CMS designated $20 million dollars for technical assistance over five years ($100 million total) to support small practices in rural and underserved areas ([SURS Technical Assistance](https://qpp.cms.gov/)). SURS Technical assistance will no longer be available after February 15, 2022.
- 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 is 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 2019 impacts payment in 2021).
- 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. Toolkit available [here](https://qpp.cms.gov/)

**Payment model/funding**

**MIPS**

- Positive or negative payment adjustment 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 allows 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](https://qpp.cms.gov/) to streamline program requirements.

**APM**

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

**Website:** [https://qpp.cms.gov/](https://qpp.cms.gov/)
Radiation Oncology 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
1] a physician group practice (PGP); 2] a freestanding radiation therapy center; or 3] a Hospital Outpatient Department (HOPD). RO Model participants can participate in the Model as Professional participants, Technical participants, or Dual participants. Some participants, like PGPs, can be both Professional participants and Dual participants.

Timeline/key dates
- December 15, 2021: Announced - Congress prohibits implementation prior to January 1, 2023; Launch of model is TBD.

Payment model/funding
The RO Model is a mandatory model that tests whether changing the way RT services are currently paid – via fee-for-service payments – to prospective, site neutral, modality agnostic, episode-based payments incentivizes physicians to deliver higher-value RT care. The design of the RO Model includes several key programmatic elements:

1. Alternative Payment:
   1. 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.
   2. 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.
   3. Professional and Technical Payment Components: Episode payments are split into professional and technical components to allow the current claims systems for PFS and OPPS to be used to adjudicate RO Model claims and for consistency with existing business relationships.

2. 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) 2.

3. RO Participants in a 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 RO Model will operate in defined, randomly selected, Core-Based Statistical Areas with a population of at least 10,000. Generally, CBSAs do not include extreme rural regions, but they do contain rural RT providers and RT suppliers. If a RO participant has furnished fewer than 20 episodes in the most recent year, 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 or CAHs participating in, or eligible to participate in the Pennsylvania Rural Health model are excluded. RT providers and suppliers that only furnish RT in Maryland and Vermont are excluded.
- A ZIP Code list providing ZIP Codes linked to the CBSAs selected for participation is on the model webpage.

Website: https://innovation.cms.gov/innovation-models/radiation-oncology-model
Skilled Nursing Facility Value-Based Purchasing Program

Aliases: SNF VBP

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

Eligibility and rural-relevant requirements
All SNFs paid under Medicare’s SNF Prospective Payment System (PPS) are included in the SNF VBP Program. CMS has adopted some exceptions for SNFs with fewer than 25 eligible stays allowing them to be held harmless from penalties under SNF VBP.

Timeline/key dates
• Starting October 1, 2018, SNFs began receiving value-based incentive payments for the quality of care they give to people with Medicare.
• There is a two-year lag between performance period and payment impact. For example, FY2021 Medicare FFS payments were based upon FY2019 performance period in comparison to FY2017 baseline period.
• FY2022 key dates timeline available here.

Payment model/funding
• CMS withholds 2% of SNFs’ fee-for-service (FFS) Part A Medicare payments to fund the program. This 2% is referred to as the “withhold”. CMS redistributes 60% of the withheld dollars to SNFs as incentive payments. To calculate incentive payments, CMS first estimates the dollar amount of SNF Medicare FFS Part A payments to be redistributed across SNFs in the applicable payment year. CMS then assigns incentive payment multipliers based on each SNF’s performance score.
• Due to COVID-19, CMS announced a nationwide extraordinary circumstance exception for qualifying claims from January 21, 2020 – June 20, 2020.
• CMS suppressed the use of SNF readmission measure data for purposes of FY 2022 scoring and payment adjustments in the FY 2022 SNF VBP Program year because the effects of the COVID-19 public health emergency on the data used to calculate the SNFRM inhibited CMS’s ability to make fair national comparisons of SNFs’ performance.

Current rural participation/impact
• All SNFs paid under the prospective payment system will receive incentive payments under the SNF VBP Program as directed by the Social Security Act
• Eligible SNFs include freestanding SNFs, SNFs associated with acute care facilities, and all non-critical access hospital (CAH) swing bed rural facilities.
• The SNF VBP Program is not optional and does not require any action by SNFs to participate.
• For FY2020, of the roughly 15,000 SNFs, 64.6% were penalized (received less than the full 2% back), of these 32.6% received a full 2% rate cut penalty (up 12% from FY2019). In contrast, 19.4% received a bonus of some amount but only 1.8% or 280 SNFs received the maximum incentive payment of an additional 3.12% (after the restoration of the 2% withhold). 2413 SNFs (15.9%) had a neutral rate adjustment under an exception.
• 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

PAGE UPDATED 01/2022
Value in Opioid Use Disorder Treatment Demonstration Program

**Aliases: Value in Treatment**

**Summary**
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 establish an OUD care team and uses such team to furnish or arrange for OUD treatment services in the outpatient setting under the demonstration, and who are 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
- Clinic certified as a certified community behavioral health clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014

**Timeline/key dates**
- April 1, 2021 – First performance period begins.
- December 31, 2024 – Anticipated end of performance period.

**Payment model/funding**
The demonstration makes available $10,000,000 from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act available each of fiscal years 2021-2024 for demonstration payments.

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

1. **A per beneficiary per month care management fee (CMF)**, which the participant may use to “deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under [Title XVIII],” and
2. **A performance-based incentive**, 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 must be based on an applicable beneficiary’s individualized OUD treatment plan. Applicable beneficiaries have a current diagnosis for OUD, are enrolled under Medicare Part A and Part B, and are not enrolled in a Medicare Advantage plan. Applicable beneficiaries include those dually eligible for Medicare and Medicare if the criteria above are also met.

**Current rural participation/impact**
The demonstration was open to providers (FQHCs, RHCs, CAHs, and others) that met eligibility requirements. Participants are in 36 states and District of Columbia and include FQHCs, behavioral health clinics, group practices, a rural health clinic, and opioid treatment programs.

Vermont All-Payer ACO Model

Aliases: None

Summary
Established as a joint effort between CMS and the state of Vermont, Vermont’s All-Payer 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 healthcare. 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, is that the Model will 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 healthcare expenditure growth to 3.5 percent (and no more than 4.3 percent), and Medicare per capita healthcare growth rate to at least 0.1 percentage point below the national average Medicare growth rate.
- Health Outcomes and Quality of Care Targets – the State will seek improvements in three prioritized areas: access to primary care, deaths from substance use disorder and suicide, and prevalence of chronic conditions.

Additionally, CMS provided a five-year extension for the State’s 1115(a) Medicaid demonstration waiver, which allowed Medicaid to operate as a full-partner in the ACO Model approach.

Eligibility and rural-relevant requirements
Participation is voluntary for both providers and other payers, including rural providers. As of 2020, 13 of Vermont’s 14 hospitals were participating in OneCare Vermont for at least one payer program, 6 of which are critical access hospitals.

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

Payment model/funding
- In 2017 CMS provided $9.5 million in initial investment to facilitate care coordination among providers in the State and improve collaboration with stakeholders.
- CMS expects at least a portion of funds to be used by Vermont to 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 addition to the six participating CAHs, several rural FQHCs and RHCs are involved.
- The goal is that at least 50 percent of Vermont All-Payer beneficiaries are aligned with an ACO by the end of 2019, thus far the state has been running below originally identified targets.

Latest evaluation information: At-a-glance Two-pager, Full Report


PAGE REVIEWED 11/2021
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 (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. Some examples include APM Framework, and Patient Attribution, Financial Benchmarking, and Performance Measurement models for Population Based Payments. While there is no rural focus, rural payers, providers, state agencies etc. are encouraged to participate in the network and utilize HCP LAN resources.

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

Hospital Quality Improvement Contractor (HQIC)

The CMS HQIC (Hospital Quality Improvement Contractor) program began September 2020, under the auspices of the Network of Quality Improvement and Innovation Contractors. This is the latest version of predecessor programs, HIIN (Hospital Improvement and Innovation Network) and HEN (Hospital Engagement Networks).

HQIC is designed to support rural, critical access hospitals and those hospitals that are low performing and serve vulnerable populations in achieving measurable outcomes under the rubrics of patient safety, addressing the opioid epidemic, and care transitions. Additionally, this Task Order shall provide support to hospitals during public health emergencies, epidemics/pandemics, and other crises as they arise.

Nine organizations were selected to implement the HQIC program across the country, and each HQIC was charged with recruiting 250-300 hospitals from the list of 2600 eligible hospitals, which were predominantly in rural and underserved areas. HQIC is not a geographically defined program; as a result, a hospital may be recruited by multiple HQICs, and can only agree to participate with one HQIC.

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 12 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 as small as a single state and as large as nine states/territories, 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.

Website: https://qioprogram.org/

VALUE-BASED CARE SUPPORT INITIATIVES - UPDATED 12/2021
Quality Payment Program - Small Practice, Underserved, and Rural Support (QPP-SURS)

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

As part of the initiative, QPP-SURS includes assistance in:
- Selecting quality measures and activities for each MIPS performance category
- MIPS reporting
- Strategic planning
- Adjusting to new payment methodologies
- Health IT optimization, including Certified Electronic Health Record Technology (CEHRT)
- Evaluating benefits and costs of joining APMs
- Technical assistance is available to MIPS-eligible practices (15 or fewer clinicians)
- Priority eligibility is available for clinicians operating in:
  - Rural areas
  - Health Professional Shortage Areas (HPSAs)
  - Medically Underserved Areas (MUAs)

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

Website: [https://qpp.cms.gov/about/small-underserved-rural-practices](https://qpp.cms.gov/about/small-underserved-rural-practices) (link will stay active after close of program)

Note: The QPP SURS initiative is scheduled to end on February 15, 2022 as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) only provided for 5 years of direct support.

After February 15, 2022: The Quality Payment Program Service Center will serve as a primary point of contact to help address QPP questions and concerns. The Service Center is able to address basic questions as well as more complex scenarios. Connect with the Service Center at 1-866-288-8292 (TTY 1-877-715-6222) or via email at QPP@cms.hhs.gov Monday - Friday 8 am - 8 pm ET
Appendix 2 – Inactive Program Archive

ACO Investment Model (AIM)

Aliases: AIM Model

Stage: No Longer Active

Summary

The ACO Investment Model 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 and underserved areas. The model encouraged current MSSP ACOs to transition to models with greater risk sharing.

Eligibility and rural-relevant requirements

Limited to two groups:

- 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 Advance Payment ACO Model.
- The ACO did not include a hospital as a participant as defined by MSSP, unless the hospital is a Critical Access Hospital or an inpatient prospective payment system (IPPS) hospitals with 100 or fewer beds.

Timeline/key dates

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

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

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

Of the 45 AIM ACO participants across 37 states:

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

Evaluation: At-a-glance 2 pager, Final report

Website: https://innovation.cms.gov/initiatives/ACO-investment-Model.
Advance Payment Accountable Care Organization (ACO) Model

**Aliases:** Advance Payment ACO Model

**Stage:** No Longer Active

**Summary**
The Advance Payment 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 36 participants.

**Evaluation:** Final report

**Website:** [https://innovation.cms.gov/innovation-models/advance-payment-aco-model](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

**Summary**
Authorized under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA 223), this program is a combined effort by HHS agencies including Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and the Office of the Assistant Secretary of Planning and Evaluation. It supports state-level efforts to increase access and improve the quality of community-based mental health and substance abuse disorder treatment delivery. In 2015, 24 states received $22.9 million in planning grants to plan for the demonstration project. The grants helped states prepare to participate in the two-year demonstration program. The funding supported states’ efforts to:
- Certify CBHCs based on federally developed criteria – emphasizing accessible and high-quality care.
- Establish a Medicaid PPS payment system for CCBHCs
- Improve data collection and reporting systems
- Engage stakeholders in how the state will implement the program

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

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

**Timeline/key dates**
- Selected states announced on December 31, 2016: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania.
- Two-year demonstration programs began July 1, 2017.
- Congress extended this program to November 2019.
- All original participants were extended through November 30, 2020 under CMS waiver 1115.

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

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

**Website:** [http://www.samhsa.gov/section-223](http://www.samhsa.gov/section-223)
Community Based Care Transitions Program (CCTP)

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

**Stage:** No longer active

**Summary**
CCTP, created by Section 3026 of the Affordable Care Act (ACA), tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of 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:
- 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://innovation.cms.gov/initiatives/CCTP/](https://innovation.cms.gov/initiatives/CCTP/)
Comprehensive Primary Care (CPC) Initiative

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

**Stage**: No longer active

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

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

**Timeline/key dates**
- Program began in 2013 and ended in 2016.

**Payment model/funding**
CPC integrated a defined payment model and practice redesign focus:

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

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

**Evaluation**: Final Report

Comprehensive Primary Care Plus (CPC+)

**Aliases:** CPC+

**Stage:** No Longer Active

**Summary**
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.
- CMS indicated that 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, 2027 – 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 provide a non-visit-based CMF paid per-beneficiary-per month (PBPM), paid on a quarterly basis, with the amount risk-adjusted for each practice’s specific population.
   - $15 PBPM across four risk tiers in Track 1.
   - $28 PBPM Medicare CMFs across five risk tiers in Track 2; $100 CMF for medically complex.

2. **Performance-Based Incentive Payment:** CPC+ prospectively pays and retrospectively reconciles a performance-based incentive based on how well a practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care.
   - Performance-Based Incentives: Track 1 receives $2.50 PBPM; Track 2 receives $4 PBPM.

3. **Payment under the Medicare Physician Fee Schedule:**
   - Track 1 continues to bill and receive payment from Medicare FFS as usual.
   - Track 2 practices also continue to bill as usual, but the FFS payment are reduced to account for CMS shifting a portion of Medicare FFS payments into Comprehensive Primary Care Payments (CPCP), which are paid in a lump sum on a quarterly basis absent a claim.

**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 one participation regions include many rural areas including the states of AR, CO, HI, MI, MT, OH, OK, OR, OH, (and northern KY). Round 2 participation regions include LA, NE, ND, and Erie and Niagara Counties of NY.
- Since the model focuses on primary care payments from Medicare Part B, RHCs and FQHCs were ineligible because they are paid on a fee schedule.

**Evaluation (most recent):** At-a-glance 2-pager, Full report

**Website:** [https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus](https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus)
Frontier Extended Stay Clinic (FESC) Demonstration

**Aliases:** FESC Demonstration

**Stage:** No Longer Active

**Summary**
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 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 clinical records system and patient medical report transfer mechanism in place. They were also required to develop quality assessment and performance improvement program.

**Timeline/key dates:**
- Demonstration was announced and the first site started on April 15, 2010.
- Demonstrated ended on April 15, 2013.
- Report to the 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 rates 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. Alaska Medicaid program also implemented higher payment rates for extended stay services based on all-inclusive ambulatory visits payment rates. Extended stays were qualified for payment if:

- Adverse weather conditions or other factors prevented transfer of patients to an acute care hospital.
- Need of extended monitoring and observation but not for inpatient hospital admission was clinically justified.

**Rural participation/impact**
The demonstration was designed for remote clinics.

**Evaluation:** Final report

**Website:** [https://innovation.cms.gov/innovation-models/frontier-extended-stay-clinic](https://innovation.cms.gov/innovation-models/frontier-extended-stay-clinic)

---

INACTIVE PROGRAM ARCHIVE – UPDATED 12/2021
Home Health Value-Based Purchasing (HHVBP) Model

**Aliases:** HHVBP Model

**Stage:** No Longer Active

**Summary**
The HHVBP Model 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 (HHCAHPS) data, and three new measures, submitted by HHAs. These scores were compared to previous performance on these measures in addition to the performance of other home health agencies on these measures within each HHA’s respective state. Payments 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.
- January 8, 2021, CMS announced intent to expand the HHVBP model nationally. Expansion needed to be implemented through rulemaking with a start date no earlier than January 1, 2022.
- November 2021, CMS announced CY 2022 Home Health Proposed Payment System Final Rule published
- 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 increase or decrease) payments based on the following timetable:
- A maximum payment adjustment of 3 percent in 2018.
- A maximum payment adjustment of 5 percent in 2019.
- A maximum payment adjustment of 6 percent in 2020.
- A maximum payment adjustment of 7 percent in 2021.

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

**Evaluation (most recent):** At-a-glance 2 pager, Full report

**Website:** https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model
Independence at Home Demonstration

Aliases: None

Stage: No Longer Active

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

Eligibility and rural-relevant requirements
- The 9 participating Primary Care practices provided documentation in their application regarding experience in providing home-based primary care to beneficiaries who are high-cost and have multiple chronic conditions; in addition, they had to serve at least 200 eligible beneficiaries.
- Beneficiaries were eligible to participate if they have two or more chronic conditions, enrolled in Medicare FFS, needed help with two or more functional activities, had a non-elective inpatient admission within the past year, and had received acute or subacute rehabilitation within the past year.

Timeline/key dates
- Two separate cohorts for implementation between 2012 – 2015
- Initial extension authorized through 2017
- A second extension through the BBA 2-year extension authorized in 2018.
- Performance period end date December 31, 2021

Payment model/funding
- The participating practices were eligible for financial incentives if they succeed in offering high quality care that reduces costs for the Medicare program. To qualify for an incentive payment, the practice’s expenditures for participating beneficiaries had to be lower than the calculated target expenditure, which represents 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 are met.
- Nine participating practices received incentive payments in Year 1. Seven practices received incentive payments in Year 2. In Year 2, CMS modified the shared savings methodology to improve the comparability between the demonstration and matched comparison group beneficiaries. Seven practices received incentive payments in Year 3
- In Performance Year 4, Independence at Home practices saved $32,900,000 in aggregate, an average of $2,819 per beneficiary. Seven participating practices earned incentive payments in the amount of $8,095,000.

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

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

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

INACTIVE PROGRAM ARCHIVE – UPDATED 12/2021
Maryland All-Payer Model

Aliases: None

Stage: Closed; Maryland now operating Total Cost of Care Model (TCOC)

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

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

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

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

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

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

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

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

Evaluation: At-a-glance 2 pager, Final Report

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

INACTIVE PROGRAM ARCHIVE – UPDATED 11/2021
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, and patient quality of life and family satisfaction, and offer new payment systems for the Medicare and Medicaid programs.

Eligibility and Rural-relevant Requirements
The program’s target population was dual eligible beneficiaries, who were eligible for Medicare or Medicaid hospice benefits. Participation in the model were 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 continues through 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 was 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
About 140 Medicare-certified hospices from both urban and rural geographic areas initially participated in the model. 37 withdrew from participation by the end of 2017. There were 43 hospices active in 2019 for Cohort 1 and 42 active for Cohort 2. As of early 2018, 1,325 beneficiaries were enrolled. Ten percent of beneficiaries approached about the Model have elected hospice immediately and nearly 80 percent of those who enrolled in MCCM elected hospice when they left the Model.

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

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

INACTIVE PROGRAM ARCHIVE – UPDATED 12/2022
Medicaid Incentives for the Prevention of Chronic Disease Program (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’s diabetes program used telehealth to reach participants living in rural areas. Nevada also utilized telehealth to reach participants in rural locations. California partnered with its Indian and Rural Health Office to provide program services to Native American clinic patients.

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

**Evaluation:** Final Report

**Website:** [https://innovation.cms.gov/initiatives/mipcd/](https://innovation.cms.gov/initiatives/mipcd/)
Medicare Shared Savings Program (SSP): Program Summary Prior to July 2019

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

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

Summary
The MSSP was established by the ACA and was a key component of Medicare delivery system reform initiatives. MSSP facilitated coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers could participate in MSSP by creating or participating in an ACO. 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 over in 3-years starting at 5 percent in year 1; 7.5 percent in year 2; and 10 percent in year 3 and any subsequent year.
  - **Track Three**: two-sided shared savings/shared loss model, 75 percent split of savings, loss sharing limit is 15 percent. In return for greater risk, it allowed for prospective beneficiary assignment, waiver of the Skilled Nursing Facility (SNF) 3-day rule, and potential flexibility around telehealth requirements for billing and reimbursement.
- **Track One Plus** was also offered for a limited time, which gave participants an option that included some of the flexibility of Track Three but limited potential downside risk.

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

Website: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram](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 spanned over a 5-year period, beginning in January 2017 and ended by December 2021.
  • Participants were announced in July 2016.

Payment model/funding
  
  • Control Group: One-time payment of $20/beneficiary to off-set costs of data collection and submission
  • Intervention group – two payments:
    o Cardiovascular Disease Risk Stratification payment: participants received a one-time $10 per-beneficiary payment for each eligible beneficiary that was assessed for CVD risk.
    o 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.

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

Website https://innovation.cms.gov/initiatives/Million-Hearts-CVDRRM/

INACTIVE PROGRAM ARCHIVE- UPDATED 12/2021
Multi-Payer Advanced Primary Care Practice

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

**Stage:** No longer active

**Summary**
The demonstration evaluated whether advanced primary care practice reduced unjustified utilization and expenditures, improved the safety, effectiveness, timeliness, and efficiency of health care 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 in historically underserved areas.

**Eligibility and rural-relevant requirements**
- Practices must have met medical home guidelines to participate; states identified and enrolled practices.

**Timeline/Key Dates**
- Vermont, New York, and Rhode Island began June 1, 2011.
- North Carolina and Michigan began October 1, 2011.

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.

**Evaluation:** Final Report

**Website:** [https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/](https://innovation.cms.gov/initiatives/Multi-payer-Advanced-Primary-Care-Practice/)
Next Generation ACO (NGACO) Model

Aliases: NGACO, Next Gen ACO

Summary
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.

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 payedthe 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

Evaluation (most recent): At-a-glance Two Pager, Full Report

Website: https://innovation.cms.gov/initiatives/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 flexibilities were intended to allow for more individualized and risk-stratified interventions.

**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 through 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.

**Evaluation (most recent):** At-a-glance Two Pager, Full Report

**Website:** https://innovation.cms.gov/initiatives/enhancedmtm/

---

INACTIVE PROGRAM ARCHIVE - UPDATED 12/2021
Pioneer Accountable Care Organization (ACO) Model

Aliases: Pioneer Accountable Care Organization

Stage: No Longer Active

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

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

Timeline/Key Dates

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

INACTIVE PROGRAM ARCHIVE – UPDATED 11/2021
### Appendix 3 – Commonly Used Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
</tr>
<tr>
<td>APM</td>
<td>Alternative Payment Model</td>
</tr>
<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
</tr>
<tr>
<td>CMMI</td>
<td>Center for Medicare &amp; Medicaid Innovation</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>ECE</td>
<td>Extraordinary Circumstance Exception</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-for-Service</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Clinic</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
</tr>
<tr>
<td>HIT</td>
<td>Health Information Technology</td>
</tr>
<tr>
<td>IPPS</td>
<td>Inpatient Prospective Payment System</td>
</tr>
<tr>
<td>MSSP</td>
<td>Medicare Shared Savings Program</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider/Physician</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health Emergency</td>
</tr>
<tr>
<td>PMPM</td>
<td>Per Member per Month</td>
</tr>
<tr>
<td>PBPM</td>
<td>Per Beneficiary Per Month</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
</tbody>
</table>