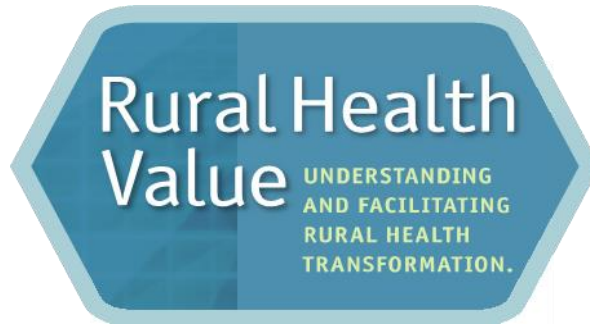




Center for Rural Health Policy Analysis



Catalog of Value-Based Initiatives for Rural Providers

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Introduction

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

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

Over a five-year period, CMS will implement and test a three-track model featuring interventions of varying intensity that link beneficiaries with community services:

- **Track 1 Awareness** – Increase beneficiary *awareness* of available community services through information dissemination and referral.
- **Track 2 Assistance** – Provide community service navigation services to *assist* high-risk beneficiaries with accessing services.
- **Track 3 Alignment** – 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 include: 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.
- For Track 1, modifications were made to reduce the minimum number of beneficiaries that applicants are required to screen annually from 75,000 to 53,000.

Timeline/key dates

- The application period closed in November 2016, and applications are currently under review.
- Award announcements are anticipated in spring 2017.

Payment model/funding

Payment/funding will go to consortiums led by bridge organizations or to bridge organizations that intend to form consortiums responsible for implementing the model. CMS funds cannot be used to pay directly or indirectly for any community services. CMS anticipates supporting up to 44 cooperative agreements.

- Up to \$1.17 million to each of 12 Track 1 – Awareness Intervention award recipients
- Up to \$2.57 million to each of 12 Track 2 – Assistance Intervention award recipients
- Up to \$4.51 million to each of 20 Track 3 – Alignment Intervention award recipients

Current rural participation/impact

The high number of minimum beneficiaries required to be screened make it unlikely that individual rural communities were eligible to apply. Rural providers/communities may be included as part of regional or health system collaborations.

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

ACO Investment Model (AIM)

Aliases: AIM Model

Summary

AIM tests use of pre-paid shared savings to encourage new Accountable Care Organizations (ACOs) to form in rural and underserved areas. The model also encourages current [Medicare Shared Savings Program](#) (MSSP) ACOs to transition to arrangements with greater risk-sharing.

Eligibility and rural-relevant requirements

Limited to two groups:

- New Shared Savings Program ACOs (2015 & 2016) – AIM specifically encourages uptake of coordinated, accountable care in rural and other areas underserved by ACOs.
- Previously participating ACOs under the MSSP starting between 2012-2014 – AIM helps previously 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 completely reported quality measures to MSSP for previous year.
- Previously participating ACOs must have 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.
- Does not include hospitals other than Critical Access Hospitals (CAHs) or inpatient prospective payment system (IPPS) hospitals with 100 or fewer beds.
- ACO is not owned by a health plan.
- ACO did not participate in the [Advance Payment ACO Model](#).

Timeline/key dates

- ACOs had to join by January 1, 2016, no current plans for another application cycle.
- AIM is an evolution of the [Advanced Payment Model ACO](#) that closed to new participants in 2013.

Payment model/funding

ACOs starting 2015 or 2016

- Upfront, Fixed Payment – \$250,000 payment in the first month of participation
- Upfront, Variable Payment – number of preliminary prospectively-assigned beneficiaries multiplied by \$36
- Monthly Variable Payment – monthly payment based on the number of preliminary prospectively-assigned beneficiaries multiplied by \$8, for up to 24 months or until ACO ceases participation in the Shared Savings Program or AIM, whichever is sooner

ACOs participating in Medicare Shared Savings Program from 2012-2014

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

Current rural participation/impact

AIM encourages new ACOs to form in underserved areas, particularly rural areas.

Of the 43 newly accepted ACO participants:

- 35 have at least 65% of delivery sites in rural areas
- 24 have at least 85% of delivery in rural areas
- 27 report having a CAH or IPPS hospital with less than 100 beds

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

Community Based Care Transitions Program (CCTP)

Aliases: Section 3026, Care Transitions Program, CCTP is a component of the [Partnership for Patients](#)

Summary

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

Eligibility and rural-relevant requirements

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

- Must provide care transition services across the continuum of care and have a formal organizational and governance structure:
 - Care transition services that begin no later than 24 hours prior to discharge,
 - Timely and 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 specific to the beneficiary's condition,
 - A comprehensive medication review and management, including—if appropriate—counseling and self-management support, and
 - Formal relationships with hospitals, other providers, and consumer representatives.
- Preference is given to Administration on Aging (AoA) grantees who partner with multiple hospitals and practitioners to provide care transition interventions or entities that provide services to medically-underserved populations, small communities and rural areas.

Timeline/key dates

- CCTP is currently at capacity and is no longer accepting applications. There are no plans for future sites to be added to the program.
- Five rounds of participants were announced between 2011 and 2015.

Payment model/funding

\$500 million between 2011-2015:

- CCTP does not pay for administrative overhead and infrastructure costs.
- CBOs are 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 will only be paid once per eligible discharge in a 180-day period for any given beneficiary. Payments from CCTP are only for Medicare Fee-for-Service (FFS) beneficiaries.

Current rural participation/impact

CBOs are only paid care transition fees for beneficiaries intervened upon immediately following discharge from a partnering IPPS hospital (not a CAH).

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

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

- CMS has implemented the CJR model in 67 geographic areas, defined by metropolitan statistical areas (MSAs). MSAs are counties associated with a core urban area and have a population of at least 50,000.
- Participation in the model was not optional in the 67 geographic areas.
- Non-MSA counties (no urban core area or urban core area of less than 50,000 population) were not eligible for selection.

Timeline/Key Dates

- The program had an April 1, 2016 start date.
- The five performance years for the model are 2016 – 2020.

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

- More research is needed to understand the implications for payment and referrals for post-acute services to CAHs and other rural hospitals when urban health systems receive bundled payments.
- Although the CJR model attempts to test a wide variety of hospitals (by requiring participation), since participation is defined by MSA, it is lacking representation by rural hospitals, who perform a significant amount of CJRs.

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

Comprehensive Primary Care (CPC) Initiative

Aliases: Comprehensive Primary Care (CPC)

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.

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 within the seven regions were selected in 2012 via an application process based on their 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 include shared savings.

Timeline/Key Dates

- Program began in 2013 and ends in 2016 (program years 1 – 4). Practices are no longer eligible to join; all selected practices were chosen in 2012.
- The next evolution of this program is [Comprehensive Primary Care Plus \(CPC+\)](#).

Payment model/funding

CPC integrated a defined payment model and practice redesign focus:

- Payment: Practices receive 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 can share in net savings, calculated at the regional level and distributed to participating practices based on their performance on quality metrics.
- Practice Redesign:
 - CPC aims 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 report progress through a CMS web portal.

Current rural participation/impact

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

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

Comprehensive Primary Care Plus (CPC+)

Aliases: CPC+

Summary

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

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

Eligibility and rural-relevant requirements

- 14 regions were selected for participation based on sufficient interest from multiple payers (measured by covered lives and alignment of proposals).
- RHCs and FQHCs are not eligible for participation.
- On May 27, 2016, CMS opened practice eligibility to allow participation in both MSSP and CPC+. Initial requirements had stated those participating in an MSSP were not eligible.
- CMS has indicated that CPC+ meets the criteria for an Advanced Payment Model (APM) under the new Provider [Quality Payment Program \(QPP\)](#).

Timeline/key dates

CPC+ is a five-year model that begins performance year in 2017.

- Payer Solicitation deadline passed on June 8, 2016.
- CMS regions were announced and practice applications were opened on August 1, 2016.
- Practice applications within CPC+ regions were open through September 15, 2016. CMS has subsequently indicated that practice applications will be re-opened in 2017.

Payment model/funding

CMS and other payers will provide prospective care management fees (CMFs) to practices in both tracks based on beneficiary risk tiers:

- \$15 Per Beneficiary Per Month (PBPM) across 4 risk tiers in Track 1.
- \$28 PBPM Medicare CMFs across 5 risk tiers in Track 2; \$100 CMF for medically complex.
- Comprehensive Primary Care Payments (CPCP):
 - Track 1 receives Medicare FFS; Track 2 receives hybrid FFS/CPCP.
- Performance-Based Incentives:
 - Track 1 receives \$2.50 PBPM; Track 2 receives \$4 PBPM.

Current rural participation/impact

- No specific rural focus, but participation regions include many rural areas including the states of AR, CO, HI, MI, MT, OH, OK, OR, OH (and northern KY).
- Since the model focuses on primary care payments from Medicare Part B, RHCs and FQHCs are ineligible (since they are paid through Medicare Part A).

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

Health Care Payment and Learning Action Network

Aliases: Health Care LAN, the LAN, HCP LAN

Summary

The Health Care Payment and Learning Action Network (HCP LAN) was established to provide a forum for public-private partnerships to help the U.S. health care payment system meet or exceed recently established Medicare goals for value-based payments and alternative payment models.

Eligibility and rural-relevant requirements

- All payers, providers, employers, purchasers, states, consumer groups, individual consumers, and others can participate in the HCP LAN. Participants will be expected to actively engage in the network by contributing to workgroups, sharing best practices, and learning from peers.
- Multi-stakeholder workgroups have developed a variety of work products with the intent of supporting implementation and alignment of value-based reimbursement and APMs. Some examples include an [APM Framework](#), and [Patient Attribution](#), [Financial Benchmarking](#), and [Performance Measurement](#) models for Population Based Payments.

Timeline/key dates

- HCP LAN is currently accepting registration for interested organizations (no charge, just an indication of commitment). A variety of opportunities for participation are available. Program expiration date is 1/31/2019.

Payment model/funding

- Not a payment model. CMS has provided funding to the CMS Alliance to Modernize Healthcare (CAMH), operated by The MITRE Corporation to support HCP LAN activities.

Current rural participation/impact

- There is no specific rural focus, but rural payers, providers, state agencies etc. are encouraged to participate in the network.

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

Hospital Acquired Conditions Reduction Program (HACRP)

Aliases: HACRP, 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

Hospitals are scored based on 2 domains

- Patient safety events using the Agency for Healthcare Research and Quality (AHRQ) patient safety indicator (PSI) 90 composite measure
- Healthcare-acquired infections
 - The Centers for Disease Control (CDC) National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) measure
 - The CDC NHSN Catheter-Associated Urinary Tract Infection (CAUTI) measure
 - The CDC NHSN Surgical Site Infection (Colon Surgery and Abdominal Hysterectomy) (SSI)
 - The CDC NHSN Methicillin-Resistant Staphylococcus Aureus (MRSA)
 - The CDC NHSN Clostridium Difficile (C. diff)

Hospitals that rank in the bottom 25% have payment reduced by 1% for the associated fiscal year

Eligibility and rural-relevant requirements

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

Timeline/key dates

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

Payment model/funding

- Hospitals that rank in the worst-performing quartile with respect to risk-adjusted HAC quality measures have their payments reduced to 99 percent of what would otherwise have been paid.
- In FY 2017, 769 hospitals received payment penalties under the HACRP versus 758 in FY 2016 and 724 in FY 2015.

Current rural participation/impact

- CAHs are exempt, but rural IPPS hospitals are included. In FY 2015, 14% of rural participants were penalized under the HACRP compared to 26% of urban participants.

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

Hospital Innovation Improvement Network (HIIN)

Aliases: HIIN, formerly known as the Hospital Engagement Networks (HENs), Part of the [Partnership for Patients \(PfP\)](#)

Summary

HIINs work at the regional, state, national or hospital system level to sustain and accelerate national progress and momentum towards continued harm reduction in the Medicare program, help identify solutions already working and disseminate them to other hospitals and providers. HIINs will:

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

HIIN goals to be achieved by the end of 2019 are:

- 20 percent reduction in overall patient harm (as measured by Hospital-Acquired Conditions [HACs]/1,000 discharges), and
- 12 percent reduction in 30-day readmissions as a population-based measure (as measured by readmissions per 1,000 people).

Eligibility and rural-relevant requirements

- On September 28, 2016, CMS awarded contracts to [16 HIINs](#). It is anticipated that more than 4,000 hospitals will be involved across the 16 HIINs.

Timeline/key dates

- The period of performance for the HIINs begins in September 2016 and consists of one 24-month base period and one 12-month option year.

Payment model/funding

- HIIN is not a payment model. Funds provided to the HIINs to support patient safety improvement activities. IPPS hospitals are subject to payment penalties for Hospital Acquired Conditions and Hospital Readmissions under the HACRP and HRRP programs. Participation in HIIN activities is one way to support improvement in those areas.

Current rural participation/impact

- No specific rural focus. In the past, a significant number of rural hospitals and CAHs participated in HEN activities in the past, and continued rural participation is anticipated with the HIINs.

Website: <https://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.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 readmissions are measured by a ratio, 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 2017 HRRP calculates excess readmission ratios for six areas: Acute Myocardial Infarction (AMI), Heart Failure, Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Bypass Graft (CABG), and Elective primary total hip and/or total knee arthroplasty (THA/TKA).

Eligibility and rural-relevant requirements

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

Timeline/key dates

- Three years of discharge data are used to calculate readmission penalties for each fiscal year. For example, payment penalties for FY 2016 are based on July 1, 2011 to June 30, 2014 discharges.
- Program criteria and methodology are updated annually through the IPPS rulemaking process.

Payment model/funding

- If a hospital performs better than an average hospital that admitted similar patients, the Excess Readmissions Ratio will be less than 1.0000. If a hospital performs worse than average, the ratio will be greater than 1.0000.
- The excess readmission ratios for each condition are multiplied times the sum of base operating Diagnosis Related Group (DRG) payments for that condition; then added together. This aggregate payment for excess readmissions is divided by the aggregate payments for all discharges, then subtracted from 1 to get the Readmissions Adjustment Factor.
- If the Readmissions Adjustment Factor is 1.000, there is no payment reduction. Any number between .9999 and .9700 would trigger a payment reduction.
- The maximum penalties increased through the first three years of the program, and are now held at a maximum of 3%.
- 2,597 hospitals were penalized in FY 2016 (based on discharges from July 1, 2011 to June 30, 2014).

Current rural participation/impact:

- No specific rural focus, though eligible rural PPS hospitals can participate if they meet specified quality reporting case volume thresholds. In FY 2015, participating rural hospitals were slightly more likely to face penalties in the HRRP program (79%) than their urban counterparts (76%), and the penalties were somewhat larger at rural (0.55%) than urban hospitals (0.46%).

Website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-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 2016 will impact payment in 2018).
- Program criteria and scoring are updated annually through the IPPS rule making process.

Payment model/funding:

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

Current rural participation/impact

- CAHs are exempt, but rural IPPS hospitals are included. In FY 2015, 11% of rural IPPS hospitals were excluded from VBP due to inadequate volumes. Participating rural hospitals had a higher average total performance score relative to urban hospitals which translated to a higher than average payment adjustment (+0.22% of base DRG payments for rural hospitals compared to +0.07% for urban hospitals).

Website: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/>

Independence at Home Demonstration

Aliases: None

Summary

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

Eligibility and rural-relevant requirements

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

Timeline/key dates

The Demonstration began on June 1, 2012, and will end on September 30, 2017. Practices can no longer join.

Payment model/funding

- The participating practices will be eligible for financial incentives if they succeed in offering high quality care that reduces costs for the Medicare program. To qualify for an incentive payment, the practice's expenditures for participating beneficiaries must be lower than the calculated target expenditure, which represents the expected Medicare FFS expenditures of participating beneficiaries in the absence of the Demonstration. Practices are required to meet stringent quality standards and ensure that financial targets are met.
- 9 participating practices received incentive payments in Year 1, 7 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.

Current rural participation/impact

- All 14 of the participating primary care practices are in urban areas, however 7 are Health Professional Shortage Areas and/or Medically Underserved Areas.

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

Medicare Shared Savings Program (MSSP)

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

Summary

The MSSP was established by the ACA and is a key component of Medicare delivery system reform initiatives. MSSP was developed to facilitate 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 3 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. Application deadlines for 2017 participation have closed. Deadlines for 2018 participation have not yet been announced.
- Deadlines for the [AIM](#) (for certain eligible MSSP participants) are outlined in that program's summary.
- Updates to program requirements and methodology are made through the Federal rule making process.

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 three-year agreement period under three tracks:
 - **Track One:** one-sided shared savings model, 50% of savings, no shared loss
 - **Track Two:** two-sided shared savings/shared losses model, 60% split of savings, limit on the amount of losses to be shared in phases in over 3-years starting at 5% in year 1; 7.5% in year 2; and 10% in year 3 and any subsequent year
 - **Track Three:** two-sided shared savings/shared loss model, 75% split of savings, loss sharing limit is 15% (Track Three is a new model defined in the 2015 Shared Savings Final Rule. In return for greater risk, it allows 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. CMS has developed a specific [Rural ACO fact sheet](#).
- The following findings are based on activity through 2015:
 - Medicare ACOs operate in 41.8 percent of all nonmetropolitan counties.
 - Non-metropolitan provider participation in ACOs has increased considerably since 2013, especially in the South, West, and Northeast census regions.
 - 101 new ACO entrants in 2016 included at least 43 ACOs with providers in non-metropolitan areas.

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

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

Aliases: Million Hearts®

Summary

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

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

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

Eligibility and rural-relevant requirements

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

Timeline/key dates

- There is a 5-year period, beginning in September 2016 and ending by August 2021.
- Participants were announced in July 2016, and the model is currently closed to additional applications.

Payment Model/funding

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

Current rural participation/impact

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

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

Multi-Payer Advanced Primary Care Practice

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

Summary

The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care. The following states are participating: ME, MI, MN, NY, NC, PA, RI, VT. Each state coordinates with Medicaid and private payers for involvement.

The purpose of this project is to:

1. Decrease variation in utilization and expenditures, particularly that variation that is 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.

All major payers in the state or region (Medicare, Medicaid, large private insurers/ managed care organizations) participate. This help ensures the availability of resources for the implementation of the advanced primary care model.

Eligibility and rural-relevant requirements

- Program pays a monthly care management fee for beneficiaries who received care from Advanced Primary Care practice (APC), which is intended to cover care coordination, enhanced access, education, and other services.
- Practices must meet medical home guidelines to participate; states will identify and enroll practices.

Timeline/Key Dates

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

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

Payment model/funding

- Under the demonstration, states will pay participating practices additional amounts for transforming their practices into medical homes and for providing services that are not otherwise covered under the traditional Medicare.

Current rural participation/impact

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

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

Next Generation ACO (NGACO) Model

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

Summary

NGACO aims to encourage experienced ACOs to assume higher levels of financial risk and reward than are currently available under other MSSP and the [Pioneer Model](#). Goal is to test whether strong incentives coupled with patient engagement and case management support tools improve outcomes and increase savings.

Eligibility and rural-relevant requirements

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

Timeline/key dates

- Letter of Intent submission deadline for 2017 cycle passed on May 25, 2016. This was the final application round for this model.

Payment model/funding

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

Current rural participation/impact

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

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

Partnership for Patients (PfP)

Aliases: PfP, the Community-Based Care Transitions Program (CCTP) and Hospital Innovation Improvement Network (HIIN) are both part of the PfP. HIINs were formerly known as Hospital Engagement Networks (HENs).

Summary

The PfP initiative is a public-private partnership working to improve the quality, safety and affordability of health care for all Americans. The PfP and its participating hospitals are focused on making hospital care safer, more reliable, and less costly through the achievement of two goals:

- Making Care Safer. Keep patients from getting injured or sicker. Decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
- Improving Care Transitions. Help patients heal without complication. Decrease preventable complications during a transition from one care setting to another so that hospital readmissions would be reduced by 20 percent compared to 2010.

Patient and Family Engagement is a key component of the PfP programs and robust efforts to engage patients and families in their care are woven throughout all aspects of the program to achieve system-wide adoption of patient and family engagement best practices.

Eligibility and rural-relevant requirements

- National campaign activity with encouragement to engage all types of hospitals

Timeline/key dates

- The Partnership for Patients was initially launched in 2011.
- See the [CCTP](#) and [HIIN](#) summaries for program details.

Payment model/funding

- PfP is not a payment model. The partnership focuses on best practice identification, dissemination, and implementation. Payment model/funding is provided to organizations to provide technical assistance and support for implementation.

Current rural participation/impact

- There is no specific rural focus, though some participating HIIN hospitals are in rural areas.

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

Pioneer ACO Model

Aliases: Pioneer Accountable Care Organization

Summary

The Pioneer ACO Model is designed for health care organizations and providers already experienced in coordinating care for patients across care settings. It allows these provider groups to 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 is designed to work 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 are 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% 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 assigns beneficiaries to Pioneer ACOs, which allows providers to know in advance the beneficiaries for whom they will be held accountable.
 - CMS determines which PCP the patient has been using for most of their PC needs and uses that to determine which beneficiaries are assigned to provider(s) annually.
 - If the patient uses less than 10% of their care with that PCP, CMS will re-align that patient's assignment to whichever provider delivers most of their care.
 - ACOs must have a minimum of 15,000 assigned Medicare FFS beneficiaries, unless they are in a rural area, then the minimum requirement is 5,000.
 - For a beneficiary to be assigned, they must be originally enrolled in FFS Part A and B; those originally enrolled in Part C are not eligible.

Timeline/Key Dates

- Performance Years 1 – 3 (2012 – 2014): initial three-year contract period.
- Performance Year 4 (2015), Performance Year 5 (2016).
- Fixed period for demonstration enrollment (which is now closed).
- Next evolution of this demonstration is the Next Generation ACO Model.

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. The shared savings in the Pioneer ACO model were determined by comparing the ACOs benchmark and trend in expenditures nationally.
- 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, ideally used to replace the FFS ACO payments. There was also an option for partial-population based payment that limits the risk and reward during year three to lower the increased risk.

Current rural participation/impact

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

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

State Innovation Model (SIM) Initiative

Aliases: SIM, some state-specific models and components have different names (e.g., Care Coordination Organizations in Oregon).

Summary

The State Innovation Models (SIM) Initiative was launched in 2013 to test the ability of state governments to use their policy and regulatory levers to accelerate health care transformation efforts in their states, with a primary goal to transform over 80 percent of payments to providers into innovative payments and service delivery models. Awards have been given in the form of Model Design, Model Pre-Test, and Model Test awards. SIM has supported over 38 states, territories, and the District of Columbia in two rounds of awards:

- In Round One, nearly \$300 million was awarded to 25 states to design or test innovative health care payment and service delivery models in the form of Model Design, Model Pre-Test, and Model Test awards.
- In Round Two, over \$660 million was awarded to 32 awardees.
- Over half of states representing 61 percent of the U.S. population (38 total SIM awardees, including 34 states, three territories and the District of Columbia) are working on efforts to support comprehensive state-based innovation in health system transformation.

Eligibility and Rural-Relevant Requirements

State Governors' Offices, the United States Territories Governors' Offices, and the Mayor's Office from the District of Columbia are the only eligible entities to apply. However, a State Governor's office may propose that an outside organization focused on quality and state delivery system transportation receive and administer the funds. Only one such request is allowed per state.

Timeline/Key Dates

Round One Awards began on April 1, 2013.

- Six states (AR, ME, MA, MN, OR, VT) were awarded 42-month model testing awards. The full test period for the Round 1 Test states was October 2013 through September 2016. However, for Massachusetts the start of the test period lagged that of the other five Test states by 3 months; and Massachusetts, Minnesota, and Vermont have all received no-cost extensions to their SIM awards.
- Three states (CO, NY, WA) received pre-testing assistance and funding to continue to work on a comprehensive State Health Care Innovation Plan, and [sixteen states](#) received model design awards. Both groups had six months to develop and submit a State Health Care Innovation Plan to CMS. Five states were awarded extensions through March 2014. A summary of the state plans can be found in the [Round One Model Design Evaluation Report](#).

Round Two Awards began on February 1, 2015.

- Eleven states (CO, CT, DE, ID, IA, MI, NY, RI, OH, TN, WA) were awarded 48-month model testing awards.
- Twenty-one awardees (including [17 states, three territories and the District of Columbia](#)) were awarded model design awards and have 12 months to develop and submit a State Health Care Innovation Plan to CMS.

Payment model/funding

- Payment/funding (\$300 million in Round One and \$660 million in Round Two) has been provided to the state, territories or District of Columbia to support planning activities in model design awards, and to support planning, implementation and evaluation activities in the model test awards.

Current rural participation/impact

- States receiving model testing awards have generally had significant rural participation.

Website: <https://innovation.cms.gov/initiatives/State-Innovations/index.html>

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. The QPP replaces the Physician Quality Reporting System (PQRS), the Medicare EHR Incentive Program (Meaningful Use), and the Value Based Modifier (VBM). 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 \$30,000/year or care for more than 100 Medicare Part B-enrolled patients/year.
 - Eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.
- For APMs, clinicians must receive 25% of their Medicare payments or see 20% of their Medicare patients through an Advanced APM (in 2017). Programs qualifying as Advanced APMs in 2017 can be found [here](#).

Timeline/Key Dates

- The first QPP performance period opens January 1, 2017 and closes December 31, 2017.
- There will be a lag between performance and payment adjustment. For example, performance in 2017 will impact payment in 2019.
- CMS announced on September 8, 2016 that it will allow clinicians to pick their pace of participation for the first performance period (2017), participating for either a full or partial calendar year or “testing” the QPP.
- The QPP program will be updated annually through the CMS rulemaking process.

Payment model/funding

- **MIPS:** Positive or negative payment adjustment will be made based on evidence-based and practice-specific quality data in four areas: Quality, Improvement Activities, Advancing Care Information, and Cost. The cost category will be calculated in 2017, but will not be used to determine payment adjustment for the first year. In 2018, CMS will start using the cost category as part of the formula for payment adjustment. For the first year, providers will earn positive or neutral MIPS payment adjustment if they submit 2017 data by March 31, 2018. Future years will bring increasing positive or negative performance adjustments plateauing at +/- 9% in 2022. In addition, 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.
- **APM:** Clinicians participating as an Advanced APM in 2017 will earn a 5% incentive payment in 2019 and are exempt from MIPS payment adjustments.

Current rural participation/impact

Since the QPP only affects Medicare Part B clinician payments, RHCs and FQHCs are ineligible (they are facilities paid through Part A). The final rule allows RHCs and FQHCs to voluntarily report data through MIPS. Under MACRA, CMS has designated \$20 million dollars for technical assistance over five years (\$100 million total) to support small practices in rural and underserved areas. 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.

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

Commonly Used Acronym List

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