CENTER FOR MEDICARE AND MEDICAID INNOVATION

2024 REPORT TO CONGRESS

DECEMBER 2024

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

TABLE OF CONTENTS

LETTER FROM THE DIRECTOR

The Critical Role of the CMS Innovation Center in the American Health Care System

The Centers for Medicare & Medicaid Services (CMS) is the nation's largest payer for health care and plays a key role in transforming the health care system toward one that provides higher value, more equitable, and affordable care that reflects individual preferences. Congress established the Innovation Center within CMS in 2010 to enable CMS to test ways to improve the quality of care and reduce Federal spending on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Over the past 10 years, the CMS Innovation Center has tested more than 50 payment and care delivery models, which have contributed to shifting how we pay for care in the United States to focus more on quality, clinical outcomes, and patient experience.

When I joined the CMS Innovation Center in 2021, we undertook a Strategy Refresh, with the goal of understanding the lessons learned from our first decade and using those to inform our strategy for the future. The strategy laid out a path to a new vision: a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. In developing our strategy and conducting our ongoing work, we consult regularly with front-line health providers, beneficiaries, health plans, states, organizations, and committees comprised of stakeholders, like the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which are essential for our ability to successfully identify and test models.

A comprehensive review and analysis of our model tests yielded important insights on the models' impacts that have broadened our perspective for ways to build on successful models. Our statute, Section 1115A of the Social Security Act (as added by Section 3021 of the Affordable Care Act), lays out a path for expansion of a model's scope or duration: the independent Office of the Actuary certifies that the model would reduce or maintain spending and the Secretary determines that model expansion would improve or maintain quality of care. Each model is tested for a limited duration. We then conduct an extensive analysis and evaluation to identify factors that may have led to improved quality or reduced spending, which can then be incorporated into other model tests or CMS programs.

In addition to expansion of a model that meets the statutory requirements, in many cases we apply learnings from our models by integrating successful elements of the tests into the Medicare and Medicaid programs, which brings innovations in care to more beneficiaries. This approach to scaling a model test outside of the expansion pathway includes the following:

- *Model innovations incorporated permanently into Medicare*, such as the advance payment option of the ACO Investment Model, which was incorporated into the Medicare Shared Savings Program (SSP);
- *Model features adopted through legislation*, for example, the inclusion of the Medicare $2 Drug List Model Concept in the FY 2025 President's Budget as well as the expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) model test nationwide through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA);

- *Successor models building on lessons from previous models*, such as the mandatory Transforming Episode Accountability (TEAM)[1] and Increasing Organ Transplant Access (IOTA)[2] models, that further innovate and advance on our earlier bundled payment and kidney models, respectively; and
- *Broader adoption of a model's innovative features*, such as the screening tool for health-related social needs developed by CMS in the Accountable Health Communities Model.[3]

Furthermore, evidence from the literature and anecdotally from interviews with nearly 150 providers, payers, management services organizations, and industry and academic experts indicate that the broader adoption of our models' innovative features has "spillover effects" resulting in a wider impact on the health system beyond the boundaries of individual model tests.[4] For example, providers participating in CMS Innovation Center models often implement model-associated care delivery changes (such as access to a 24/7 nursing phone line) for all patients, regardless of payer and alignment to a model, leading to positive spillover effects on patients' health outcomes and expenditures.[5] Interviewees reported that this has subsequently contributed to greater adoption and acceleration of value-based care across the industry—including through increased creation of and participation in private payer "lookalike" models similar to CMS Innovation Center models—and changes in attitudes toward value-based care and how care is delivered.

Incorporating mechanisms to detect spillover effects when setting up model evaluations' comparison groups may allow us to more comprehensively evaluate changes in care quality and spending. We are committed to incorporating insights regarding spillover effects into both current and future model designs with the goals of broadening our models' impact and better measuring the overall effect of the CMS Innovation Center models.

[1] Final Rule available on the Federal Register at: https://www.federalregister.gov/documents/2024/08/28/2024-17021/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient.

[2] Final Rule available on the Federal Register at: https://www.federalregister.gov/public-inspection/2024-27841/medicare-program-alternative-payment-model-updates-and-the-increasing-organ-transplant-access-model.

[3] Cancer Support Community, "A New Screening Tool Identifies Unmet Health-Related Social Needs (HRSN)," Available at: https://www.cancersupportcommunity.org/blog/new-screening-tool-identifies-unmet-health-related-social-needs-hrsn.

[4] JAMA, "Alternative Payment Models — Victims of Their Own Success?" Available at: https://jamanetwork.com/journals/jama/fullarticle/2767680; JAMA, "Association of Participation in the Oncology Care Model With Medicare Payments, Utilization, Care Delivery, and Quality Outcomes." Available at: https://jamanetwork.com/journals/jama/fullarticle/2785949; PNAS, "Randomized trial shows healthcare payment reform has equal-sized spillover effects on patients not targeted by reform." Available at: https://www.pnas.org/doi/epdf/10.1073/pnas.2004759117.

[5] Health Affairs, "Market Momentum, Spillover Effects, And Evidence-Based Decision Making On Payment Reform." Available at: https://www.healthaffairs.org/content/forefront/market-momentum-spillover-effects-and-evidence-based-decision-making-payment-reform.

Recent Progress and Plans for the Future

Since our last biennial Report to Congress in 2022, the CMS Innovation Center has made substantial progress executing on our strategy.

This progress includes announcing nine new models: Making Care Primary (MCP), Guiding an Improved Dementia Experience (GUIDE), States Advancing Health Equity and Development (AHEAD), Transforming Maternal Health (TMaH), Innovation in Behavioral Health (IBH), Cell and Gene Therapy Access Model (CGT Access), ACO Primary Care Flex (ACO PC Flex), Transforming Episode Accountability Model (TEAM), and Increasing Organ Transplant Access (IOTA). Each model includes specific features and requirements to deliver on our five strategic objectives—driving accountable care, advancing health equity, supporting innovation, addressing affordability, and partnering to achieve system transformation. For example, the GUIDE Model is designed to improve the quality of life for people living with dementia and their caregivers by keeping them in their communities through greater support, including respite services for certain beneficiaries and their unpaid caregivers. The ACO PC Flex Model is an important part of the progress toward our goal to have all people with Medicare in a care relationship with accountability for quality and total cost of care by 2030 by promoting the development of new physician-led accountable care organizations in the Shared Savings Program. The IOTA and TEAM models reflect our commitment to health equity and improving care for beneficiaries through testing models with mandatory participation.

The CMS Innovation Center has addressed the strategic goal of advancing health equity in both new and existing models by including policies focused on reducing health disparities and increasing our impact on care for underserved populations. We have implemented payment adjustments in models to bridge the gap between historic spending levels and actual costs of caring for underserved beneficiaries, as well as to support participants who serve a higher proportion of underserved populations. A key measure of the success of these policies is that we have significantly expanded the number of safety net providers, such as Federally Qualified Health Centers, participating in Medicare models.

We also have made significant strides encouraging other payers to align their payment approaches with the work of the CMS Innovation Center. Most of the newly introduced models described above demonstrate our concerted effort to work more closely with state governments and to build a greater CMS Innovation Center focus on working with Medicaid, including the MCP, AHEAD, TMaH, IBH, and CGT Access models. The core principles of the AHEAD and MCP models include collaboration to achieve alignment between commercial payers, Medicaid, and Medicare in transformative new payment models.

The CMS Innovation Center also has focused on creating pathways for model participants who are new to value-based care. The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model, for example, has a specific track to support providers that are new to ACOs. Additionally, through a progressive pathway to value-based payment including three tracks that increase in care delivery and payment advancement over time, MCP provides resources that are aimed at smaller, independent practices.

The CMS Innovation Center is continuing to build on lessons learned to implement these new models and to inform future ones. Equipped with the experience of the first 10 years of testing models, the CMS Innovation Center continues to prioritize model tests that fill critical gaps in care delivery; are feasible; are aligned with broader CMS efforts; have the potential to improve the quality of care and care experience for people with Medicare, Medicaid, and CHIP; and reduce spending in these programs. Beyond reducing costs and improving quality, a model's success must also be measured by how it impacts existing CMS programs, beneficiaries and families, providers, payers, states, and the broader health care system to ensure they all benefit from and participate in this vision.

Elizabeth Fowler

REPORT TO CONGRESS HIGHLIGHTS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Center for Medicare and Medicaid Innovation
2024 REPORT TO CONGRESS HIGHLIGHTS

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established by statute in 2010 to test "innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care" provided to individuals receiving benefits from Medicare, Medicaid, or the Children's Health Insurance Program. Section 1115A(g) of the Social Security Act requires the Secretary of the U.S. Department of Health and Human Services to submit to Congress a report on the CMS Innovation Center's activities under section 1115A at least once every other year. This seventh biennial report covers activities conducted between October 1, 2022 and September 30, 2024.

STRATEGIC DIRECTION SETS COURSE FOR NEW MODELS

Models announced during the reporting period support the vision of a health system that achieves equitable outcomes through high quality, affordable, person-centered care and help advance the five related strategic objectives:

BY THE NUMBERS: CMS INNOVATION CENTER 2022–2024

57 MILLION+
BENEFICIARIES SERVED

192,000+
PROVIDERS PARTICIPATING

37
ACTIVE MODELS AND INITIATIVES

9
NEW MODELS ANNOUNCED

52
EVALUATION REPORTS POSTED

130+
HOSTED AUDIENCE ENGAGEMENT EVENTS

Center for Medicare and Medicaid Innovation
2024 REPORT TO CONGRESS HIGHLIGHTS

MODELS INFORM ONGOING HEALTH SYSTEM TRANSFORMATION

A retrospective review of select models informed a new framework to assess the CMS Innovation Center's contributions to health system transformation, including care delivery strategies and tactics associated with better quality, outcomes, and patient experience at lower costs. The review found:

Models fostered care coordination and person-centered strategies

Practice changes promoted tailored patient care

Care delivery changes extended beyond Innovation Center models

NEWLY ANNOUNCED MODELS

ACCOUNTABLE CARE

- ACO Primary Care Flex (ACO PC Flex)
- Making Care Primary (MCP)

DISEASE-SPECIFIC & EPISODE-BASED

- Guiding an Improved Dementia Experience (GUIDE)
- Increasing Organ Transplant Access (IOTA)
- Transforming Episode Accountability Model (TEAM)

PRESCRIPTION DRUG

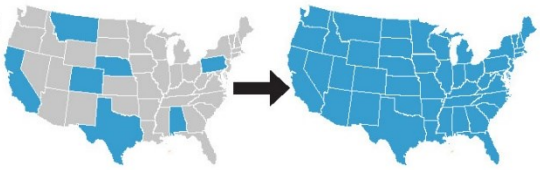
- Cell and Gene Therapy Access (CGT Access)

STATE & COMMUNITY-BASED

- Innovation in Behavioral Health (IBH)
- States Advancing Health Equity and Development (AHEAD)
- Transforming Maternal Health (TMaH)

BUILDING ON SUCCESS

In addition to certification and formal expansion, the CMS Innovation Center has leveraged other pathways to scale models that have demonstrated success at improving quality, reducing cost or both, based on the model evaluation. Scaling approaches may include incorporating successful elements of models into CMS programs and successor models.



QUALITY PATHWAY RENEWS FOCUS ON ACCOUNTABLE CARE

A newly developed Quality Pathway puts stronger emphasis on patient outcomes and experience in CMS Innovation Center models. It aligns model design with patient-centered quality goals and measures to effectively and accurately evaluate model impact on people served by CMS. This gives CMS a greater opportunity to nationally expand, or otherwise scale up, models if they improve quality of care.

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (CMS Innovation Center) was established in 2010 as part of the Affordable Care Act for the purpose of testing "innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care" provided to individuals who receive benefits from Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).[6] The Secretary of the Department of Health and Human Services (HHS) has the authority under section 1115A(c) of the Social Security Act (the Act) to expand through rulemaking the duration and scope of a model being tested, including implementation on a nationwide basis if the model meets certain statutory criteria. To exercise this authority, the Secretary and CMS actuaries review the model evaluations and determine whether the expansion is expected to either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and to ensure that the expansion would not deny or limit the coverage or provision of any benefits.

Section 1115A(g) of the Act requires the Secretary to submit to Congress a report on the CMS Innovation Center's activities at least once every other year beginning in 2012. The CMS Innovation Center is submitting this seventh biennial report covering model activities conducted between **October 1, 2022 and September 30, 2024** (the period of report). CMS estimates that during the period of this report more than 57 million Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by, have received care from, or will soon be receiving care furnished by the more than 192,000 health care providers and/or plans participating in the CMS Innovation Center payment and service delivery models and initiatives.[7]

Partnerships with Other CMS Components and Federal Agencies

Section 1115A(a)(3) of the Act requires the CMS Innovation Center to "consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management." In addition to consulting regularly with front-line health providers, beneficiaries, health plans, states, organizations, and stakeholder-focused committees, like the Physician-Focused Payment Model Technical Advisory Committee (PTAC), the CMS Innovation Center has accordingly consulted and worked with components across CMS, the Department of Health and Human Services (HHS), states, and other Federal agencies since its inception. These partnerships are crucial to drive health system transformation, including the adoption of the CMS Innovation Center's lessons learned into the Medicare and Medicaid programs. The CMS Innovation Center has coordinated with the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Food and Drug Administration, and the Administration for Community Living for input on recently announced models. Moreover, such partnerships may

[6] Section 1115A of the Social Security Act appropriated $5 million for fiscal year 2010 and provided a total of $10 billion for fiscal years 2011–2019, in addition to $10 billion for each 10-year fiscal period thereafter.

[7] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or other individual might be included in multiple model tests. The beneficiary and provider numbers fluctuate depending on the composition of the model portfolio.

improve data collection and analysis used to develop models and new initiatives, as well as to make changes to existing programs. As an additional example, this collaboration helps the CMS Innovation Center examine how Medicare and Medicaid payments can incorporate best practices established by Federal partners for addressing patients' social needs to achieve improved and more sustainable outcomes.

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

For some models tested under the CMS Innovation Center's authorizing statute, other CMS components are involved throughout the model test process, including initial design, implementation, and expansion.

STRATEGIC ACCOMPLISHMENTS

The CMS Innovation Center, in consultation with its Federal partners and external groups, established a strategic vision for a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. Five objectives provide the foundation to shift our health care delivery system toward meaningful transformation: drive accountable care, advance health equity, support innovation, address affordability, and partner to achieve system transformation. These objectives will help CMS progress toward the goal of having all people with Medicare and a vast majority of people with Medicaid in a care relationship with accountability for quality and total cost of care by 2030. Table 1 highlights several of the CMS Innovation Center's strategic accomplishments aligned to each objective since its last Report to Congress.

Table 1: Strategic Accomplishments by Objective

Drive Accountable Care

- Redesigned and launched the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model as an additional avenue for people with Medicare to establish accountable care relationships with their providers. The CMS Innovation Center grew ACO REACH participation from 53 ACOs and about 350,000 covered lives in 2021 to 132 ACOs and 2.1 million covered lives in 2023.
- Launched the Making Care Primary (MCP) Model in eight states to move toward value-based payment for participating primary care clinicians and to equip them with tools to form partnerships with health care specialists. MCP includes a pathway for primary care clinicians with varying levels of experience in value-based care, including Federally Qualified Health Centers (FQHCs), to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration.
- Announced the ACO Primary Care Flex (ACO PC Flex) Model to encourage transition from Fee-For-Service and position more primary care clinicians and providers to assume greater accountability for quality and costs over time by implementing more flexible prospective primary care payment in the Medicare Shared Savings Program.
- Launched the Enhancing Oncology Model (EOM), which focuses on integrating enhanced care coordination and increasing accountability for cost and quality into cancer care.
- Scaled successful features of the ACO Investment Model through the advance investment payment option in the Medicare Shared Savings Program for eligible ACOs.
- Supported ACOs through the integration of primary and specialty care as outlined in the CMS Innovation Center's published strategy to support person-centered, value-based specialty care.

Advance Health Equity

- Focused on including and supporting safety net providers new to value-based payments to reach more underserved beneficiaries. New models include such features as upfront infrastructure payments as in the MCP, Innovation in Behavioral Health (IBH) and Guiding an Improved Dementia Experience (GUIDE) models and tailored technical assistance as in the Transforming Maternal Health (TMaH) Model for states to support recruitment of safety net providers and partners in rural and other high-need areas.
- Tested payments adjusted for social risk in new models to increase resources available to care for underserved populations. For example, ACO REACH includes a financial benchmark adjustment for participating ACOs that disproportionally serve underserved populations. This increased funding also is intended to support more targeted services, such as those provided by community-based organizations, to address health-related social needs (HRSN) that affect patient health and costs.
- Collected and reported patient-reported sociodemographic and HRSN data in models (where feasible), in accordance with the voluntary U.S. Core Data for Interoperability standards, to support robust monitoring and evaluation.
- Designed the Medicare Advantage Value-Based Insurance Design (VBID) Model with the intent to more fully address drug affordability and the HRSN of beneficiaries in the Medicare Advantage program—including those with low incomes, such as dual Medicare and Medicaid eligible beneficiaries.
- Helped model participants identify and address disparities in access and care for the populations they serve by requiring health equity plans in some new models. The ACO REACH Model, for example, requires model participants to develop a Health Equity Plan, which is a tool or framework to help participants identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.

Support Innovation

- Developed a strategy and announced a commitment to increase the use of patient-reported outcome measures to measure what matters to beneficiaries and evaluate the experience of patients and caregivers in models.
- Designed new approaches to incorporate screenings and referrals for HRSN. Six CMS Innovation Center models that began testing in 2024 require HRSN screening for food insecurity, housing insecurity, and transportation difficulties. Five recently announced models (AHEAD, GUIDE, IBH, MCP, and TMaH) require model participants to submit HRSN data to CMS.

- Led an initiative to improve the interoperable exchange of cancer data, as part of the White House Cancer Moonshot workstream and in conjunction with Office of the National Coordinator for Health Information Technology and the National Institutes of Health. This led to the creation of U.S. Core Data for Interoperability "Plus" (USCDI+) for Cancer and a cross-agency data summit. The Enhancing Oncology Model serves as the first use case for advancing cancer data interoperability, which includes a Fast Healthcare Interoperability Resources (FHIR) implementation guide.[8]
- In February 2024, CMS released episode-based claims data ("shadow bundles") to ACOs in the Medicare Shared Savings Program and the ACO REACH Model. Shadow bundles represent payments made for all services and supplies associated with a discrete episode of care. They help ACOs assess the cost and quality of care for these episodes, as well as demonstrate patterns of specialist care within the ACO. This claims data can increase transparency and consistency across time to support high-value, accountable care.[9]

Address Affordability

- Saw nationwide adoption of elements of the Part D Senior Savings Model when Congress made a similar benefit available to all beneficiaries with coverage under a Medicare prescription drug plan.
- Responded to Executive Order 14087 "Lowering Prescription Drug Costs for Americans," which was issued by President Biden, with a report to the White House that outlined selected models aimed at improving prescription drug affordability and access:
  - Announced the voluntary Cell and Gene Therapy Access (CGT Access) Model for states and manufacturers to test whether a CMS-led approach to developing and administering outcomes-based agreements for cell and gene therapies improves Medicaid beneficiaries' access to innovative treatment, improves their health outcomes, and reduces health care costs and burdens to state Medicaid programs.
  - Announced development of the Medicare $2 Drug List Model that would improve beneficiary access to prescription drugs with stable, predictable copayments for a standardized list of low cost, clinically important generics.[10]

[8] Health Affairs, "The CMS Innovation Center's Strategy To Support Person-Centered, Value-Based Specialty Care: 2024 Update." Available at https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care.

[9] Health Affairs, "The CMS Innovation Center's Strategy To Support Person-Centered, Value-Based Specialty Care: 2024 Update." Available at https://www.healthaffairs.org/content/forefront/cms-innovation-center-s-strategy-support-person-centered-value-based-specialty-care.

[10] After the conclusion of the reporting period for this Report to Congress, the CMS Innovation Center continued development of the Medicare $2 Drug List Model with the release of a Request for Information on October 9, 2024. Available at: https://www.cms.gov/files/document/m2dl-model-rfi.pdf.

- Continued to review opportunities for a model that would test ways to encourage timely completion of confirmatory trials for drugs approved by the Food and Drug Administration under the accelerated approval pathway.

Partner to Achieve System Transformation

- Launched the AHEAD Model to focus on multi-payer alignment for state and regional health care transformation, with the goal of improving the total health of a state population and lowering costs.
- Announced the IBH Model to center on Federal–state partnership in support of primary care and behavioral health integration. IBH is a state-based model focused on community-based behavioral health practices that treat Medicaid and Medicare beneficiaries.
- Released the Multi-Payer Alignment Blueprint which compiles successful initiatives from state-level efforts to advance quality measure alignment, health equity, alternative payment model (APM) design, and data sharing through the State Transformation Collaboratives.
- Published data for more than 20 models in the Chronic Conditions Warehouse Virtual Research Data Center to give external researchers and organizations the opportunity to analyze and generate insights on the impact of models on patients, the health care delivery system, and costs.
- Produced approximately 20 publications and webinars to share new CMS Innovation Center strategic direction and learnings, and to solicit input and feedback.

LEARNING SYSTEMS AND BENEFICIARY ENGAGEMENT

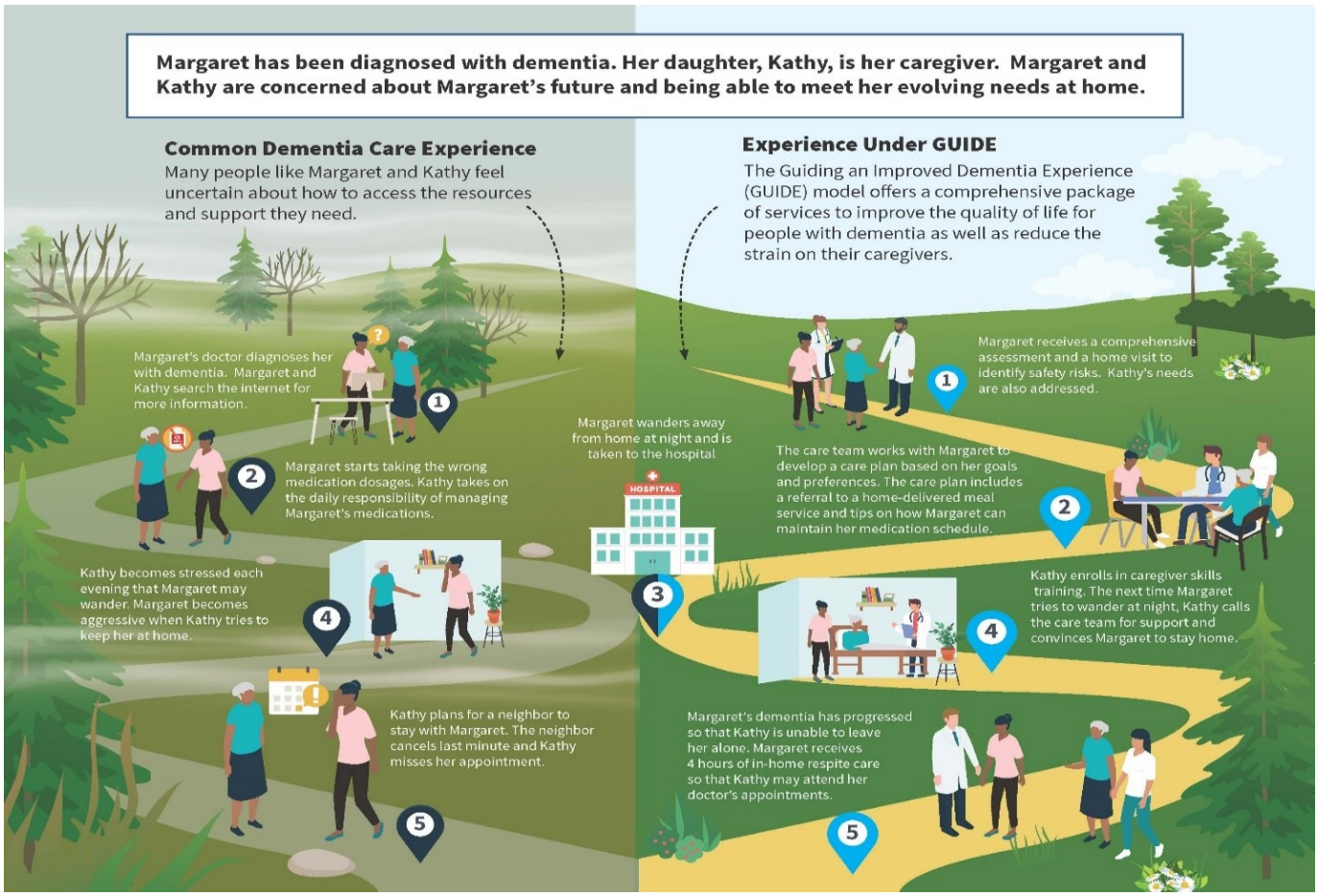
During this reporting period, the CMS Innovation Center provided learning system support to models through more than 130 live and asynchronous virtual and in-person events, and through the development of tools such as case studies, toolkits, dashboards and other durable resources.

Beginning at the early stages of development and continuing throughout a model's life cycle, the CMS Innovation Center provides models and their participants with customized learning system support aligned to model objectives and participant demographics and needs. Further, learning system strategies support models in achieving Center-wide priorities, such as health equity, person-centered care and advancing multi-payer alignment. Learning systems aim to identify and rapidly disseminate effective strategies to achieve model aims. They also provide opportunities for participants to engage in peer-to-peer sharing and collaboration around challenges, tactics, and accomplishments to accelerate adaptation and adoption of successful strategies using a quality improvement approach. Data obtained from the learning systems play an integral role in the CMS Innovation Center's ability to refine existing model policy; formulate future model policy; and identify best practices in care, quality, and payment that can be scaled across multiple models.

Beneficiary Experience

The CMS Innovation Center solicits feedback from beneficiary representatives and organizations to develop models designed to improve the beneficiary experience of care, equity, and outcomes. The CMS Innovation Center launched a strategy in September 2022 to ensure that all models engage beneficiaries, caregivers, and patient groups throughout the model lifecycle, which spans model design and development, announcement, participant recruitment, implementation, and evaluation. The CMS Innovation Center holds at least two public listening sessions per year focused on patient and caregiver experience, alongside model-specific listening sessions and webinars engaging the public on model features.

The CMS Innovation Center uses beneficiary journey mapping strategies to elevate the importance of patient and caregiver experience and understand how this experience relates to improving quality, outcomes, and equity within models while reducing costs. The CMS Innovation Center uses information gathered from interviews, listening sessions, and other research to assess how patients and caregivers are currently experiencing care, identify challenges along their continuum of care, and determine how model design features can address those barriers. Through journey mapping, the CMS Innovation Center has developed visual tools to illustrate how the patient relationship with a health care provider or organization—their journey receiving care—contributes to model success. The CMS Innovation Center is leveraging journey mapping strategies throughout the model lifecycle, with the goal of using these strategies to gather real-world feedback throughout the model to create a continuous feedback loop with patients and caregivers. Journey mapping strategies have been used to strengthen model design and support outreach strategies for models, including Guiding an Improved Dementia Experience (GUIDE) (see graphic below), Transforming Maternal Health (TMaH), Innovation in Behavioral Health (IBH), and Cell and Gene Therapy Access (CGT Access).



The Guiding an Improved Dementia Experience (GUIDE) Model Dementia Pathways Infographic is an example of a CMS Innovation Center beneficiary journey map. The CMS Innovation Center's journey maps highlight the patient and caregiver experience and how this experience relates to improving quality, outcomes, and equity within models.

Health Care Payment Learning and Action Network

Launched in March 2015, the Health Care Payment Learning and Action Network (LAN) is a nationwide public–private collaborative seeking to accelerate the adoption of alternative payment models (APMs) across the public and private sectors. The LAN brings together industry stakeholders—such as payers, providers, states, patient advocates, trade associations, and philanthropy—to drive the adoption of accountable, person-centered care. The LAN is currently operating five strategic initiatives to drive national alignment: the Accountable Care Action Collaborative, the State Transformation Collaboratives, the Health Equity Action Team, the Person's Perspectives Council, and the National Plan Workgroup. Additionally, the LAN conducts an annual survey to benchmark progress toward APM and accountable care adoption goals.

Outreach Initiatives

Listening Sessions

The CMS Innovation Center hosted several events to engage audiences on various topics surrounding models and Center initiatives. The CMS Innovation Center holds both public and closed-door listening sessions. Public listening sessions are open for all to attend so that the CMS Innovation Center can share information about its evolving strategies and programs with the public; collect feedback from stakeholders to understand their priorities; and establish ongoing, two-way opportunities for communication. The sessions are promoted via CMS listservs, social media accounts, and the CMS Innovation Center webpage. Closed-door roundtable sessions are used to collect specific, targeted feedback from select experts and representatives on a particular topic to inform model strategies. When identifying participants for roundtable sessions and speakers for listening sessions, the CMS Innovation Center considers guiding questions, such as the following:

- Does the individual bring extensive expertise on the topic?
- Has the individual presented for the CMS Innovation Center before?
- Do the individuals invited represent diverse stakeholder groups and backgrounds?

Notable sessions include a roundtable on safety net provider participation in models and a discussion on the Center's strategy to support person-centered, value-based specialty care. Additionally, the CMS Innovation Center hosted three patient-centered sessions that focused on leveraging relationships with community-based organizations to meet health-related social needs, elevating the care experience across models to improve outcomes and equity, and the CMS Innovation Center's commitment to partnering with patients throughout a model's lifecycle.

Across the 13 events held between October 1, 2022 and September 30, 2024, the CMS Innovation Center interacted with 1,995 overall attendees in the following participant groups:

- Federal Contractors (146),
- Accountable Care Organizations (125),
- Federal Government (111),
- Professional Association/Trade Organizations (82),
- Beneficiary/Community Stakeholder Groups (53),
- Specialty Care Organizations (52),
- Academic Medical Centers (52),
- Primary Care Practices (51),
- Managed Care Organizations (47),
- Beneficiaries/Caregivers (24), and
- Private Payers (20).

More information can be found in the Past Events section of the Strategy webpage.

Rural Health Hackathon

In August 2024, the CMS Innovation Center hosted three Rural Health Hackathons in Montana, Texas, and North Carolina to generate new ideas to address some of the top challenges impacting health care in rural settings. Based on extensive outreach to rural communities through site visits and listening sessions, these events focused on three specific challenge areas: care delivery, access to care, and workforce. They convened more than 140 health care organizations serving rural communities along with community organizations, industry and tech entrepreneurs, funders, policy experts, and beneficiaries.

Value-Based Care Spotlight

The CMS Innovation Center launched the Value-Based Care Spotlight in January 2024. This website aims to enhance understanding of value-based care as a cornerstone of transforming health care with helpful information for both the public and health care providers. The site features a section called Patient and Provider Voices that showcases different aspects of value-based care as told through the personal experiences of CMS Innovation Center model participants, health care providers, and patients.

EVALUATION

Evaluating Results and Advancing Best Practices

Section 1115A(b)(4) of the Act requires the CMS Innovation Center to conduct independent evaluations of CMS Innovation Center models. Evaluations include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes, and changes in spending influenced by the model. In addition to measuring effects on spending and quality, CMS Innovation Center model evaluations assess provider and patient experiences, model implementation, and transformation of the health care marketplace.

The CMS Innovation Center designs model test evaluations to be rigorous, timely, and actionable. Evaluations generally incorporate qualitative and quantitative analyses—a mixed-methods approach—and examine the impact of the model relative to a matched comparison group. Some evaluation measures, such as total spending and hospital utilization, are standard across all models, while others, such as patient-reported experience or spending during an episode of care, are customized to align with specific features of a model.

During model implementation, data on performance and outcomes measures are collected, monitored, and reviewed at prescribed intervals. The evaluations include advanced statistical methods and defined comparison groups, as appropriate, to ensure that models deemed to be successful represent true opportunities for savings and high-value investments of taxpayer dollars.

The CMS Innovation Center releases detailed evaluation reports and "At-A-Glance" summaries with key findings and takeaways. Best practices and lessons learned from evaluation reports are often used to inform the next iterations of model tests and broader CMS policy. Primary care, bundled payments, and state and community-based models are all areas where evaluations have informed model changes and the design of future policy.

Evaluations of primary care models have shown that CMS Innovation Center models can drive care delivery changes within practices. The design of the MCP and PCF models built upon the lessons learned from the evaluation of the Comprehensive Primary Care (CPC) Model and CPC Plus (CPC+) Model and reflect the fact that health care system transformation will continue to require support for primary care in parallel with efforts to right-size payments for low-value services, specialists, and hospitals, and to increase incentives for primary and specialty care coordination.

Within bundled payments models, evaluation results have identified both successes and areas where changes are needed. In the Bundled Payments for Care Improvement Advanced Model (BPCI Advanced), evaluation results from the first three years informed changes to episode target prices. Results from the fourth year showed net savings for both surgical and medical episodes after these changes took effect. Lessons learned from BPCI Advanced and the Comprehensive Care for Joint Replacement (CJR) Model evaluations have both informed the Transforming Episode Accountability Model (TEAM).

Results from state- and community-based evaluations have informed the design of future models. Lessons from the Maryland All-Payer Model and the Maryland Total Cost of Care Model have informed some components of the AHEAD Model, such as hospital global budgets and the primary care component of the model. Findings from the Strong Start Model evaluation played a big part in the design of the TMaH Model. The Accountable Health Communities (AHC) Model evaluation showed that addressing health related social needs (HRSNs)—such as food insecurity and unstable housing—can positively affect how people manage their health conditions. Although AHC was not expanded, the CMS Innovation Center has incorporated the HRSN screener tool, developed under the AHC Model, into 11 current and future models, including the Guiding an Improved Dementia Experience (GUIDE) and Integrated Care for Kids (InCK) Models. The GUIDE Model is incorporating aggregate HRSNs into its required reporting for participants, and InCK Model award recipients developed tailored standard operating procedures for patient needs assessments.

As of 2024, CMS requires hospitals to report on two screening-related measures in the Hospital Inpatient Quality Reporting Program (IQR): Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health, and has either finalized or proposed inclusion of these measures across several other quality programs, including the End Stage Renal Disease Quality Incentive Program.[11] Further reflecting the impact of findings from AHC, CMS now covers social determinants of health risk assessments, as well as community health integration and principal illness navigation services in the Medicare FFS program.[12]

During this reporting period, the CMS Innovation Center analyzed evaluation results across multiple models to identify major themes that could:

- inform broader thinking about CMS Innovation Center impact on the health system, in addition to cost savings; and
- direct opportunities to improve model design and evaluation.[13]

Two additional significant outcomes of this analysis are the Transformation Initiative and the Quality Pathway.

Transformation Initiative

The CMS Innovation Center is committed to developing a stronger evidence base through iterative learning and evaluation across models to accelerate health system transformation. The Transformation Initiative, launched in 2023, was informed by a retrospective review of 23 current or recently ended models to identify delivery changes with the greatest impact on accelerating health care transformation.

[11] 2024 Medicare Hospital Inpatient Prospective Payment Systems/Long-Term Care Hospital Payment System (IPPS/LTCH) Final Rule, 88 FR 58640 (Aug. 28, 2023); 2024 ESRD Final Rule, 88 FR 76344 (Nov. 6, 2023).

[12] 2024 Medicare Physician Fee Schedule Final Rule, 88 FR 78818 (Nov. 16, 2023).

[13] New England Journal of Medicine, "Accelerating Care Delivery Transformation—The CMS Innovation Center's Role in the Next Decade." Available at https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0228.

Three key themes emerged from this original analysis:

1. Participants across models used care coordination and other person-centered strategies to deliver care.
2. Models facilitated practice changes that enabled providers to better tailor their care based on their patients' needs.
3. Care delivery trends and changes extend beyond CMS Innovation Center models.

The Transformation Initiative will continue to put greater emphasis on systematically evaluating what care delivery strategies and tactics in models most accelerate health system transformation (that is, generate better quality, outcomes, and patient experience at lower costs).

Through work on this initiative, the CMS Innovation Center is building a framework to:

- Support and encourage health transformation in model design and incentives.
- Expand use of evaluation methodologies to:
  - capture and assess, more systematically, care delivery system changes in models;
  - explore the model features and participant actions that are most associated with improved outcomes;
  - understand how models may interact with each other and synthesize findings from across models; and
  - capture the transformational impact to care delivery of systematic changes in the processes, structure, relationships, and culture of participating provider organizations.
- Use learning systems to better support model participants and generate cross-model learnings to accelerate transformation.
- Disseminate promising delivery changes within and beyond model participants.[14]
- Implement prospective, rapid trials to assess discrete care delivery strategies and tactics to identify what works.

Learn more about the Transformation Initiative.

Quality Pathway

In 2024, the CMS Innovation Center undertook efforts to strengthen its focus on quality—particularly patient outcomes and care experience—through a new Quality Pathway. The goal of the Quality Pathway is to elevate the focus on quality improvement in model design and to build evaluation strategies that assess model impact on patient-centered quality goals.

The CMS Innovation Center's statutory authority specifies that a payment model may be expanded if the testing results demonstrate it will *either* reduce spending without worsening quality *or* improve

[14] For example, see the *Transformation Spotlights* for the Maryland Total Cost of Care Model and the Oncology Care Model.

quality without increasing spending under the applicable title. To date, the CMS Innovation Center has only expanded models based on cost savings. The Quality Pathway incorporates new internal processes to support the expansion of models on the basis of quality improvement.

The Quality Pathway, building on the previous decade of model testing and evaluation, incorporates three key principles:

1. Align quality goals within models, from design through evaluation.
2. Elevate outcomes and experience performance measures, particularly the use of patient-reported measures.
3. Design evaluations to optimally assess the impact of models on patient-centered quality goals and create an opportunity for expansion.

Based on the Quality Pathway, going forward, the CMS Innovation Center will emphasize quality from model design through evaluation. Model design will identify primary areas of quality improvement, with an emphasis on outcomes and experience, and other model components—such as care redesign and learning systems—that will reinforce these primary quality goals. The quality measurement strategy for models will incorporate the voice of the patient through patient-reported measures. Finally, in order to generate evidence to support expansion, model evaluations will be designed to better assess impact on broad areas of quality including patient experience. The Quality Pathway will benefit all model tests by promoting broader health system transformation and rigorous assessment and dissemination of key evaluation findings that lead to better outcomes and experience for patients.

Learn more about the Quality Pathway.

CMS INNOVATION CENTER MODEL TESTS

The 37 model tests and Congressionally mandated demonstration projects described in this section were either active, announced, or launched between October 1, 2022, and September 30, 2024.

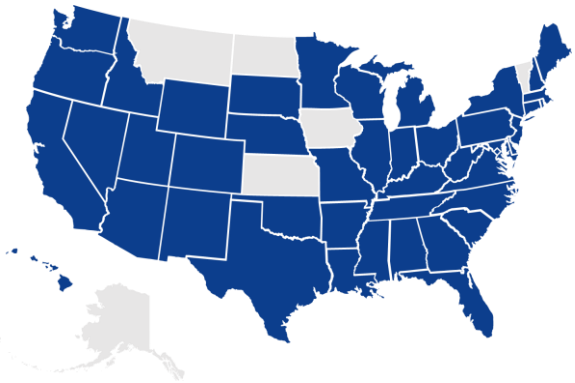
CMS estimates that, during the period of this report, more than 57 million Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by or have received care from the more than 192,000 health care providers and/or plans participating in CMS Innovation Center payment and service delivery models and initiatives.

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

Accountable Care Models

Accountable care models are models in which a clinician, group of health care providers, or hospital takes financial responsibility for improving quality of care—including advanced primary care services, care coordination, and health outcomes for a defined group of patients— thereby reducing care fragmentation and unnecessary costs for patients and the health system.

Accountable Care Organization Realizing Equity, Access, and Community Health Model (ACO REACH)



Model Announcement Date: April 22, 2019

Model Performance Period: January 1, 2023–December 31, 2026

Model Participants: Accountable Care Organizations (ACOs)

Number of Participants: 122 ACOs

Model Classification: Voluntary

Geographic Scope: 44 states nationwide and District of Columbia (D.C.)

Model Description: The Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model encourages health care providers—including primary and specialty care doctors, hospitals, and others—to come together to form an Accountable Care Organization, or ACO. ACOs break down silos and deliver high-quality, coordinated care to their patients, improve health outcomes, and manage costs. Patients may have greater access to enhanced benefits, such as telehealth visits, home care after leaving the hospital, and help with co-pays.

The ACO REACH Model is designed to advance health equity by bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. All model participants must develop and implement a robust Health Equity Plan in which they identify health disparities and then define their goals, strategy, implementation plan, and monitoring approach for evaluating progress in improving health equity within their aligned beneficiary population. Additionally, the model tests an innovative payment approach to support care delivery and coordination for people in underserved communities.

Key Takeaways: In its first two performance years (PY 2021 and PY 2022), participants in the Global and Professional Direct Contracting (GPDC) Model[15] focused on reducing avoidable utilization, better managing patient care, and improving primary care through improved data sharing and analytic tools as well as support for care management infrastructure. The model did not reduce total spending net of shared savings payments but did show decreases in hospitalization rates for ambulatory care sensitive conditions and increases in rates of recommended care for diabetes. Evaluation results for the first year of ACO REACH (PY 2023) are expected in 2025.

Model Milestones and Evaluation Reports 2021–2024:

- August 15, 2022: PY 2023 provisionally accepted applicants announced
- January 17, 2023: PY 2023 model participants announced
- October 23, 2023: GPDC first evaluation report (PY 2021) released
- January 29, 2024: PY 2024 model participants announced

Additional information is available on the ACO REACH Model webpage and Global and Professional Direct Contracting (GPDC) Model webpage.

ACO Primary Care Flex Model (ACO PC Flex)

Model Announcement Date: March 19, 2024

Model Performance Period: January 1, 2025–December 31, 2029

Model Participants: Accountable Care Organizations (ACOs)

Number of Participants: N/A

Model Classification: Voluntary

Geographic Scope: Nationwide

Model Description: The ACO Primary Care Flex (ACO PC Flex) Model focuses on primary care delivery in the Medicare Shared Savings Program and tests how prospective payments and increased funding for primary care in ACOs impact health outcomes as well as the quality and cost

[15] CMS announced that it had redesigned and renamed the Global and Professional Direct Contracting Model (GPDC) Model to the ACO Realizing Equity, Access and Community Health (ACO REACH) Model on February 22, 2022.

of care. The ACO PC Flex Model aims to increase the number of low-revenue ACOs in the Shared Savings Program, which tend to be mainly made up of physicians and might include a small hospital or serve rural areas. Low-revenue ACOs have historically performed better in the Shared Savings Program, demonstrating more savings and stronger potential to improve the quality and efficiency of care delivery.

The model's Prospective Primary Care Payment (PPCP) provides a regionally consistent payment rate for primary care spending and includes payment enhancements as additional resources to eligible ACOs to support increased access to primary care, provision of care, and care coordination, as well as promoting health equity. This payment methodology is designed to be an attractive option to new ACOs and ACOs with Federally Qualified Health Center and Rural Health Clinic participants in part because the ACO's PPCP rate will be based on its average county primary care spending rather than on the ACO's historical spending, which might increase payment for providers to invest in underserved areas and populations. The PPCP also includes, where appropriate, payment enhancements and adjustments to the county rate to provide additional resources to providers caring for underserved populations. A one-time advanced shared savings payment will be paid to each ACO to help cover costs associated with forming an ACO and administrative costs for model activities.

Evaluation Status/Key Takeaways: The model is expected to start on January 1, 2025.

Model Milestones and Evaluation Reports 2022–2024:

- May 30, 2024: ACO PC Flex Request for Applications released

Additional information is available on the ACO PC Flex Model webpage.

Comprehensive Primary Care Plus Model (CPC+)

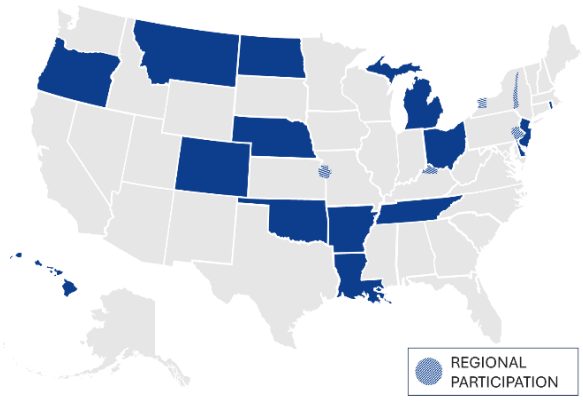
Model Announcement Date: April 11, 2016

Model Performance Period: First cohort: January 1, 2017–December 31, 2021;
Second cohort: January 1, 2018 – December 31, 2021

Model Participants: Primary care practices

Number of Participants: N/A, model ended

Model Classification: Voluntary



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

Model Description: The Comprehensive Primary Care Plus (CPC+) Model was a national advanced primary care model that aimed to better support patients with complex needs by moving practices away from a Fee-For-Service (FFS) structure toward a population-based payment approach. CPC+ offered two tracks of care delivery requirements and payment options to address the diverse needs of primary care practices. The model required practices to transform across five care delivery functions: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health.

CPC+ provided important lessons for current/follow-on primary care models, such as Primary Care First, on how to drive accountable care. The model also worked to advance broader health system transformation by creating a unique public–private partnership in which practices were supported by 52 aligned payers that gave them additional financial resources and flexibility to make investments, improve quality of care, and reduce the number of unnecessary services their patients received.

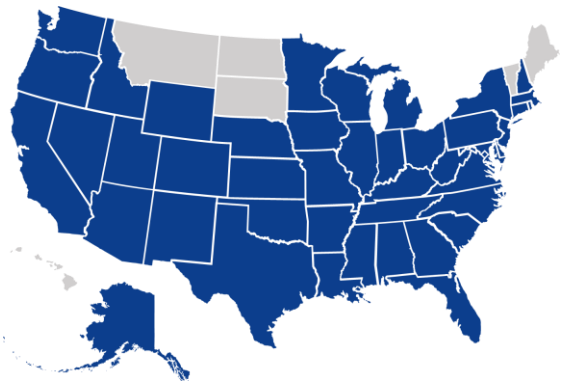
Evaluation Status/Key Takeaways: CPC+ was shown to reduce emergency department visits, acute inpatient hospitalizations, and acute inpatient expenditures. These reductions, however, were not sufficient to reduce total Medicare expenditures or achieve net savings after accounting for increased expenditures in other areas, such as physician services, inpatient rehabilitation and hospice, and enhanced CPC+ payments. Without direct incentives for specialists and hospitals to reduce costs, primary care practitioners were found to lack control over critical aspects of care that drive large portions of unnecessary utilization and total Medicare expenditures. Model testing showed that achieving health care system transformation will continue to require more support for primary care in parallel with efforts to right-size payments for low-value services, specialists, and hospitals, and to increase professional and other incentives for primary and specialty care coordination. The model also was found to result in small improvements in other quality-of-care outcomes, including receipt of diabetes services, breast cancer screening, and hospice use.

Model Milestones and Evaluation Reports 2022–2024:

- May 17, 2022: CPC+ fourth evaluation report and associated materials released
- December 15, 2023: CPC+ fifth evaluation report and associated materials released

Additional information is available on the CPC+ Model webpage. Read more about active primary care models.

Kidney Care Choices Model (KCC)



Model Announcement Date: July 10, 2019

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

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

Number of Participants: 80 KCEs and 19 KCF Practices

Model Classification: Voluntary

Geographic Scope: 44 states nationwide

Model Description: In the Kidney Care Choices (KCC) Model, groups of nephrologists (kidney doctors) and other kidney care providers and practices come together to take responsibility for patients who have late-stage chronic kidney disease (CKD), end-stage renal disease (ESRD), or a kidney transplant. They offer coordinated and seamless care that includes dialysis, transplant, and end-of-life care, if appropriate. Patients receive needed services while retaining the freedom to choose providers. By providing financial incentives to improve the quality of kidney care, the model aims to reduce the number of patients developing kidney failure, have more eligible patients in home dialysis, and increase the number of kidney transplants, so patients can live longer, healthier lives.

The patient is central to the model design. People living with kidney disease tend to undergo the most expensive treatment path, with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment. They may experience fragmented care and high-cost treatments that do little to slow disease progression. Often, they receive limited to no education about their disease and treatment options from their health care providers. By increasing education and understanding of the kidney disease process, the KCC Model aims to better prepare people living with kidney disease to actively participate in shared decision-making for their care.

The design of the KCC Model was influenced by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) submission by the Renal Physicians Association (RPA). This proposal focused on the transition to dialysis and the subsequent six months, which aligns to the KCC Model focus on optimal starts. The KCC Model also includes beneficiaries with earlier stage kidney disease, including stages 4 and 5 CKD, in order to optimize care before the transition to dialysis. Other areas that align very closely with the RPA proposal include a practice-level participant (vs. entity level), which is how the Kidney Care First option was established, and the RPA bonus for completed transplants, which inspired the kidney transplant bonus feature in the KCC Model. The kidney transplant feature rewards nephrologists for their work in navigating beneficiaries through the transplant process and recognizes the long-term benefits to a beneficiary receiving a transplant.

Evaluation Status/Key Takeaways: In the first performance years of KCC, home dialysis increased and in-center dialysis decreased in KCF practices, and peritoneal dialysis increased among both KCF practices and KCEs; there were no significant impacts on other major utilization measures such as hospitalizations, readmissions, or emergency department (ED) visits. There were no significant changes in Total Medicare Parts A and B spending per member per month (PMPM), but total dialysis payments increased in KCEs and home dialysis payments increased in KCF practices and KCEs. There was a significant increase in the number of optimal starts for patients with ESRD in the KCEs.

Model Milestones and Evaluation Reports 2022–2024:

- January 17, 2023: KCC PY 2023 participants announced
- September 17, 2024: KCC first evaluation report released

Additional information is available on the KCC Model webpage. Two related model tests are End-Stage Renal Disease Treatment Choices (ETC) and Increasing Organ Transplant Access (IOTA); read more about the kidney models.

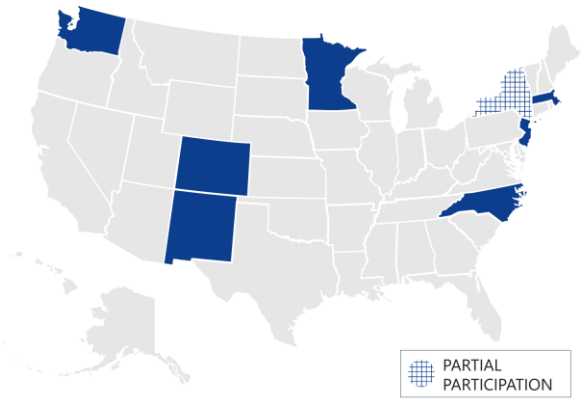
Making Care Primary Model (MCP)

Model Announcement Date: June 8, 2023

Model Performance Period: July 1, 2024–December 31, 2034

Model Participants: Solo Primary Care Practices, eligible Indian Health Programs, Federally Qualified Health Centers (FQHCs), Group practices, Health Systems, certain Critical Access Hospitals

Number of Participants: 133 participants, 772 practices



Model Classification: Voluntary

Geographic Scope: Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, certain counties in New York, [16] North Carolina, and Washington

Model Description: Primary care clinicians address multiple care needs for their patients, including disease prevention, health screenings, chronic condition management, overall wellness, and care coordination with specialists. The Making Care Primary (MCP) Model is designed to make primary care practices accountable for patient outcomes. MCP gives participants model-specific payments, data, learning support, and other resources to strengthen coordination between primary care clinicians, specialists, social service providers, and behavioral health clinicians, ultimately seeking

[16] Putnam; Rockland; Orange; Albany; Schenectady; Montgomery; Greene; Columbia; Rensselaer; Saratoga; Fulton; Schoharie; Washington; Otsego; Hamilton; Delaware; Ulster; Dutchess; Sullivan; Warren; Essex; Clinton; Franklin; Saint Lawrence; Onondaga; Cayuga; Oswego; Madison; Cortland; Tompkins; Oneida; Seneca; Chenango; Wayne; Lewis; Herkimer; Jefferson; Tioga; Broome; Erie; Genesee; Niagara; Wyoming; Allegany; Cattaraugus; Chautauqua; Orleans; Monroe; Livingston; Yates; Ontario; Steuben; Schuyler; Chemung.

to prevent chronic disease, reduce emergency room visits, and improve health outcomes. This 10.5 year multi-payer model builds upon lessons learned from the Comprehensive Primary Care, CPC+, and Primary Care First models, as well as the Maryland Primary Care Program.

MCP is focused on improving health equity among aligned beneficiaries by supporting data-driven decision making, care coordination and facilitating partnerships with state Medicaid agencies, social service providers, FQHCs, and specialty care providers. Participants are required to develop a strategic Health Equity Plan for identifying and addressing disparities, as well as evidence-based interventions such as screening and referrals for health-related socials needs (HRSNs). Additionally, MCP allows participants to reduce cost-sharing for patients in need with certain payments adjusted by clinical indicators and social risk.

Evaluation Status/Key Takeaways: The MCP Model evaluation will assess implementation experience and will measure whether the financial incentives being tested result in improved quality of care, quality of life, and decreased Medicare expenditures and utilization. Annual evaluation reports will be available on the MCP Model website beginning 2026.

Model Milestones and Evaluation Reports 2022–2024:

- August 14, 2023: MCP Request for Applications released
- July 10, 2024: MCP participants announced

Additional information is available on the MCP Model webpage. Read more about primary care models.

Primary Care First Model (PCF)

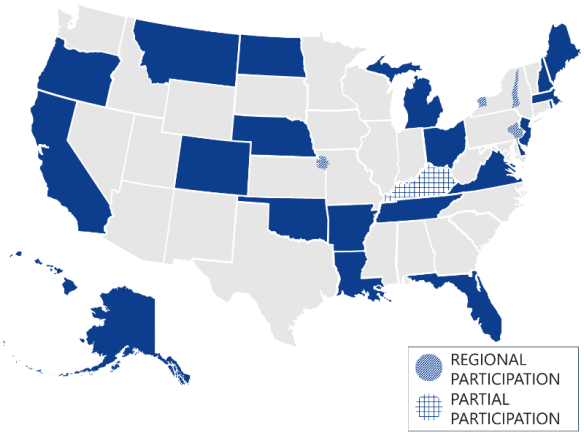
Model Announcement Date: April 22, 2019

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

Model Participants: Primary care practices

Number of Participants: 2,167

Model Classification: Voluntary



Geographic Scope: 26 regions: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern

Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide)

Model Description: The Primary Care First (PCF) Model aims to improve health care quality, lower cost, and reduce avoidable hospitalizations by enhancing primary care services. The model supports practices in offering comprehensive care, particularly for patients with complex, chronic conditions. The model includes flexible model payments and requires participants to take a patient-centered approach to care through features such as 24/7 clinician access and social support.

PCF enhances accountable care and payment reform by transitioning away from traditional FFS to value-based payment, focusing on quality, patient outcomes, and Medicare cost savings. Building on insights from the CPC+, PCF adds a layer of accountability, requiring practitioners take on upside and downside financial risk. By partnering with both commercial and public payers in PCF, CMS aims to further drive transformation by providing practices with enhanced alternative payments, data feedback, and comprehensive learning support to foster a patient-centered health care system focused on outcomes and efficiency.

Evaluation Status/Key Takeaways: Practices have been focusing on refining existing strategies to enhance outcomes, particularly in patient follow-up post-hospital discharge, and expanding services for chronic conditions, aiming to reduce hospitalizations and care costs. They also have been emphasizing improving access to care (telehealth), integrating behavioral health, advanced care planning, and leveraging data analytics more effectively. Assessing the first two years of the model, PCF practice revenues average about 30 percent higher than what participating practices would have received under the Medicare physician fee schedule. Medicare expenditures, including model payments, grew by an estimated 1.5 percent over the first two years of the model relative to a comparison group. There was no measurable reduction in acute hospitalizations.

Model Milestones and Evaluation Reports 2022–2024:

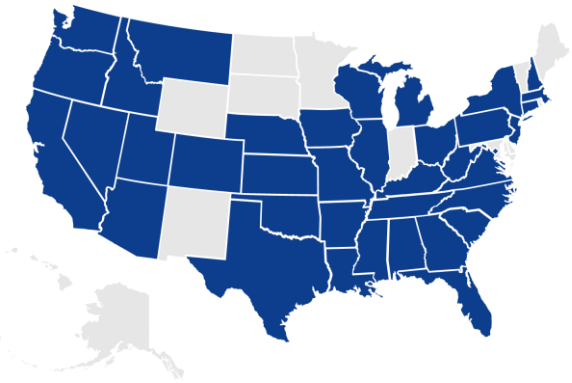
- December 6, 2022: PCF first evaluation report released
- November 8, 2023: PCF PY 2022 results released
- February 26, 2024: PCF second evaluation report released

Additional information is available on the PCF Model Options webpage. Read more about primary care models.

Disease-Specific and Episode-Based Models

Disease-specific and episode-based models are models that aim to address deficits in care for a defined population with a specific shared disease or medical condition, procedure, or care episode.

Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)



Model Announcement Date: January 9, 2018

Model Performance Period: October 1, 2018–December 31, 2025

Model Participants: Medicare-enrolled Acute Care Hospitals and Physician Group Practices (PGPs)

Model Classification: Voluntary

Number of Participants: 207

Geographic Scope: 38 states nationwide

Model Description: People admitted to the hospital (or having an outpatient procedure) often have a medical team who do not know their full medical history and are not in communication with their primary care doctor, which can contribute to problems for immediate treatment, follow-up care and recovery. Hospitals and physician group practices participating in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model are responsible for ensuring a person's entire health care team—including providers from all health care settings—communicate and collaborate on quality and total cost of care during a clinical episode (from hospital admission or outpatient procedure through 90 days after discharge) to meet the person's full care needs. The goal is to support a successful recovery and reduce the frequency and length of preventable hospital stays and emergency department use.

BPCI Advanced is helping to drive accountable care for clinical episodes. The bundled payment approach positions model participants to take responsibility for the cost and quality of care of their patients and support greater coordination and person-centeredness. In addition, the BPCI Advanced Model is evaluating its reach to underserved populations to better understand how to reach groups in need of clinical intervention more effectively; findings suggest medical hospitalization may be an important access point for developing ongoing care relationships.

Evaluation Status/Key Takeaways: An evaluation of the first three model years showed that BPCI Advanced achieved net savings for Medicare from surgical clinical episodes, but this was offset by increased costs of medical clinical episodes. To improve savings, CMS made substantial changes to the target pricing methodology starting in model year 4. The most recent evaluation report showed that both surgical and medical clinical episodes achieved net savings, driven by significant reductions in institutional post-acute care use. Quality of care was generally maintained as measured by readmission rates, mortality rates, and patient-reported functional status. Estimated model effects on patient-reported care experience varied depending on the type of clinical episode

(medical vs. surgical) and the type of provider (hospital vs. PGP) initiating the episode. These results informed the design of the Transforming Episode Accountability Model, which will test episode-based payments for certain types of surgeries.

Model Milestones and Evaluation Reports 2022–2024:

- January 18, 2022: BPCI Advanced participant list, Episode Initiators and Clinical Episode Selection documents for model year 5 released
- February 1, 2022: BPCI Advanced third evaluation report released
- October 13, 2022: Two-year BPCI Advanced extension (2024–2025) and changes to the pricing methodology for model year 6 (2023) announced
- January 1, 2023: BPCI Advanced participant list, Episode Initiators and Clinical Episode Selection documents for model year 6 released
- March 3, 2023: BPCI Advanced fourth evaluation report released
- December 31, 2023: BPCI Advanced participant list, Episode Initiator and Episode Selection documents for model year 7 released
- January 1, 2024: Model year 7 and two-year extension began

Additional information is available on the BPCI Advanced Model webpage.

Comprehensive Care for Joint Replacement Model (CJR)

Model Announcement Date: July 9, 2015

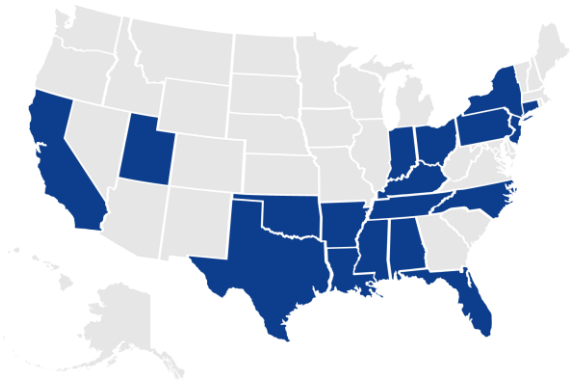
Model Performance Period: April 1, 2016–December 31, 2024

Model Participants: Hospitals located in 34 metropolitan statistical areas

Number of Participants: Approximately 324 hospitals in 34 metropolitan statistical areas or MSAs

Model Classification: Mandatory

Geographic Scope: 34 metropolitan statistical areas among 18 states nationwide



Model Description: Hip, knee, and ankle replacements, also known as lower extremity joint replacements, are the most common surgeries Medicare beneficiaries receive. Many patients experience confusing, uncoordinated care before and after their surgery, which can lead to complications or prolonged recovery. The Comprehensive Care for Joint Replacement (CJR) Model is a mandatory model that holds participating hospitals responsible for ensuring patients undergoing lower extremity joint replacements receive high-quality, coordinated care by all health care providers from the time of the procedure through recovery, including physical therapy and any other at-home rehabilitation care. Providers work with their patients to develop a plan for recovery, including whether they prefer to recover at home instead of a rehabilitation facility. The goal of CJR is

for patients to have a safe, effective, and positive recovery experience that is free from complications, while maintaining their freedom of choice in providers and services. CJR was originally set to end in 2021 but was extended through December 2024.

The CJR Model is an example of how the CMS Innovation Center is delivering on its "supporting innovation" strategic objective by taking a person-centered approach to care that integrates an individual's needs across multiple settings and providers. Participant hospitals are held financially accountable for the quality and cost of a CJR episode of care, which incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers. CMS provides additional tools to participant hospitals to improve the effectiveness of care coordination that includes: providing hospitals with relevant spending and utilization data, waiving certain Medicare requirements to encourage flexibility in the delivery of care, and facilitating the sharing of best practices between participant hospitals through a learning and diffusion program.

The development of a successor mandatory model supports the CMS Innovation Center's specialty care strategy by continuing the momentum and successes of acute, episode-based payment models. CMS expects that the successor Transforming Episode Accountability Model (TEAM) will help capture providers new to value-based care as well as some current CJR participants, to continue implementing a value-based approach to further care transformation, advance health equity, and improve health care provided to Medicare beneficiaries.

The model aligns with the Center's direction to develop a successor mandatory episode-based payment model that continues and sustains the value-based care changes that have been implemented because of CJR participation.

Evaluation Status/Key Takeaways: CJR participant hospitals used a multifaceted approach across the entire episode of care to achieve the goals of the CJR Model. Hospitals enhanced pre-surgical education to set patient and caregiver expectations and engaged interdisciplinary teams to coordinate care for patients. Enhancing relationships with orthopedic surgeons and post-acute care providers led to improved communication and information sharing. These efforts can reduce the need for expensive settings, such as post-acute care facilities like skilled nursing facilities and inpatient rehabilitation facilities, and toward less expensive options, such as home health care. Mandatory CJR hospitals have consistently generated net savings, with the exception of PY 5. CMS waived downside risk for all CJR episodes during the pandemic, resulting in substantially larger payments to hospitals that offset payment reductions and led to net losses. In PY 6, CJR returned to its pattern of achieving savings. These results informed the design of TEAM which will test episode-based payments for surgeries including lower extremity joint replacements.

During the first six PYs of the CJR Model test, mandatory CJR hospitals continued to reduce episode payments, driven by reductions in institutional post-acute care use and increases in discharges home. Despite the reduction in institutional post-acute care use, the impact on quality measures such as complication rates and readmissions were generally positive, although size of impacts varied by year. Beneficiaries maintained their functional improvements under the model, and quality measures showed improved patient satisfaction, particularly for underserved patients. Interviews

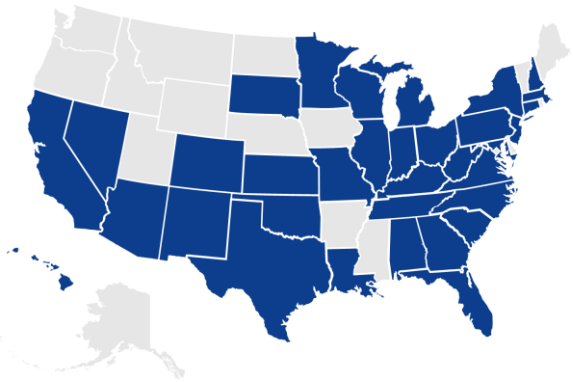
suggested that participation in a Medicare ACO and the CJR Model resulted in an increased awareness and greater alignment toward value-based care among hospital staff. This alignment supports care transformation and may contribute to better CJR outcomes. Strategies adopted to improve the care pathway, coordinate post-acute care, and monitor patient outcomes were used by both CJR hospitals and ACOs.

Model Milestones and Evaluation Reports 2022–2024:

- May 31, 2023: CJR fifth evaluation report released

Additional information is available on the CJR Model webpage.

Emergency Triage, Treat, and Transport Model (ET3)



Model Announcement Date: February 14, 2019

Model Performance Period: January 1, 2021–December 31, 2023

Model Participants: Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers

Number of Participants: 147

Model Classification: Voluntary

Geographic Scope: 34 states nationwide

Model Description: The Emergency Triage, Treat, and Transport (ET3) Model was a voluntary payment model to provide ambulance teams with greater flexibility to address emergency health care needs of people with Traditional Medicare following a 911 call.

In lieu of going to a hospital emergency department, with patient consent, model participants could provide transport to an alternative destination partner (a primary care office, urgent care clinic, or community health center), or provide on-site treatment with the help of a Medicare-enrolled qualified health care partner—either at the scene of the 911 emergency response or via telehealth.

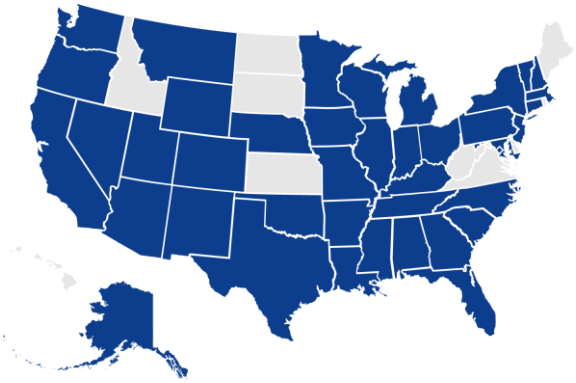
The ET3 Model was intended to support person-centered care, recognizing that not all people experiencing a non-life-threatening medical event require treatment at a hospital emergency department. Instead, it enabled people with Medicare experiencing this type of medical event to access the most appropriate health care services delivered at the right place and time, with the aim of improving overall quality of care. The ET3 Model also intended to provide relief to ambulance services by lowering costs through a reduction in avoidable transports to an emergency department, and avoidable hospitalizations following those transports.

Evaluation Status/Key Takeaways: The ET3 Model ended early on December 31, 2023, two years prior to the five-year performance period end date. CMS determined that it was in the public interest to end ET3 early. CMS made this determination based on a number of factors, including the number

of interventions performed by model participants in 2023. The number of interventions performed was lower than the number anticipated when the model was designed. This affected the cost of operating the model relative to its expected benefits, the ability of CMS to conduct a robust quantitative evaluation of the model's impact, and the model's ability to achieve the estimated Medicare savings in the model's design. For these reasons, CMS determined that it was not in the public interest to test the model in performance year 4 (calendar year 2024) through performance year 5 (calendar year 2025).

Additional information is available on the ET3 Model webpage.

End-Stage Renal Disease Treatment Choices Model (ETC)



Model Announcement Date: July 10, 2019

Model Performance Period: January 1, 2021–June 30, 2027

Model Participants: Dialysis facilities and managing clinicians

Number of Participants: (January 1, 2022–December 31, 2023): 2,416 end-stage renal disease facilities and 3,100 managing clinicians

Model Classification: Mandatory

Geographic Scope: 40 states nationwide and D.C.

Model Description: The goal of the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model is for patients to have greater independence and flexibility by receiving home dialysis and have longer, healthier lives resulting from a kidney transplant. Dialysis facilities and Managing Clinicians who are part of ETC, are encouraged to offer patients education to support their choice of treatment option to replace kidney function. ETC provides additional support to health care providers who treat underserved patients, including those who are dually eligible for Medicare and Medicaid, as well as Medicare beneficiaries who are eligible to receive assistance with prescription drug costs through the Part D program (also known as the Low-Income Subsidy or "Extra Help").

ETC directly addresses health equity through social determinants of health, which have a significant impact on the ability of ESRD beneficiaries to access home dialysis and kidney transplantation. The model aims to encourage dialysis facilities and health care providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status. While people from all backgrounds can be diagnosed with ESRD, it is more common in minority and low-income populations.

Evaluation Status/Key Takeaways: Over the first two years of ETC, home dialysis grew similarly across ETC areas and the comparison group. There were no significant impacts on home dialysis, transplant waitlisting, or living donor transplantation. There are no differences in Medicare spending and no notable complications among dialysis patients in terms of patient mortality or experience of

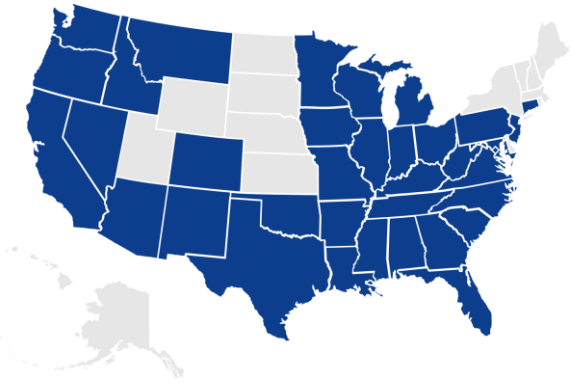
care. The evaluation did not reveal early detectible patterns of different effects of the model on underserved populations. Given the challenges and the complexity of impacting home dialysis and transplant rates and the early stage of the model implementation, it is too early to form conclusions about possible longer-term effects of the model. The third annual evaluation report is expected in early 2025.

Model Milestones and Evaluation Reports 2022-2024:

- July 17, 2023: ETC first evaluation report released
- January 4, 2024: ETC second evaluation report released

Additional information is available on the ETC Model webpage. Two related model tests are Kidney Care Choices (KCC) and Increasing Organ Transplant Access (IOTA); read more about the kidney models.

Enhancing Oncology Model (EOM)



Model Announcement Date: June 27, 2022

Model Performance Period: July 1, 2023–June 30, 2030

Model Participants: Oncology practices and commercial payers

Number of Participants: 41 physician group practices, 3 payers

Model Classification: Voluntary

Geographic Scope: 36 states nationwide and D.C.

Model Description: The Enhancing Oncology Model (EOM) aims to drive care transformation and improve care coordination in oncology care by preserving or enhancing the quality of care provided to beneficiaries undergoing treatment for cancer while reducing program spending under Medicare FFS. Under EOM, participating oncology practices will take on financial and performance accountability for episodes of care surrounding cancer treatment for patients with certain common cancer types. Oncology practices participating in EOM are eligible to receive payments to support enhanced services aimed at providing whole-person, patient-centered, equitable care—such as patient navigation, screening for HRSNs such as housing and transportation assistance, and using electronic patient-reported outcomes data to identify patient needs and incorporate patient preferences and goals as part of treatment. The goal of EOM is for oncology practices in the model to improve care management, coordination, and equitable access to care and treatment and support personalized services for beneficiaries undergoing cancer treatment for certain cancer types while reducing costs.

EOM builds on lessons learned in the Oncology Care Model (OCM) and is an example of how the CMS Innovation Center is driving accountable care by emphasizing a patient-centered approach to

support providers transforming care through enhanced patient coordination and navigation. The model also advances health equity by providing additional support to participants who treat patients living in medically underserved communities or patients with lower incomes, specifically those who are dually eligible for Medicare and Medicaid. The model supports care in underserved communities, requires practices to collect and report patient-level sociodemographic data, as well as screen for HRSNs and develop a Health Equity Plan to implement evidence-based strategies for mitigating health disparities identified within their patient populations.

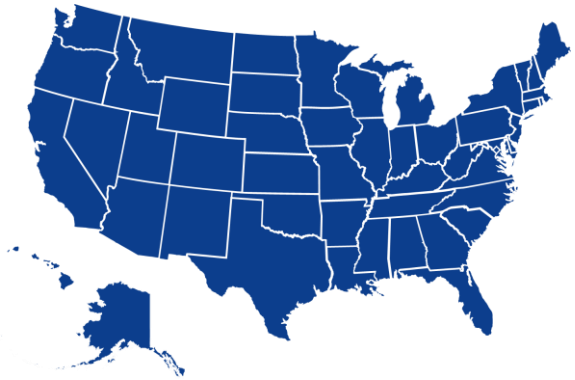
Evaluation Status/Key Takeaways: The EOM evaluation will measure whether the care coordination and financial incentives being tested result in better cost and quality outcomes for cancer patients receiving cancer treatment. The impact analysis will examine the effect of EOM on key outcomes including improved quality of care and quality of life and decreased Medicare expenditures and utilization.

Model Milestones and Evaluation Reports 2022–2024:

- June 27, 2022: EOM Request for Applications released
- June 27, 2023: EOM participants announced
- July 1, 2023: Model launched
- May 30, 2024: EOM Request for Applications for second cohort released

Additional information is available on the EOM webpage.

Guiding an Improved Dementia Experience Model (GUIDE)



Model Announcement Date: July 31, 2023

Model Performance Period: July 1, 2024–June 30, 2032

Model Participants: Medicare Part B-enrolled providers or suppliers, excluding Durable Medical Equipment (DME) and laboratory suppliers, that establish a dementia care program to provide ongoing, longitudinal care to people with dementia.

Number of Participants: 390

Model Classification: Voluntary

Geographic Scope: Nationwide

Model Description: People living with dementia often have multiple chronic conditions and receive fragmented care, leading to high rates of hospitalization and emergency department visits. For caregivers, the challenges of managing health care, providing constant support, and addressing the behavioral and psychological symptoms of dementia can present a significant mental, physical, emotional, and financial burden. Drawing on earlier work with dementia care projects through the Health Care Innovation Awards, the Guiding an Improved Dementia Experience (GUIDE) Model

focuses on dementia care management and aims to improve quality of life for people living with dementia and enable them to remain in their homes and communities while reducing strain on their caregivers. To do so, the model requires participants to provide comprehensive care coordination and care management to aligned beneficiaries with dementia, caregiver education and support for their caregivers, and respite-like services to beneficiaries with dementia in certain situations.

Delivering equitable care and addressing health disparities in dementia are crucial aspects of GUIDE. Caregiver burden is often exacerbated for underserved communities. For example, Black and Hispanic populations have a higher prevalence of dementia and are less likely to receive a timely diagnosis, have more unmet needs, are more likely to experience high caregiving demands, and spend a higher share of their family assets on dementia care. CMS actively seeks out the participation of eligible organizations that provide care to underserved communities and offers a variety of financial and technical supports to ensure that participating safety-net providers can develop their infrastructure, improve their care delivery capabilities, and participate successfully in the model. GUIDE also includes beneficiaries with dementia who are dually eligible for Medicare and Medicaid and, as with other beneficiaries supported by the model, help them to continue to live safely in the community.

Evaluation Status/Key Takeaways: The GUIDE evaluation will measure the effect of the model on key outcomes, including improved quality of care and quality of life of those living with dementia and their caregivers and decreased Medicare expenditures and utilization. Annual evaluation reports will be available on the GUIDE website beginning 2026.

Model Milestones and Evaluation Reports 2022–2024:

- November 15, 2023: GUIDE Request for Applications released
- July 8, 2024: GUIDE Model launched

Additional information is available on the GUIDE Model webpage.

Increasing Organ Transplant Access Model (IOTA)

Model Announcement Date: May 8, 2024

Model Performance Period: July 1, 2025–June 30, 2031[17]

Model Participants: Kidney transplant hospitals

Number of Participants: Includes approximately half of the eligible kidney transplant hospitals in the United States

Model Classification: Mandatory

Geographic Scope: Nationwide

Model Description: The IOTA Model aims to increase access to life-saving transplants for patients living with end-stage renal disease and reduce Medicare expenditures. The model encourages transplant hospitals to use more of the kidneys that become available for transplantation and facilitate more transplants from living donors. Additionally, the model supports greater care coordination, improved patient-centeredness of the process of being waitlisted for and receiving a kidney transplant, and greater access to kidney transplants.

This proposed model is part of a wider effort by the Department of Health and Human Services' Organ Transplant Affinity Group (OTAG), a collaboration of CMS and the Health Resources and Services Administration, to increase access to organ transplants, improve accountability for the U.S. organ transplantation system, and increase the availability and use of donated organs.

Evaluation Status/Key Takeaways: IOTA is a six-year, mandatory model that begins on July 1, 2025.

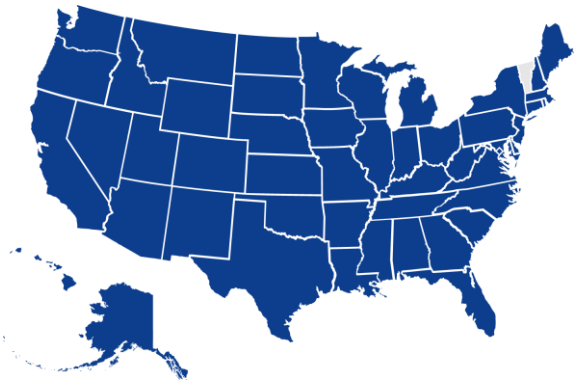
Model Milestones and Evaluation Reports 2022–2024:

- May 17, 2024: Notice of Proposed Rulemaking published

Additional information is available on the IOTA Model webpage. Two related model tests are Kidney Care Choices (KCC) and End-Stage Renal Disease Treatment Choices (ETC); read more about the kidney models.

[17] After the conclusion of the reporting period for this Report to Congress, the CMS Innovation Center announced the final rule of for the IOTA Model. The final rule moved back the start date of the model to July 1, 2025, from the proposed date of January 1, 2025. The final rule is available on the Federal Register at: https://www.federalregister.gov/public-inspection/2024-27841/medicare-program-alternative-payment-model-updates-and-the-increasing-organ-transplant-access-model.

Medicare Diabetes Prevention Program Expanded Model (MDPP)



Model Announcement Date: July 7, 2016

Model Performance Period: April 1, 2018–March 31, 2028 (extended model performance period)

Model Participants: Health care providers including physicians, hospitals, community-based organizations, gyms, state and local health departments, and other qualifying entities.

Number of Participants: 817 participants as of February 3, 2024, representing the number of MDPP locations across the U.S. There are 287 approved suppliers, and approximately 3 locations per supplier.

Model Classification: Voluntary

Geographic Scope: 49 states nationwide

Model Description: The Medicare Diabetes Prevention Program (MDPP) Expanded Model was certified for expansion in 2016 and is an evidence-based behavior change intervention to prevent the onset of type 2 diabetes among Medicare beneficiaries. Model participants offer a year-long, group-based program that provides people who are pre-diabetic with education delivered by trained coaches on how to manage their health and reduce the risk of disease onset.

MDPP uses the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program (National DPP) curriculum, which includes at least 16 intensive core sessions furnished over six months in group/classroom-style settings. These sessions cover topics including dietary change, physical activity, and behavior change for weight control. After completing the core sessions, people have six monthly follow-up sessions to ensure they are maintaining healthy behaviors. The model measures success by monitoring diabetes risk reduction in people taking part in the program, for example represented by a 5 or 9 percent weight loss goal.

The decision to certify MDPP for expansion was made due to evidence from the 2012–2016 Diabetes Prevention Program (DPP) model test, which indicated that 44 percent of people who attended at least four core sessions achieved a 5 percent weight loss. The model test also showed a statistically significant gross savings in each of the first five quarters of the program and significant reductions in inpatient hospital admissions.

Evaluation Status/Key Takeaways: The model's second evaluation report found that MDPP patients have lost weight and are largely meeting physical activity goals, thereby meeting the immediate goals of the program. On average, people who took part in the program lost 5.1 percent of their starting weight; more than half met the 5 percent weight-loss goal, and a quarter met the 9 percent weight-loss goal. Low participation due to the COVID-19 public health emergency has limited the program's impact on the overall population health of people with Medicare. As of the

second evaluation report, evidence suggests that the program does not impact Medicare expenditures, and it was too early to assess the program's impact on diabetes incidence due to the limited number of beneficiaries with long term follow-up periods.

Model Milestones and Evaluation Reports 2022–2024:

- November 14, 2022: MDPP second evaluation report released
- April 28, 2023: Announced virtual delivery flexibilities for MDPP suppliers from the Public Health Emergency (PHE) would be extended through December 31, 2023
- July 13, 2023: Published proposed rule on the Federal Register to extend PHE flexibilities and simplify MDPP payments
- November 2, 2023: Published Calendar Year (CY) 2024 Physician Fee Schedule (PFS) Final Rule on the Federal Register allowing all MDPP suppliers to use specific MDPP COVID-19 PHE flexibilities, including delivery through distance learning, through December 31, 2027

Additional information is available on the MDPP Model webpage.

Million Hearts®: Cardiovascular Disease Risk Reduction Model

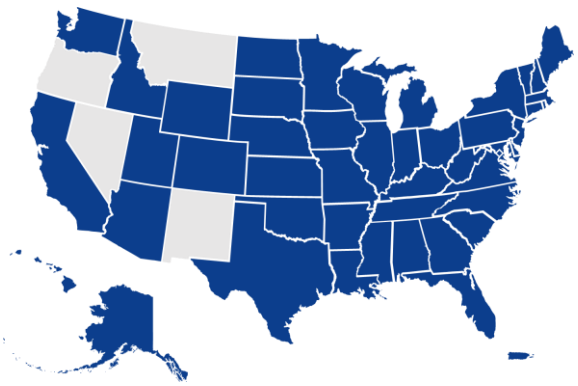
Model Announcement Date: May 28, 2015

Model Performance Period: January 3, 2017–December 31, 2021. The model's final evaluation report was released in October 2023.

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

Number of Participants: 345

Geographic Scope: 46 states nationwide, D.C., and Puerto Rico



Model Description: The Million Hearts® Cardiovascular Disease Risk Reduction (Million Hearts) Model had the goal of preventing one million heart attacks by providing financial incentives to health care practitioners to identify people with Medicare (ages 40–79) who were at highest risk for atherosclerotic cardiovascular disease, and to help them manage that risk. As part of the five-year randomized trial, model participants used a modified version of the American College of Cardiology/American Heart Association (ACC/AHA) atherosclerotic cardiovascular disease ten-year pooled cohort risk calculator to develop risk modification plans based on patient risk profiles. The model's risk stratification approach aimed to reduce the number of first-time heart attacks and strokes among people with Medicare at high risk.

Evaluation Status/Key Takeaways: The final model evaluation report was released in October 2023. Over five years, the model reduced the incidence of first-time heart attacks and strokes by 3 to 4 percent, preventing about one event for every 250 to 400 high- and medium-risk patients enrolled, and reduced the all-cause mortality rate by 4.3 percent. This followed from improved

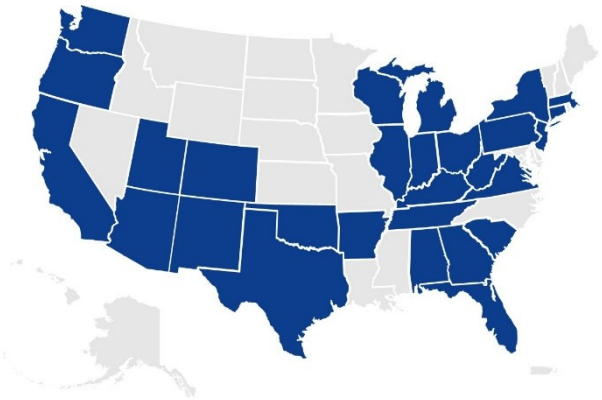
preventative care for cardiovascular disease, with providers' increased use of cardiovascular disease risk assessment and patients' greater use of statins and antihypertensive medications. Despite the improvements in cardiovascular outcomes, the model had no measurable impact on Medicare spending. Additionally, participating hospitals reported improvements in team-based approaches to patient care, improved patient communication, and development of practical tools to educate patients. To incorporate lessons learned from the Million Hearts Model and increase access to life-saving interventions, the CY 2025 PFS proposed rule proposes coding and payment for an Atherosclerotic Cardiovascular Disease (ASCVD) risk assessment service and risk management services.

Model Milestones and Evaluation Reports 2022–2024:

- April 28, 2023: Case studies highlighting participant successes shared
- October 17, 2023: Million Hearts final evaluation report released
- July 10, 2024: CY 2025 PFS Proposed rule released with proposed coding and payment for an Atherosclerotic Cardiovascular Disease risk assessment

Additional information is available on the Million Hearts® Model webpage.

Oncology Care Model (OCM)



Model Announcement Date: February 2015

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

Model Participants: Physician Group Practices and Payers

Number of Participants: Model ended; 122 physician group practices and five commercial payers

Model Classification: Voluntary

Geographic Scope: 28 states nationwide

Model Description: The Oncology Care Model (OCM) aimed to provide higher quality, better coordinated care for people with cancer undergoing chemotherapy while not increasing Medicare costs. OCM encouraged participating physician practices to comprehensively address the complex needs of the cancer patients receiving chemotherapy treatment and heighten the focus on providing services that improve the patient experience or health outcomes, such as care coordination and patient navigation. Under OCM, physician group practices were eligible to receive Monthly Enhanced Oncology Services (MEOS) per beneficiary per month payments to support care transformation. Model participants had the potential to receive performance-based payments for lowering the total cost of care and performance on quality measures. The model also involved CMS partnering with commercial payers.

OCM, which concluded in June 2022, provided lessons learned for EOM which launched in July 2023. This model offered important insight on how to drive accountable care for people with cancer, as well as addressing affordability and accelerating the use of biosimilars.

Evaluation Status/Key Takeaways: OCM transformed cancer care for patients of practices participating in the model to be more person-centered and standardized through care pathways that benefitted the wider panel of patients seen by the participating practices, not just those in Medicare. Case studies revealed that OCM led to more data-driven quality initiatives and greater attention to the use of high-value supportive care drugs to prevent nausea, neutropenia, and cancer-related bone fractures. OCM practices also saw higher adoption of cost-saving biosimilars and improved patient adherence to high-cost oral drugs. OCM practices saw improvement in quality metrics linked to payment, though they did not improve significantly relative to the comparison group of non-OCM practices. OCM improved performance on practice-reported measures of quality, though there continues to be room for improvement in measures that capture quality of care at end-of-life. Patient-reported experience of care remained high throughout the model. While OCM significantly reduced total episode payments, these reductions were offset by model payments, resulting in overall net losses. The relative reduction in total episode payments was driven by payment reductions in higher-risk episodes—mainly for high-risk breast cancer, lymphoma, lung cancer, and colorectal/small intestine cancer. These findings inform EOM's focus on high-risk cancers.

Model Milestones and Evaluation Reports 2022–2024:

- May 31, 2023: OCM evaluation report for performance periods 1–9 and associated materials posted
- May 30, 2024: OCM final evaluation report for performance periods 1–11 released

Additional information is available on the OCM webpage.

Transforming Episode Accountability Model (TEAM)

Model Announcement Date: April 10, 2024

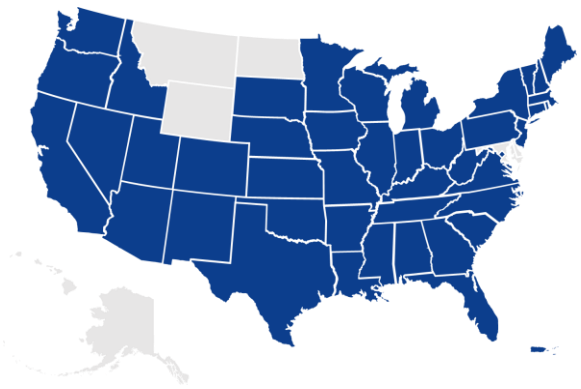
Model Performance Period: January 1, 2026–December 31, 2030

Model Participants: Acute Care Hospitals

Number of Participants: Approximately 750

Model Classification: Mandatory

Geographic Scope: 188 Core-based Statistical Areas nationwide



Model Description: People with Traditional Medicare who undergo surgery may experience fragmented care, which can lead to complications or prolonged recovery. The mandatory Transforming Episode Accountability Model (TEAM) was informed by more than a decade of past

episode-based payment model work, such as the CJR Model, and aims to improve the patient experience from surgery through recovery by supporting the coordination and transition of care between providers and promoting a successful recovery that can reduce avoidable hospital readmissions and emergency department use. TEAM episodes will begin with lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures. Selected acute care hospitals will coordinate care for people with Traditional Medicare who undergo one of the surgical procedures included in the model (initiate an episode) and assume responsibility for the cost and quality of care from surgery through the first 30 days after the Medicare beneficiary leaves the hospital. For purposes of TEAM, CMS will provide participating hospitals with a target price that will represent most Medicare spending during an episode of care. This will include the surgery (hospital inpatient stay or outpatient procedure) and items and services following hospital discharge, such as skilled nursing facility stays or provider follow-up visits. Holding hospitals accountable for all the costs of care for an episode incentivizes care coordination and improving patient care transitions to decrease the risk of avoidable readmission. In addition, TEAM includes a voluntary Decarbonization and Resilience Initiative through which CMS will assist TEAM participants in increasing quality of care by addressing ongoing threats to patient health and the health care system presented by climate change.

Evaluation Status/Key Takeaways: TEAM will be evaluated to measure the effects of an episode-based approach on quality of and access to care, utilization patterns, expenditures, and patient experience. Hospital performance will be assessed by: 1) comparing a participating hospital's actual Medicare FFS spending to their target price and 2) performance on quality measures such as hospital readmission, patient safety, and patient-reported outcomes. The evaluation will also capture the evolving nature of care delivery transformation. The evaluation design will include a range of analytic methods, including regression and other multivariate methods appropriate to the analysis of stratified randomized experiments.

Additional information is available on the TEAM webpage.

Health Plan Models

Health plan models are models comprising Medicare Advantage plans.

Medicare Advantage (MA) Value-Based Insurance Design Model (VBID)

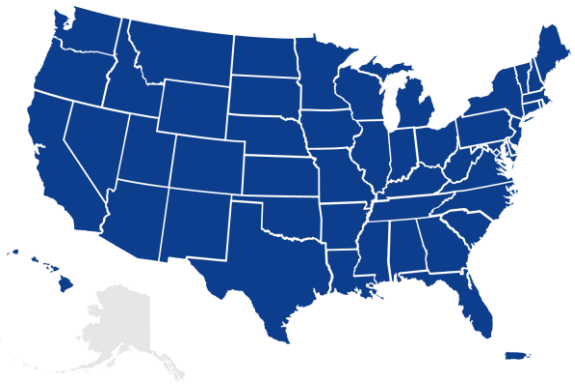
Model Announcement Date: September 1, 2015

Model Performance Period: January 1, 2017–December 31, 2030

Model Participants: Medicare Advantage Organizations (MAOs)

Number of Participants: 69 for CY 2024

Model Classification: Voluntary



Geographic Scope: All states nationwide (with the exception of Alaska), D.C., and Puerto Rico

Model Description: The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model improves access to high quality, person-centered health care and addresses HRSNs to help people better manage their health. Participating MA plans may offer targeted supplemental benefits based on socioeconomic status or chronic condition that remove obstacles to care. Such benefits may include lower costs for prescription drugs; grocery assistance to address unmet nutrition needs; transportation services to attend medical appointments; and support for managing chronic health conditions. The Hospice Benefit Component of VBID helps patients at the end-of-life seamlessly transition to hospice care, if desired, by making MA plans financially responsible for all services, including hospice. However, after carefully considering feedback about the increasing operational challenges of the Hospice Benefit Component and limited and decreasing participation among MA organizations in the model that may impact a thorough evaluation, CMS has decided to conclude the Hospice Benefit Component as of December 31, 2024 after four years of testing and implementation. For more information, read the CMS statement "The Future of the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model."

In 2023, CMS extended VBID for calendar years 2025–2030 and made several changes to advance health equity, among others. Medicare Advantage Organizations (MAOs) in the model will be required to offer supplemental benefits in at least two of three health-related social needs (HRSN) areas: food, transportation, and housing insecurity and/or living environment. Additionally, a new flexibility is available for MAOs that offer supplemental benefits to address HRSNs of people with Medicare living in socioeconomically disadvantaged areas as defined by the Area Deprivation Index.

Evaluation Status/Key Takeaways: Due to limited availability of comprehensive data, the most recent evaluation results do not extend past 2022. Participation in VBID more than doubled between 2021 and 2022 with interventions increasingly focused on socioeconomic status, supplemental benefits (particularly to address needs of underserved beneficiaries), and Part D cost-sharing reductions. VBID's most common intervention, eliminating Part D prescription drug cost sharing, was associated with greater adherence to treatment. However, VBID was also associated with increases in diagnosis-based risk scores and inpatient stays in 2020; improved Star Ratings and costs to CMS in 2021; and higher premiums in 2021 and 2022. The CMS Innovation Center took action to revise certain aspects of VBID's design to strengthen understanding of cost drivers and ensure the model has effective tools to be responsive to evaluation findings and statutory requirements. CMS continues to closely review the evaluation results.

Model Milestones and Evaluation Reports 2022–2024:

- September 29, 2022: CY 2023 VBID Model Participants (including MAOs participating in the Hospice Benefit Component) released
- October 17, 2022: Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test First Two Years of Implementation (2020–2021) released
- December 16, 2022: CY 2024 Request for Applications released

- September 26, 2023: CY 2024 VBID Model Participants (including MAOs participating in the Hospice Benefit Component) released
- October 10, 2023: Evaluation of Phase II of the Medicare Advantage Value-Based Insurance Design Model Test First Three Years of Implementation (2020–2022) released
- December 13, 2023: CY 2025 Request for Applications and associated materials released
- January 17, 2024: Request for Information for VBID released
- March 4, 2024: Ending of Hospice Benefit Component announced

Additional information is available on the VBID Model webpage.

Prescription Drug Models

Prescription drug models are models that seek to improve access to and/or the affordability of prescription drugs covered under Medicare (Part B and D) or Medicaid.

Cell and Gene Therapy Access Model (CGT Access)

Model Announcement Date: January 30, 2024

Model Performance Period: Rolling starts between January 1, 2025, and January 1, 2026, for up to approximately 11 years, depending on the outcomes-based agreements term for each state

Model Participants: Manufacturers of gene therapies approved or licensed by the U.S. Food and Drug Administration for the treatment of sickle cell disease and states (including D.C. and Puerto Rico)

Number of Participants: Up to two manufacturer applicants and open to 50 states nationwide, D.C., and Puerto Rico

Model Classification: Voluntary

Geographic Scope: Up to 50 states nationwide, D.C., and Puerto Rico

Model Description: The Cell and Gene Therapy Access Model (CGT Access) aims to improve the lives of people with Medicaid living with rare and severe diseases by increasing access to potentially transformative treatments. The initial focus of the model is to increase access to gene therapy treatments for people living with sickle cell disease, a genetic blood disorder that disproportionately affects Black Americans. This model can potentially help address the historic disparities, poor health outcomes, and low life expectancy associated with sickle cell disease—and possibly other diseases in the future—by increasing access to gene therapy.

Under the model, CMS directly negotiates key terms for outcomes-based agreements (OBAs) with cell and gene therapy manufacturers on behalf of states. States then decide whether to enter into supplemental rebate agreements with manufacturers that reflect the OBA key terms. Upon

agreement, CMS will support implementation, reconciliation, and evaluation. By taking on this role, CMS can ease the administrative burden on state Medicaid agencies, help states tie payment to outcomes, and potentially lower prices.

Evaluation Status/Key Takeaways: The CGT Access Model evaluation will test whether a CMS-led approach to developing and administering OBAs for cell and gene therapies improves access to innovative treatment, spending and utilization, and health outcomes among Medicaid enrollees with sickle cell disease.

Model Milestones and Evaluation Reports 2022–2024:

- March 7, 2024: CGT Access Manufacturer Request for Applications released
- May 1, 2024: Manufacturer responses to Manufacturer Request for Applications received
- June 28, 2024: CGT Access State Request for Applications released
- August 15, 2024: State Notice of Funding Opportunity released

Additional information is available on the CGT Access Model webpage. The CGT Access Model was developed in response to President Biden's Executive Order 14087, "Lowering Prescription Drug Costs for Americans" and was first proposed in a report responding to the executive order directed by the Secretary of the Department of Health and Human Services.

Part D Senior Savings Model

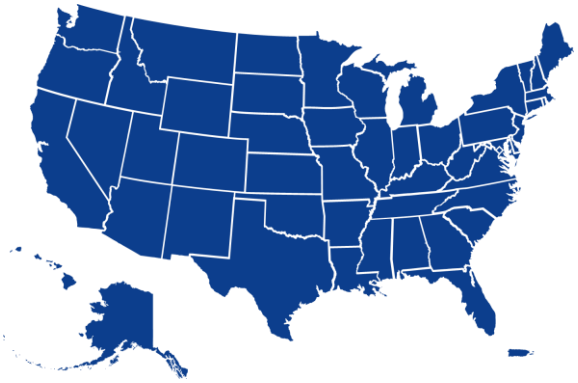
Model Announcement Date: March 11, 2020

Model Performance Period: January 1, 2021–December 31, 2023

Model Participants: Part D sponsors and pharmaceutical manufacturers

Number of Participants: 116 Part D sponsors and five pharmaceutical manufacturers

Model Classification: Voluntary



Geographic Scope: All states nationwide, D.C., and Puerto Rico

Model Description: The Part D Senior Savings Model provided some people with Medicare with the choice of prescription drug plans that offered insulin covered under Part D at an affordable and predictable cost. A one-month supply of insulin was capped to cost no more than $35 per prescription for enrollees in Part D plans that voluntarily participated in the model. More than 3.3 million Medicare beneficiaries use insulin and gaps in access can increase risk of serious complications, ranging from vision loss to kidney failure to amputation to heart attacks.

The Inflation Reduction Act of 2022 permanently capped the cost-sharing for insulin at $35 per month's supply per covered insulin product for all Medicare beneficiaries with Medicare Part D prescription drug coverage, and for Medicare beneficiaries that use insulin covered under Part B

(e.g., via pumps). Since the benefit in the law closely mirrored the benefit under the model, CMS ended the Part D Senior Savings Model early in December 2023.

Evaluation Status/Key Takeaways: People in model-participating plans who used insulin had better access to the medication and lower out-of-pocket spending. Interviewed insulin users generally did not feel that the model improved their ability to fill their medication, despite quantitative evidence of an increase in insulin adherence. Manufacturers' rebates to plans increased, consistent with their concerns about the model design's effect on their costs. There was no or weak evidence that the model affected premiums or costs to CMS.

Model Milestones and Evaluation Reports 2022–2024:

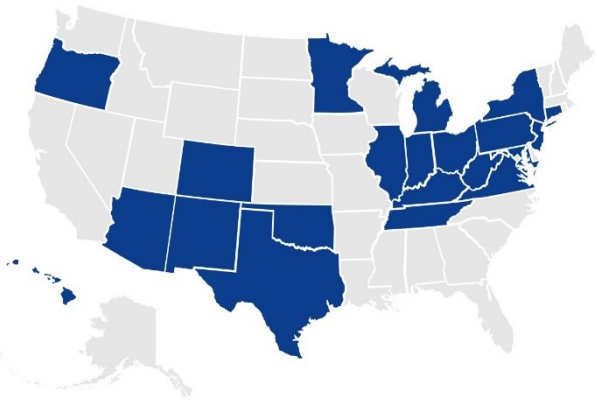
- September 29, 2022: Part D Senior Savings CY 2023 participants announced
- December 28, 2023: Part D Senior Savings second evaluation report released

Additional information is available on the Part D Senior Savings Model webpage.

State and Community-Based Models

State and community-based models are models in which a state or community-based organization serves as the main contractual participant, including managed care organizations serving Medicaid beneficiaries.

Accountable Health Communities Model (AHC)



Model Announcement Date: January 5, 2016

Model Performance Period: May 1, 2017–April 30, 2022. Some awardees received no cost extensions, allowing them to opt to extend their period of performance until April 30, 2023.

Model Participants: Community-based organizations, health care practices, hospitals and health systems, health plans, university or research organizations, health information exchanges, community health departments, and local governmental entities (all serving as community bridge organizations)

Number of Participants: 28 bridge organizations (10 in Assistance Track, 18 in Alignment Track) as of April 2022, including community-based organizations, health care practices, hospitals, health systems, and local governmental entities

Model Classification: Voluntary

Geographic Scope: 21 states nationwide

Model Description: The Accountable Health Communities (AHC) Model was a five-year model that tested how connecting people enrolled in Medicare and/or Medicaid to community resources for

identified health-related social needs (HRSNs) could positively impact health care utilization outcomes and overall costs. The model assessed Medicare, Medicaid, and dually eligible beneficiaries for specific HRSNs, including housing, transportation, utilities, food, and risk of interpersonal violence. In addition to referrals to appropriate community resources, AHC provided community navigation resources for high-risk individuals (participants in both tracks) and encouraged an alignment of clinical and community services to ensure they were available and responsive to the needs of the communities they serve (only participants in the Alignment Track). AHC provided financial support to participating community bridge organizations to assist with infrastructure and staffing needs.

The successes of AHC align with CMS' view on the importance of identifying and providing support for HRSNs in future initiatives—something that all future CMS models will require, where feasible. The model showed addressing needs, such as food insecurity and unstable housing, can have a positive effect on a person's ability to manage their health conditions. AHC has informed initiatives across CMS, including the development and adoption of new social determinants of health (SDOH) quality measures across CMS quality programs and introduction of coverage for SDOH Risk Assessment, Community Health Integration and Principal Illness Navigation in Medicare.[18] Surveys by health information trade groups indicate that the AHC screening tool is the assessment tool most often used by hospitals.[19]

Evaluation Status/Key Takeaways: Over the entire model performance period, AHC included 32 bridge organizations that applied to one of two tracks: 1) the Assistance Track, in which bridge organizations provided navigation services to high-risk beneficiaries with one or more HRSNs and two self-reported emergency department visits within the 12 months prior to screening, or 2) the Alignment Track, in which bridge organizations similarly offered navigation services to high-risk eligible beneficiaries *and also* encouraged alignment to ensure community services were available and responsive to the beneficiaries' HRSNs.

Beneficiaries were receptive to the screening and navigation services offered through the AHC Model. Needs resolution was more likely for beneficiaries who are Hispanic, are Black or African American, have diabetes, or have multiple needs. Despite observing only moderate social needs resolution, the model decreased Medicare and Medicaid spending for beneficiaries in the Assistance Track. While there were similar spending reductions in the Alignment Track, the outcomes were not statistically significant, likely due to the randomized design of the Assistance Track. The model improved quality related to hospital use, including reducing hospital admissions and emergency department visits by between 4 and 6 percent in both tracks. This help to beneficiaries may have led to these favorable spending and hospital service use impacts.

[18] 2024 Medicare Hospital Inpatient Prospective Payment Systems/Long-Term Care Hospital Payment System (IPPS/LTCH) Final Rule, 88 FR 58640 (Aug. 28, 2023); 2024 ESRD Final Rule, 88 FR 76344 (Nov, 6, 2023); 2024 Medicare Physician Fee Schedule Final Rule, 88 FR 78818 (Nov. 16, 2023).

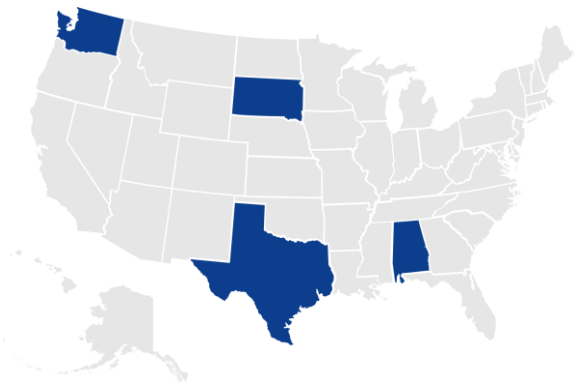
[19] Social Determinants of Health Data: Survey Results on the Collection, Integration, and Use. NORC at the University of Chicago and American Health Information Management Association. Feb. 2023. Available at: https://www.ahima.org/media/03dbonub/ahima_sdoh-data-report.pdf.

Model Milestones and Evaluation Reports 2022–2024:

- May 17, 2023: AHC second evaluation report released
- January 1, 2024: New Medicare coverage for SDOH risk assessment, community health integration and principal illness navigation

Additional information is available at the AHC Model webpage.

Community Health Access and Rural Transformation Model (CHART)



Model Announcement Date: August 11, 2020

Model Performance Period: October 1, 2021–September 30, 2023 (Model ended early)

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

Number of Participants: In the fall of 2021, CMS awarded cooperative agreement funding to four entities under the CHART Community Transformation Track: University of Alabama Birmingham, State of South Dakota Department of Social Services, Texas Health and Human Services Commission, and Washington State Healthcare Authority.

Model Classification: Voluntary

Geographic Scope: Nationwide, with a specific focus in rural communities in Alabama, South Dakota, Texas, and Washington

Model Description: The Community Health Access and Rural Transformation (CHART) Model was developed to help Americans who live in rural communities more easily access health care services. The model sought to address common obstacles to access—including limited transportation options and a lack of available resources and service settings—by coupling financial incentives with operational and regulatory flexibilities for program participants. Ultimately, due to insufficient hospital participation needed to accurately evaluate the model, CMS made the decision to end CHART early in September 2023.

CHART aimed to provide rural communities with the flexibilities necessary to design high-quality care customized to their population's unique needs, including strategies to promote health equity. By offering value-based payment approaches to providers, the intention was that providers would then be able to offer additional services that addressed HRSNs, including food, housing, and transportation.

Evaluation Status/Key Takeaways: Based on feedback received from model stakeholders, as well as a lack of hospital participation, CHART ended early on September 30, 2023. CMS believes that

the lessons learned from the CHART Model will continue to aid in the development of a potential future rural health care model at the CMS Innovation Center. Supporting rural health remains a key priority, and CMS is actively examining additional ways to expand access to high-quality health care and address the unique needs and challenges in rural areas. The lessons learned from the CHART Model will be critical as we continue to examine additional ways to support rural communities.

Model Milestones and Evaluation Reports 2022–2024:

- September 30, 2023: Model ended

Additional information is available on the CHART Model webpage.

Innovation in Behavioral Health Model (IBH)

Model Announcement Date: January 1, 2024

Model Performance Period: January 1, 2025–December 31, 2032

Model Participants: State Medicaid Agencies will be *Cooperative Agreement Recipients*.

Practice participants will be community-based behavioral health organizations and practices, including Community Mental Health Centers, opioid treatment programs, safety net providers, and public or private practices where individuals can receive outpatient mental health services.

Number of Participants: CMS anticipates issuing awards to up to eight state Medicaid agencies.

Model Classification: Voluntary

Geographic Scope: Up to 8 states, D.C. and territories nationwide

Model Description: The Innovation in Behavioral Health (IBH) Model focuses exclusively on a commonly overlooked but continually growing population: adults enrolled in Medicaid and/or Medicare who suffer from moderate to severe mental health conditions and/or substance use disorder. Behavioral health practice participants contracted by the state Medicaid agency under IBH will create a customized treatment plan that engages providers across the continuum of care to assess and support that person's behavioral, physical, and social needs. As a result of this more integrated approach to care, people served by the IBH Model are more likely to remain engaged with their care team and experience improved health outcomes.

IBH reflects CMS' commitment to testing models that focus on person-centered care. People with Medicare and Medicaid are disproportionately impacted by moderate to severe mental health and substance use disorders, which can result in challenges related to managing their co-occurring physical health conditions.

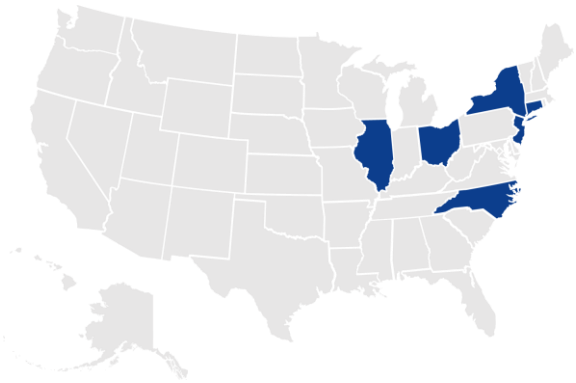
Evaluation Status/Key Takeaways: The mixed-methods IBH evaluation will focus on measures of health and well-being among the priority population, as well as tracking measures of care coordination, including referrals to physical health providers and to address identified HRSNs. Associated measures of progress in health IT infrastructure advancement will also be analyzed. Further, the evaluation will examine the efficacy of implementation based on practice participant and beneficiary characteristics and experiences. To the extent possible, given sample size and available data, CMS will additionally investigate whether the intervention reduces emergency department use and hospitalizations, along with tracking other cost and utilization metrics. The initial IBH evaluation report is planned for mid-2027.

Model Milestones and Evaluation Reports 2022–2024:

- June 17, 2024: Notice of Funding Opportunity (NOFO) released

Additional information is available on the IBH Model webpage.

Integrated Care for Kids Model (InCK)



Model Announcement Date: August 23, 2018

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

Model Participants: State Medicaid agencies, local health care providers ("Lead Organizations"), and partnership councils

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

Model Classification: Voluntary

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

Model Description: The Integrated Care for Kids (InCK) Model is a child-centered local service delivery and state payment model. Its aim is to improve the quality of care and reduce avoidable expenditures for children under 21 covered by Medicaid and CHIP through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs. Some programs offered through InCK also support pregnant women over age 21 who are covered by Medicaid. These interventions are designed to increase behavioral health access, respond to the opioid epidemic, reduce out-of-home placements for children and positively impact the health of the next generation.

InCK aims to achieve these goals through the early identification and treatment of children with multiple physical, behavioral, or other health-related needs and risk factors. The model also focuses on integrated care coordination and case management across physical health, behavioral health, and other local service providers for children with health needs impacting their day-to-day

functionality. InCK will achieve these goals by using the development of state-specific alternative payment models (APMs) to align payment with care quality and supporting accountability for improved child health outcomes and long-term health system sustainability.

Evaluation Status/Key Takeaways: Results from the first implementation year (2022) showed that all award recipients began needs screening; however, assessing the full population across all needs remains a challenge. Awardees designed their own pediatric APM, screening processes and eligibility criteria for integrated care coordination and case management, as well as strategies to integrate services. APM development took time, but all made progress on implementation.

Model Milestones and Evaluation Reports 2022–2024:

- January 1, 2022: Five-year implementation period began
- August 23, 2022: InCK first evaluation report released
- February 16, 2024: InCK second evaluation report released

Additional information is available on the InCK Model webpage.

Maryland Total Cost of Care Model (Maryland TCOC)

Model Announcement Date: May 14, 2018

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

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

Number of Participants: 52 hospitals and 524 primary care practices

Model Classification: Voluntary

Geographic Scope: State of Maryland

Model Description: CMS and the state of Maryland partnered to test the Maryland Total Cost of Care (TCOC) Model, a predecessor to the States Advancing All-Payer Health Equity Approaches (AHEAD) Model, which sets a per-capita limit—and holds the state fully accountable—for the total cost of care for Maryland residents who have Medicare. The goal is to improve the overall health of Marylanders and the patient experience in health care settings and reduce avoidable hospital readmissions and emergency department visits. To do so, the model promotes person-centered care and better coordination among health care providers to avoid unnecessary expenditures.

The Maryland TCOC Model also commits the state to a sustainable growth rate in per-capita total cost of care spending for this Medicare population. The model includes three programs: the Hospital Payment Program, Care Redesign Program, and Maryland Primary Care Program. It builds

upon the CMS Innovation Center's Maryland All-Payer Model, which set a limit on per-capita hospital expenditures in the state.

Because hospitals and health care providers have a more stable, predictable source of revenue, they can focus more attention and funds on offering higher quality care through investment in health promotion and disease prevention interventions.

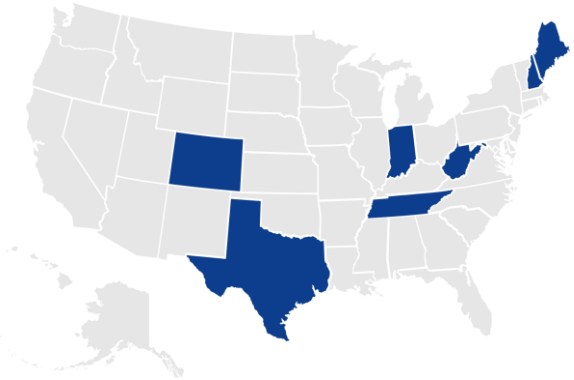
Evaluation Status/Key Takeaways: The Maryland TCOC Model's evaluation report showed comprehensive improvement during the first four years of the model's performance (2019–2022). The model continued to reduce total Medicare spending due to reductions in hospital spending, as well as hospital admissions and emergency department visits. The model generated an estimated $689 million in net savings to Medicare Parts A and B over its first three years (2019–2021) after accounting for non-claims payments. The report also found substantial reductions in disparities by race and place.

Model Milestones and Evaluation Reports 2022–2024:

- June 13, 2022: Maryland Primary Care Program Track 3 Request for Application (RFA) announced
- December 20, 2022: Maryland TCOC Quantitative-Only Report for the Model's First Three Years released
- April 8, 2024: Evaluation of the Maryland TCOC Model: Progress Report released

Additional information is available on the Maryland TCOC Model webpage.

Maternal Opioid Misuse Model (MOM)



Model Announcement Date: October 23, 2018

Model Performance Period: January 1, 2020–December 31, 2024

Model Participants: State Medicaid Agencies (SMAs) and care-delivery partners

Number of Participants: 7

Model Classification: Voluntary

Geographic Scope: Seven states nationwide—currently Colorado, Indiana, Maine, New Hampshire, Tennessee, Texas, and West Virginia

Model Description: The Maternal Opioid Misuse (MOM) Model addresses increased substance-use related illness and deaths in pregnant women by supporting state-driven programs that integrate maternal physical and behavioral health with opioid use disorder (OUD) treatment. The model centers on improving the quality of care for pregnant and postpartum women and their infants while also reducing overall associated Medicaid costs by expanding access, service-delivery capacity,

and infrastructure based on state-specific needs. MOM also aims to create sustainable coverage and payment strategies that support ongoing coordination and integration of care.

In addition to promoting integrated care delivery and evidence-based practices in physical and behavioral health, MOM Model programs provide care coordination and other comprehensive support to alleviate common barriers to care including transportation, childcare, and addressing stigma around seeking treatment for OUD. To support the model's sustainability efforts, program participants work to fold model services into existing per-member-per-month (PMPM) payments.

Evaluation Status/Key Takeaways: The model's third evaluation report was released in June of 2024. Although model enrollment nearly doubled during the second implementation year, enrollment remains substantially lower than anticipated, based on patients eligible for the model. Barriers to enrollment have included difficulty engaging MOM-eligible beneficiaries due to comorbid behavioral health conditions, the changing opioid landscape (i.e., increases in exposure to fentanyl and polysubstance use), fear of child welfare involvement, provider capacity and care access limitations, and fear of discrimination and stigma. The six key findings from the third annual MOM Model report are: 1) peer recovery services are emerging as a promising practice for pregnant and postpartum individuals with OUD; 2) integrated MOM Models are more likely to facilitate provider communication; 3) enrollment in MOM Models increased but remains lower than expected; 4) HRSNs are common among MOM Model patients; 5) MOM Models are developing capacity to support and sustain services; and 6) MOM Models are helping women succeed in their recovery.

Model Milestones and Evaluation Reports 2022–2024:

- February 16, 2022: MOM pre-implementation evaluation report released
- May 30, 2023: MOM second evaluation report released
- June 17, 2024: MOM third evaluation report released

Additional information is available on the Maternal Opioid Misuse Model webpage.

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

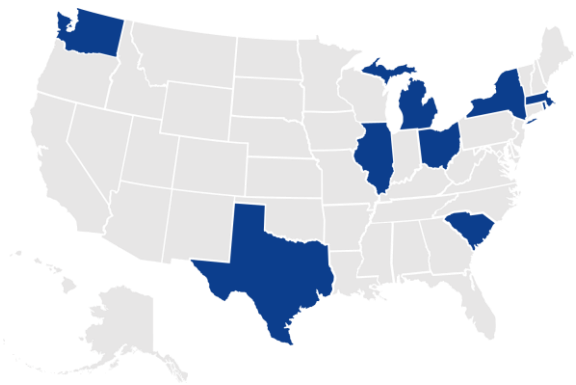
Model Announcement Date: July 1, 2011

Model Performance Period: Performance periods vary depending on the states—Washington will end on December 31, 2024, and the eight remaining capitated states will end on December 31, 2025

Model Participants: State Medicaid Agencies (SMAs) and health plans

Number of Participants: 10 demonstrations in 9 different states

Model Classification: Voluntary



Geographic Scope: Nationwide—current demonstrations are active in states including Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Washington

Model Summary: The Financial Alignment Initiative (FAI) aims to improve care coordination for people with both Medicare and Medicaid by improving financial alignment between the two programs, as well as integrating primary, acute, and behavioral health care, and long-term services for dually eligible populations. FAI is comprised of two models in which qualifying states may choose to participate: the capitated model and/or the managed FFS model. Under the capitated model, states, CMS, and a health plan commit to a three-way contract, and the plan receives an upfront payment to provide comprehensive and coordinated care. Under the managed FFS model, a state and CMS enter into an agreement where states are eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for Medicare and Medicaid.

Evaluation Status/Key Takeaways: Each demonstration is independently evaluated to assess its impact on improving quality and lowering cost. Only Washington has shown significant reductions in total Medicare expenditures. Most other demonstrations have shown increases in Medicare expenditures. States where Medicaid data are available have shown increases in Medicaid costs (California, Massachusetts, South Carolina), or no significant impact on Medicaid costs (New York FIDA-IDD, Texas). A few demonstrations have shown reductions in hospitalizations, increased evaluation and management physician visits, and/or decreased long-stay nursing home utilization.

Model Milestones and Evaluation Reports 2022–2024:

- April 12, 2023: Evaluation reports for California, Illinois, Massachusetts, New York, and Washington released
- October 5, 2023: Evaluation reports for New York and Ohio released
- December 20, 2023: Multiple FAI evaluation and savings reports released from participating states, including Texas, New York, Rhode Island, and South Carolina
- April and December of 2023: Savings Reports for Year 7 and Year 8 released

Additional information and links to the reports are available on the Financial Alignment Initiative webpage.

Pennsylvania Rural Health Model (PARHM)

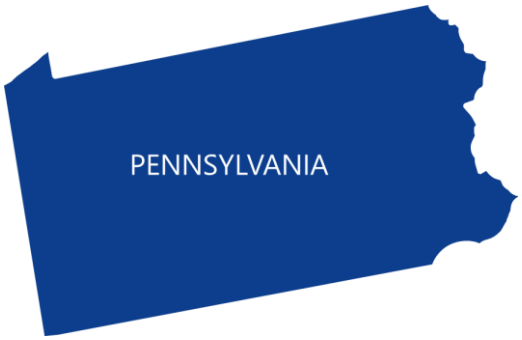
Model Announcement Date: January 12, 2017

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

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

Number of Participants: 18 hospitals

Model Classification: Voluntary



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

Model Description: The Pennsylvania Rural Health Model (PARHM) was designed to promote health transformation for rural communities across the state and improve health care delivery, while also reducing the growth of hospital expenditures across payers. Participating payers include Medicare and Medicaid, and commercial plans may also voluntarily participate in the model. PARHM provides participating hospitals with a predictable, fixed upfront payment, eliminating their reliance on meeting a certain patient volume to cover hospital costs.

Participating rural hospitals are responsible for redesigning care delivery in accordance with their CMS and State-approved Rural Hospital Transformation Plans to improve quality of care and meet the needs of their local communities. This may include better coordination and linkage of medical and social needs services, chronic disease management, preventive screenings, and substance use disorder treatment.

PARHM is the third state-specific model being tested by the CMS Innovation Center, in concert with the Maryland Total Cost of Care and the Vermont All-Payer Accountable Care Organization Models. Lessons learned from the PARHM have been incorporated into other state-based models, including the States Advancing All Payer Health Equity Approaches and Development (AHEAD) Model.

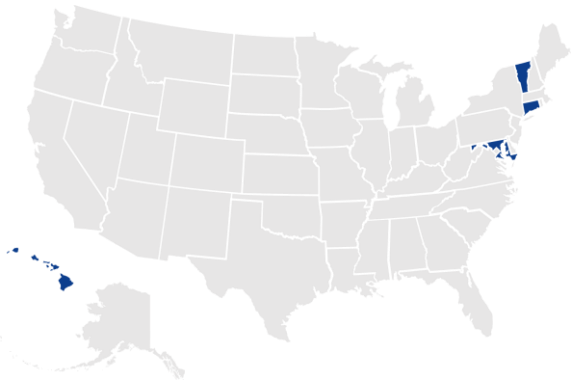
Evaluation Status/Key Takeaways: PARHM served as a motivating factor for participating hospitals to engage with new community partners and served as a catalyst to accelerate existing community engagement strategies. Participating hospitals also reported planning service line additions to address unmet community needs. The low participation precluded estimates that account for factors outside the model that may have caused the observed changes in spending or quality. The evaluation reports are limited to qualitative case studies and descriptive quantitative trends for participating hospitals that are rigorous and accurate but may not allow exclusive attribution of the outcomes as an impact of the model. Where feasible for comparison purposes, there are in-state non-participating hospital and population trends. The third and most recent evaluation report found that after a substantial drop in 2020, service use and spending rose during 2021, but did not return to pre-pandemic levels. Inpatient hospital service use declined while outpatient hospital service use increased. While participating hospitals reported that their global budgets were insufficient to completely fund hospital care transformation activities, the planning process did encourage hospitals to focus their attention on hiring of new staff to coordinate care and engage community partners.

Model Milestones and Evaluation Reports 2022–2024:

- June 23, 2022: PARHM second evaluation report released
- September 14, 2023: PARHM third evaluation report released

Additional information is available on the PARHM Model webpage.

States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD)



Model Announcement Date:
September 5, 2023

Model Performance Period: 2024–2034

Model Participants: States (including their state Medicaid agencies), Hospitals, and Primary Care Practices

Number of Participants: Up to 8 states nationwide, with Maryland, Vermont, Connecticut and Hawaii already selected; states can participate statewide or in a defined sub-state region.

Model Classification: Voluntary

Geographic Scope: Nationwide

Model Description: The AHEAD Model is a state-based total cost of care model whereby participating states will assume responsibility for managing the quality and costs of health care across all payers (including Medicare, Medicaid, and private coverage) to improve the total health of a state population and lower costs. The AHEAD Model provides a flexible framework to promote health care transformation and improve health outcomes. Under the AHEAD Model, participating states will receive funding via cooperative agreements and targeted support from CMS to develop and implement strategies to improve quality and reduce costs including hospital global budgets, advanced primary care, multi-payer alignment, and investments in population health activities. The goal of these strategies is to drive a reduction in health outcome-related disparities and increase investment in primary care and prevention, while curbing the growth of health care costs.

Advancing health equity is a focal point of AHEAD and is incorporated in the model's design in several ways. All participating states must develop a Statewide Health Equity Plan (HEP) that identifies health disparities and population health focus areas and specifies their activities that support the reduction of identified health-related disparities and aim to improve population health. Participating hospitals must also create HEPs that illustrate their alignment with the statewide plans. Participating primary care practices will also provide whole-person care and screen for HRSNs.

Evaluation Status: The first AHEAD evaluation report will be made available in 2027 and will describe the implementation experience of participating states and may include some preliminary impact estimates. Subsequent evaluation reports will examine key outcomes of the model, such as the impact of AHEAD on health care spending and utilization, quality of care, and health equity.

Model Milestones and Evaluation Reports 2022–2024:

- November 16, 2023: First of two Notice of Funding Opportunities (NOFOs) announced

- March 18, 2024: First NOFO application period for cohorts 1 and 2 closed
- July 2, 2024: Cohorts 1 (MD and VT) and 2 (CT and HI) participant selection announced
- August 12, 2024: Final NOFO application period for cohort 3 closed

Additional information is available on the AHEAD Model webpage.

Transforming Maternal Health Model (TMaH)

Model Announcement Date: December 15, 2023

Model Performance Period: 2025–2034

Model Participants: State Medicaid Agencies

Number of Participants: CMS anticipates issuing Cooperative Agreements to up to 15 state Medicaid agencies.

Model Classification: Voluntary

Geographic Scope: Up to 15 states, D.C., and territories nationwide are eligible to participate

Model Description: The Transforming Maternal Health (TMaH) Model is focused on improving maternal health care for people enrolled in Medicaid and CHIP. TMaH's goal is to improve health outcomes, safety and overall patient experiences for mothers and their newborns, while also reducing total program expenditures. The model provides targeted technical assistance and financial incentives to participating state Medicaid agencies to support the development of whole-person approaches to pregnancy, childbirth, and postpartum care. These strategies will address physical and mental health, as well as HRSNs. Additionally, the model aims to enhance access to care, infrastructure, and workforce capacity. Addressing maternal health disparities among underserved populations is a key focus for TMaH.

TMaH offers targeted, state-specific technical assistance to support state Medicaid agencies and providers, including those in rural and other high-need areas. Technical assistance will focus on increasing providers' capabilities to screen and refer for HRSNs, care delivery process improvements, expanding access to diverse types of maternity care providers, improving data infrastructure, and implementing patient safety protocols. This support also enables states to develop a value-based alternative payment model for maternity care services that will improve quality and health outcomes and promote long term sustainability of services. All participating states will also be required to develop and implement a Health Equity Plan unique to each population's needs.

Evaluation Status/Key Takeaways: TMaH's initial evaluation report will be available in the summer of 2027 and will assess model and state performance, and subsequent evaluation reports will occur annually through the end of the model. The evaluation will assess the Pre-implementation Technical Assistance (TA) and Implementation Periods using approaches that account for care delivery

partner type, specific model goals, and state and local contexts. The evaluation will seek to determine whether targeted TA, payment reforms, expanded workforce, and implementation of evidence-informed approaches improves experience and outcomes for pregnant and postpartum Medicaid beneficiaries and their newborns, decreases disparities among subpopulations, and optimizes spending.

Additional information is available on the TMaH Model webpage.

Vermont All-Payer Accountable Care Organization Model

Model Announcement Date: October 26, 2016

Model Performance Period: January 1, 2017–December 31, 2025[20]

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

Number of Participants: 1

Model Classification: Voluntary

Geographic Scope: State of Vermont

Model Description: The Vermont All-Payer Accountable Care Organization (ACO) Model, a predecessor to the AHEAD Model (in which Vermont will be a participant) tests whether scaling an ACO structure across all major payers in the state, including Medicare, Medicaid and commercial insurance, will incentivize broad delivery system transformation to reduce statewide spending and improve population health outcomes.

Green Mountain Care Board is a key partner in helping to administer the model as an independent entity responsible for overseeing the development and implementation and evaluating the effectiveness of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont.

By establishing state and ACO-level accountability for health outcomes for the state's entire population, the Vermont All-Payer ACO Model incentivizes collaboration between the care delivery and public health systems necessary to achieve these outcomes. While not required, the model encourages payers and health care providers in the state to enter into ACO arrangements, with payer-specific benchmarks and financial settlement calculations.

Evaluation Status/Key Takeaways: The model's fourth evaluation report found that in its first five years, the Vermont All-Payer ACO Model has produced cumulative reductions in spending for people currently aligned to the Medicare ACO in Vermont, with savings driven primarily by reductions in hospital utilization. Hospital participation has not reached the originally intended levels (particularly within the VT Medicare ACO), and payers continue to use different payment mechanisms, with hospital and practice revenue remaining predominantly FFS. However, 53

[20] The model's performance period was extended by three years.

percent of eligible Vermont residents are attributed to providers currently participating in the Vermont All-Payer ACO Model. Mostly inspired by the Vermont All-Payer ACO Model, there have been many interwoven efforts to establish, expand, and strengthen population health initiatives; however, the ripple effects of COVID-19 still impact full attainment of model goals. Overall, the Vermont All-Payer ACO Model is seen by many stakeholders as a focal point to continue transformation toward a culture of value-based care.

Model Milestones and Evaluation Reports 2022–2024:

- December 2, 2022: Vermont All-Payer ACO second model evaluation report released
- July 20, 2023: Vermont All-Payer ACO third model evaluation report released
- June 28, 2024: Vermont All-Payer ACO fourth model evaluation report released

Additional information is available on the Vermont All-Payer ACO Model webpage.

Statutory Models and Demonstrations

Statutory models are models and demonstrations requiring testing as determined by Congress and/or the Secretary of Health and Human Services.

Frontier Community Health Integration Project (FCHIP)

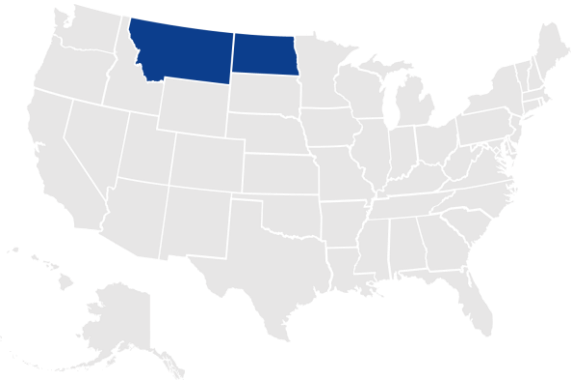
Demonstration Announcement Date: 2008[21]

Demonstration Performance Periods: August 1, 2016–July 31, 2019; January 1, 2022–June 30, 2027

Demonstration Participants: Critical access hospitals

Number of Participants: 10 (2016–2019); 5 (2022–present)

Demonstration Classification: Voluntary



Geographic Scope: Three states nationwide (Montana, Nevada[22], and North Dakota)

Demonstration Description: The Frontier Community Health Integration Project (FCHIP) Demonstration is a statutorily mandated demonstration launched by the CMS Innovation Center in collaboration with the Federal Office of Rural Health Policy, located in the Health Resources and Services Administration. It is an effort to increase access to care for Medicare beneficiaries in areas of the country where people live long distances from health care providers and struggle to receive health care services. The demonstration encourages critical access hospitals to provide essential services in these rural communities with the goals of improving quality of care and care

[21] The Frontier Community Health Integration Project Demonstration was originally authorized by Section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110 275). The demonstration has been extended by Section 129 of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260) for an additional five years.

[22] Nevada had no participants during the reporting period of this report.

coordination, reducing unnecessary emergency department visits, increasing patient satisfaction, and lowering health care costs. The demonstration ended on July 31, 2019, then was reauthorized and resumed for a five-year period beginning January 1, 2022.

Evaluation Status/Key Takeaways: The evaluation for the resumed demonstration slated for 2028 will measure whether the financial incentives being tested result in better cost and quality outcomes for beneficiaries.

Demonstration Milestones and Evaluation Reports 2022–2024: The FCHIP Demonstration has a statutory requirement to be budget neutral. Each year, a demonstration status report and details on the methodology for budget neutrality is published in the Federal Register as part of the Medicare Program, Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule.

- Federal Register: IPPS/LTCH PPS Final Rule

Additional information is available on the FCHIP Demonstration webpage.

Independence at Home Demonstration (IAH)

Demonstration Announcement Date: 2010

Demonstration Performance Period: June 2012 – December 2023

Demonstration Participants: Home-based primary care practices

Number of Participants: 7 (2022), 1 (2023)

Demonstration Classification: Voluntary

Geographic Scope: Nationwide—active at one site in New York in 2023

Demonstration Description: The Independence at Home (IAH) Demonstration tested the use of home-based primary care to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. Its goal was to improve the overall quality of their care and lower health care costs, including by reducing the need for care in institutional settings. IAH began as a three-year demonstration in 2012 and was extended multiple times by Congress, most recently beginning January 1, 2021. The demonstration's final performance year ended on December 31, 2023.

Evaluation Status/Key Takeaways: According to the latest IAH evaluation report for Year 8 (2021), IAH practices did not significantly reduce total spending through the first eight years of the demonstration. Total hospital admissions or readmissions were also not significantly lowered, but there were small declines in the rates of potentially avoidable hospitalizations and hospital admissions through the emergency department in earlier years of the demonstration.

Demonstration Milestones and Evaluation Reports 2022–2024:

- May 23, 2022: IAH year seven payment incentive results fact sheet released
- May 26, 2023: IAH year eight payment incentive results fact sheet released
- February 23, 2024: IAH year eight evaluation report and associated materials released
- May 20, 2024: IAH year nine payment incentive results fact sheet released

Additional information is available on the Independence at Home Demonstration webpage.

Intravenous Immune Globulin Demonstration (IVIG)

Demonstration Announcement Date:
December 2012

Demonstration Performance Period:

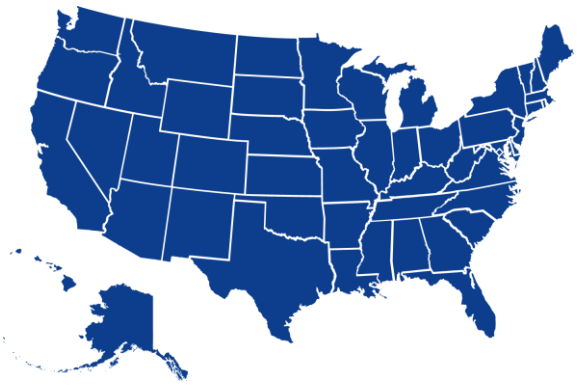
October 2014–December 31, 2023

Demonstration Participants: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers

Number of Participants: 468 at demonstration end

Demonstration Classification: Voluntary

Geographic Scope: 50 states nationwide and D.C.



Demonstration Description: The Medicare Intravenous Immune Globulin (IVIG) Demonstration, a voluntary, three-year program created by 2012 legislation with the demonstration performance period beginning in 2014 and extended in 2017 and 2021, provided a bundled payment for items and services involved with in-home administration of the IVIG therapy for beneficiaries with specific Primary Immunodeficiency Disorders diagnoses. The demonstration covered items such as infusion sets and tubing, and services including nursing services to complete IVIG infusions lasting on average three to five hours.

The demonstration had a rolling application cycle until it reached or was projected to reach the statutory limit on funding and/or enrollment.

The demonstration ended on December 31, 2023, and as of January 1, 2024, Section 4134 of the Consolidated Appropriations Act makes the IVIG in-home coverage permanent with no need for patients or eligible suppliers to enroll in the demonstration.

Evaluation Status/Key Takeaways: The final evaluation report covered the entire period of the evaluation, October 2014 through December 2023. During this time, 5,075 eligible Medicare FFS beneficiaries enrolled in the demonstration, of which about 75 percent received in-home IVIG therapy. Active demonstration participants received a greater number of IVIG infusions compared to non-participants, had reduced likelihood of missing or having to postpone their IVIG therapies, and experienced fewer infections relative to the comparison group. In surveys, 71 percent of enrollees

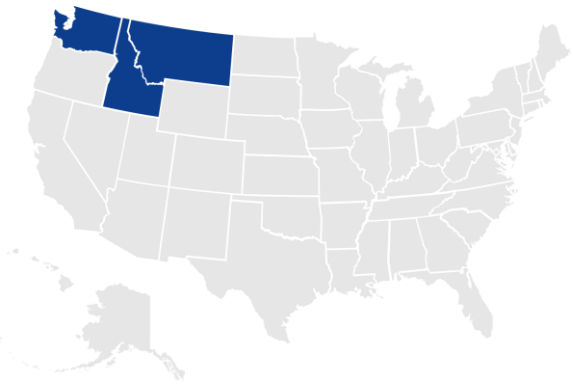
reported better health, better access to IVIG therapy, and less trouble obtaining their treatments than non-enrollees. Overall annual Medicare payments increased on average by $3,528 per beneficiary among active demonstration participants relative to the comparison group.

Demonstration Milestones and Evaluation Reports 2022–2024:

- October 6, 2022: Updated interim Report to Congress released
- October 28, 2024: Final Report to Congress released

Additional information is available on the IVIG Demonstration webpage.

The Medicare Pilot Program for Asbestos Related Disease (MPPARD)



Program Announcement Date: June 13, 2011

Program Performance Period: July 1, 2011–present

Program Participants: Medicare beneficiaries exposed to Environmental Health Hazards (EHH) in specified geographies in Idaho, Montana, and Washington

Number of Participants: 1,610 beneficiaries currently enrolled

Program Classification: Voluntary

Geographic Scope: Idaho (Benewah, Bonner, Boundary, Clearwater, Kootenai, Latah, and Shoshone Counties); Montana (Flathead, Glacier, Lake, Lincoln, Mineral, Missoula, and Sanders Counties); and Washington (Ferry, Lincoln, Pend Oreille, Spokane, Stevens, and Whitman Counties)

Program Description: The passage of the Affordable Care Act in 2010 authorized a pilot program[23] to provide additional services for certain Medicare beneficiaries who are entitled to free Medicare Part A (Hospital Insurance, HI) based on exposure to Environmental Health Hazards (EHH), and the ability to enroll in Medicare Part B (Supplemental Medical Insurance, SMI). The Medicare Pilot Program for Asbestos Related Disease (MPPARD) began July 1, 2011, with voluntary participation by EHH Medicare beneficiaries living in certain ZIP codes in Lincoln and Flathead counties, Montana. The Pilot Program was expanded on March 1, 2014, to include EHH individuals who currently reside in additional counties in Idaho, Montana, and Washington, as well as a limited group of other individuals who previously resided in these counties.

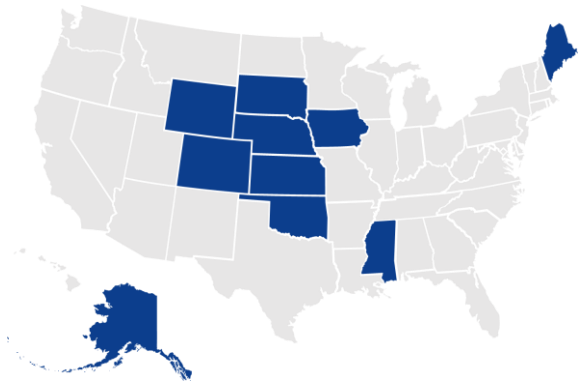
The MPPARD provides comprehensive, coordinated, and cost-effective care, including services not normally covered under Medicare. People who developed certain medical conditions from exposure to EHH are eligible for Medicare coverage under the program, even if they would not otherwise qualify due to age or disability. In addition to being eligible for services not traditionally covered by

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

Medicare, participating beneficiaries may also work with a nurse case manager to help coordinate care and services.

Program Milestones and Evaluation Reports 2022–2024: N/A

Rural Community Hospital Demonstration (RCHD)



Demonstration Announcement Date:
December 8, 2003[24]

Demonstration Performance Period:

October 1, 2004–June 30, 2028

Demonstration Participants: Small rural hospitals

Number of Participants: 21

Demonstration Classification: Voluntary

Geographic Scope: 9 states nationwide—currently Colorado, Iowa, Kansas, Maine, Mississippi, Nebraska, Oklahoma, South Dakota, and Wyoming

Demonstration Description: The Rural Community Hospital Demonstration (RCHD) supports participating small rural community hospitals that are too large to be critical access hospitals (CAHs) to meet the needs of people with Medicare by providing higher Medicare payments for covered inpatient hospital services. The goal of the demonstration is to improve quality of care and care coordination, reduce unnecessary emergency department visits, and increase patient satisfaction in rural communities. The demonstration has been reauthorized three times.

Evaluation Status/Key Takeaways: RCHD hospitals received, on average, higher Medicare payments for covered inpatient services than they would have if not in the demonstration. Higher payments resulted in improved Medicare inpatient margins and improved total operating margins and remained relatively constant during 2016–2018.

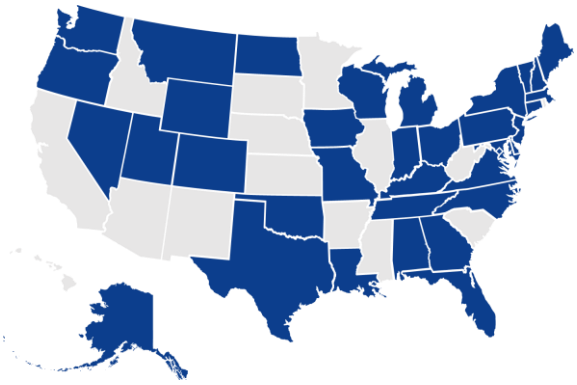
Demonstration Milestones and Evaluation Reports 2022–2024:

- January 24, 2023: RCHD second interim evaluation report released

Additional information is available on the Rural Community Hospital Demonstration webpage.

[24] The Rural Community Hospital Demonstration was originally authorized by section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173). The demonstration has been extended three times since the original five-year period mandated by the MMA, each time for an additional five years. These extensions were authorized by sections 3123 and 10313 of the Affordable Care Act (Pub. L. 111-148) (ACA), section 15003 of the 21st Century Cures Act (Pub. L. 114-255) (Cures Act) enacted in 2016, and most recently, by section 128 of the Consolidated Appropriations Act, of 2021 (Pub. L. 116-260).

Value in Opioid Use Disorder Treatment Demonstration Program (VIT-OUD)



Demonstration Announcement Date:
April 1, 2021

Demonstration Performance Period:
April 1, 2021–December 31, 2024

Demonstration Participants: Opioid treatment programs, physicians, group practices with at least one physician, hospital outpatient departments, Federally Qualified Health Centers, certified community behavioral health clinics, and a community mental health center

Number of Participants: 45

Demonstration Classification: Voluntary

Geographic Scope: Nationwide

Demonstration Description: Value in Treatment–Opioid Use Disorder (VIT-OUD) is a four-year demonstration program authorized under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). It supports a growing number of people with Medicare living with opioid use disorder (OUD). VIT–OUD's purpose is to increase access to OUD treatment services, improve health outcomes, and to the extent possible, reduce Medicare costs through new care management fees and performance-based incentives.

Evaluation Status/Key Takeaways: For the first 1.5 years of the demonstration, Medicare beneficiary enrollment was low but for the beneficiaries who did enroll, the demonstration had favorable impacts on Medicare spending, inpatient admissions, and emergency department visits.

Demonstration Milestones and Evaluation Reports 2022–2024:

- The VIT-OUD Demonstration performance period is anticipated to end on December 31, 2024. Per statute, the Intermediate Evaluation Report covering the first 1.5 years of the demonstration was delivered to Congress and released to the public in April 2024.

Additional information is available on the Value in Treatment Program webpage.

SUPPORTING ACTIVITIES

Quality Payment Program

The CMS Innovation Center continues to play a critical role in developing policy and processes for the Quality Payment Program (QPP), which began in January 2017 and implements provisions of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). These provisions changed the way that Medicare pays physicians and other clinicians for Covered Professional Services under Medicare Part B.

QPP rewards clinicians with financial incentives for providing high-quality care to Medicare patients and may reduce payments to clinicians who do not perform as well as their peers on program requirements. Clinicians have two tracks to choose from in the QPP: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs). An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Advanced APMs are APMs that meet certain additional criteria. Most Advanced APMs are developed and implemented by the CMS Innovation Center. CMS determined that 12 APMs, including the Medicare Shared Savings Program, meet the criteria for Advanced APMs for the 2023 Qualifying APM Participant (QP) Performance Period.

Eligible Clinicians achieve QP status by meeting certain threshold levels of participation in Advanced APMs, based on patient counts or payment amounts. Eligible clinicians can attain QP status through the Medicare Option based on participation in Advanced APMs with CMS or through the All-Payer Option by participating in a combination of Advanced APMs with CMS Other Payer Advanced APMs. Eligible clinicians who attain QP status in a performance year (PY) currently earn a lump-sum APM Incentive Payment in the corresponding payment year that occurs two years later. Those payments were set by statute at 5 percent of estimated aggregate paid amounts for covered professional services furnished by the QP during the calendar year immediately preceding the payment year through PY 2022 (payment year 2024), decreased to 3.5 percent in PY 2023 (payment year 2025), and further decreased to 1.88 percent in PY 2024 (payment year 2026). Per the Medicare statute, APM Incentive Payments are scheduled to sunset after PY 2024 (payment year 2026).

Eligible clinicians who are QP for the year are also excluded from reporting to the MIPS track—thus reducing administrative burden—and from the MIPS payment adjustment. In 2023, 226,681 eligible clinicians became QPs and received an APM Incentive Payment. Through its recently launched models, the CMS Innovation Center is helping broaden participation in Advanced APMs, including offering options and opportunities for eligible clinicians in small practices, underserved locations, and specialty care practices to participate. Additionally, beginning in 2021, the CMS Innovation Center reduced the burden on APM participants who are subject to MIPS by providing a streamlined reporting opportunity through the APM Performance Pathway and reweighting MIPS performance categories to account for these clinicians' APM participation to reduce duplication in MIPS of the reporting they perform and scoring they receive.

For more information on the Quality Payment Program, including a comprehensive list of Advanced APMs, see the Quality Payment Program webpage and the Quality Payment Program Resource Library.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to make comments and recommendations to the Secretary of the Department of Health and Human Services (HHS) on proposals for Physician-Focused Payment Models (PFPMs). The PTAC meets approximately quarterly in public meetings to review PFPM proposals submitted by stakeholders and assess the extent to which they meet 10 criteria established by the Secretary in the Quality Payment Program final rule.[25] CMS reviews all proposals recommended by the PTAC to the Secretary, posts a response to the PTAC's comments and recommendations on the proposals, meets regularly with the PTAC, and meets with PFPM submitters on an ad hoc basis.

There have been no PFPM submissions since the 2022 CMS Innovation Center biennial Report to Congress. Just before that report, in September 2021, the PTAC announced a new vision statement which highlights their role as "providing a forum where those in the field may directly convey both their ideas and their concerns on how to deliver high-value care for Medicare beneficiaries and others seeking health care services in our nation." This vision goes on to emphasize that the "PTAC is committed to ensuring our stakeholders have access to independent, expert input and their perspectives and innovations reach the Secretary of Health and Human Services."[26]

During this reporting period, the PTAC has engaged in a series of theme-based discussions during their public meetings, including specialty integration, transitions of care, rural participation in value-based payment models, and most recently on developing and implementing performance measures in population-based total cost of care models.

These theme-based discussions are quite relevant to CMS' work. As an example of how the theme-based approach has influenced CMS model design, the March 2023 public meeting focus on improving care delivery and specialty integration in population-based models was based on earlier proposals submitted by various medical specialty societies, including the revised Medical Neighborhood Model proposal.[27] The PTAC Environmental Scan on Improving Care Delivery and Integrating Specialty Care in Population-Based Models and discussions with the meeting subject matter experts collectively influenced the design of the new CMS Making Care Primary alternative payment model's specialty integration policies.

[25] 42 CFR 414.1465(b) Part 414–Payment for Part B Medical And Other Health Services Physician-focused payment models.

[26] ASPE, Physician-Focused Payment Model Technical Advisory Committee (PTAC) Vision Statement. Available at: https://aspe.hhs.gov/collaborations-committees-advisory-groups/ptac.

[27] ACP and NCQA, "The 'Medical Neighborhood' Advanced Alternative Payment Model (AAPM) Proposal." Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/261881/ProposalACPNCQA-Resubmitted.pdf.

BENEFICIARIES AND INDIVIDUALS INCLUDED IN CMS INNOVATION CENTER ACTIVITIES

The number of beneficiaries and individuals estimated to be included in CMS Innovation Center model tests and initiatives is listed in Table 2 below. The table also breaks down the aggregate number of beneficiaries and individuals specifically covered by Medicare Fee-For-Service (FFS), Medicare Advantage, Medicaid and the Children's Health Insurance Program (CHIP), Medicare and Medicaid dually eligible beneficiaries, private insurance, and those either uninsured or not covered by any of the aforementioned payers.

Table 2: Estimated number of beneficiaries and individuals currently or previously included in models or other initiatives implemented under section 1115A of the Social Security Act between October 1, 2022, and September 30, 2024.

Beneficiaries and Individuals Included in CMS Innovation Center Models and Initiatives[28] (Estimate as of September 30, 2024)	
TOTALS[29]	**Total Beneficiaries and Individuals Impacted[30]**
Medicare FFS, including Medicare and Medicaid dually eligible enrollees	12,149,588
Medicare Advantage, including Medicare and Medicaid dually eligible enrollees	19,970,422
Non-dually eligible Medicaid enrollees	1,724,185
Medicare Part D Prescription Drug Plan and Medicare Advantage Prescription Drug Plan beneficiaries, including Medicare and Medicaid dually eligible enrollees	21,840,161
Individuals with Private Insurance and Those Who were Either Uninsured or Not Covered by Any of the Aforementioned Payers	1,642,858
Medicare and Medicaid dually eligible enrollees	10,793,456[31]
ESTIMATED TOTAL FOR ALL BENEFICIARIES & INDIVIDUALS	57,327,214[32]

[28] To view an interactive map that shows models run at the state level and health care facilities where models are being tested, visit https://www.cms.gov/priorities/innovation/where-innovation-happening.

[29] Certain exclusions to beneficiary eligibility for inclusion in these models may apply. Specific information can be obtained by visiting respective CMS Innovation Center webpages.

[30] Values represent estimated unique counts between October 1, 2022, and September 30, 2024, unless otherwise specified.

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

[32] The CMS Innovation Center counts impacted beneficiaries and individuals by model test. In specific circumstances, it is possible that a beneficiary or individual might be included in multiple model tests. CMS Innovation Center incorporates policies into model design to deal with these "overlaps."

PAYMENTS MADE ON BEHALF OF BENEFICIARIES AND INDIVIDUALS INCLUDED IN MODELS

Table 3 is an account of the estimated payments made from October 1, 2022 to September 30, 2024 on behalf of beneficiaries included in model tests and initiatives authorized under section 1115A of the Act.

In addition to payments made to model and initiative participants under section 1115A of the Act, the table includes payments under Title XVIII or XIX of the Act and CMS Innovation Center funds obligated to support the design, implementation, and evaluation of model tests and initiatives developed under section 1115A of the Act. The table represents obligations less any recoveries of obligated funds during the Fiscal Year (FY) 2023–2024 period for the following: current model tests and initiatives; those that were originally housed in the CMS Innovation Center but are now funded under different authorities and implemented by different CMS components; those that have ended; and those that have been announced but not implemented.

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

Table 3: As of September 30, 2024, estimates of payments made to model participants (including health care providers, states, conveners, ACOs, and others), including payments under Title XVIII or XIX of the Act and CMS Innovation Center funds obligated to support activities initiated under section 1115A of the Act.

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

Estimated Payments for 1115A Model Tests and Initiatives[33] Fiscal Years 2023-2024 (Estimate as of September 30, 2024)

Initiative	*CMS Innovation Center payments made to model and initiative participants under section 1115A of the Act in United States dollars[34]*	*Payments under Title XVIII or XIX of the Act made for services on behalf of beneficiaries in United States dollars[35]*	*Other CMS Innovation Center funds under section 1115A of the Act obligated to support design, implementation, and evaluation in United States dollars[36]*
Accountable Health Communities Model	$0	Not Applicable	$0
ACO Primary Care Flex Model	Not Applicable	Payments Not Yet Made	$13,569,915
ACO Realizing Equity, Access, and Community Health Model	Not Applicable	$5,795,351,232	$62,697,673
Bundled Payments for Care Improvement Advanced Model	Not Applicable	Data Not Yet Available	$34,144,788
Cell and Gene Therapy Access Model	Not Applicable	Not Applicable	$15,041,298
Comprehensive Care for Joint Replacement Model	Not Applicable	$33,463,089	$13,119,075

[33] This table excludes administrative costs that are not associated with specific models or initiatives.

[34] The column titled "CMS Innovation Center payments made to model participants under section 1115A of the Act in United States Dollars" reflects payments made to participants in the testing of models, such as health care providers, states, conveners, ACOs, and others. These payments are paid through CMS Innovation Center funds as provided under section 1115A of the Act. These payments were made by September 30, 2024.

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

[36] The column titled "Other CMS Innovation Center funds under section 1115A obligated to support model design, implementation, and evaluation in United States Dollars" reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2024, September 30, 2024, such as contract awards for administrative and evaluation obligations, but excluding payments listed in the column titled "CMS Innovation Center payments made to model participants under section 1115A of the Act."

Estimated Payments for 1115A Model Tests and Initiatives[33] Fiscal Years 2023-2024 (Estimate as of September 30, 2024)			
Comprehensive End-Stage Renal Disease Care Model	Not Applicable	$136,414,333	$0
Comprehensive Primary Care Plus Model	Not Applicable	$243,394	$0
Emergency Triage, Treat, and Transport Model	Payments Not Yet Made	$3,758	$3,866,559
Enhanced Medication Therapy Management Model	Not Applicable	$0	$0
Enhancing Oncology Model	Not Applicable	Payments Not Yet Made	$20,481,750
End-Stage Renal Disease Treatment Choices Model	Not Applicable	Data Not Yet Available	$10,421,738
Expanded Home Health Value-Based Purchasing Model	Not Applicable	Not Applicable	$10,959,743
Global and Professional Direct Contracting Model	Not Applicable	$0	$0
Guiding an Improved Dementia Experience Model	Data Not Yet Available	Data Not Yet Available	$26,592,928
Health Care Payment Learning and Action Network[37]	Not Applicable	Not Applicable	$11,492,542
Home Health Value-Based Purchasing Model	Not Applicable	Not Applicable	$0

[37] The Health Care Payment Learning and Action Network is a public–private learning initiative and not a model test that directly serves beneficiaries.

Estimated Payments for 1115A Model Tests and Initiatives[33] Fiscal Years 2023-2024 (Estimate as of September 30, 2024)			
Innovation in Behavioral Health Model	Data Not Yet Available	Not Applicable	$5,522,650
Integrated Care for Kids Model	$27,879,082	Not Applicable	$4,035,452
Kidney Care Choices Model	$11,200,000	$234,382,976	$29,406,723
Making Care Primary Model	Payments Not Yet Made	$6,674,571	$32,196,607
Maryland Total Cost of Care Model	Not Applicable	$425,103,044	$17,276,637
Maternal Opioid Misuse Model	$12,076,578	Not Applicable	$8,665,711
Medicare Advantage Value-Based Insurance Design Model	Not Applicable	Not Applicable	$21,665,381
Medicare Care Choices Model	Not Applicable	Not Applicable	$0
Medicare Diabetes Prevention Program Expanded Model	Not Applicable	Not Applicable	$3,274,071
Medicare-Medicaid Financial Alignment Initiative and State Demonstration to Integrate Care for Dually Eligible Individuals	$3,713,444	$0	$31,643,433
Million Hearts Model	$0	Data Not Yet Available	$0
Million Hearts®: Cardiovascular Disease Risk Reduction Model	$0	Not Applicable	$0
Next Generation ACO Model	$0	$263,082,361	$0

Estimated Payments for 1115A Model Tests and Initiatives[33] Fiscal Years 2023-2024 (Estimate as of September 30, 2024)			
Oncology Care Model	Not Applicable	$170,116,219	$3,193,985
Part D Payment Modernization Model	Not Applicable	Data Not Yet Available	$0
Part D Senior Savings Model	Not Applicable	Not Applicable	$3,532,391
Pennsylvania Rural Health Model	$0	$240,470,251[38]	$1,789,763
Primary Care First Model	Data Not Yet Available	$1,034,692,545	$87,248,050
State Advancing All-Payer Health Equity Approaches and Development Model	$12,992,243	Not Applicable	$7,943,888
Transforming Maternal Health Model	Data Not Yet Available	Not Applicable	$8,008,545
Vermont All-Payer ACO Model	$0	$608,598,254	$5,286,005
ESTIMATED TOTALS:	$67,861,347	$8,948,596,029	$493,077,302

[38] $240,470,251 is an unreconciled PARHM global budget figure for FY 2024 and is subject to change. At the time of this report's composition, a reconciled figure was not available. The global budget figure was included in the 2022 Report to Congress.

RECOMMENDATIONS

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

CONCLUSION

Since the last Report to Congress, the CMS Innovation Center has announced, tested, or issued Notices of Proposed Rulemaking for nine new models and initiatives intended to achieve better care, improve health outcomes, and reduce expenditures for Medicare, Medicaid, and CHIP beneficiaries. These models are driven by the CMS Innovation Center goal of a health system that achieves equitable outcomes through high-quality, person-centered care and aligns with the Center's strategic objectives to drive accountable care, advance health equity, support innovation, address affordability, and foster partnerships to achieve system transformation.

During the period of this report, the CMS Innovation Center used learnings from model tests to successfully scale mode test elements into Medicare and Medicaid programs and design successor mandatory models. Additionally, in both new and existing models, the CMS Innovation Center has included policies to address health disparities and increase its impact on care for underserved populations.

CMS estimates that, during the period of this report, more than 57 million Medicare and Medicaid beneficiaries and individuals with private insurance in multi-payer model tests have been impacted by or received care furnished by the more than 192,000 health care providers and/or plans participating in the CMS Innovation Center models and initiatives across the United States. Furthermore, more than 57 million Americans are served by the CMS Innovation Center and the Medicare Shared Savings Program, a statutorily mandated Accountable Care Organization program that incorporates lessons learned from CMS Innovation Center model testing. This reflects great progress toward the CMS goal of having all people with Medicare and a vast majority of people with Medicaid in a care relationship with accountability for quality and total cost of care by 2030. The CMS Innovation Center looks forward to providing updates in the 2026 Report to Congress on progress toward advancing our strategic direction through initiatives to improve the quality of care for people with Medicare and Medicaid and reduce Federal health care spending.