Advanced Payment Models in Medicare and Medicaid
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Secretary of Health and Human Services (HHS) Burwell recently announced a goal for Medicare of having 30% of fee-for-service (FFS) payments tied to quality or value through alternative payment models by 2016 and 50% by 2018.[1] Reaching this goal will depend in part on the performance of the Department's many Medicare delivery reform initiatives launched by the Center for Medicare & Medicaid Innovation (CMMI). These initiatives seek to improve the performance of Medicare providers in all dimensions of the Triple Aim – higher quality, better experience and lower spending. Some of the initiatives have already run their course, been discontinued or subsumed under new models. Others have been modified to incorporate findings from interim independent evaluations that CMMI obtains for each initiative. Some are in the planning or start-up stages.

Only a subset of the CMMI initiatives employ payment innovations such as shared financial risk that are likely to be sufficiently robust to shift the volume-based incentives inherent to FFS reimbursement to more value-based purchasing that achieves measureable and significant improvements in quality while also lowering costs. These initiatives may be understood as examples of the most advanced models in a progression from FFS to population-based payment. Few organizations participating in these initiatives have as yet advanced along the continuum beyond very limited sharing of financial risk.

The following describes some of the major CMMI advance payment model initiatives with direct relevance to Medicare and Medicaid. Attachments to this brief present a framework for the progression of payment to clinicians and organizations in payment reform and a list of CMMI's initiatives/demonstrations.

Accountable Care Organizations (ACOs)

ACOs are viewed by HHS as a core part of its efforts to transition FFS Medicare to value-based provider payments in the years ahead. An ACO is defined as a group of doctors, hospitals and other health care providers who voluntarily come together to provide coordinated care to patients. The goal is to give groups of FFS providers the incentives to reduce Medicare spending and improve quality, similar to the incentives given to private plans under the MA program. ACOs are expected to do this by promoting shared accountability across participating providers, increasing coordination of care, and promoting investment in infrastructure and the redesign of care services. Key drivers of these improvements are performance-based incentives and a gradually increasing amount of shared financial risk.

CMMI is currently administering three major ACO initiatives. They differ in the extent to which participants bear financial risk for patient care and on other parameters such as the extent to which the ACO's providers reimbursement is based on Medicare FFS payment systems; the process for which a FFS beneficiary is aligned with an ACO; and the methodology for sharing risk and rewarding improvements in quality and outcomes. All three models preserve beneficiary freedom of choice of provider (i.e., they can get care from non-ACO providers) and participation is voluntary for both beneficiaries and providers.

CMMI's ACO Models: Certain Key Design Features			
	Medicare Shared Savings Program – November 2011 Final rule	**Pioneer ACOs**	**Next Generation ACOs**
Beneficiary alignment (assignment)	Retrospective alignment based largely on plurality of where beneficiary receives primary care services.	Prospective alignment, based on utilization during 3 historic baseline years (or, under some circumstances, beneficiary attestation).	Same methodology as Pioneers for assignment but also allows beneficiaries a decision in their alignment to an ACO (or to opt out).
Beneficiary incentive/ enrollment for participation	Not applicable. Beneficiary is retroactively aligned to ACO.	ACO can eliminate requirement of the 3-day inpatient stay prior to a SNF admission.	ACO can offer a waiver of 3-day inpatient stay for SNF care; telehealth expansion; and/or post-discharge home visits for beneficiaries; also may offer $50 per year award if 50% of patient encounters are with ACO entities.
Risk sharing	FFS payments plus one-sided risk (shared savings) or two-sided risk (shared savings/losses) <u>One sided model:</u> minimum savings rate (2%-3.9% depending on size of ACO) required for shared savings; 50/50 for maximum quality score up to 10% limit. <u>Two-sided model:</u> minimum savings(loss) rate of 2%; 60% ACO/40% Medicare shared savings for maximum quality score up to 15% limit' phased in for losses.	FFS payments during first and second periods plus shared savings/losses. Several options for shared savings/losses that incorporate some elements of the Medicare Shared Savings program and include options for increased shared savings and losses. For 3rd period, transition to population-based payment if ACO has generated minimum average annual savings over 1st two periods.	Four different payment options ranging from FFS with some infrastructure payments to full capitation. <u>A) Increased shared risk</u> • 80% shared risk (2016-2018); 85% shared risk (2019-2020); • 15% savings/losses cap • Discount (i.e. reduction)* <u>B) Full performance risk</u> 100% risk for Medicare Parts A and B* • 15% savings/loss cap • Discount (i.e. reduction)*
Insurance/financial solvency requirements	For 2-sided risk, must meet any applicable state insurance laws	Must attest that the organization is state-licensed as a risk bearing entity or is exempt from such licensure.	Must meet any applicable state insurance laws

*For the Next Generation ACOs, instead of a minimum savings rate, a discount (between 0.5% and 4.5%) will be applied once the baseline has been calculated, trended, and risk adjusted. It will reflect the: (1) ACO quality score; (2) ACO baseline expenditures compared to regional FFS expenditures (regional efficiency); and (3) regional FFS expenditures (in the baseline year) compared to national FFS expenditures (national efficiency). Under each approach, individual beneficiary expenditures are capped at the 99th percentile of expenditures to mitigate outlier effects.

Medicare Shared Savings Program (MSSP).[2] Established by the ACA, this program is designed to create incentives for providers to work together to treat an individual FFS beneficiary across

care settings. The program operates under regulations published in 2011; changes were proposed by CMS in December 2014 but have not been finalized.[3]

Beneficiaries currently are retrospectively assigned (aligned) to ACOs based on where they received a plurality of primary care services. Eligible entities range from networks of individual medical practices with professionals who meet statutory definitions to hospitals. An ACO must agree to accept responsibility for at least 5,000 Medicare FFS beneficiaries and to participate in the MSSP for 3 years.

In return for achieving savings relative to a pre-established benchmark, an MSSP ACO elects one of two tracks that applies for the whole of its first period of agreement with CMS: shared savings only (i.e., one-sided risk) or both savings and losses (i.e. two-sided risk). The one-sided risk option is viewed as an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, allowing them to gain experience with population management before transitioning to a shared losses model. The two-sided risk option is designed to give experienced ACOs that are ready to share in losses the opportunity to enter a sharing arrangement that provides a greater share of savings but with the responsibility of repaying Medicare a portion of any losses. Losses in excess of a specified limit (cap) are not shared by the ACO.[4] At present, almost all of the MSSPs have elected one-sided risk. After the initial agreement period, all ACOs that seek to participate for another period are supposed to participate in two-sided risk but this may be changed (see below).

CMS assesses each ACO's quality and financial performance based on a population's use of primary care services at the end of each year to determine whether it should be credited with improving care and reducing growth in expenditures compared to a benchmark.[5] The benchmark, which takes into account beneficiary characteristics and other factors that may affect the need for health care services, is an estimate of what the total Medicare FFS Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services were not provided by providers in the ACO. It is updated for each performance year within the agreement period.

CMS' recently proposed MSSP rule seeks to address concerns raised by ACOs and others, including uncertainty and inexperience at transitioning to increasing levels of risk, lack of timely and accurate data, changes in attributed patient populations from year-to-year, and financial benchmarks that fail to account for regional variations that may make it easier for those ACOs in high benchmark areas to do better than those in low ones. The final regulation is expected soon and is anticipated that in order to retain participants, CMS will permit them to continue with one-sided risk (i.e., earn bonuses but avoid penalties) under a new track 3 (for a total of 6 years). Additional changes may include some of the features of the Next Generation Model, described below.

Pioneer ACOs. Designed for organizations experienced with providing integrated care across settings, this initiative was launched in late 2011 with 32 organizations of diverse structures from 18 states. Organizations agreed to an initial 3-year performance period with the option to extend two more years. The objective was to transition such organizations from a shared savings payment model to a population-based model (per-beneficiary, per month payment) that would replace a significant portion of the Medicare FFS payment. Eligible providers are the same as

those eligible for the MSSP with a few exceptions. Each Pioneer is required to have a minimum of 15,000 Medicare beneficiaries who generally are prospectively "aligned" with a primary care provider so that the ACO knows which beneficiaries are attributed to it. The ACO must commit to entering outcomes-based contracts with other purchasers such that the majority of the ACO's total revenue is derived from such arrangements. These contracts include financial accountability (shared savings/financial risk), evaluation of patient experience of care and provision for quality performance incentives. Performance measures are the same as used for the MSSP.

In general, Pioneers continue to get paid Medicare FFS during the first two years along with shared savings and financial risk. (The levels of savings and risk are higher than in the MSSP.) In the third year, the Pioneers transition from FFS payment to population-based payment and full risk. However, options are available for alternative payment arrangements that accommodate organizations wanting less financial risk in the first year and more population based risk in the third year.

Next Generation ACO Model. CMS announced in early 2015 that Medicare ACOs experienced in coordinating care for populations of patients could apply to participate in this new model in which provider groups are asked to assume higher levels of financial risk and reward than are now available. The goal is to test whether these increased financial incentives along with other changes intended to support better patient engagement and care management (including benefit enhancements and financial incentives for beneficiaries to participate) can improve health outcomes and lower expenditures for FFS beneficiaries. Fifteen to 20 ACOs are expected by CMS to participate, each having at least 10,000 aligned beneficiaries (7,500 if in a rural area).[6]

Assessment of ACO Initiatives. As of January 1, 2015, there were 404 Shared Savings Program ACOs in 49 states, Washington, D.C. and Puerto Rico. All but 1% of these ACOs is being paid on the basis of the one-sided risk model. About 56% of ACOs are comprised of networks of individual practices. Currently, 19 Pioneer ACOs are participating. Some of the original Pioneers transitioned to the MSSP, some have withdrawn altogether, some are expected to transition to the Next Generation model.[7] CMS expects about 178,000 physicians to participate in a Medicare ACO in 2015 (inclusive of Pioneers), up from 100,000 in 2013.[8] About one in six FFS beneficiaries receive care from physicians, hospitals, and other providers participating in Medicare ACOs.[9]

Early results from both the MSSP and Pioneer ACOs show both promise and challenges for moving ahead. Individual ACOs have achieved high quality in many areas but only about one-fourth of those in the MSSP have been able to reduce spending enough to share in savings generated so far from their efforts. (An ACO can achieve the requisite savings but lose out on being able share in them because it failed to satisfactorily report quality metrics.) Data released by CMS in 2014 indicated that the MSSP had generated over $700 million in savings relative to the spending benchmarks in the program. This is about 1 percent of the costs of care for beneficiaries affected by Medicare ACO initiatives, which some say is significant given that they are working within FFS program constraints.[10] Pioneer ACOs yielded total program savings of $96 million in the program's second year, with participants sharing in savings of $68 million. Pioneers were able to improve mean quality scores by 19% and increase performance on 28 of 33 measures between performance year one and performance year two.[11]

Underlying these aggregate data, however, are wide variations in performance both on quality and costs. Experts conclude that more experience and learning will have to occur before most ACOs are willing to accept downside financial performance risk. Dimensions on which changes are likely to be needed include technical adjustments to benchmarks and payments (and, ultimately, more person-based payments); greater beneficiary engagement; improved performance metrics and better alignment with those used by other payers; improved data; and other design changes to align cost with quality and health outcome performance.

Bundled Payments

CMMI is testing several bundled payment initiatives. These initiatives use episodes, or "bundles" of care as the bases of payment. Bundles often include services furnished by more than one provider (e.g. a hospital and physicians) and are characterized by increased performance accountability and increased financial accountability generally via a requirement that participating organizations provide Medicare with a discount relative to a baseline calculation.

Bundled Payments for Care Initiative. Under this initiative, providers enter into payment arrangements for an episode of care that are centered around and triggered by an inpatient hospital admission. There are currently four models that, according to CMS, 243 organizations are actively testing and that differ from one another based on the amount of care bundled together as well as the duration of the bundle. The four initiatives, described in the table below, are:

- Model 1. Retrospective Acute Care Hospital Stay Only;
- Model 2: Retrospective Acute Care Hospital Stay Plus Post-Acute Care;
- Model 3: Retrospective Post-Acute Care Only; and
- Model 4: Prospective Acute Care Hospital Stay Only.

Bundled Payment for Care Initiative: Certain Key Design Features				
	Model 1	**Model 2**	**Model 3**	**Model 4**
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions. (Participants can obtain a waiver of the 3-day hospital stay requirement for SNF payment.)	All non-hospice Part A and B services during the post-acute period and readmissions.	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Medicare pays hospital a discounted amount based on IPPS.	Medicare pays FFS payments to providers and suppliers for episodes. Afterwards, the total payment for an episode is reconciled against a	Medicare pays individuals providers FFS with retrospective reconciliation against an established target	Prospective payment to hospital, which pays other participants based on target price discounted by

		target price with a responsible awardee receiving savings or repaying excess.	price and gains may be shared if quality targets are met.	between 3 and 3.25%
Risk	Gainsharing	Two-sided risk	Two-sided risk	Two-sided risk
Gainsharing = payments shared among providers that represent a portion of the gains achieved due to more coordinated, efficient, higher quality care. Two-sided risk = Providers share in some portion of savings and are at risk for some portion of spending over the target. Sources: CMS - CMMI website; Evaluation report (http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf); CMS Innovation Center Report to Congress, December 2014.				

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are compared to target prices developed based on historical FFS payments for the participant's Medicare beneficiaries in the episode. The target prices incorporate a discount which, so far, have been in the 2 to 3.5% range. Awardees choose between three levels of reconciliation risk, for each episode. The awardee can opt to bear risk up to the 75th, 95th, or 99th percentile. Awardees bear 100 percent of the risk up to the risk track threshold and 20 percent of payments above the threshold for a given risk track.[12] Recent changes have eased the risk for providers involved in Model 2, however. The range of awardee payments/repayment has been limited to be no greater than + or – 20% of the sum of the target price and the Medicare discount aggregated across all episodes. In addition, Medicare waived the requirement to repay negative amounts for the fourth quarters of 2013 and for 2014.[13]

Assessment. A comprehensive evaluation of Models 2-4 of the BPCI initiatives prepared for CMS found improvements in provider performance and some shifts in utilization that could suggest substitution of lower cost providers for higher cost providers. The effects on Medicare costs were mixed. This early evaluation is limited, however, because it is based on a very small group of the first 15 awardees that signed up for BPCI during the first quarter of the program.[14]

Evidence from the literature generally indicates that episode-based payments have been successful in reducing utilization – although the research fails to identify which interventions were most important in achieving the new treatment patterns.[15] An earlier bundled payment initiative for specific cardiovascular and orthopedic procedures, which concluded in 2013, was found to have a favorable effect on costs and use of certain services. Under the Medicare Acute Care Episode (ACE) Demonstration, the use of certain services was reduced, while utilization of other services increased. Taking discounted payments into account, the evaluation confirmed that Medicare costs were reduced.[16]

Oncology Model. The Oncology Model, which is the second specialty care model to be announced by CMS/CMMI, is a multi-payer initiative in which physician practices enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration for cancer patients.[17] The goal is to recruit at least 100 physician practices and to begin the 5-year initiative by the spring of 2016.

The model involves 6-month episodes triggered by administration of chemotherapy. Eligible beneficiaries who receive chemotherapy from a participating practice will be automatically enrolled. Participating physician practices will receive a per beneficiary per month (PBPM)

payment of $160 during the episode in addition to usual FFS payments and will qualify for performance-based payments.

To receive performance-based payments, participating providers will need to demonstrate achievement and improvement on certain quality measures. The amount that providers can receive for performance-based payments will be capped based on the difference between an episode-based benchmark amount and the cost of the episode at its completion.

The episode-based benchmark will be calculated based on historic data for all Part A/B services and some Part D costs (for beneficiaries with Part D coverage). Those amounts will be risk adjusted and discounted to provide Medicare up-front savings. The difference between the benchmark and the performance year actual expenditures will represent the maximum performance-based payments that the practice could receive. Practices that do not qualify for a performance-based payment by the end of the third performance year will be removed from the model.

One-sided risk can apply for the entire 5 years, but practices will be offered the option to switch to two-sided risk on a semi-annual basis beginning in the third model year. Initially, the up-front savings discounts will be 4% under one-sided risk. For those practices moving to two-sided risk in year three, the discount will drop to 2.75%.[18]

Financial Alignment Initiative for Medicare-Medicaid Enrollees

Under the financial alignment initiatives, state Medicaid agencies are undertaking demonstrations intended to improve care coordination and reduce costs for dual Medicare/Medicaid-eligible individuals. Participating states are responsible for coordinating and integrating Medicare and Medicaid benefits and spending for demonstration-eligible enrollees through contracts with private managed care plans. In January of 2015, about 350,000 people were enrolled in plans under this initiative.

The initiatives are usually targeted to a sub-group of dual eligible individuals such as those residing in certain regions or counties of the state, those with disabilities or those who are receiving care in community based settings.

Three models are being tested, but almost all of the activity is in only one of the three models – the capitated, integrated managed care model – which is being tested in 10 states. Two states are testing a managed FFS model which combines improved care management with the traditional FFS delivery system; and one state is testing a model to coordinate Medicare and Medicaid administrative functions only.

Under the capitated managed care model, states are negotiating contracts with managed care plans to provide a broadened scope of services – integrating services covered by the Medicare and the Medicaid programs, sometimes integrating acute and long term services and support; and/or integrating physical and behavioral health (BH) services. The negotiated payment rate for such "3-way contracts" – or contracts negotiated between the state Medicaid agencies, the managed plans, and CMS on behalf of Medicare – includes a built-in savings assumption that

begins at 1% below the estimated cost of those services under traditional Medicaid and Medicaid. That rate rises to between 3 and 5.5% over the three years of the demonstrations. In addition, a quality withhold starts at 1% in year 1 and rises to 3% in year 3. Plans meeting quality targets are able to earn back the withheld amounts.

Assessment. At this time, no evaluations are available. CMS has indicated that its plan to release evaluations of two state programs during the first half of 2016. Experience with the programs, however, has been mixed. At its outset, as many as half of the states indicated interest in pursuing this approach. Today, only 9 states have both approved capitated models and plan to continue with implementation. One of those states has recently re-negotiated its savings assumptions to reduce the targeted savings. Further, some remaining states and plans have indicated that achieving savings has been more difficult than expected putting their continued participation in jeopardy. For example, the demonstration was reportedly included in the California budget as costing money instead of saving and the Governor indicated that its continued operation is at risk.[19]

Other Alternative Payment Innovations

CMMI is testing a number of other models, some of which include payment innovations including shared risk in their design (see Attachment 2). For example, the Comprehensive Primary Care Initiative, launched in 2012, created a collaboration between CMS with commercial and state health insurance plans in seven regions of the country (including practices serving about 300,000 Medicare beneficiaries) to offer population-based care management fees and shared savings opportunities to participating primary care practices for a core set of primary care functions (e.g., planned care for chronic conditions and prevention). Participating practices are also expected to employ continuous use of data to guide improvement, and meaningful use of health information technology, with the expectation of improving outcomes and achieving lower costs.[20] Early results indicate that expenditures are trending downward.[21]

State innovation models (SIM) currently being tested in 17 states incorporate many of the payment innovations discussed above. Under those demonstrations, states are collaborating with the federal government and other payers to test patient centered medical homes and ACOs. Payment innovations under those demonstrations include shared savings arrangements, episode–based reimbursement designs and performance-based bonus payments.

Final Observations

About 12 million covered lives are now under private ACO arrangements and an increasing number of private payers are joining with delivery systems to shift from FFS toward bundled or global payment contracts. Although Medicare and state Medicaid programs have learned much from this private sector experience, Medicare Advantage plans may also benefit from the experiences and findings from the CMMI initiatives in designing or refining value-based payment models as a way to help their provider communities achieve Triple Aim objectives. Based on the early results of the CMMI initiatives, however, it appears that FFS Medicare has a way to go before provider risk-sharing of any significant extent is widely adopted. Provider participation in CMMI initiatives might increase with the recent passage of The Medicare Access

and CHIP Reauthorization ACT (Public Law 114 – 10), which prescribes physician payment updates and incentives that will replace the SGR formula and also includes financial incentives for participation in alternative payment models. However, the underlying concepts and objectives of increasing value, better coordinating care and integrating of services and payments are likely to continue to drive innovation and experimentation, both for public and private payers.

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[1] In 2014, Medicare spent roughly 20% of the $362 billion Medicare fee-for-service budget compared with nearly 0% prior to the passage of the ACA. Melanie Evans and Paul Demko, Medicare's Payment Reform Push Draws Praise and Fears, *Modern Healthcare*, January 26, 2015.

[2] CMS, *Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program*, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Summary_Factsheet_ICN907404.pdf.

[3] *Federal Register*, December 8, 2014, p. 72760-72872.

[4] In addition, a Minimum Savings Rate (MSR) and a Minimum Loss Rate (MLR) are applied to the ACO "to account for normal variations in health care spending." CMS defines the MSR as a percentage of the benchmark that ACO expenditure savings must meet or exceed in order for an ACO to qualify for shared savings in any given year. An ACO with expenditures at or above the MLR is accountable for repaying shared losses. ACOs in the one-sided model that have smaller populations (and having more variation in expenditures) have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided model, CMS applies a flat 2 percent MSR to all ACOs. Under both models, if an ACO meets quality standards and achieves savings and also meets or exceeds the MSR, the ACO shares in savings, based on the quality score of the ACO. ACOs share in all savings, not just the amount of savings that exceeds the MSR, up to a performance payment limit. Similarly, ACOs with expenditures meeting or exceeding the MLR share in all losses, up to a loss sharing limit. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf

[5] To encourage organizations to participate, first-year participants electing one- or-two-sided risk only have to report quality measures. After the first year, the ACO must not only report but also perform well on selected quality measures in order to qualify for shared savings.

[6] Applications are due by June 1, 2015 for a January 1, 2016 start date and June 1, 2016 for a January 1, 2017 start date.

[7] Centers for Medicare & Medicaid Services, *Fast Facts, All Medicare Shared Savings Program ACOs and Pioneer ACOs*, Data is current as of January 1, 2015, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf.

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *FY 2016 Budget Justifications.*

[9] McClellan. Mark, Changes Needed to Fulfill the Potential of Medicare's ACO Program, *Health Affairs Blog*, April 8, 2015, http://healthaffairs.org/blog/2015/04/08/changes-needed-to-fulfill-the-potential-of-medicares-aco-program-2/

[10] Conway, Patrick, Center for Medicare and Medicaid Innovation Center Update, November 10, 2014 presentation, http://innovation.cms.gov/Files/slides/CMSInnovCtrUpdateOne.pdf; Hoangmai H. Pham et al, The Pioneer Accountable Care Organization Model, Journal of the American Medical Association, October 22/29, 2014, http://jama.jamanetwork.com/article.aspx?articleid=1906488; McClellan. Mark, Changes Needed to Fulfill the Potential of Medicare's ACO Program, *Health Affairs Blog*, April 8, 2015, http://healthaffairs.org/blog/2015/04/08/changes-needed-to-fulfill-the-potential-of-medicares-aco-program-2/; McClellan, Mark et al, Early Evidence On Medicare ACOs And Next Steps for The Medicare ACO Program (Updated), *Health Affairs Blog*, January 22, 2015, http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/.

[11] McClellan, Mark et al, *A More Complete Picture of Pioneer ACO Results*, Brookings Up Front, http://www.brookings.edu/blogs/up-front/posts/2014/10/09-pioneer-aco-results-mcclellan#recent_rr/

[12] CMS Innovation Center:Background Information on Models 2 and 3 found at http://innovation.cms.gov/Files/x/BPCI_Model2Background.pdf and http://innovation.cms.gov/Files/x/BPCI_Model3Background.pdf .

[13] CMS Innovation Center: Report to Congress, December 2014, http://innovation.cms.gov/Files/reports/RTC-12-2014.pdf.
[14] Lewin Group, CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report, February 2015, http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf.
[15] Friedberg, Chen, White, et al, Effects of Health Care Payment Models on Physician Practice in the United States, RAND Corporation and the American Medical Association, 2015, http://www.rand.org/pubs/research_reports/RR869.html.
[16] Centers for Medicare and Medicaid Services, Evaluation of the Medicare Acute Care Episode (ACE) Demonstration, Final Evaluation Report, May 31, 2013, http://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf.
[17] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-02-12.html?DLPage=1&DLFilter=oncology&DLSort=0&DLSortDir=descending
[18] See also http://innovation.cms.gov/Files/x/ocmfaqs.pdf for additional details on calculating the benchmark and performance payments.
[19] Dickson, V., Future of dual-eligible demonstrations questions due to low enrollment," Modern Healthcare, April 21, 2015.
[20] Practices serving Medicare beneficiaries receive their Medicare FFS reimbursement plus a monthly care management fee. The practices shares in any savings for the total cost of care after two years.
[21] Conway, Patrick, Center for Medicare and Medicaid Innovation Center Update. November 10, 2014 presentation, http://innovation.cms.gov/Files/slides/CMSInnovCtrUpdateOne.pdf.

Attachment 1.

Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

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Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA. Doi:10.1001/jama.2014.3703

Attachment 2.

DELIVERY MODEL	STAGE
Accountable Care	
Accountable Care Organizations (ACOs): General Information	Not Applicable
ACO Investment Model	Applications under review
Advanced Payment ACO Model	Ongoing
Comprehensive ESRD Care Initiative	Applications under review
Medicare Health Care Quality Demonstration	No longer active
Next Generation ACO Model	Announced
Nursing Home Value-Based Purchasing Demonstration	Ongoing
Physician Group Practice Transition Demonstration	No longer active
Pioneer ACO Model	Ongoing
Private, For-Profit Demo Project for the Program of All-Inclusive Care for the Elderly	Ongoing
Rural Community Hospital Demonstration	Ongoing
Bundled Payment for Care Improvement	
Model 1: Retrospective Acute Care Hospital Stay Only	Participants Announced, Ongoing
BPCI Model 2: Retrospective Acute & Post-Acute Care Episode	Participants Announced, Ongoing
BPCI Model 3: Retrospective Post-Acute Care Only	Participants Announced, Ongoing
BPCI Model 4: Prospective Acute Care Hospital Stay Only	Participants Announced, Ongoing
Bundled Payments for Care Improvement (BPCI) Initiative: General Information	Not applicable
Medicare Acute Care Episode (ACE) Demonstration	No longer active
Medicare Hospital Gainsharing Demonstration	No longer active
Oncology Care Model	Accepting Letters of Intent, Accepting Applications
Physician Hospital Collaboration Demonstration	No longer active
Specialty Practitioner Payment Model Opportunities: General Information	Not applicable
Primary Care Transformation	

Advanced Primary Care Initiatives	Under development
Comprehensive Primary Care Initiative	Ongoing
FQHC Advanced Primary Care Practice Demonstration	Ongoing
Frontier Extended Stay Clinic Demonstration	No longer active
Graduate Nurse Education Demonstration	Ongoing
Independence at Home Demonstration	Ongoing
Medicare Coordinated Care Demonstration	Ongoing
Multi-Payer Advanced Primary Care Practice	Ongoing
Transforming Clinical Practices Initiative	Applications under review
Initiatives Focused on the Medicaid and CHIP Population	
Medicaid Emergency Psychiatric Demonstration	Ongoing
Medicaid Incentives for the Prevention of Chronic Diseases Model	Ongoing
Medicaid Innovation Accelerator Program	Announced
Strong Start for Mothers and Newborns Initiative: Effort to Reduce Early Elective Deliveries	Participants Announced
Strong Start for Mothers and Newborns Initiative: General Information	Not applicable
Financial Alignment Initiative for Medicare-Medicaid Enrollees	Applications Under Review, Ongoing
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	Ongoing
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	
Frontier Community Health Integration Project Demonstration	Announced
Health Care Innovation Awards	Ongoing
Health Care Innovation Awards Round Two	Ongoing
Health Plan Innovation Initiatives	Under Development
Maryland All-Payer Model	Announced
Medicare Care Choices Model	Applications Under Review
Medicare Intravenous Immune Globulin (IVIG) Demonstration	Accepting Applications
State Innovation Models Initiative: General Information	Not Applicable
State Innovation Models Initiative: Model Design Awards Round One	Ongoing
State Innovation Models Initiative: Model Design Awards Round Two	Announced

State Innovation Models Initiative: Model Pre-Testing Awards	No Longer Active
State Innovation Models Initiative: Model Test Awards Round Two	Announced
State Innovation Models Initiative: Model Test Awards Round One	Ongoing
State Innovation Models Initiative: Round Two	Announced
Initiatives to Speed the Adoption of Best Practices	
Beneficiary Engagement Model Opportunities: General Information	Under Development
Community-based Care Transitions Program	Ongoing
Health Care Payment Learning and Action Network	Announced
Innovation Advisors Program	Ongoing
Medicare Imaging Demonstration	No Longer Active
Million Hearts	Ongoing
Partnership for Patients	Ongoing

http://innovation.cms.gov/initiatives/index.html#views=models