AHLA PG Toolkit

CMS VALUE-BASED CARE TOOLKIT

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Regulation, Accreditation, and Payment Practice Group

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INTRODUCTION

This summary of Centers for Medicare & Medicaid Services (CMS) value-based payment models is intended to provide a brief, at-a-glance comparison of selected CMS initiatives. For purposes of this analysis, a "value-based" model is one designed to shift the reimbursement system from a "volume-based" fee-for-service model to a model incorporating incentives to reduce costs while maintaining or improving quality.

The concept of value-based care has proliferated throughout many aspects of CMS's work in the last decade. This summary focuses on formal *models* designed to promote value-based care. Therefore, it does not address more wholesale payment system changes such as the Physician Fee Schedule's Merit-based Incentive Payment System. However, it does cover the Medicare Shared Savings Program and most of the active models operated by the Center for Medicare and Medicaid Innovation (CMMI).

Please note that models are subject to change at any time for reasons including modifications in CMMI policies, regulatory modifications, programmatic changes, or contractual amendments. We have used our best efforts to ensure the information included here is correct. However, parties should not rely wholly on this set of comparisons, and instead should consult the material linked herein to understand the current state of the programs.

Notwithstanding these changes, we feel this document provides a useful summary of the goals, target population, and financial incentives implemented across CMS's robust portfolio of value-based care options. We hope you find this product useful.

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Accountable Care Models

	Medicare Shared Savings Program
Official or alternate names (if applicable)	Original Medicare ACO, Pathways ACO, Permanent ACO Program
Common acronym	MSSP
Objective	MSSP offers providers and suppliers an opportunity to create or join an ACO (i.e., groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated service and health care, improve health outcomes, and manage costs). ACOs are responsible for the quality, cost, and care experience for an assigned Medicare fee-for-service beneficiary population. An ACO may be eligible to share in the savings it achieves for Medicare and it may also be responsible for increases in costs.
Relevant statutory and regulatory provisions	42 U.S.C. § 1395jj 42 C.F.R. Part 425
CMS website	https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos
Start date	2012
End date	N/A; this is a permanent program with an annual cycle. Annual cycle details can be found here.
Performance Year	CY
Core documents setting out model terms	*See* regulatory provisions at 42 C.F.R. Part 425. MSSP Participation Agreement and key guidance.
Accepting new applications?	Yes, MSSP has an annual application cycle.
Eligible parties	Definitions at 42 C.F.R. § 425.20: **Accountable care organization** ("ACO") means a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number ("TIN"), and is formed by

	Medicare Shared Savings Program
	one or more ACO participants(s) that is/are defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b). The ACO must also meet the eligibility criteria described at 42 C.F.R. Part 425, Subpart B. **ACO participant** means an entity identified by a Medicare-enrolled billing TIN through which one or more ACO providers/suppliers bill Medicare, that alone or together with one or more other ACO participants compose an ACO, and that is included on the list of ACO participants that is required under § 425.118. ACOs may only be formed by those ACO participants or combinations of ACO participants described in 42 C.F.R. § 425.102(a). Other kinds of participants may join an ACO formed by such entities. **ACO provider/supplier** means an individual or entity that meets all of the following: (1) is a Provider or Supplier (as defined at 42 C.F.R. § 400.202); (2) is enrolled in Medicare; (3) bills for items and services furnished to Medicare fee-for-service beneficiaries during the agreement period under a Medicare billing number assigned to the TIN of an ACO participant in accordance with applicable Medicare regulations; and (4) is included on the list of ACO providers/suppliers that is required under § 425.118. The composition of ACO participants may cause an ACO to be deemed "high revenue" or "low revenue" as defined at 42 C.F.R. § 425.20. For example, ACOs that include hospitals as participants are much more likely to be deemed "high revenue."
Focused beneficiary population	All Medicare fee-for-service beneficiaries attributed to the ACO pursuant to 42 C.F.R. Part 425, Subpart E.
Intermediate entities between CMS and provider	For most ACOs, a distinct ACO legal entity is responsible for receiving and dividing shared savings and repaying shared losses. ACOs must meet the eligibility requirements of 42 C.F.R. Part 425, Subpart B.
Where are changes communicated?	Since the inception of the MSSP, CMS has made programmatic changes in several places, including dedicated MSSP federal rules, other CMS payment rules (such as the Medicare Physician Fee Schedule annual rule), guidance documents posted to the MSSP website (e.g., Program Updates; Program

	Medicare Shared Savings Program
	Statutes & Regulations; Program Guidance & Specifications), and the MSSP "portal" that is only accessible to ACO entities.
Brief description of the financial arrangement	ACO will earn shared savings if the Medicare expenditures for an attributed patient population (adjusted to reflect the ACO's performance under required quality measures) are sufficiently below a benchmark reflecting the historic Medicare expenditures of that population. ACO may also be required to pay shared losses if the quality-adjusted Medicare expenditures sufficiently exceed the benchmark. ACOs may also be eligible for Advance Investment Payments if (1) the ACO is not a renewing or a re-entering ACO; (2) the ACO has applied and is eligible to participate in the MSSP under any level of the BASIC track's glide path; (3) the ACO is inexperienced with performance-based risk Medicare ACO initiatives; and (4) the ACO is a low-revenue ACO. 42 C.F.R § 425.630.
Shared losses?	As of 2024, ACOs in the MSSP have the option to take on risk but may not be required to do so. New ACOs are placed on a "Pathways" model composed of a "BASIC" track with risk "Levels" from A-E (the "glide path") and an "Enhanced" track. As the ACO progresses across the glide path, the ACO takes on additional risk but is also eligible for a greater portion of the savings. Starting in 2019, ACOs were required to progress through the glide path over a five-year term, increasing the risk Level each year. The Pathways model consists of Level A-E, followed by an "Enhanced" track with the highest degree of shared savings and shared risk. Level A and B are "upside-only" levels (i.e., levels without shared losses), while Levels C-E and the Enhanced track involve potential shared losses. 42 C.F.R. § 425.600(a)(3) and (4). Starting in 2024, an ACO can choose to enter the glide path at any Level and can choose to advance to higher Levels non-sequentially (e.g., from A to C). An ACO that starts in Level A may also choose to remain in Level A for the full five-year period, provided that it is not deemed to be a "renewing" ACO or "experienced with performance-based risk Medicare ACO initiatives". 42 C.F.R. § 425.600(a)(4)(C) and (g). ACOs have certain options to select the degree of risk-sharing through a "Minimum Loss Rate / Maximum Sharing Rate" process described at 42 C.F.R. § 425.605(b) (Basic Track) or 425.610(b) (Enhanced Track).

	Medicare Shared Savings Program
Attribution terms	Beneficiaries are assigned to ACOs using two methodologies: prospective attribution by beneficiary selection ("voluntary alignment") and retrospective attribution based on the plurality of primary care services delivered by an ACO participant ("claims-based assignment"). 42 C.F.R. § 425.400(a)(4)(ii)(A); Ctrs. for Medicare & Medicaid Serv's., *Medicare Shared Savings Program Shared Savings and Losses, Assignment and Quality Performance Standard Methodology* (January 2023 Version #1), available here. Under the voluntary alignment methodology, beneficiaries who designate an ACO professional participating in an ACO as responsible for coordinating their overall care are prospectively assigned to that ACO annually at the beginning of each benchmark and performance year, assuming certain conditions are met. 42 C.F.R. § 425.402(e)(1)-(2). Under the claims-based assignment methodology, if the beneficiary has had at least one primary care service during the applicable assignment window with a physician who is an ACO professional in the ACO (among other requirements), CMS reviews the allowed charges for a beneficiary's primary care services and assigns the beneficiary to the ACO that provided the greatest proportion (the "plurality") of the beneficiary's primary care services. 42 C.F.R. § 425.402(b)(1)-(3). If the beneficiary has not received at least one primary care service during the applicable assignment window from a primary care provider (regardless of whether the provider is in an ACO), CMS reviews the allowed charges for primary care services and assigns the beneficiary to the ACO whose specialty physicians provided the greatest plurality of the beneficiary's primary care services. 42 C.F.R. § 425.402(b)(4). Beginning in performance year 2025, for beneficiaries that are not captured by the prior two categories (i.e., beneficiaries who had at least one primary care service with a non-physician ACO professional in the ACO during the applicable assignment window), CMS will review the allowed charges for primary care services delivered by ACO professionals in the ACO who are primary care physicians, non-physician ACO professionals, and physicians with specialty designations (during the applicable expanded window for assignment) and assign the beneficiary to the ACO that provided the plurality of the beneficiary's primary care services. 42 C.F.R. § 425.402(b)(5).
Costs considered	Total cost of care (i.e., average per capita Medicare Parts A & B expenditures for attributed population, risk-adjusted based on CMS Hierarchical Condition Categories, subject to certain policy adjustments). 42 C.F.R. §§ 425.605(a); 425.610(a).

	Medicare Shared Savings Program
Permitted repayment mechanisms	An ACO that participates in a two-sided model must establish one or more of the following repayment mechanisms in an amount and by a deadline specified by CMS in accordance with this section: (i) an escrow account with an insured institution; (ii) a surety bond from a company included on the U.S. Department of Treasury's List of Certified Companies; or (iii) a line of credit at an insured institution (as evidenced by a letter of credit that the Medicare program can draw upon). 42 C.F.R. § 425.204(f)(2).
CMS recovery mechanisms for shared losses	If an ACO incurs shared losses, CMS will first collect the losses via the repayment mechanism. If CMS collects via a repayment mechanism, the funds in the repayment mechanism must be "replenished" in an amount determined by CMS. 42 C.F.R. § 425.204(f)(5). If the funds in the repayment mechanism are not sufficient to cover the total amount of the shared losses owed by the ACO, the ACO will be required to repay any remaining balance using alternative funding sources. *See* CMS Repayment Mechanisms Guidance. If the ACO fails to repay the full amount of shared losses, the debt may be referred to the Department of Treasury. CMS may also deem the ACO to be out of compliance with MSSP requirements, which can result in termination or non-renewal. *See, e.g.*, Ctrs. for Medicare & Medicaid Serv's., *Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other changes to Part B Payment Policies; Medicare shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements*, 86 Fed. Reg. 64996, 65283 (Nov. 19, 2021).
Public disclosure obligations?	CMS requires public disclosure of certain information on a web page following a prescribed format. 42 C.F.R. § 425.308; *see also* the "Public Reporting" section of the Program Guidance & Specifications page.
Events requiring CMS notice	An ACO must notify CMS within 30 days of any significant change (i.e., when an ACO is no longer able to meet MSSP's eligibility or program requirements). 42 C.F.R. § 425.214(a)(1) and (3).
CMS events of termination	If CMS concludes that termination of an ACO from the MSSP is warranted, CMS may (but is not required to) take one or more of the following pre-termination actions: (i) provide a warning notice to the ACO regarding noncompliance with one or more program requirements; (ii) request a corrective action plan from the ACO; and/or (iii) place the ACO on a special monitoring plan. 42 C.F.R. § 425.216(a).

	Medicare Shared Savings Program
	Generally, CMS may terminate the participation agreement with an ACO when an ACO, the ACO participants, ACO providers/suppliers or other individuals or entities performing functions or services related to ACO activities fail to comply with any of the requirements of the MSSP under 42 C.F.R. Part 425. 42 C.F.R. § 425.218(a). CMS may terminate the participation agreement for reasons including, but not limited to the following: (1) non-compliance with eligibility and other requirements described in Part 425; (2) the imposition of sanctions or other actions taken against the ACO by an accrediting organization or State, Federal or local government agency leading to the ACO's inability to comply with the requirements under Part 425; (3) violations of the physician self-referral prohibition, civil monetary penalties ("CMP") law, Anti-Kickback Statute, antitrust laws, or any other applicable Medicare laws, rules, or regulations that are relevant to ACO operations; (4) failure to comply with CMS' requests for documentation or other information by CMS' specified the deadline; or (5) submitting false or fraudulent data or information. 42 C.F.R. § 425.218(b).
Fraud and abuse flexibilities?	Waivers of the Anti-Kickback Statute and Stark Law subject to certain procedural and public reporting requirements. *See* Ctrs. for Medicare & Medicaid Serv's., *Medicare Program; Final Waivers in Connection With the Shared Savings Program*, 80 Fed. Reg. 66726 (Oct. 29, 2015) and supplemental guidance.
Data Sharing	CMS makes certain aggregate and beneficiary-identifiable Medicare Part A, B, and D information available to ACOs subject to the requirements of 42 C.F.R. Part 425, Subpart H. In order to receive beneficiary-identifiable information, ACOs must be a covered entity, business associate, or part of an organized health care arrangement and must give beneficiaries notice and an opportunity to opt out of data sharing. CMS will not share information protected by 42 C.F.R. Part 2. Supplemental guidance and report templates are available here.
Data Sharing Limitations	ACOs and ACO vendors or partners performing services on behalf of the ACO must execute a Data Use Agreement ("DUA"). 42 C.F.R. §§ 704(a), 710. A copy of the DUA is available here.

	ACO Investment Model
Official or alternate names (if applicable)	
Common acronym	AIM
Objective	This model aims to encourage ACO formation in areas of low ACO penetration in order to produce better care and lower costs for Medicare fee-for-service (FFS) beneficiaries (e.g., Original Medicare).
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act; Section 1115A and 1115A(b) of the Social Security Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/aco-investment-model
Start date	April 1, 2015 [See FAQ]
End date	September 2020 [Final annual report posted, see CMS Website]
Performance Year	2015 and 2016 [*See* CMS Website: "The CMS ACO Investment Model (AIM) consisted of 45 participating ACOs (List), that served beneficiaries across 38 states, including 2 ACOs that began participating in the Model in 2015 and 43 ACOs that began participating in the Model in 2016."]
Core documents setting out model terms	Accountable Care Organization Investment Model (AIM) Request for Applications; Fact Sheet; FAQ https://www.cms.gov/priorities/innovation/innovation-models/aco-investment-model
Accepting new applications?	No
Eligible parties	An ACO was eligible to participate in AIM if it was eligible to participate in MSSP and satisfied the following requirements: • The ACO had a preliminary prospective beneficiary alignment of 10,000 or fewer beneficiaries, as determined in accordance with the MSSP program regulations.

	ACO Investment Model
	• The ACO did not include a hospital as an ACO participant or an ACO provider/supplier (as defined by the MSSP regulations), unless the hospital was a critical access hospital (CAH) or inpatient prospective payment system (IPPS) hospital with 100 or fewer beds. • The ACO was not owned or operated in whole or in part by a health plan. [See RFA pg. 3]
Focused beneficiary population	AIM sought to encourage ACO development in rural and underserved areas to improve outcomes for Medicare beneficiaries. [See FAQ.]
Intermediate entities between CMS and provider	N/A
Where are changes communicated?	CMS Website
Brief description of the financial arrangement	Selected organizations received pre-payment of expected Medicare shared savings. AIM funds were partially distributed as a lump sum in the first month of participation in the model and the rest as ongoing monthly payments. Pre-paid shared savings were recovered primarily through the ACOs' earned shared savings, if any, in the Medicare Shared Savings Program. [See RFA pg. 1] ACO Investment Test 1 offered "start-up" financial support to ACOs that began their first MSSP agreement period in 2016. Test 1 received three types of payments: An upfront fixed amount, an upfront variable amount, and a monthly payment of varying amount depending on the size of the ACO. [See RFA pg. 2] ACO Investment Test 2 received two types of payments: An upfront variable amount and a monthly payment of varying amount depending on the size of the ACO. [See RFA pg. 5]
Shared losses?	Yes, for Track 2 ACOs. [See RFA bottom of pg. 2 and pg. 5]
Attribution terms	No

	ACO Investment Model
Costs considered	AIM provided up-front payments to participating Medicare Shared Savings Program (MSSP) ACOs, which were paid back to CMS through their earned shared savings from the Shared Savings Program. AIM payments assisted MSSP ACOs in transforming care by funding infrastructure investments or staffing. [See AIM Final Annual Report pg. 7] ACOs submitted a spend plan for how they planned on using these funds to build care coordination capabilities and meet other criteria. [See RFA pg. 1].
Permitted repayment mechanisms	Pre-paid shared savings were recovered primarily through the ACOs' earned shared savings, if any, in the Medicare Shared Savings Program. [See RFA pg. 1]. In order to ensure recovery of AIM funds from Test 2 ACOs, CMS required the ACO to demonstrate its ability to repay the AIM balance through a financial guarantee in the form of (1) funds place in an escrow; (2) a line of credit; (3) a surety bond; or (4) an alternative payment mechanism determined by CMS to be acceptable. [See RFA pg. 5]
CMS recovery mechanisms for shared losses	For Test 1 ACOs, CMS recovered all pre-payments up to the total shared savings earned by the ACO but did not pursue amounts in excess of the earned shared savings. [See RFA pg. 3]. Test 2 ACOs were required to repay all pre-paid shared savings amounts. If a Test 2 ACO had not earned sufficient shared savings in the first MSSP agreement period to fully repay all pre-paid shared savings payments, and the ACO did not renew its MSSP participation for a second agreement period, then CMS pursued full recovery of the remaining amount from that ACO. In order to ensure recovery of AIM funds, CMS required the ACO to demonstrate its ability to repay the AIM balance through a financial guarantee in the form of (1) funds placed in an escrow; (2) a line of credit; (3) a surety bond; or (4) an alternative payment mechanism determined by CMS to be acceptable. [See RFA pg. 5]
Public disclosure obligations?	AIM ACOs were required to file periodic reports documenting their use of funds to allow monitoring of compliance with this provision. [See RFA pg. 3.]
Events requiring CMS notice	Applicants were required to disclose sanctions, investigations, probations or corrective action plans that were imposed on the applicant in the last three years. [See RFA pg. 2]
CMS events of termination	CMS could terminate an ACO's MSSP agreement and AIM agreement should the ACO fail to comply with regulations and terms of the MSSP agreement. CMS could terminate an ACO's AIM agreement if that ACO expended funds in a manner inconsistent with the approved spend plan or if

	ACO Investment Model
	that ACO failed to comply with the regulations or terms of the AIM agreement. [See RFA pg. 3]
Fraud and abuse flexibilities?	No waivers of fraud and abuse laws were necessary to test this model. However, an ACO participating in AIM could distribute or use pre-paid shared savings received under this model in accordance with existing waivers issued for MSSP. [See RFA pg. 1-2]
Data Sharing	ACOs were required to completely and accurately report quality measures to the Medicare Shared Savings Program in the most recent per performance year, if the ACO started in the Medicare Shared Savings Program in 2012, 2013 or 2014, excluding ACOs starting in 2015 or 2016. Model Participants were required to submit data and information to the CMS evaluation contractor. [See FAQ].
Data Sharing Limitations	

	ACO REACH
Official or alternate names (if applicable)	ACO Realizing Equity, Access, and Community Health Model; prior to January 1, 2023, Global and Professional Direct Contracting (GPDC) Model
Common acronym	ACO REACH
Objective	The model focuses on promoting health equity and addressing healthcare disparities for underserved communities, continuing the momentum of provider-led organizations participating in risk-based models, and protecting beneficiaries and the model with more applicant vetting, participant monitoring, and public transparency.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act, Sections 1115A and 1115A(b)(2) of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/aco-reach
Start date	January 1, 2023
End date	January 1, 2026
Performance Year	CY
Core documents setting out model terms	ACO REACH Request for Application
Accepting new applications?	Not presently.
Eligible parties	All ACOs must contract with Participant Providers (or Preferred Providers) that include but are not limited to: Physicians or other practitioners in group practice arrangements, Networks of individual practices of physicians or other practitioners, Hospitals employing physicians or other practitioners, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs). Each Participant Provider and Preferred Provider under the ACO must be a Medicare-enrolled provider or supplier.

	ACO REACH
	Three types of ACOs under the ACO REACH Model: (i) Standard ACOs comprised of organizations that generally have experience serving Medicare FFS beneficiaries, including dually eligible beneficiaries; (ii) New Entrant ACOs comprised of organizations that have not traditionally provided services to a Medicare FFS population and that may primarily rely on voluntary alignment; High Needs Population ACOs that serve Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries, who are aligned to the ACO through voluntary alignment or claims-based alignment. [See RFA page 10]
Focused beneficiary population	Intended only for applicants that serve a general, heterogenous population of FFS Medicare beneficiaries or that serve a sub-population of FFS Medicare beneficiaries for which a targeted total cost of care initiative does not exist. [See RFA Section V. page 9] Beneficiary Eligibility: Beneficiaries are considered alignment-eligible in a given month if they meet the following criteria: Are enrolled in both Medicare Parts A and B; Are not enrolled in an MA plan, Medicare Cost Plan under section 1876, PACE organization, or other Medicare health plan; Have Medicare as the primary payer; Are a resident of the United States; Reside in a county included in the ACO's service area ; and For individuals to be eligible to be aligned to a High Needs Population ACO, they must also meet at least one of the following conditions: (1) have conditions that impair their mobility; and/or (2) meet the high needs special conditions for eligibility. Medicare FFS beneficiaries, including dually eligible beneficiaries, meeting at least one of these conditions are eligible for alignment to a High Needs Population ACO. [See RFA Section VI(A). page 23]
Intermediate entities between CMS and provider	An ACO formed by two or more Participant Providers, each of which is identified by a unique TIN, must be a legal entity separate from the legal entity of any of its Participant Providers or Preferred Providers. If the ACO is formed by one or more Participant Providers that bill under a single TIN (such as a group practice), the ACO's legal entity and governing body may be the same as that of the Participant Provider(s). [See RFA page 13]
Where are changes communicated?	https://www.cms.gov/priorities/innovation/innovation-models/aco-reach

	ACO REACH
Brief description of the financial arrangement	ACOs assume accountability for the total cost of care of beneficiaries aligned to their organization for the performance year, according to the risk sharing option selected by their organization. The ACO REACH Model will offer two risk sharing options: Professional: offers a partial risk sharing option of 50% of savings/losses, with risk corridors and optional stop-loss protection risk mitigation strategies. Global: offers a full risk sharing option of 100% of savings/losses, with broader risk corridors and optional stop-loss protection risk mitigation strategies. [See RFA Section B. page 23 and page 33]
Shared losses?	Yes
Attribution terms	No
Costs considered	ACOs assume accountability for the total cost of care of beneficiaries aligned to their organization for the performance year, according to the risk sharing option selected by their organization. [See RFA Section B. page 23] Additionally, all ACOs participating in the ACO REACH Model must select a Capitation Payment Mechanism. The two Capitation Payment Mechanisms available to ACOs are: Total Care Capitation Payment: A PBPM capitated payment that will reflect the estimated total cost of care for the ACO's aligned population. Only available to ACOs participating in Global. Primary Care Capitation Payment: A PBPM capitated payment generally equal to seven percent of the estimated total cost of care for the ACO's aligned population. ACOs participating in the Professional risk-sharing option must select the Primary Care Capitation Payment. ACOs participating in the Global risk-sharing option may choose between Primary Care Capitation Payment and Total Care Capitation Payment. [See RFA page 40]
Permitted repayment mechanisms	Stop-Loss arrangement (optional) [See RFA pg. 35], Provisional financial settlement (optional) [pg. 36], Financial guarantee in form of escrow/line of credit/surety bond [pg. 37-38], Capitation Payment Mechanism: Total Care Capitation Payment, Primary Care Capitation Payment, Advanced Payment Option. [pg. 38]

	ACO REACH
CMS recovery mechanisms for shared losses	If CMS does not receive payment for Shared Losses and other monies owed by the date the payment is due, CMS shall pursue payment under the financial guarantee and may withhold payments otherwise owed to the ACO under this model or any other CMS program or initiative. [See RFA pg. 38]
Public disclosure obligations?	Yes. At a minimum, ACOs will be required to publicly report information regarding their (1) organizational structure, including identification of the members of the ACO's governing body and Participant Providers and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the Quality Measures. [See RFA Section XVII Public Reporting pg. 86]
Events requiring CMS notice	Disclosure requirements: With respect to the Applicant ACO, persons with an ownership or control interest in the Applicant ACO, Key Executives, equity partners, and individuals and entities that the Applicant ACO expects will be Participant Providers or Preferred Providers: (i) any sanctions or corrective action plans imposed under Medicare, Medicaid, or state licensure authorities within the last three years (including corporate integrity agreements); (ii) any fraud investigations initiated, conducted, or resolved within the last three years; (iii) any outstanding debts owed to the Medicare program, including any debts owed under an Innovation Center model, or any agency of the federal government; (iv) any awards of a CMS contract in the past 5 years, and, if applicable, the contract number and period of performance for such award; (v) whether any such individuals or entities are on a government suspension, debarment, or exclusion list relating to procurement and non-procurements; (vi) any instances of criminal conduct; and (vii) any instances of bankruptcy. [RFA see pg. 110]
CMS events of termination	CMS may immediately or with advance notice terminate an ACO's IP3 Participation Agreement or MPP Participation Agreement at any point during the model for non-compliance with the terms and conditions of the relevant agreement, or as otherwise specified in the IP3 Participation Agreement or MPP Participation Agreement or required by section 1115A(b)(3)(B) of the Act. [See Section XVIII, page 87 ACO REACH RFA.]
Fraud and abuse flexibilities?	Waiver of 1877(a) of the Act (relating to the Federal physician self-referral law) and sections 1128B(b)(1) and (2) of the Act (relating to the Federal anti-kickback statute) with respect to any startup arrangement between a DCE and one or more DC Participant Providers or Preferred Providers or both.

	ACO REACH
	The anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR § 1001.952(ii)(1)) is available to protect certain DCE financial arrangements between or among the DCE, one or more DC Participant Providers, one or more Preferred Providers, or a combination thereof, provided that such arrangements comply with the applicable requirements set forth in the Participation Agreement for the Model Performance Period ("MPP Participation Agreement"). The anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)(2)) is available to protect certain in-kind patient incentives and Beneficiary Engagement Incentives furnished to a DC Beneficiary by a DCE, a DC Participant Provider, or a Preferred Provider, as applicable, provided that such incentives are furnished in a manner that complies with the relevant requirements set forth in the MPP Participation Agreement. [RFA pg. 6]
Data Sharing	Health Equity Data Collection Requirement – ACOs are required to "collect and report certain beneficiary-reported demographic data and social determinants of health data on their aligned beneficiaries to enable CMS to monitor the model . . ." CMS plans to make several types of Medicare data available to ACOs participating in the ACO REACH Model. For the model performance period, ACOs will be permitted to use data provided for purposes of clinical treatment, care management and coordination, quality improvement activities, and provider incentive design and implementation. [RFA See pg. 83 Section XI(A) Data Sharing.] The data that the ACO may request include: alignment reports, risk score reports, claim and claim line feed files for services furnished by Medicare-enrolled providers and suppliers to aligned beneficiaries during the performance year, fee reduction files, utilization and expenditure data, benchmark and other financial reports, quality repots. [See RFA pg. 83-84]
Data Sharing Limitations	The data may be used only in a manner consistent with the terms of the applicable CMS agreements, including the MPP Participation Agreement and HIPAA-Covered Data Disclosure Request Form. All requests for data will be granted or denied at CMS' sole discretion based on CMS' available resources and technological capabilities, the limitations in applicable CMS agreements, and applicable law. [RFA See pg. 83 Section XI(A) Data Sharing.]

	ACO REACH
	ACOs will be required to provide aligned beneficiaries who inquire about or wish to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences and opt out of data sharing. [See RFA pg. 84]

	Advance Payment ACO Model
Official or alternate names (if applicable)	Advance Payment Initiative
Common acronym	AP ACO Model
Objective	The Advance Payment Model was designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve.
Relevant statutory and regulatory provisions	§ 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/advance-payment-aco-model
Start date	April 1, 2012
End date	December 31, 2015
Performance Year	Partial year 2012 (for ACOs that started in April or July 2012) and CY thereafter.
Core documents setting out model terms	Federal Register Announcement: https://www.federalregister.gov/documents/2011/11/02/2011-27458/medicare-program-advanced-payment-model Announcement of New Application Deadline: https://www.federalregister.gov/documents/2011/11/30/2011-30845/medicare-program-announcement-of-a-new-application-deadline-for-the-advance-payment-model Application Process Guidance: https://www.cms.gov/priorities/innovation/files/slides/advance-payment-model-aco-odf-application-process-slides.pdf Fact Sheet: https://www.cms.gov/priorities/innovation/files/fact-sheet/advanced-payment-aco-model-fact-sheet.pdf

	Advance Payment ACO Model
	Public Comments: https://www.cms.gov/priorities/innovation/files/x/advance-payment-aco-model-combined-public-comments-doc.pdf
Accepting new applications?	No; not active.
Eligible parties	Designed to help smaller ACOs with less capital participate in the Medicare Shared Savings Program (MSSP), including rural and physician-led ACOs. The model was only open to MSSP ACOs that (1) did not have any inpatient facilities and had less than $50 million in total annual revenue; *or* (2) ACOs in which the only inpatient facilities were critical access hospitals and/or Medicare low-volume rural hospitals and that had less than $80 million in total annual revenue. ACOs that were co-owned by a health plan or insurer were not eligible to participate. Advance Payment ACO Model Fact Sheet.
Focused beneficiary population	All Medicare fee-for-service beneficiaries attributed to the ACO.
Intermediate entities between CMS and provider	For most ACOs, a distinct ACO legal entity is responsible for receiving and dividing shared savings and repaying shared losses.
Where are changes communicated?	CMS announced application deadlines and other information through the Federal Register and sub-regulatory guidance posted on the Advance Payment Model website.
Brief description of the financial arrangement	Participating ACOs received three types of payments: • An upfront, fixed payment of $250,000; • An upfront variable payment of $36 multiplied by the number of the ACO's historically assigned beneficiaries; • A monthly payment of $8 per the number of historically assigned beneficiaries for 24 months. CMS calculated the financial performance of each ACO by comparing expenditures for its assigned beneficiaries to performance year-specific benchmarks. ACOs were held accountable for their performance on 33

	Advance Payment ACO Model
	quality measures. If performance-year expenditures were less than the benchmark, the ACO generated shared savings. If performance-year expenditures were more than the benchmark, the ACO generated shared losses. Since AP ACOs were part of MSSP, each ACO had the option to participate under one of two tracks: an upside-only track or an upside and downside track. AP ACOs were only required to pay back advance payments if they earned enough shared savings to offset the payments during the three-year agreement. Evaluation of CMMI Accountable Care Organization Initiatives: Advance Payment ACO Final Report.
Shared losses?	Yes, depending on the track selected.
Attribution terms	Consistent with MSSP; no specific AP ACO Model considerations.
Costs considered	Consistent with MSSP; no specific AP ACO Model considerations.
Permitted repayment mechanisms	Consistent with MSSP; no specific AP ACO Model considerations.
CMS recovery mechanisms for shared losses	Advanced payments were recouped through offsets to an ACO's earned shared savings. If an ACO did not generate sufficient savings to repay the advance payments, CMS continued to offset shared savings in subsequent performance years and future agreement periods, or could pursue recoupment where appropriate. Advance Payment ACO Model Fact Sheet. ACOs that did not complete the full agreement period and that did not earn shared savings were not required to repay the advance payment. 76 Fed. Reg. 68012.
Public disclosure obligations?	Consistent with MSSP; no specific AP ACO Model considerations.
Events requiring CMS notice	Consistent with MSSP; no specific AP ACO Model considerations.
CMS events of termination	Consistent with MSSP; no specific AP ACO Model considerations.
Fraud and abuse flexibilities?	Consistent with MSSP; no specific AP ACO Model considerations.
Data Sharing	Consistent with MSSP; no specific AP ACO Model considerations.

	Advance Payment ACO Model
Data Sharing Limitations	Consistent with MSSP; no specific AP ACO Model considerations.

	Comprehensive Primary Care Plus
Official or alternate names (if applicable)	N/A
Common acronym	CPC+
Objective	Comprehensive Primary Care Plus (CPC+) was a national advanced primary care medical home model that aimed to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.
Relevant statutory and regulatory provisions	§ 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus
Start date	January 1, 2017
End date	December 31, 2021
Performance Year	CY
Core documents setting out model terms	Overview: https://www.cms.gov/priorities/innovation/files/fact-sheet/cpcplus-overview.pdf Request for Applications: https://www.cms.gov/priorities/innovation/files/x/cpcplus-rfa.pdf Template Memorandum of Understanding between CMS and Payers: https://www.cms.gov/priorities/innovation/files/x/cpcplus-payermou.pdf External Frequently Asked Questions: https://www.cms.gov/priorities/innovation/files/x/cpcplus-practiceapplicationfaq.pdf Payer Frequently Asked Questions: https://www.cms.gov/priorities/innovation/files/x/cpcplus-payersolicitationfaq.pdf

	Payer Fact Sheet: https://www.cms.gov/priorities/innovation/files/fact-sheet/cpcplus-payer-factsheet.pdf CPC+ Archived Materials: https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-primary-care-plus/archived-materials
Accepting new applications?	No; not active.
Eligible parties	CPC+ was intended for primary care practices with varying levels of experience and capabilities. All CPC+ practices had multi-payer support, Certified EHR Technology, and other infrastructural capabilities. Practices applied to participate in Track 1 or Track 2. Track 1 was intended for practices with multi-payer support that had the health information technology and basic infrastructure necessary to deliver comprehensive primary care. Track 2 was intended for practices proficient in comprehensive primary care that sought to increase the scope of care delivered to patients, including those with complex needs. RFA Round 2; External Frequently Asked Questions. Eligible primary care practices included those that: passed program integrity screening, provided services to a minimum of 150 attributed Medicare fee-for-service (FFS) beneficiaries; submitted claims on a Medicare Physician/Supplier claim form and were paid according to the Medicare Physician Fee Schedule for office visits; and that met the requirements of the CPC+ Participation Agreement. RFA Round 2. Practices and payers partnered in 18 regions. CPC+ Overview. Over 2,600 participants were involved in the model. CPC+ Website.
Focused beneficiary population	All Medicare FFS beneficiaries.
Intermediate entities between CMS and provider	CPC+ was a public-private partnership, in which practices were supported by 52 aligned payers in 18 regions. These partnerships between providers, payers, and CMS allowed practices to access additional financial resources and improve care quality.
Where are changes communicated?	CMS announced key program deadlines and posted guidance documents on the CMS website: Program updates.

Brief description of the financial arrangement	CPC+ included three payment elements: • Care Management Fee (CMF): A non-visit-based fee paid per beneficiary per month (PBPM). Medicare FFS CMFs were paid quarterly, and the amount was risk adjusted by practice to account for the practice's specific population. Beneficiaries were assigned to a risk tier based on the individual's hierarchical condition category score. Greater CMFs were paid for more complex beneficiaries. o Track 1: Averaged $15 PBPM o Track 2: Averaged $28 PBPM. RFA Round 2. • Performance-Based Incentive Payment: Prospectively paid and retrospectively reconciled based on a practice's performance on patient experience, clinical quality, and utilization measures. • Medicare Physician Fee Schedule Payments: Track 1 received payment from Medicare FFS as usual. The Track 2 FFS payment was reduced to account for CMS shifting some of the Medicare FFS payment into a Comprehensive Primary Care Payment, which was paid on a quarterly basis absent a claim. CPC+ Website.
Shared losses?	No.
Attribution terms	Eligible beneficiaries were attributed to the practice that either billed for the plurality of their primary care allowed charges, or for the most recent claim for Chronic Care Management services during the most recently available 24-month period. If a beneficiary had an equal number of claims for Primary Care Services at more than one CPC+ practice, the beneficiary was attributed to the practice with the most recent claim for a primary care service. CMS provided each practice with a list of prospectively attributed beneficiaries for each quarter. External Frequently Asked Questions. "Attribution look back period" means the period of time in which a patient must have received primary care health services at a participating practice in order to be attributed to the practice. [PAYER] can design an attribution methodology and define [PAYER'S] attribution look back period in the manner best suited for [PAYER]. MOU between CMS and Payers.
Costs considered	Total cost of care (the Performance-Based Incentive Payment was, in part, based on how well a practice performed on measures that drive total cost of care).

Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	The Performance-Based Incentive Payment was paid prospectively, however, practices were only allowed to keep the funds if they met the annual performance thresholds. Practices were considered "at risk" for the amounts prepaid, and CMS maintained the authority to recoup unwarranted payments. RFA Round 2.
Public disclosure obligations?	During the application process, applicants were required to disclose to CMS any sanctions, investigations, probations, actions, or corrective action plans that the applicant or its physicians/practitioners, owners/managers, or other participating entities were undergoing or had recently undergone. RFA Round 2.
Events requiring CMS notice	N/A
CMS events of termination	Termination could occur for non-remedial failures, as established in the Participation Agreement or determined by CMS, or when expected remediation did not occur. CMS maintained the authority to periodically determine whether practices should be subject to administrative actions, such as corrective action plans or termination. RFA Round 2.
Fraud and abuse flexibilities?	No fraud and abuse waivers were included in the Model's RFA. RFA Round 2.
Data Sharing	Payers agreed to share utilization and/or total cost of care data related to attributed members with participating practices at least quarterly, as well as lists of the payer's attributed members at the beginning of each attribution look back period. At a minimum, payers agreed to develop a mechanism to allow participating practices to review relevant claims data and analyses with respect to attributed members. MOU between CMS and Payers. Payers also agreed to share data with CMS, as requested, including data related to covered lives, per-member-per-month non-visit-based financial support paid to participating practices, information regarding the Performance-Based Incentive Payments paid to participating practices, and more. MOU between CMS and Payers.
Data Sharing Limitations	N/A

	Global and Professional Direct Contracting (GPDC) Model
Official or alternate names (if applicable)	Global and Professional Direct Contracting (GPDC) Model
Common acronym	GPDC Model
Objective	The purpose of the GPDC Model was to create a new opportunity for CMS to test a variety of financial risk-sharing arrangements expected to reduce Medicare expenditures while maintaining or improving the quality of care. Specifically, this model was intended to reduce the burden on providers; focus on a complex, chronically, and seriously ill patient population; and encourage participation from providers that have not previously participated in Medicare FFS models.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act (the "Act") (added by Section 3021 of the Affordable Care Act) (42 U.S.C. § 1315a). *See* Request for Applications ("RFA") pg. 4.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model
Start date	Implementation Period began October 2020 (Direct Contracting Entities engaged in beneficiary alignment activities, care coordination, and care management.)
End date	January 1, 2023. The GPDC Model transitioned to the new ACO REACH Model on January 1, 2023. *See* https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model.
Performance Year	Performance Year 1 was from April 2021 through December 2021. *See* RFA pg. 4. Performance Year 2 took place during calendar year 2022 and was the final performance year.
Core documents setting out model terms	GPDC Model Request for Applications; FAQs
Accepting new applications?	No

	Global and Professional Direct Contracting (GPDC) Model
Eligible parties	The Direct Contracting Entity (DCE) was required to be a legal entity that contracted with DC Participant Providers and may have contracted with Preferred Providers. Participant Providers included, but were not limited to, physicians or other practitioners in group practice arrangements; networks of individual practices of physicians or other practitioners; hospitals employing physicians or other practitioners; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs); Critical Access Hospitals (CAHs). Organizations participating in the NGACO Model, Shared Savings Program, and MCOs, particularly those with parent organizations that operate fully integrated dual eligible special needs plans or Medicare-Medicaid Plans. *See* RFA pg. 8-9. There were three types of DCEs under direct contracting: Standard DCEs comprised of organizations that generally had experience serving Medicare FFS beneficiaries, including dually eligible beneficiaries; New Entrant DCEs comprised of organizations that had not traditionally provided services to a Medicare FFS population and primarily relied on voluntary alignment; and High Needs Population DCEs that served Medicare FFS beneficiaries with complex needs, including dually eligible beneficiaries, who were aligned to the DCE through voluntary alignment or claims-based alignment. *See* RFA pg. 10-11.
Focused beneficiary population	Beneficiaries were considered alignment-eligible in a given month if they met the following criteria: were enrolled in both Medicare Parts A and B; were not enrolled in an MA plan, Medicare Cost Plan under section 1876, PACE organization, or other Medicare health plan; had Medicare as the primary payer; were a resident of the United States; and resided in a county included in the DCE's service area. For individuals to be eligible to be aligned to a High Needs Population DCE, they had to meet at least one of the following conditions: (1) had conditions that impaired their mobility; and/or (2) met the high needs special conditions for eligibility. Medicare FFS beneficiaries, including dually eligible beneficiaries, that met at least one of these conditions were eligible for alignment to a High Needs Population DCE. *See* RFA pg. 16-17. Beneficiaries must have also met the DCE alignment criteria, which varied by DCE type. *See* RFA, Table 6.1, pg. 17-18.
Intermediate entities between	A DCE must have been a legal entity identified by a federal taxpayer identification number (TIN) formed under applicable state, federal, or tribal law and authorized to conduct business in each state in which it operated. A

	Global and Professional Direct Contracting (GPDC) Model
CMS and provider	DCE formed by two or more DC Participant Providers, each of which was identified by a unique TIN, must have been a legal entity separate from the legal entity of any of its DC Participant Providers or Preferred Providers. If the DCE was formed by a single DC Participant Provider (such as a group practice), the DCE's legal entity and governing body could be the same as that of the DC Participant Provider. *See* RFA pg. 11.
Where are changes communicated?	https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model
Brief description of the financial arrangement	DCEs assumed accountability for the total cost of care of beneficiaries aligned to their organization for the performance year, according to the risk arrangement selected by their organization. Direct Contracting offered two risk arrangements, which determined the portion of the savings or losses in relation to the Performance Year Benchmark that accrued to the DCE as Shared Savings or Shared Losses. The applicable risk arrangement depended on whether the DCE participated in the Professional or the Global option: Professional: offered a partial risk arrangement of 50% of savings/losses, with risk corridors and optional stop-loss protection risk mitigation strategies. Global: offered a full risk arrangement of 100% of savings/losses, with broader risk corridors and optional stop-loss protection risk mitigation strategies. *See* RFA pg. 26-27.
Shared losses?	Yes
Attribution terms	No
Costs considered	DCEs assumed accountability for the total cost of care of beneficiaries aligned to their organization for the performance year, according to the risk arrangement selected by their organization. *See* RFA pg. 17. Additionally, the DCE selected a Capitation Payment Mechanism: Total Care Capitation: A PBPM payment amount that reflected the estimated total cost of care for the DCE's aligned population. Available only to DCEs participating in the Global option.

	Global and Professional Direct Contracting (GPDC) Model
	Primary Care Capitation: A PBPM payment equal to seven percent of the estimated total cost of care for the DCE's aligned population. Required for DCEs participating in Professional and available to DCEs participating in the Global option. *See* RFA pg. 32.
Permitted repayment mechanisms	Stop-loss, Provisional Financial Reconciliation (optional) (*see* RFA pg. 26], financial guarantee (*see* RFA pg. 30), Capitation Payment Mechanisms and Advanced Payment (*id.*).
CMS recovery mechanisms for shared losses	If CMS did not receive payment for Shared Losses and Other Monies Owed by the date the payment was due, CMS pursued payment under the financial guarantee and had the option to withhold payments otherwise owed to the DCE under this model or any other CMS program or initiative. *See* RFA pg. 30.
Public disclosure obligations?	Yes. At a minimum, DCEs were required to publicly report information regarding their (1) organizational structure, including identification of the members of the DCE's governing body and the DCE's DC Participant Providers and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the quality measures. *See* RFA pg. 69.
Events requiring CMS notice	With respect to the applicant, its owners, key executives, DC Participant Providers, and Preferred Providers: (i) any sanctions or corrective action plans imposed under Medicare, Medicaid, or state licensure authorities within the last three years; (ii) any fraud investigations initiated, conducted, or resolved within the last three years; and (iii) any outstanding debts owed to the Medicare program, including any debts owed under an Innovation Center model. For purposes of this disclosure, key executives are individuals who manage or have oversight responsibility for the DCE, its finances, personnel, and quality improvement, including without limitation, a CEO, CFO, COO, CIO, medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data. *See* RFA pg. 87.
CMS events of termination	CMS reserved the right to terminate a DCE's Participation Agreement at any point during the model for reasons associated with poor performance, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act. *See* RFA pg. 69.

	Global and Professional Direct Contracting (GPDC) Model
Fraud and abuse flexibilities?	Pursuant to section 1115A(d)(1) of the Act, section 1877(a) of the Act (relating to the Federal physician self-referral law) and sections 1128B(b)(1) and (2) of the Act (relating to the Federal anti-kickback statute) were waived with respect to any startup arrangement between the DCE and one or more DC Participant Providers or Preferred Providers or both, provided all of the eligibility conditions were met. *See* https://www.cms.gov/files/document/notice-waiver-certain-fraud-and-abuse-laws-connection-global-and-professional-options-direct.pdf. Effective April 1, 2021, the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 C.F.R. § 1001.952(ii)(1)) was available to protect certain DCE financial arrangements between or among the DCE, one or more DC Participant Providers, one or more Preferred Providers, or a combination thereof, provided that such arrangements complied with the requirements set forth in Section 3.04.M.1 of the GPDC Model Performance Period Participation Agreement. *See* https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model. Effective April 1, 2021, the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) was available to protect certain in-kind patient incentives and Beneficiary Engagement Incentives furnished by a DCE, DC Participant Provider, or Preferred Provider to a Beneficiary or DC Beneficiary (as applicable), provided that such incentives were furnished in a manner that complied with the requirements set forth in Section 5.08.B of the Participation Agreement. *See* https://www.cms.gov/priorities/innovation/innovation-models/gpdc-model.
Data Sharing	During the IP and the Performance Period, the DCE could request the minimum necessary data for their respective provisionally aligned and aligned beneficiaries to develop and implement care coordination and quality improvement activities. During the IP and the Performance Period, CMS provided DCEs with detailed claims data. At the beginning of a performance year (PY), CMS provided DCEs with historical Claim and Claim Line Feed (CCLF) files. During both the IP and the PYs, CMS provided DCEs with operational reports on a regular basis. During PY1 – PY5, CMS provided quarterly baseline benchmark reports (BBRs) to DCEs to enable them to monitor their financial performance throughout the performance year. *See* RFA pg. 66.
Data Sharing Limitations	For both the IP and the Performance Period, the data had to be used exclusively in accordance with the terms of the applicable CMS agreements, including the Participation Agreement, DC Participant Provider/Preferred

	Global and Professional Direct Contracting (GPDC) Model
	Provider Certification forms and Data Use Agreements (DUAs). *See* RFA pg. 66. DCEs were required to provide provisionally aligned and aligned beneficiaries who inquired about or wished to modify their preferences regarding claims data sharing for care coordination and quality improvement purposes with information about how to modify their data sharing preferences and opt out of data sharing. *See* RFA pg. 67.

	Kidney Care Choices (KCC) Model
Official or alternate names (if applicable)	N/A
Common acronym	KCC
Objective	KCC builds upon the Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model by adding financial incentives for providers to manage the care for beneficiaries with chronic kidney disease (CKD) Stages 4 and 5 and ESRD with the goal of delaying the onset of dialysis and incentivizing kidney transplantation. This model has four payment options.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/kidney-care-choices-kcc-model
Start date	January 1, 2022
End date	December 31, 2026
Performance Year	CY
Core documents setting out model terms	KCC Request for Applications (RFA) KCC Model Fact Sheet
Accepting new applications?	CMS does not plan to conduct any further solicitations for KCC Model participants.[1]
Eligible parties	**Kidney Care First Option (KCF):**[2] • Only nephrology practices are eligible to apply for the KCF Option. KCF Practices include nephrology professionals, which refers collectively to nephrologists and non-physician clinicians – such as Nurse Practitioners

[1] https://www.cms.gov/priorities/innovation/innovation-models/kidney-care-choices-kcc-model
[2] RFA, pgs. 13-14

	Kidney Care Choices (KCC) Model
	and Physician Assistants – who specialize in nephrology or primarily provide nephrology services. Dialysis facilities and other non-nephrologist supplier and provider types cannot participate in the KCF Option. Nephrology professionals must be enrolled in Medicare and have a National Provider Identifier (NPI) associated with a primary specialty in kidney health and the treatment of kidney diseases or self-identify as nephrology professionals. • At least 50% of the practice's total Medicare payments from the previous 12 months must come from nephrology services furnished by nephrologists to beneficiaries with CKD Stages 4 or 5, beneficiaries with ESRD, or beneficiaries with a functioning kidney transplant. • At least 80% of all nephrologists that have reassigned their rights to receive Medicare payment to the practice and provide dialysis management services included in the Monthly Capitation Payment (MCP) in an outpatient setting must participate in the Model. • The practice must maintain a minimum of 350 CKD Stages 4 and 5 and 200 ESRD aligned Medicare beneficiaries over the course of the Model. • The practice and its nephrology professionals must use the CEHRT (defined under 42 C.F.R. § 414.1305). • The practice must demonstrate the ability to assume financial risk and make any required repayments to the Medicare program. **Comprehensive Kidney Care Contracting (CKCC) Options:**[3] • In addition to governance requirements, each Kidney Contracting Entity (KCE) must include at least one nephrology professional and one transplant provider. • A KCE may include any of the following optional Medicare-enrolled providers or suppliers as KCE Participants: o Medicare-certified dialysis facilities, including facilities owned by large dialysis organizations (LDOs), facilities owned by small dialysis organizations (SDOs), or independently-owned dialysis facilities.

[3] RFA, pgs. 41-44

	Kidney Care Choices (KCC) Model
	LDOs may only participate in the Professional and Global options of CKCC. o Other Medicare-enrolled providers and suppliers. • All types of providers and suppliers other than nephrology professionals and transplant providers are optional KCE Participants, including dialysis facilities, dieticians, and SNFs. DMEPOS suppliers, ambulance suppliers, and drug/device manufacturers are prohibited from participating in a KCE.
Focused beneficiary population	• Medicare beneficiaries with CKD Stages 4 and 5. • Medicare beneficiaries with ESRD receiving maintenance dialysis. • Medicare beneficiaries who were aligned to a KCF practice or KCE by virtue of having CKD Stage 4 or 5 or ESRD and receiving dialysis that then receive a kidney transplant.
Intermediate entities between CMS and provider	**KCF Model**:[4] KCF Practices are the entities through which providers participate in the KCF Model. KCF Practices must be governed through the existing organizational structure of the practice, as long as the existing structure is a single legal entity authorized to undertake the activities required under the applicable KCF Participation Agreement and meets all the requirements in the RFA. **CKCC Models**:[5] KCEs are the entities through which providers participate in the CKCC Model. Each KCE must be identified by a single TIN and, unless there is only one KCE Participant, must be a separate and unique legal entity that is recognized and authorized to conduct business under applicable federal, state, or tribal law. KCEs must include as KCE Participants at least one nephrology professional and at least one transplant provider.
Where are changes communicated?	CMS Innovation Center listserv ; KCC listserv.

[4] RFA, pg. 13
[5] 40. Additional requirements for KCEs are set forth in Section IV.A of the RFA.

	Kidney Care Choices (KCC) Model
Brief description of the financial arrangement	There are four payment Options: (1) CMS Kidney Care First (KCF) Option, (2) Comprehensive Kidney Care Contracting (CKCC) Graduated Option, (3) CKCC Professional Option, and (4) CKCC Global Option. Under the KCF Option, CMS will make adjusted capitated payments to participating nephrology practices (KCF Practices) for managing beneficiaries with CKD Stages 4 and 5 and ESRD. CMS will additionally make performance-based payment adjustments to both participating nephrology practices and, separately, to their nephrology professionals based on how well the practice performs on specified quality measures. For the three CKCC Options, nephrology professionals must partner with transplant providers and may partner with dialysis facilities and other providers and suppliers to become Kidney Contracting Entities (KCEs). KCEs will receive adjusted capitated payments for managing beneficiaries with CKD Stages 4 and 5, ESRD, and kidney transplants. The KCE will select a total cost of care accountability framework, and its payments under the Model will be adjusted based on its performance on quality measures. KCEs participating in the CKCC Options select one of following three options: the Graduated Option, the Professional Option, and the Global Option.[6]
Shared losses?	Yes
Attribution terms	**KCF**:[7] CMS will prospectively align eligible beneficiaries to KCF Practices through a claims-based alignment process. Aligned beneficiaries may obtain nephrology services from nephrology professionals not participating in a KCF Practice, as well as practices that are not participating in the KCF Option, which could cause them to be de-aligned from a KCF Practice retroactively during alignment reconciliation. Aligned beneficiaries will be assigned a status, depending on whether they have CKD Stages 4 and 5, ESRD, or are a transplant recipient who was previously aligned to the KCF Practice while they had CKD Stages 4 and 5 or ESRD. CMS will also retrospectively finalize beneficiary alignment as part of a reconciliation process after each Performance Year, allowing for a minimum of three months claims run-out. Once aligned, beneficiaries remain aligned to the KCF Practice until they meet one of the criteria for de-alignment.

[6] RFA, pg. 5. See additional details in the "Costs Considered" section.
[7] RFA, pgs. 15, 16

	Kidney Care Choices (KCC) Model
	CKCC:[8] CMS will prospectively align eligible beneficiaries to KCEs through a claims-based alignment process. Aligned beneficiaries may obtain nephrology services from health care providers not participating in a KCE, which could cause them to be de-aligned to a KCE retroactively during alignment reconciliation. Alignment to KCEs will occur through nephrology professionals that are KCE Participants for each stage of kidney care and will differ based on the beneficiary's kidney disease status. Alignment will be as prospective as is feasible and will be retrospectively finalized as part of a reconciliation process after each Performance Year, allowing for a minimum of three months claims run-out. Beneficiaries will be de-aligned from the KCE's list of aligned beneficiaries if they do not receive certain health services from a nephrology professional identified by the KCE as an aligning provider during the Performance Year or receive the majority of certain health services outside of the KCE's Service Area.
Costs considered	**KCF and CKCC:**[9] • CKD Quarterly Capitation Payments (QCP): combines payment for Nephrology Services into a single capitated payment. • Adjusted Monthly Capitation Payments (AMCP): standardizes the MCP for home dialysis and in-center dialysis patients by paying KCF Practices an additional $35 per MCP home dialysis claim for services delivered to aligned ESRD beneficiaries. CMS will make this payment to KCF Practices at the end of the Performance Year. • Kidney Transplant Bonuses (KTB): reimbursement based on kidney transplants received by aligned beneficiaries with CKD or ESRD during the Model performance period.[10] **CKCC Only**:[11] Shared savings/shared losses under one of the following Options: • Graduated – KCEs enter at a lower level of risk and transition to higher risk in future years (enter in either a lower-reward one-side option or a

[8] RFA pgs. 45-47
[9] Each model has its own specifications and requirements, but both KCF and CKCC contain a QCP, AMCP, and KTB component.
[10] RFA pg. 20. The KCF Model also contains a performance-based adjustment which could increase the amount of the CKD QCP and the MCP component of the AMCP for a KCF Practice by up to 20 percent, or reduce that amount by as much as 20 percent (see pgs 26-31).
[11] RFA, pg. 55

	Kidney Care Choices (KCC) Model
	two-sided option with a lower level of risk and incrementally phase in risk and additional potential reward. • Professional: KCEs share in 50% of savings or losses in the total cost of care for Medicare Part A and B services for aligned beneficiaries relative to a benchmark. • Global: KCEs share in 100% of the total cost of care for all Medicare Part A and B services for aligned beneficiaries relative to a benchmark.
Permitted repayment mechanisms	No specific repayment mechanisms are provided. According to CMS, the practice "must demonstrate the ability to assume financial risk and make any required repayments to the Medicare program." RFA pg. 14.
CMS recovery mechanisms for shared losses	CMS will withhold a percentage of the CKD Quarterly Capitation Payments amount paid each quarter to account for changes in alignment status and will calculate alignment-based adjustments after the Performance Year to ensure CMS did not overestimate the withhold. Additional withholdings are made by CMS to account for further variables. KCEs participating in a model with downside risk must establish one of the following financial guarantees: an escrow account with an FDIC-insured institution, a surety bond from a company included on the U.S. Department of Treasury's List of Certified Companies, or a line of credit at an FDIC-insured institution.[12]
Public disclosure obligations?	Yes, certain waivers require the arrangement to be publicly disclosed and maintained on a public-facing website.[13]
Events requiring CMS notice	Termination of participation.[14]
CMS events of termination	CMS may take remedial action against a participant for a variety of reasons, including but not limited to the following: • The participating entity (KCF Practice or KCE) or its participants' noncompliance with any term of the participation agreement;

[12] RFA, pgs. 64, 65
[13] Notice of Waiver of Certain Fraud and Abuse Laws in Connection With the Comprehensive Kidney Care Contracting Options of the Kidney Care Choices Model
[14] RFA, pg. 34

	Kidney Care Choices (KCC) Model
	• Failure to submit or implement a corrective action plan; • Participating entity or its participants engage in actions that threaten the health or safety of a patient or patient quality of care; • Submission of false data or other information in connection with the Model; and • Participating entity or participants' past or present program integrity issues. Based on the severity of the issue identified, CMS may take a variety of actions, including terminating the participation agreement.[15]
Fraud and abuse flexibilities?	CMS has waived certain Medicare payment requirements as necessary solely for purposes of testing the KCF and CKCC Options. Certain payment rule waivers, referred to as "Benefit Enhancements," are detailed in Table 8 (KCF Option) and Table 18 (CKCC Option) of the RFA.[16] **KCF**: the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect the following patient incentives, provided that such remuneration is furnished in a manner that complies with the terms of the safe harbor and the relevant requirements set forth in the Performance Period Participation Agreement for the KCF Option: (i) certain in-kind items and services furnished by a KCF Practice or a KCF Nephrology Professional to a KCF Beneficiary; (ii) certain cost sharing support for face-to-face visits with KCF Beneficiaries; and (iii) certain chronic disease management rewards furnished by the KCF Practice to certain KCF Beneficiaries. **CKCC**: there is a waiver of §1877(a) of the Social Security Act (relating to the Federal physician self-referral law) and § 1128B(b)(1) and (2) (relating to the Federal anti-kickback statute) with respect to any startup arrangement between a KCE that has entered into an Implementation Period Participation Agreement and one or more KCE Participants or Preferred Providers or both (provided that the conditions of the waiver are satisfied). Because there is no Implementation Period for new applicants, this waiver is not available for the second cohort of the CKCC Option. Additionally, for the CKCC Option, the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 C.F.R. § 1001.952(ii)(1)) is available to protect certain

[15] RFA, pgs. 7, 8
[16] RFA, pg. 10

	Kidney Care Choices (KCC) Model
	KCE financial arrangements. In addition, the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect the following patient incentives in the CKCC Option, provided that they are furnished in a manner that complies with the terms of the safe harbor and the relevant requirements set forth in the Performance Period Participation Agreement: (i) certain in-kind incentives furnished by a KCE, KCE Participant, or Preferred Provider; (ii) certain cost sharing support for Part B services provided to certain KCE Beneficiaries by a KCE, KCE Participant, or Preferred Provider; and (iii) certain chronic disease management rewards furnished by a KCE to certain KCE Beneficiaries.
Data Sharing	CMS will make historical and monthly claims data available upon request, consistent with data sharing practices in shared savings models and programs, and consistent with all applicable laws and regulations, including HIPAA and the Part 2 regulations governing the disclosure and use of certain substance use disorder patient records.[17]
Data Sharing Limitations	Upon request, data will be made available only for the sole purposes of developing and implementing activities related to care coordination and quality assessment and improvement for aligned beneficiaries. Historical data files for aligned beneficiaries will be limited to three years of historical data. The claims data provided will not include individually identifiable data for aligned beneficiaries who have opted out of data sharing.[18]

[17] RFA, pg. 20
[18] RFA, pg. 20

	Making Care Primary (MCP) Model
Official or alternate names (if applicable)	N/A
Common acronym	MCP
Objective	The purpose of this model is to improve care management and care coordination, provide primary care clinicians with tools to form partnerships with health care specialists, and leverage community-based connections to address patients' health and health-related social needs.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act; Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary
Start date	July 1, 2024
End date	December 31, 2034
Performance Year	Performance year (PY) 1 is six months and will run from 7/1/24 to 12/31/24. PY2 and onwards will align with calendar years.[19]
Core documents setting out model terms	MCP Request for Applications (RFA) MCP Overview Factsheet
Accepting new applications?	No, the application deadline was November 2023.[20]
Eligible parties	Medicare-enrolled organizations that provide primary care services to Medicare beneficiaries, including solo primary care practices, group practices, health systems, eligible Indian Health Programs, and FQHCs located in Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, upstate New York, North Carolina, and Washington.

[19] RFA, pg. 59.

[20] MCP Overview Factsheet, pg. 1.

	Making Care Primary (MCP) Model
	To be eligible to apply to participate in MCP, an organization must: • Be a legal entity formed under applicable state, federal, or Tribal law that is authorized to conduct business in each state in which it operates; • Be Medicare-enrolled; • Serve as the regular source of primary care for a minimum of 125 attributed Medicare beneficiaries; and • Have the majority (at least 51%) of their primary care site(s). The following organizations are ineligible: PCF practices and ACO REACH Participant Providers that have not withdrawn or been terminated from either model as of 5/31/23; Grandfathered Tribal FQHCs; Practices that provide concierge care; and Rural Health Clinics. In general, CMS will not allow organizations and clinicians to participate in MCP while participating in other Innovation Center models.[21]
Focused beneficiary population	Beneficiaries who will benefit from enhanced care management, care coordination, and their primary care provider's increased ability to leverage health care specialists and community-based services. The model places an emphasis on behavioral health needs, health equity and ensuring that underserved populations have access to efficient care as well as health-related social needs, such as housing and nutrition.[22]
Intermediate entities between CMS and provider	None
Where are changes communicated?	MCP Website
Tracks in the MCP Model	There are three progressive tracks that increase in accountability and care delivery requirements. Track 1 is for applicants with no experience in value-based care; participants in Tracks 2 and 3 may, but do not need to, have experience in value-based care. **Track 1** participants will build the foundation to implement advanced primary care services through activities such as risk-stratifying their

[21] RFA, pgs. 12-14, 56.

[22] See MCP Website.

	Making Care Primary (MCP) Model
	population, developing workflows for care management, chronic disease management, and behavioral health and HRSN screenings. **Track 2** participants continue to meet the requirements of Track 1 while also expanding and integrating the services available to their patients (e.g., once patients are risk stratified and care management workflows established, implementing chronic care management for high-risk patients). **Track 3** participants will continue to meet and build upon the requirements of Tracks 1 and 2, to further optimize and expand care delivery and specialty care integration (e.g., once patients are risk stratified, chronic care management for high risk patients is established, taking this further and ensuring there are individualized care plans for all high risk patients aligned to their chronic health needs as well as connections to community-based supports).[23]
Brief description of the financial arrangement	MCP will introduce six (6) payment types:[24] 1. Upfront Infrastructure Payment (UIP) for Infrastructure Building: A time-limited, lump sum infrastructure payment for eligible Track 1 participants. Examples of permitted uses for the financial support are increased staffing, SDOH strategies, and investment in health care infrastructure (e.g., health IT investments, such as connecting with Health Information Exchanges (HIE), e-consult technology investments, patient health data systems (i.e., patient portals), event notification systems, or EHR interfaces, which are not otherwise billable under Medicare FFS). 2. Enhanced Services Payment: A Per Beneficiary Per Month (PBPM) payment, adjusted to reflect the attributed population's risk level with a higher payment for beneficiaries at the highest levels of clinical and social risk. These payments, for participants of all Tracks, will be paid prospectively on a quarterly basis and are intended to fund ongoing care management activities described in the Care Delivery section with respect to MCP beneficiaries. 3. Prospective Primary Care Payment (PPCP): PPCP payments are made quarterly and are based on the historical primary care spending for each participant's attributed beneficiary population. Track 1 participants continue to bill and receive payment from Medicare FFS as usual (and FQHCs will

[23] RFA, pg. 19

[24] RFA, pgs. 31-32

	Making Care Primary (MCP) Model
	continue to be paid according to the Medicare FQHC PPS). Track 2 participants receive a hybrid payment consisting of partial PPCP with reduced FFS payments. Track 3 participants receive an alternative to FFS payment made up of full PPCP and certain FFS payments are not paid. 4. Performance Incentive Payment: Opportunity for a positive adjustment to the sum of FFS amounts and PPCP to each participant (all Tracks) for PPCP Services based on performance on the MCP Performance Measure Set. 5. MCP e-Consult (MEC): Participants in Track 2 will be eligible to bill an e-consult code that is unique to MCP. This code will also be included in the list of PPCP services for Track 3. 6. Ambulatory Co-Management (ACM): Specialty Care Partner physicians that partner with participants in Track 3 will be eligible to bill a short-term coordination code focused on communication and collaboration that is unique to the MCP model.
Shared losses?	No.[25]
Attribution terms	Eligible Medicare beneficiaries will be prospectively attributed to a participant who will receive model-specific payments for that beneficiary and be held accountable for their quality outcomes. Attribution is first determined by CMS based on the beneficiary's chosen alignment to a clinician in Medicare.gov (Voluntary Alignment). Beneficiaries can select a primary care clinician and the location (including FQHC locations) where they receive care on Medicare.gov. Such a choice will supersede the claims-based alignment methodology (described below). For purposes of attribution, eligible clinicians for non-FQHCs are all primary care clinicians billing under the TIN of the participant whose NPI is included on the participant's MCP Clinician List submission; for FQHC participants, this includes all clinicians rendering services under the participating list of CCNs linked to their TIN. If the beneficiary has not chosen a clinician on Medicare.gov, CMS will attribute the beneficiary to the participant if one or more of the participant's eligible clinicians furnished the plurality of the beneficiary's primary care visits and/or eligible Chronic Care Management (CCM) services, or if one of the participant's eligible clinicians billed the beneficiary's most recent claim for an Annual Wellness Visit or a Welcome to Medicare Visit during the most recently available 24-month period. Attributed beneficiaries will

[25] RFA, pgs. 5,9

	Making Care Primary (MCP) Model
	retain their freedom of choice of providers under Medicare and may receive services from providers other than the participant they are attributed to or their Specialty Care Partners.[26]
Costs considered	Varies costs considered for each type of payment:[27] • UIP: Infrastructure costs; start-up costs to value-based care • Enhanced Services Payment: population risk level • Prospective Primary Care Payment: Primary care spending for attributed beneficiary population • Performance Incentive Payment: Performance-based • MEC: The MEC will be valued at the same level as the existing requesting physician Interprofessional Consultation (IPC) code (99452), including geographic adjustments and facility non-facility adjustments.[28] • ACM: The ACM code will be priced at $50, before the geographic adjustment is applied.[29]
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A; any necessary downside adjustments are made in the form of recoupments that are applied prospectively.[30]
Public disclosure obligations?	None.
Events requiring CMS notice	Termination of MCP Participation.
CMS events of termination	CMS reserves the right to terminate a participant's Participation Agreement at any point during the model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or as otherwise specified in the

[26] RFA, pgs. 29-30
[27] RFA, pgs. 31-32
[28] RFA, pgs. 48-49
[29] RFA, pg. 49
[30] RFA, pg. 41

	Making Care Primary (MCP) Model
	Participation Agreement or required by Section 1115A(b)(3)(B) of the Social Security Act.[31]
Fraud and abuse flexibilities?	No separate waivers are available, but in addition to or in lieu of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)) will be available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the MCP participation documentation.[32]
Data Sharing	CMS will provide MCP participants with multiple types of data feedback to inform their care.[33] • CMS Innovation Center's Data Feedback Tool (DFT) will give participants information about their quality, utilization, and payment metrics relevant to model performance. The DFT also allows participants to compare their metrics with other participants in their region and nationally. • CMS intends to make several enhancements to the DFT, including adding analytics to help clinicians identify high-quality specialists with whom they would like to partner. Metrics are expected to include cost, utilization, and quality measures and may include measures of low-value care and appropriateness in the future. • Participants will also be able to request and receive Claim and Claim Line Feed files (CCLFs) on a monthly basis, which contain historical claims data from CMS. • CMS will use the state-based learning infrastructure described in the Learning Systems section to provide MCP participants with data from multiple payers.
Data Sharing Limitations	The MCP requires participants to report certain health equity data (demographic data and health-related social needs (HRSN)) on their patients

[31] RFA, pg. 54

[32] RFA, pg. 55

[33] RFA, pg. 52

	Making Care Primary (MCP) Model
	to allow CMS and participants to evaluate health disparities and inequities in MCP communities.
Misc.	Special considerations exist for payments to participating FQHCs and Indian Health Programs.[34]

[34] RFA, pg. 50

	Next Generation (ACO) Model
Official or alternate names (if applicable)	
Common acronym	NGACO
Objective	The purpose of this model was to test whether strong financial incentives, plus tools to support better patient engagement and care management, could improve health outcomes and lower expenditures for FFS beneficiaries. This model expanded upon MSSP by allowing provider groups with experience in care coordination to assume higher levels of financial risk and reward than were available in MSSP.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. § 1315a) and Section 1115A(b)(2) of the Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/next-generation-aco-model
Start date	January 1, 2016
End date	December 31, 2021
Performance Year	CY
Core documents setting out model terms	Next Generation ACO Model RFA; 2021 FAQs; Fact Sheet.
Accepting new applications?	No
Eligible parties	Next Generation ACOs were formed by Next Generation Participants structured as: • Physicians or other practitioners in group practice arrangements • Networks of individual practices of physicians or other practitioners

	Next Generation (ACO) Model
	• Hospitals employing physicians or other practitioners • Partnerships or joint venture arrangements between hospitals and physicians Any other Medicare-enrolled Next Generation Participants or Preferred Providers were allowed to participate in an ACO formed by one or more of the entities listed above, provided that they satisfied the requirements of the Model and were not Prohibited Participants. *See* RFA pg. 7-8. To be eligible for participation in the Next Generation Model, ACOs needed to maintain an aligned population of at least 10,000 Medicare beneficiaries. Next Generation ACOs that were deemed to be Rural ACOs were permitted to have a minimum population of 7,500 Medicare beneficiaries. *See* RFA pg. 20.
Focused beneficiary population	During the base- or performance-year, the beneficiary must have: • Been covered under Part A in January of the base- or performance-year and in every month of the base- or performance-year in which the beneficiary is alive; • Had no months of coverage under only Part A; • Had no months of coverage under only Part B; • Had no months of coverage under a Medicare Advantage or other Medicare managed care plan; • Had no months in which Medicare was the secondary payer; and, • Been a resident of the United States.
Intermediate entities between CMS and provider	A Next Generation ACO must have been a legal entity identified by a Federal taxpayer identification number (TIN) formed under applicable State, Federal, or Tribal law and authorized to conduct business in each State in which it operated for purposes of the following: • Receiving and distributing shared savings; • Repaying shared losses or other monies determined to be owed to CMS;

	Next Generation (ACO) Model
	• Establishing, reporting, and ensuring Next Generation Participant compliance with health care quality criteria, including quality performance standards; and • Fulfilling other ACO functions identified in the Next Generation ACO Model Participation Agreement. An ACO formed by two or more Next Generation Participants, each of which is identified by a unique TIN, must have been a legal entity separate from the legal entity of any of its Next Generation Participants or Preferred Providers. If the ACO was formed by a single Next Generation Participant, the ACO's legal entity and governing body could have been the same as that of the Next Generation Participant. *See* RFA pg. 5-6.
Where are changes communicated?	https://www.cms.gov/priorities/innovation/innovation-models/next-generation-aco-model
Brief description of the financial arrangement	The Next Generation Model sought to test ACO capacity to take on near-complete financial risk in combination with a stable, predictable benchmark and payment mechanisms that encouraged ACO investments in care improvement infrastructure. Benchmark Methodology: In the first three years of the Model (calendar years 2016-2018), for each Next Generation ACO, the prospective Benchmark was established through the following steps: (1) determine the ACO's historic baseline expenditures; (2) apply the regional projected trend; (3) risk adjust using the CMS Hierarchical Condition Category (HCC) model; and (4) apply the discount, which was derived from one quality adjustment and two efficiency adjustments. In the last two performance years of the Model (calendar years 2019-2020), which were governed by a new Participation Agreement, CMS had the option to employ an alternative benchmarking methodology. Risk Arrangements: The Next Generation Model offered a choice of two risk arrangements that determined the portion of the savings or losses that accrued to the Next Generation ACO. In both arrangements: (1) the sharing rate was higher than those in MSSP or the Pioneer Model; (2) individual beneficiary expenditures were capped at the 99th percentile of expenditures to prevent substantial impacts by outliers (the Next Generation ACO was not accountable for expenditures beyond the 99th percentile); and (3) aggregate savings or losses were capped at 15% of the benchmark.

	Next Generation (ACO) Model
	Payment Mechanisms: (1) Normal FFS Payment; (2) Normal FFS Payment + Monthly Infrastructure Payment (an additional per-beneficiary per-month (PBPM) payment unrelated to claims); (3) Population-Based Payments (PBP) (an estimate of the total amount by which FFS payments were reduced for Medicare Part A and B services rendered by PBP-participating Next Generation Participants and Preferred Providers who agreed to accept Reduced FFS Payments when providing care to aligned beneficiaries during the upcoming Performance Year; (4) All-Inclusive Population-Based Payments (AIPBP) (determined by estimating total annual expenditures for care furnished to aligned beneficiaries by Next Generation Participants and Preferred Providers who agreed to participate in AIPBP and CMS would pay that projected amount to the ACO in a PBPM payment.). Saving/Losses Calculation: An ACO's savings or losses were determined by comparing total Parts A and B spending for Next Generation Beneficiaries to the benchmark (with individual expenditures capped at the 99th percentile). The risk arrangement was then applied to determine the ACO's share of savings or losses. Savings payment or loss recoupment occurred annually following a year-end financial reconciliation. CMS also accounted for monthly payments that occurred during the performance year through PBP, infrastructure payments, or AIPBP. *See* RFA pgs. 13-20.
Shared losses?	Yes. *See* RFA bottom of pg. 19 – Saving Losses Calculation.
Attribution terms	No
Costs considered	Total cost of care. Beginning in PY2 (2017), Next Generation ACOs had the option to participate in a capitation-like payment mechanism (AIPBP). *See* 2021 FAQ pg. 2.
Permitted repayment mechanisms	Next Generation ACOs were required to have in place a financial guarantee sufficient to cover potential losses. The specific amount of the financial guarantee was set forth in the Participation Agreement. *See* RFA pg. 20.
CMS recovery mechanisms for shared losses	The ACO had the ability to repay all shared losses and other monies owed for which it may have been liable under the terms of the participation agreement and was required to provide a financial guarantee for each performance year. If CMS did not receive payment in full by the date payment was due, CMS pursued payment under the financial guarantee and had the option to withhold payments otherwise owed to the ACO under the participation

	Next Generation (ACO) Model
	agreement or any other CMS program or initiative. If the ACO failed to pay the amounts due to CMS in full within 30 days after the date of a demand letter or settlement report, CMS assessed simple interest on the unpaid balance at the rate applicable to other Medicare debts under 45 C.F.R. § 30.18 and 42 C.F.R. § 405.378. CMS and the U.S. Department of the Treasury could use any applicable debt collection tools available to collect the total amount owed by the ACO.
Public disclosure obligations?	At a minimum, Next Generation ACOs were required to publicly report information regarding their (1) organizational structure, including identification of the members of the ACO's governing body and the ACO's Next Generation Participants and Preferred Providers; (2) Shared Savings and Shared Losses information; and (3) performance on the quality measures. *See* RFA pg. 32.
Events requiring CMS notice	Proceedings relating to bankruptcy; any proposed transfer of rights under the agreement; a Change in Control. *See* Participation Agreement, pg. 63-65. Early termination of the escrow account and any change in the amount of funds held in escrow; any change in the amount of credit in a letter of credit *See* Participation Agreement pg. 174.
CMS events of termination	Poor performance, non-compliance with the terms and conditions of the Participation Agreement, program integrity issues, or as otherwise required under Section 1115A(b)(3)(B) of the Social Security Act. *See* RFA pg. 32.
Fraud and abuse flexibilities?	Next Generation ACO Participation Waiver: Section 1877(a) of the Social Security Act (physician self-referral law) and sections 1128B(b)(l) and (2) of the Act (the Federal anti-kickback statute) were waived with respect to any arrangement of the Next Generation ACO, one or more of its Next Generation Participants, or a combination thereof, provided that certain conditions were met. *See* Amended Notice of Waivers. Shared Savings Distribution Waiver: Section 1877(a) of the Social Security Act (physician self-referral law) and sections 1128B(b)(l) and (2) of the Act (the Federal anti-kickback statute) were waived with respect to distributions or use of Shared Savings earned by the Next Generation ACO, provided that certain conditions were met. *See* Amended Notice of Waivers. Waiver for Patient Engagement Incentives: Pursuant to 1115A(d)(l) of the Act, section 1128A(a)(5) of the Act (relating to civil monetary penalties for beneficiary inducements), and sections 1128B(b)(l) and (2) of the Act (relating to the Federal anti-kickback statute) were waived with respect to the following three categories of incentives if the conditions in the applicable

	Next Generation (ACO) Model
	category were met: (1) in-kind incentives, (2) chronic disease management rewards, and (3) Cost Sharing Support. *See* Amended Notice of Waivers. AIPBP Payment Arrangement Waiver: Pursuant to section 1115A(d)(l) of the Act, section 1877(a) of the Act (relating to the physician self-referral law) and sections 1128B(b)(l) and (2) of the Act (relating to the Federal anti-kickback statute) were waived with respect to an AIPBP Payment Arrangement, provided that certain conditions were met. *See* Amended Notice of Waivers.
Data Sharing	Upon request from the ACO, CMS provided (1) data on aligned Next Generation Beneficiaries that included individually identifiable demographic and Medicare eligibility status information and various summary reports with data relevant to ACO operations and performance in the Model; and (2) detailed claims data files that included individually identifiable claim and claim line data for services furnished by Medicare-enrolled providers and suppliers to aligned Next Generation Beneficiaries. *See* RFA pg. 26. CMS had the option to make available de-identified beneficiary data to Next Generation ACOs for the express purpose of submitting such data to approved local multi-purchaser databases in order to support comprehensive performance assessment by the ACO or its Next Generation Participants. *See* RFA pg. 26. Next Generation ACOs that elected the AIPBP payment mechanism received claims and payment information from CMS for the services furnished to Next Generation beneficiaries by Next Generation Participants and Preferred Providers. *See* RFA pg. 26.
Data Sharing Limitations	Data sharing was made under appropriate data use agreements with CMS. The data and reports provided to the ACO did not include individually identifiable data for Next Generation Beneficiaries who opted out of data sharing with the ACO and the Next Generation Model honored the data sharing opt-out decisions by beneficiaries who were previously given that choice while an aligned beneficiary in another Medicare ACO initiative. *See* RFA pg. 26. Data sharing was offered to Next Generation ACOs in accordance with HIPAA for all aligned beneficiaries who were either: (1) not previously

	Next Generation (ACO) Model
	aligned to any ACO; or (2) previously aligned to an ACO but did not opt out of data sharing. *See* RFA pg. 26.

	Primary Care First Model Options
Official or alternate names (if applicable)	N/A
Common acronym	PCF
Objective	Primary Care First aims to improve quality, improve patient experience of care, and reduce expenditures. CMS believes that the model will achieve these aims by increasing patient access to advanced primary care services.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options
Start date	Cohort 1: January 2021 Cohort 2: January 2022
End date	Cohort 1: December 2025 Cohort 2: December 2026
Performance Year	Primary Care First will be tested over six performance years, with two staggered cohorts of participating practices, each participating for five performance years; one cohort is participating in the model from 2021 through 2025 and a second cohort participates from 2022 through 2026.
Core documents setting out model terms	Primary Care First Request for Applications Fact Sheet
Accepting new applications?	No

	Primary Care First Model Options
Eligible parties	Eligible practices must:[35] • • be located in one of the following twenty-six Primary Care First 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); • • include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, or hospice and palliative medicine; • • provide health services to a minimum of 125 attributed Medicare beneficiaries; • • have primary care services account for at least 50% of the practices' collective billing based on revenue (in the case of a multi-specialty practice, 50% of the practice's eligible primary care practitioners' combined revenue must come from primary care services); • • have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to FFS payments such as full or partial capitation; • • use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and if available, connect to their regional health information exchange (HIE); and

[35] https://www.cms.gov/priorities/innovation/media/document/pcf-cohort2-rfa, pgs. 7 & 8; https://www.cms.gov/priorities/innovation/events/pcf-intro

	Primary Care First Model Options
	• • attest to a limited set of advanced primary care delivery capabilities, including 24/7 access to practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team. Practices participating in the Medicare Shared Savings Program may participate in Primary Care First if they meet the above eligibility criteria. However, practices participating in models that have a policy prohibiting overlapping participation in PCF are ineligible for PCF. Furthermore, the following practice types are not eligible to participate in the model: • Concierge practices (any practice that currently charges patients a retainer fee, or intends to do so at any point during the 5-year performance period under the model Participation Agreement); • Rural Health Clinics; • Federally Qualified Health Centers; and • Critical Access Hospitals that have elected to bill under Method II
Focused beneficiary population	Primary Care First is designed for primary care practices with advanced primary care capabilities, including those that specialize in caring for complex, chronically ill patient populations, that are prepared to accept increased financial risk in exchange for greater flexibility and potential rewards based on practice performance.[36]
Intermediate entities between CMS and provider	None. The legal entity whose TIN is used to bill Medicare for services rendered at the practice site address must sign a Participation Agreement with CMS as a condition of the practice's participation in Primary Care First. If the same legal entity operates at multiple practice site addresses, it must sign a separate Participation Agreement for each participating practice site address.
Where are changes communicated?	PCF Model Options listserv; PCF Model Options homepage
Brief description of the financial arrangement	Participating practices take on upside and downside financial risk for the most common primary care services for their attributed Medicare fee-for-service (FFS) population. CMS assigns practices to one of four risk groups based on the average Hierarchical Condition Category (HCC) score among

[36] https://www.cms.gov/priorities/innovation/media/document/pcf-cohort2-rfa, pg. 7

	Primary Care First Model Options
	their Medicare FFS beneficiaries. Practices receive flat visit fees and a prospective population-based payment that varies by risk group. Starting in the second year of participation, practices' payments are adjusted based on performance on acute hospitalization use (risk groups 1 and 2) or total cost of care (risk groups 3 and 4) and quality metrics.[37] Under PCF, practices will be accountable for their attributed beneficiary population through a 2- tiered payment structure: (1) a Total Primary Care Payment (TPCP), consisting of a Professional Population-based Payment (PBP) and Flat Primary Care Visit Fee (FVF) payment, and (2) a Performance-based Adjustment (PBA) tied to 1 of 2 outcome measures—Acute Hospital Utilization (AHU) 1 or Total Per Capita Cost (TPCC), adapted for PCF.
Shared losses?	Yes, up to 10%
Attribution terms	CMS attributes eligible beneficiaries to practices participating in PCF through 2 broad, sequential processes: voluntary alignment and claims-based attribution.[38] Voluntary alignment uses a Medicare beneficiary's selected primary care practitioner to attribute the beneficiary to a practice. The Medicare beneficiary selects their primary care practitioner through attestation. The voluntary alignment process involves electronic retrieval of beneficiary attestations and verification of the eligibility of the attested practitioner. Voluntary alignment can occur through Medicare.gov.[39] PCF voluntary alignment is limited to PCF-eligible beneficiaries. For the PCF-eligible beneficiaries who have made an attestation via Medicare.gov, CMS applies a voluntary alignment algorithm. CMS uses a list of PCF-eligible beneficiaries and their attested practitioners and practices to check practitioner and practice eligibility. If the attested practitioner does not meet the practitioner eligibility requirements, CMS uses the claims-based attribution process for the eligible beneficiary. CMS first identifies eligible primary care visits for eligible beneficiaries, then attributes the eligible beneficiaries to the

[37] https://www.cms.gov/priorities/innovation/data-and-reports/2022/pcf-first-eval-aag-rpt, pg. 1

[38] https://www.cms.gov/files/document/pcf-py24-payment-meth.pdf, pgs. 23-33

[39] https://cmmi.my.salesforce.com/sfc/p/#i0000000iryR/a/t0000001hENo/Mp8Cbnv2haziDeBVI8s0E71uMpMdvSYpuEhuxiNRU2c

	Primary Care First Model Options
	practice by the recency of Annual Wellness Visits (AWVs) or Welcome to Medicare Visits (WMVs), or the plurality of eligible primary care visits. CMS uses the pool of Medicare claims during the lookback period to identify eligible primary care visits to use for attribution. The lookback period is the 24-month period ending 3 months before the start of the quarter.
Costs considered[40]	At the beginning of each performance year, CMS assigns practices to 1 of 4 risk groups using their attributed Medicare beneficiaries' average CMS-HCC risk score. Practice Risk Groups 1 and 2 are measured on Acute Hospital Utilization, and Practice Risk Groups 3 and 4 are measured on Total Per Capita Cost, adapted for PCF. Practices receive a flat Medicare payment for all face-to-face primary care visits with their attributed beneficiaries. The flat payment only applies to the Medicare portion of the claim payment, and varies based on National base rate, geography, and Medicare sequestration. Each risk group is associated with a per beneficiary per-month (PBPM) Professional PBP that ranges from $28 to $175. The Professional PBP is subject to the Merit-based Incentive Payment System (MIPS) adjustment and is geographically adjusted to account for nationwide variations in cost. The Professional PBP amounts also are adjusted to include the Payment Accuracy Adjustment and the PBA of the Professional PBP. All model payment segments are also subject to the 2% Medicare sequestration, as required by federal rulemaking.
Permitted repayment mechanisms	NA.
CMS recovery mechanisms for shared losses	CMS applies debits to the Professional PBPs paid each quarter to account for prior Professional PBP overpayments, including debits for beneficiary ineligibility and debits resulting from negatively assessed performance-based adjustment. CMS also calculates a Payment Accuracy Adjustment and applies it to an applicable practice's corresponding Professional PBP for the quarter.
Public disclosure obligations?	None required in the Fraud and Abuse Waiver.

[40] https://www.cms.gov/files/document/pcf-py24-payment-meth.pdf, pg. 10-12

	Primary Care First Model Options
Events requiring CMS notice	Termination of participation[41]
CMS events of termination	CMS reserves the right to terminate a practice's Participation Agreement at any point during the model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or if otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act.[42]
Fraud and abuse flexibilities?	For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. On December 16, 2020, the OIG issued waivers for certain beneficiary incentives entered into by specified individuals and entities participating in the PCF Component of the Primary Care First Model.[43]
Data Sharing	Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, if requested by participating practices, clearly and actionably on a quarterly basis. Practices can request claims line feeds for their attributed patient population and incorporate any claims data received into their own analytic tools.[44]
Data Sharing Limitations	
Misc.	PCF Model is expected to be an Advanced APM for the 2024 QP Performance Period.[45]

[41] https://www.cms.gov/priorities/innovation/media/document/pcf-cohort2-rfa, pg. 9

[42] https://www.cms.gov/priorities/innovation/media/document/pcf-cohort2-rfa; pg. 32

[43] https://www.cms.gov/medicare/regulations-guidance/physician-self-referral/fraud-and-abuse-waivers#PCF

[44] https://www.cms.gov/priorities/innovation/media/document/pcf-cohort2-rfa, pg. 14

[45] https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other, pg. 52718

	Primary Care Flex
Official or alternate names (if applicable)	ACO Primary Care Flex Model
Common acronym	ACO PC Flex Model
Objective	ACO PC Flex Model aims to 1) expand access to high-quality, accountable care and improve the patient experience for people with Medicare; 2) enhance primary care payment and spur innovative approaches to care delivery, such as team-based care that is proactive and person-centered and drives quality improvement; 3) narrow disparities in health care outcomes; 4) reduce program expenditures while preserving or enhancing the quality of care for people in the Shared Savings Program; and 5) strengthen participation incentives for new and low revenue ACOs in the Shared Savings Program.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act. The Shared Savings Program regulations define "low revenue ACO" under 42 CFR § 425.20.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model
Start date	January 1, 2025
End date	December 31, 2029
Performance Year	Not yet available. Likely calendar year based on MSSP.
Core documents setting out model terms	Not yet available. General information detailed on CMS Website (available here) and ACO PC Flex Model FAQs (available here). ACO PC Flex Model Request for Applications will be available in second quarter of 2024.
Accepting new applications?	Yes. ACO PC Flex Model application period opens May 2024 and closes August 2024.
Eligible parties	ACOs participating in the Medicare Shared Savings Program and are considered "low-revenue" ACOs per 42 C.F.R. § 425.20.

	Primary Care Flex
	Exact eligible parties participating in ACO PC Flex Model accountable care organizations to be determined upon CMS publication of governing documents. Likely focus on Medicare enrolled primary care providers, including physician practices, individual physicians, Federally Qualified Health Centers (FQHC), and Rural Health Clinics (RHC).
Focused beneficiary population	Medicare beneficiaries.
Intermediate entities between CMS and provider	Not yet available.
Where are changes communicated?	To be determined. Changes currently communicated via CMS website for ACO PC Flex Model.
Brief description of the financial arrangement	CMS has proposed two types of payments under ACO PC Flex Model: • Each participating ACO will receive the same one-time advanced shared savings payment of $250,000. The advanced payment is intended to cover costs associated with forming an ACO (if applicable) and administrative costs for required ACO PC Flex Model activities. • Each participating ACO will receive monthly prospective, population-based primary care payments ("PPCPs") that replace FFS reimbursement for most primary care services provided by the ACO's participating primary care providers ("PCPs"). The PPCPs will include a base rate derived from the average primary care spend in the ACO's county and an enhanced amount calculated based on certain ACO characteristics and the ACO's assigned beneficiary population.
Shared losses?	Not yet available. CMS guidance indicates MSSP calculations for shared losses may apply. See ACO PC Flex Model FAQs (available here).
Attribution terms	Not yet available.
Costs considered	Not yet available. CMS guidance indicates MSSP total cost of care benchmark will apply with portions of the PPCPs included as expenditures

	Primary Care Flex
	in calculation of MSSP shared savings and losses. See ACO PC Flex Model FAQs (available here).
Permitted repayment mechanisms	Not yet available.
CMS recovery mechanisms for shared losses	Not yet available.
Public disclosure obligations?	Yes. ACO PC Flex Model will include policies requiring plan public reporting on use of funds. See ACO PC Flex Model FAQs (available here).
Events requiring CMS notice	Not yet available.
CMS events of termination	Not yet available.
Fraud and abuse flexibilities?	Not yet available.
Data Sharing	Not yet available.
Data Sharing Limitations	Not yet available.

Disease-Specific & Episode-Based Models

	BPCI Advanced
Official or alternate names (if applicable)	Bunded Payments for Care Improvement Advanced
Common acronym	BPCI Advanced
Objective	Under this model, the BPCI Advanced participant is responsible for ensuring that the patient's entire health care team – in all settings) collaborates on quality and the total cost of the patient's care in order to reduce the frequency and length of preventable hospital stays and emergency department use.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act; Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/bpci-advanced
Start date	10/1/2018
End date	12/31/2025
Performance Year	CY
Core documents setting out model terms	Participation Agreement; Participant Resources
Accepting new applications?	No
Eligible parties	Acute care hospitals (ACHs), physician group practices (PGPs), and non-provider conveners
Focused beneficiary population	Medicare beneficiaries that have an inpatient admission or outpatient procedure that corresponds to one of 8 Clinical Episode Service Line Groups (comprised of 29 Inpatient, 3 Outpatient, and 2 multi-setting Clinical Episode Categories).

	BPCI Advanced
Intermediate entities between CMS and provider	Convener Participant, which is a type of Participant that brings together at least one entity referred to as "Downstream Episode Initiators" (Downstream EIs)—which must be either ACHs or PGPs—to participate in BPCI Advanced, facilitate coordination among them, and bear and apportion financial risks. Convener Participants enter into agreements with the EIs, whereby EIs agree to participate in BPCI Advanced and comply with all applicable Model requirements. By contrast, a Non-Convener Participant is the Episode Initiator (EI) that bears financial risk only for itself and does not have any Downstream EIs. Only PGPs and ACHs may participate in BPCI Advanced as a Non-Convener Participant.
Where are changes communicated?	BCPI Advanced Website; BCPI Advanced Participant Portal
Brief description of the financial arrangement	Participant is in a two-sided Risk Arrangement and bears 100 percent financial risk to CMS for up to the 99th percent of national Medicare FFS spending on each item or service included in each Clinical Episode for which the Participant has selected for participation. The aggregate FFS payment (AFP) for each Clinical Episode is Winsorized at the 1st and 99th percentiles of the standardized AFP, during both the baseline year and the Performance Period. CMS continues to pay the standard Medicare FFS payment for items and services furnished to beneficiaries during Clinical Episodes, subject to an initial Reconciliation and at least two subsequent Reconciliation true-ups, as well as the performance of a Post-Episode Spending Calculation. Depending on the results of the Reconciliation calculations, CMS pays the Participant a Net Payment Reconciliation Amount (NPRA) or the Participant pays CMS a Repayment Amount. Depending on the results of the Post-Episode Spending Calculation, the Participant may be required to pay CMS an Excess Spending Amount in the amount, as specified in the Post-Episode Spending Calculation Report.
Shared losses?	No
Attribution terms	Retrospective attribution based on beneficiary receiving services that constituted an Episode of Care corresponding to a Clinical Episode selected for participation by the BPCI Participant.

	BPCI Advanced
Costs considered	Clinical Episodes.
Permitted repayment mechanisms	Recoup funds from future Medicare payments or secondary repayment sources (escrow funds or letter of credit).
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	Change of control; any change in TIN, CCN, NPI, or other identifier specified by CMS with respect to the Participant.
CMS events of termination	Change of control, failure to comply with Participation Agreement, investigation by HHS or DOJ regarding allegation of fraud or other misconduct.
Fraud and abuse flexibilities?	Yes – OIG and CMS jointly issued waivers for specified arrangements involving BPCI Model participants. BCPI Model 1-4 Waivers.
Data Sharing	Line-level beneficiary claims data and reconciliation data.
Data Sharing Limitations	Must agree to a CMS Data Use Agreement, must use data shared by CMS only for certain purposes connected to BPCI operations, and must destroy all data upon termination or expiration of Participation Agreement except in certain limited situations defined by the DUA.

	Bundled Payments for Care Improvement (BPCI) Initiative: General Information
Official or alternate names (if applicable)	Bundled Payments for Care Improvement Initiative
Common acronym	BPCI
Objective	To achieve higher quality and more coordinated care at a lower cost across four broadly defined models of care, which link payments for multiple services that beneficiaries receive during an episode of care.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/bundled-payments
Start date	Model 1: 4/1/2013 Models 2, 3, and 4: 10/1/2013
End date	Model 1: 12/31/2016 Models 2, 3, and 4: 9/30/2018
Performance Year	CY
Core documents setting out model terms	BPCI Participation Agreement; Model-specific materials (archived)
Accepting new applications?	No
Eligible parties	Acute care hospitals, physician group practices, inpatient rehabilitation facilities, skilled nursing facilities, long term care hospitals, home health agencies, non-provider entities operating as a convener (e.g., health system, care/contract coordination entity, etc.).

	Bundled Payments for Care Improvement (BPCI) Initiative: General Information
Focused beneficiary population	Hospital and post-acute care furnished to Medicare beneficiaries whose care corresponded to one of 48 Clinical Episodes.
Intermediate entities between CMS and provider	Conveners
Where are changes communicated?	BPCI website
Brief description of the financial arrangement	Model 1: an episode of care was defined as the inpatient stay in the acute care hospital. Medicare paid the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare continued to pay physicians separately for their services under the Medicare Physician Fee Schedule. Model 2 and Model 3: consisted of a retrospective bundled payment arrangement where actual expenditures were reconciled against a target price for an episode of care. In Model 2, the episode included the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days post-hospital discharge. In Model 3, the episode of care was triggered by an acute care hospital stay but began at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency. Under these retrospective payment models, Medicare continued to make fee-for-service (FFS) payments; CMS later reconciled the total expenditures for the episode against a bundled payment amount (the target price). Medicare then made a payment or recoupment amount that reflected the aggregate expenditures compared to the target price. Model 4: CMS made a single, prospectively-determined bundled payment to the hospital that encompassed all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasted the entire inpatient stay. Physicians and other practitioners submitted "no-pay" claims to Medicare and were paid by the hospital out of the bundled payment.

	Bundled Payments for Care Improvement (BPCI) Initiative: General Information
Shared losses?	No
Attribution terms	Retrospective attribution based on beneficiary receiving services that constituted an Episode of Care corresponding to a Clinical Episode selected for participation by the BPCI Participant.
Costs considered	Clinical episodes
Permitted repayment mechanisms	Recoup funds from future Medicare payments or secondary repayment sources (escrow funds or letter of credit).
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	Change of control; any change in TIN, CCN, NPI, or other identifier specified by CMS with respect to the Participant.
CMS events of termination	Change of control, failure to comply with Participation Agreement, investigation by HHS or DOJ regarding allegation of fraud or other misconduct.
Fraud and abuse flexibilities?	Yes – OIG and CMS jointly issued waivers for specified arrangements involving BPCI Model participants.
Data Sharing	Line-level beneficiary claims data; reconciliation data
Data Sharing Limitations	Must agree to a CMS Data Use Agreement, must use data shared by CMS only for certain purposes connected to BPCI operations, and must destroy all data upon termination or expiration of Participation Agreement except in certain limited situations defined by the DUA.

	Comprehensive Care for Joint Replacement Model
Official or alternate names (if applicable)	Comprehensive Care for Joint Replacement Model
Common acronym	CJR
Objective	The CJR Model is designed to improve care for Medicare patients undergoing hip and knee replacements (also called lower extremity joint replacements or LEJR) performed in the inpatient or outpatient setting and for total ankle replacements performed in the inpatient setting.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act 42 U.S.C. 1302, 1315a, and 1395hh 42 CFR 510 et seq
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/cjr
Start date	8/1/2016
End date	12/31/2024
Performance Year	CY
Core documents setting out model terms	Authority and Background: https://www.cms.gov/priorities/innovation/media/document/cjr-auth-and-backgrnd November 2015 Final Rule establishing model: https://www.federalregister.gov/documents/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals May 2021 Final Rule extending and revising model: https://www.federalregister.gov/documents/2021/05/03/2021-09097/medicare-program-comprehensive-care-for-joint-replacement-model-three-year-extension-and-changes-to

	Comprehensive Care for Joint Replacement Model
	Provider and Technical Fact Sheet for PYs 6-8: https://www.cms.gov/priorities/innovation/files/fact-sheet/cjr-providerfs-finalrule.pdf
Accepting new applications?	No
Eligible parties	Model Participants: Acute care hospitals in selected geographic areas that are required to participate in the model CJR Collaborators: • ACO in MSSP that is not in Track 3 • SNF • HHA. • LTCH • IRF • Physician. • Nonphysician practitioner • Therapist in private practice • CORF • Provider of outpatient therapy services • Physician Group Practice (PGP) • Hospital • CAH • Non-Physician Provider Group Practice (NPPGP) • Therapy Group Practice (TGP)
Focused beneficiary population	Medicare beneficiaries who have an inpatient hospitalization for a lower extremity joint replacement as designated by Medicare Severity Diagnosis Related Group (MS-DRGs) 469, 470, 521, or 522, or who receive an outpatient total knee replacement or total hip replacement as designated by CPT codes (27447 or 27130)
Intermediate entities between CMS and provider	None
Where are changes communicated?	Annual Medicare payment rules, dedicated federal rules, postings to CJR website

	Comprehensive Care for Joint Replacement Model
Brief description of the financial arrangement	Providers and suppliers are paid under the existing FFS payment systems in the Medicare program for episode services throughout the year. For each participant hospital on an annual basis, the model sets Medicare target episode prices that include payment for all related services received by eligible Medicare FFS beneficiaries who have LEJR procedures at that hospital. Following the end of a model performance year, actual episode spending for a participant hospital will be compared to the applicable Medicare target episode prices for that hospital. Depending on the participant hospital's quality and episode spending performance, the hospital may receive an additional payment from Medicare or may need to repay Medicare for a portion of the episode spending.
Shared losses?	No
Attribution terms	Retrospective attribution based on beneficiary receiving services that constituted an Episode of Care corresponding to a Clinical Episode, where Episode of Care is initiated by Participant.
Costs considered	Clinical episodes
Permitted repayment mechanisms	Stop-loss and stop-gain limits of 20 percent, direct payment to CMS or recoupment of future Medicare payments
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	N/A
Events requiring CMS notice	N/A
CMS events of termination	From CJR Final Rule, 80 Fed. Reg. 73274, 73462 (Nov. 24, 2015): • Takes any action that threatens the health or safety of patients; avoids at-risk Medicare beneficiaries. • Is subject to sanctions or final actions of an accrediting organization or federal, state or local government agency that could lead to the inability to comply with the requirements and provisions of CJR.

	Comprehensive Care for Joint Replacement Model
	• Takes or fails to take any action that CMS determines for program integrity reasons is not in the best interests of the CJR model. • Is subject to action by HHS (including OIG and CMS) or the Department of Justice to redress an allegation of fraud or significant misconduct, including intervening in a False Claims Act qui tam matter, issuing a pre-demand or demand letter under a civil sanction authority, or similar action. • Is subject to action involving violations of the physician self-referral law, civil monetary penalties law, federal anti-kickback statute, antitrust laws, or any other applicable Medicare laws, rules, or regulations that are relevant to the CJR model.
Fraud and abuse flexibilities?	Yes – OIG and CMS jointly issued waivers for specified arrangements involving CJR participants: Original CJR waivers: https://www.cms.gov/files/document/2015-cjr-model-waiverspdf.pdf New/Revised CJR waivers (that supersede prior waivers): https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/downloads/2017-cjr-model-waivers.pdf
Data Sharing	Following the end of a model performance year, actual total spending for the episode is compared to the target price for the participant hospital where the beneficiary had the initial LEJR surgery. Historical claims (includes enrollment, raw claim, and episode summary information) Historical claim summaries (statistics on episodes for each hospital and region)
Data Sharing Limitations	Limitations specified in the CJR Model Data Request and Attestation Form

	Comprehensive ESRD Care Model
Official or alternate names (if applicable)	Comprehensive ESRD Care Initiative
Common acronym	CEC Model
Objective	This model was designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD) through person-centered, high-quality care.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/comprehensive-esrd-care
Start date	October 1, 2015
End date	March 31, 2021
Performance Year	CY
Core documents setting out model terms	CEC Model RFA: https://www.cms.gov/priorities/innovation/files/x/cec-py2-rfa.pdf CEC Model Fact Sheet: https://www.cms.gov/priorities/innovation/files/fact-sheet/cec-fs.pdf CEC Model RFA Fact Sheet: https://www.cms.gov/priorities/innovation/files/fact-sheet/cec-py2.pdf Attribution Fact Sheet: https://www.cms.gov/priorities/innovation/files/fact-sheet/cec-attributionfs.pdf Model Frequently Asked Questions: https://www.cms.gov/priorities/innovation/files/x/cecfaq.pdf Federal Register Extension of the Submission Deadline for the Letters of Intent and Applications:

	https://www.federalregister.gov/documents/2014/04/17/2014-08758/medicare-program-comprehensive-esrd-care-initiative-extension-of-the-submission-deadlines-for-the
Accepting new applications?	No; not active.
Eligible parties	The following providers were eligible to form an ESRD Seamless Care Organization (ESCO) to apply to participate in the Model: • Medicare certified dialysis facilities, including facilities owned by large dialysis organizations (LDOs), facilities owned by non-large dialysis organizations (non-LDOs), hospital-based facilities, and independently-owned dialysis facilities; • Nephrologists and/or nephrology practices; and • Other Medicare enrolled providers and suppliers (described in more detail below). CEC Model RFA. An "ESCO" or "ESRD Seamless Care Organization" was an Accountable Care Organization (ACO) composed of providers and suppliers who voluntarily came together to form a legal entity that offered coordinated care to beneficiaries with ESRD. An ESCO was required to have participant owners that included at least one nephrologist or nephrology group practice and at least one dialysis facility. CEC Frequently Asked Questions. Medicare-enrolled providers of services and suppliers were eligible to participate in the CEC Model, including physicians, non-physician practitioners, and other health care suppliers *except* for: (1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, (2) ambulance suppliers, and (3) drug and/or device manufacturers. CEC Model RFA.
Focused beneficiary population	Medicare fee-for-service beneficiaries with ESRD.
Intermediate entities between CMS and provider	Each ESCO was required to be a separate and unique legal entity authorized to conduct business under applicable state law. The ESCO could be an existing legal entity if it conformed to all requirements set forth in the RFA, including that it was capable of receiving and distributing shared savings payments, repaying shared losses, if applicable; and, establishing reporting mechanisms and ensuring ESCO participant compliance with program requirements. CEC Model RFA.

<table>
<tr><td>Where are changes communicated?</td><td>Announcements were communicated through the CMS website (Program Updates) and Federal Register.</td></tr>
<tr><td>Brief description of the financial arrangement</td><td>All applicants with LDO ownership were required to participate in the two-sided payment track. Applicants with non-LDO ownership had the option of choosing to be in the one-sided payment track or the two-sided payment track. The key design features of the payment arrangements were as follows:
<table>
<tr><th>Feature</th><th>LDO Model</th><th>Non-LDO Model I</th><th>Non-LDO Model II</th></tr>
<tr><td>Risk</td><td>2-sided</td><td>1-sided</td><td>2-sided</td></tr>
<tr><td>Minimum Savings / Loss Rate (MSR/MLR)</td><td>+/-1% threshold for first-dollar shared savings or losses (option for higher threshold if desired)</td><td>4.75% MSR for first-dollar shared savings at 350 beneficiaries, decreasing to 4% at 500 beneficiaries, decreasing to 2% as number of beneficiaries increased to 2,000</td><td>+/-1% threshold for first-dollar shared savings or losses (option for higher threshold if desired)</td></tr>
<tr><td>Guaranteed Discount</td><td>Guaranteed discount applied only to non-dialysis FFS Part A and B per capita benchmark. Model PY 1 (2016): 0% Model PY 2 (2017): 1% Model PY 3 (2018): 2% Model PY4+(2019-): 3%</td><td>None</td><td>None</td></tr>
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<tr><td></td><td>
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<tr><td>Shared Savings / Shared Loss Percentages</td><td>After locking in guaranteed discounts, sharing up to 70% of first- dollar savings/losses in year 1, 75% in years 2+</td><td>50%</td><td>75%</td></tr>
<tr><td>Caps on Shared Savings / Shared Losses</td><td>10% Model PY 1/2
15% Model PY 3+</td><td>5%</td><td>10% Model PY 1/2
15% Model PY 3+</td></tr>
<tr><td>Rebasing</td><td>No rebasing</td><td>No rebasing</td><td>No rebasing</td></tr>
</table>

See CEC Model RFA.
</td></tr>
<tr><td>Shared losses?</td><td>Yes. CMS shared in savings and losses with the ESCO. All participant owners in an ESCO with two-sided risk were required to take on the risk of shared losses. Only ESCO Participants and the dialysis organization that directly or indirectly owns all of the ESCO’s Participant Owner dialysis facilities were permitted to receive any distribution of shared savings. CEC Model RFA.</td></tr>
<tr><td>Attribution terms</td><td>Beneficiaries were aligned to an ESCO based on dialysis utilization using a “first touch” approach. An eligible beneficiary’s first visit to a CEC Model participant dialysis facility prospectively aligned that beneficiary to the dialysis facility and the ESCO. A beneficiary remained aligned to the ESCO for the performance year, unless the beneficiary lost eligibility (e.g., ceased dialysis treatment). CEC Frequently Asked Questions.

Alignment was retrospectively finalized as part of a reconciliation process after each performance year. CEC Model RFA.</td></tr>
<tr><td>Costs considered</td><td>A core operational element of the Model included total cost of care. CEC Model RFA.</td></tr>
<tr><td>Permitted repayment mechanisms</td><td>CMS provided ESCOs with the option of truncating an assigned beneficiary’s total annual Medicare Parts A and B FFS per capita expenditures to minimize variation with large claims. If an ESCO did not elect this option, the ESCO was required to maintain aggregate stop loss protection that provided an actuarially equivalent level of coverage. CEC Model RFA.</td></tr>
</table>

CMS recovery mechanisms for shared losses	N/A.
Public disclosure obligations?	Applicants were required to disclose any sanctions, investigations, probations or corrective action plans that the applicant, its proposed ESCO participants, and/or its owners or managers were currently undergoing or had recently undergone. CEC Model RFA.
Events requiring CMS notice	N/A.
CMS events of termination	CMS reserved the right to terminate an ESCO's CEC Model Participation Agreement at any point during the Model for reasons associated with poor performance, non-compliance, or as otherwise specified in the Participation Agreement. CEC Model RFA.
Fraud and abuse flexibilities?	The Office of Inspector General and CMS jointly issued waivers for specified arrangements involving LDOs (LDO Waiver) and small dialysis organizations (non-LDOs) participating in the CEC Model. The waivers applied only to arrangements that complied with the criteria set forth in the applicable waiver.
Data Sharing	CMS shared certain data files and reports with ESCOs on a regular basis, including: • At the start of the first performance year: Historical (three years) claims data on aligned beneficiaries who have not opted out of data sharing • Monthly: Standard beneficiary-level claims feeds (e.g., beneficiary identifiers), total Part A and B expenditures and claims lag reports with no claims runout • Quarterly: Total Part A and B expenditures with a three-month claims run-out • Annually: Financial reconciliation reports. CEC Model RFA.
Data Sharing Limitations	Under appropriate data use agreements and upon the ESCO's request, CMS would share Medicare data with ESCOs to support care improvement efforts. ESCOs were required to notify aligned beneficiaries that CMS would share their data with the ESCO, and aligned beneficiaries had the option to opt out of data sharing. CEC Model RFA.

	Enhancing Oncology Model
Official or alternate names (if applicable)	Enhancing Oncology Model
Common acronym	EOM
Objective	This model aims to improve quality and reduce costs for beneficiaries undergoing treatment for cancer through payment incentives and required participant redesign activities.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model
Start date	7/1/2023
End date	6/30/2028
Performance Year	CY
Core documents setting out model terms	EOM participation agreement Model-specific documents posted on website
Accepting new applications?	Yes, a second round of applications will open in July 2024.
Eligible parties	Participants: • Physician Group Practices (PGPs) -- note that Medicare-enrolled oncology PGPs that routinely refer beneficiaries to PPS-Exempt Cancer Hospitals for chemotherapy services are not eligible to participate in EOM, and entities other than PGPs are also ineligible to participate in EOM. Care Partners:

	• Medicare-enrolled provider or supplier that engages in at least one of EOM's PRAs during a performance period; has entered into a Care Partner arrangement with an EOM participant; is identified on the EOM participant's Care Partner list; and is not an EOM practitioner. EOM Payers: • Commercial payers, Medicare Advantage plans, and state Medicaid agencies are eligible to apply to partner with CMS in the model as EOM Payers. Participating payers are required to partner with at least one EOM participant throughout the entirety of the model; however, this does not need to be the same participant for the entire duration.
Focused beneficiary population	Similar to the Oncology Care Model (which concluded on 6/30/2022), EOM focuses on value-based, patient-centered care for cancer patients undergoing chemotherapy based on 6-month episodes of care, with a specific focus on health equity. Subject to certain exceptions, EOM includes the following seven cancer types for beneficiaries undergoing systemic chemotherapy: breast cancer, chronic leukemia, small intestine/colorectal cancer, lung cancer, lymphoma, multiple myeloma, and prostate cancer.
Intermediate entities between CMS and provider	None
Where are changes communicated?	https://www.cms.gov/priorities/innovation/innovation-models/enhancing-oncology-model
Brief description of the financial arrangement	EOM Payment Methodology: https://www.cms.gov/priorities/innovation/media/document/eom-payment-methodology Under EOM, participants are incentivized to consider the whole patient and engage with them proactively, during and between appointments. Through EOM, CMS is testing whether an alternative payment model in which PGPs:

	• Take on financial and performance accountability for episodes of care surrounding chemotherapy administration; • Have the opportunity to bill for provision of Enhanced Services furnished to beneficiaries, and; • Are encouraged to promote health equity, improve beneficiaries' health outcomes and reduce costs. Pooling: • Pooling in EOM is an arrangement between two or more EOM participants whose episode expenditures are aggregated for the purposes of reconciliation. Participants in a pool will be jointly responsible for the total cost of care for all EOM episodes attributed to participants in their pool. For each pool, CMS will calculate a single benchmark amount, calculate total expenditures as the sum of expenditures for all episodes attributed to participants in the pool, and determine whether the pool earned a performance-based payment (PBP) or owes CMS a performance-based recoupment (PBR). • As part of the pooling arrangement, pools will designate one participant to receive PBPs and pay PBRs on behalf of the pool. Pools may be voluntary or mandatory. Pooling will be mandatory when CMS determines that an EOM participant has billing overlap with another oncology PGP in excess of a mandatory pooling threshold. Reconciliation is conducted in the same manner for voluntary and mandatory pools. If a pool is voluntary, an EOM participant in that pool may terminate a pooling arrangement or terminate an EOM participation agreement without jeopardizing participation in EOM by other participants in that pool. If an EOM participant in a mandatory pool terminates its EOM participation agreement, the other participant(s) in the mandatory pool will need to reduce their billing overlap with that EOM participant below the mandatory pooling threshold in order to continue participating in EOM and may be required to maintain the mandatory pooling relationship amongst the remaining participants.
Shared losses?	No
Attribution terms	CMS attributes an episode to the EOM participant that provided the first qualifying E&M service after the beneficiary received the initiating cancer therapy, as long as that participant provided at least 25% of all qualifying E&M services during the episode. Otherwise, CMS will attribute the episode

	to the oncology PGP that billed the plurality of qualifying E&M services furnished to the beneficiary during the episode.
Costs considered	Episode of care
Permitted repayment mechanisms	Participants and pools will select between two risk arrangements: 1. Risk Arrangement 1 (RA1): • EOM discount: 4% of the benchmark amount • Target amount: 96% of the benchmark amount • Downside risk (stop-loss): 2% of the benchmark amount • Upside risk (stop-gain): 4% of the benchmark amount 2. Risk Arrangement 2 (RA2): • EOM discount: 3% of the benchmark amount • Target amount: 97% of the benchmark amount • Downside risk (stop-loss): 6% of the benchmark amount • Upside risk (stop-gain): 12% of the benchmark amount In both risk arrangements, the threshold for recoupment is 98% of the benchmark amount, meaning that expenditures above this amount would be repaid by the EOM participant to CMS, up to the stop-loss limit. Practices or pools whose total expenditures are greater than their target amount and less than or equal to the threshold for recoupment will fall into the neutral zone and will neither earn a performance-based payment (PBP) nor owe a performance-based recoupment (PBR).
CMS recovery mechanisms for shared losses	Recoupment from Medicare FFS payments and stop-loss provisions
Public disclosure obligations?	No
Events requiring CMS notice	Changes specified in EOM Participation Agreement

CMS events of termination	Poor performance, non-compliance with the terms and conditions of the participation agreement, or as otherwise specified in the participation agreement.
Fraud and abuse flexibilities?	No dedicated OIG/CMS waivers for EOM. EOM's website states: • CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 C.F.R. § 1001.952(ii)(1)) will be available, beginning July 1, 2023, to protect certain "pooling arrangements" (as described in Section VII.B.ii of the RFA) between or among one or more EOM participants, and certain Care Partner Arrangements (as discussed in section VII.B.i of the RFA) between an EOM participant and its Care Partners, provided that such arrangements comply with the requirements of the safe harbor and the requirements to be set forth in the EOM participation agreement. Further, CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)(2)) is available to protect certain in-kind patient incentives furnished by an EOM participant, EOM practitioner, or Care Partner to an eligible beneficiary, as discussed in section VIII.M. of the RFA, provided that such incentives are furnished in a manner that complies with the requirements to be set forth in the EOM participation agreement. The terms EOM participant, EOM practitioner, Care Partner, Care Partner Arrangements, and eligible beneficiary are described in the RFA and will have the meanings that will be set forth in the EOM participation agreement.
Data Sharing	Data sharing by EOM Participants to CMS: • Quality measure data • Clinical and staging data • Beneficiary-level sociodemographic data Data sharing by CMS to EOM Participants: • Quarterly feedback reports • Semiannual reconciliation reports, attribution lists, and episode-level files

	• Monthly claims data
Data Sharing Limitations	Must agree to a CMS Data Use Agreement, must use data shared by CMS only for certain purposes connected to EOM operations, and must destroy all data upon termination or expiration of Participation Agreement except in certain limited situations defined by the DUA.

	ESRD Treatment Choice (ETC) Model
Official or alternate names (if applicable)	
Common acronym	ETC
Objective	This model is intended to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD while reducing Medicare expenditures and preserving or enhancing the quality of care furnished to beneficiaries with ESRD.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act; 42 CFR Part 512, Subpart C
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/esrd-treatment-choices-model
Start date	January 1, 2021
End date	June 30, 2027
Performance Year	CY
Core documents setting out model terms	Fact Sheet; Specialty Care Models Final Rule (85 Fed. Reg. 61114), ESRD PPS PY2022 Final Rule (86 Fed. Reg. 61874), ESRD PPS PY2023 Final Rule (87 Fed. Reg. 67136), ESRD PPS PY2024 Final Rule (88 Fed. Reg. 76344); and other documents on the Model website.
Accepting new applications?	No
Eligible parties	Mandatory participation of ESRD facilities and Managing Clinicians (i.e., Medicare-enrolled physician or non-physician practitioner who bills the monthly capitation payment (MCP) for managing one or more adult ESRD beneficiaries) from 30% of randomly-selected Hospital Referral Regions (HRRs).

	ESRD Treatment Choice (ETC) Model
Focused beneficiary population	Dually-eligible Medicare and Medicaid beneficiaries, 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).
Intermediate entities between CMS and provider	N/A
Where are changes communicated?	CMS website
Brief description of the financial arrangement	The ETC Model includes two payment adjustments: • The Home Dialysis Payment Adjustment (HDPA) is an upward adjustment on home dialysis and home dialysis-related claims with claim service dates between January 1, 2021 and December 31, 2023, the initial three years of the ETC Model. • The Performance Payment Adjustment (PPA) creates upward or downward performance-based adjustment on dialysis and dialysis-related claims with claim service dates between July 1, 2022 and June 30, 2027. The PPA amount will depend on the ETC Participant's performance on the ETC Model's home dialysis rate and transplant rate among the beneficiaries attributed to the ETC Participant.
Shared losses?	No
Attribution terms	Beneficiaries will be attributed to selected Managing Clinicians and ESRD facilities on a month-by-month basis for purposes of calculating certain payment adjustments under the Model (except where the beneficiary, at any point, meets certain criteria, including but not limited to electing hospice, receiving a diagnosis of dementia, or residing in or receiving dialysis in a skilled nursing facility or nursing facility). A beneficiary will generally be attributed to the ESRD facility accounting for the most dialysis treatments during the month, and to the Managing Clinician billing the first MCP for the month.
Costs considered	N/A

	ESRD Treatment Choice (ETC) Model
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	N/A
CMS events of termination	N/A
Fraud and abuse flexibilities?	The Federal anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)(2)) is available to protect the kidney disease patient education coinsurance waivers that satisfy the requirements of such safe harbor and meet other requirements under 42 C.F.R. § 512.397(c)(1). Additionally, CMS will monitor for potential coercion, steering, and inappropriate referrals to the targeted modalities by model participants and assess the impacts of the Model on mortality and hospitalizations. Beneficiaries will maintain freedom of choice among health care providers, and all other current protections afforded under Medicare. An ESRD facility or Managing Clinician selected for participation in the Model will be required to post a notification to that effect, and there will be no change in beneficiary cost sharing amounts due to changes in payments under the Model test.
Data Sharing	CMS shares certain beneficiary-identifiable data and aggregate data with ETC Participants regarding their attributed beneficiaries and performance under the Model. Beneficiary-identifiable data includes the ETC Participant's attributed beneficiaries' names, Medicare Beneficiary Identifiers, dates of birth, dual eligible status, and LIS recipient status, as well as the number of months the beneficiary was attributed to the ETC Participant, home dialysis months, self-dialysis months, nocturnal in-center dialysis months, transplant waitlist months, and months following a living donor transplant. Aggregate data includes the following de-identified information: the ETC Participant's performance scores on the home dialysis rate, transplant waitlist rate, living donor transplant rate, and the Health Equity Incentive; the ETC Participant's aggregation group's scores on the

	ESRD Treatment Choice (ETC) Model
	home dialysis rate, transplant waitlist rate, and living donor transplant rate, and the Health Equity Incentive; information on how the ETC Participant's and ETC Participant's aggregation group's scores relate to the achievement benchmark and improvement benchmark; and the ETC Participant's MPS and PPA for the corresponding PPA Period.
Data Sharing Limitations	In order to receive beneficiary-identifiable data, the ETC Participant must, at least annually, complete and submit a signed data sharing agreement.

	Expanded Home Health Value-Based Purchasing Model
Official or alternate names (if applicable)	Expanded Home Health Value-Based Purchasing Model
Common acronym	Expanded HHVBP Model
Objective	The goal of this model is to improve the quality and efficiency of home health care by improving the patient care experience, strengthening patients' physical function, and addressing patients' health issues before they require an emergency room visit.
Relevant statutory and regulatory provisions	42 CFR part 484, subpart F; Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule (80 FR 68624).
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model
Start date	The Expanded HHVBP Model began on January 1, 2022. This followed the initial program, Home Health Value-Based Purchasing (HHVBP) Model ("original Model") was implemented in nine states on January 1, 2016.
End date	None at this time as application of the Model is included in regulation.
Performance Year	CY
Core documents setting out model terms	42 CFR part 484, subpart F established elements of the Expanded HHVBP Model.
Accepting new applications?	Applications not required. The Model includes Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories. Calendar Year (CY) 2022 was the pre-implementation year. During CY 2022, CMS provided HHAs with resources and training, to allow HHAs time to prepare and learn about the expectations and requirements of the expanded HHVBP Model without risk to payments. The first full

	Expanded Home Health Value-Based Purchasing Model
	performance year for the expanded HHVBP Model was CY 2023, with CR 2025 being the first payment year.
Eligible parties	Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories.
Focused beneficiary population	The Expanded HHVBP Model focuses on home health care patients across the nation to improve these patients' experience with their care, strengthen their physical function and address health issues before they require an emergency room visit.
Intermediate entities between CMS and provider	HHAs receive FFS payment adjustments directly from CMS.
Where are changes communicated?	Proposed changes are included in proposed rulemaking in the Federal Register. CMS also issues the HHVBP Newsletter on a quarterly basis.
Brief description of the financial arrangement	The Expanded HHVBP Model aims to shift paying for Medicare home health services based on volume alone, to a system that pays based on value. This Model expands the Original HHVBP model from no states to all Medicare certified HHAs in the 50 States, Territories, and the District of Columbia. CY 2022 was a pre-implementation year when CMS provided HHAs with training and resources to prepare for success. CY 2023 was the first performance year for the Expanded Model with payment adjustments occurring in CY 2025. Payment adjustments will be based on each HHA's performance on a set of quality measures in a given performance year relative to other HHAs grouped in the same cohort. The measure categories are Outcome and Assessment Information Set (OASIS) based, claims-based, and completed Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey-based measures. Cohorts are identified based on the unique nature of the HHAs beneficiaries served in the year prior to the performance year. Patient assignment is based on either nationwide large-volume or nationwide small-volume of similar size and quality performance HHAs. Payment adjustments will range from

	Expanded Home Health Value-Based Purchasing Model
	-5% to +5% of Medicare fee-for-service payments based on the HHA's Total Performance Score.
Shared losses?	Cost sharing is not applicable for this program.
Attribution terms	Cohorts are determined based on each HHA's unique beneficiary count in the prior calendar year. HHAs are assigned to either a nationwide larger-volume cohort or nationwide smaller-volume cohort to group HHAs that are of similar size and are more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments.
Costs considered	CMS scores Medicare HHAs based on identified quality measures. An HHS's Total Performance Score will then result in a positive or negative payment adjustment relative to other HHA's in the same cohort.
Permitted repayment mechanisms	Not applicable.
CMS recovery mechanisms for shared losses	Not applicable.
Public disclosure obligations?	Although the HHAs do not have public disclosure obligations, CMS will publicly report performance data for the Expanded HHVBP Model beginning with CY 2023 performance year. The data will be posted on the CMS Expanded HHVBP Model website.
Events requiring CMS notice	Not applicable.
CMS events of termination	Not addressed.
Fraud and abuse flexibilities?	No.
Data Sharing	Guidelines for required data reporting are included at § 484.355, "Data reporting for measures and evaluation and the public reporting of model data under the expanded Home Health Value-Based Purchasing (HHVBP) Model."

	Expanded Home Health Value-Based Purchasing Model
Data Sharing Limitations	Not addressed.

	Guiding and Improved Dementia Experience Guide (GUIDE) Model
Official or alternate names (if applicable)	Guiding an Improved Dementia Experience (GUIDE) Model
Common acronym	GUIDE Model
Objective	The GUIDE Model will focus on dementia care management and aims to improve quality of life for people living with dementia, reduce strain on their unpaid caregivers, and enable people living with dementia to remain in their homes and communities.
Relevant statutory and regulatory provisions	SSA Section 1115A(d)(1) (fraud and abuse waivers; telehealth benefit engagement) 42 CFR 403.1110(b) (Data Reporting) 42 CFR 414.1305 (CEHRT) 42 CFR § 414.1367 (APM voluntary scoring)
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/guide
Start date	July 1, 2024
End date	June 30, 2032
Performance Year	July 1 – June 30
Core documents setting out model terms	Guiding an Improved Dementia Experience Request for Applications Version: 1 (Last Modified: November 7, 2023) Participation Agreement (forthcoming)
Accepting new applications?	No (Applications were due January 30, 2024, participant selection deadline is Spring 2024)
Eligible parties	Providers: • Meet the interdisciplinary care team, care delivery, and training requirements;

	Guiding and Improved Dementia Experience Guide (GUIDE) Model
	• Use an electronic health record platform that meets CMS and Office of the National Coordinator for Health Information Technology (ONC) standards for Certified Electronic Health Record Technology (CEHRT); • May provide care delivery services virtually or in-person but must have the ability to conduct an initial home visit in-person for aligned beneficiaries who have moderate to severe dementia; • Must make available for eligible beneficiaries GUIDE Respite Services in the beneficiary's home. Participants have the option to offer eligible beneficiaries GUIDE Respite Services at an adult day center or a facility that can provide 24-hour care. • Maintain an up-to-date GUIDE Practitioner Roster and Partner Organization Roster (if applicable). • Comply with all model reporting requirements, including care delivery, sociodemographic data, and quality reporting. CMS will allow organizations (identified at the TIN level) to participate in both the GUIDE Model and all other current Innovation Center models for which they meet the eligibility criteria, as well as the Medicare Shared Savings Program. Both beneficiaries and participants may overlap in any of the following models: • Shared Savings Program and Innovation Center ACO Mode o ACO Reach; Shared Savings Program; Kidney Care Choices • Advanced and Comprehensive Care for Joint Replacement (CJR) Models o BCPI Advanced; Comprehensive Care for Joint Replacement • Innovation Center Models with Care Management Payment (CMS may recoup parts of the DCMP if deemed duplicative of the same payments for the same provider and beneficiary combination in a different Innovation Center model) o Primary Care First; Making Care Primary; Maryland Primary Care Program; Enhancing Oncology Care Model

	Guiding and Improved Dementia Experience Guide (GUIDE) Model
Focused beneficiary population	Medicare beneficiaries with dementia
Intermediate entities between CMS and provider	None --Participants must be Medicare Part -enrolled providers or suppliers (excluding durable medical equipment (DME) and laboratory suppliers) that establish Dementia Care Programs ("DCPs") to provide ongoing, longitudinal care to people with dementia.
Where are changes communicated?	GUIDE Model website: Guiding an Improved Dementia Experience (GUIDE) Model | CMS
Brief description of the financial arrangement	MIPS APM -the Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics, plus a separate payment for respite services. The five main components of the GUIDE Model's payment methodology are: 1) Monthly DCMP (tiered by patient complexity); 2) A health equity adjustment to the DCMP; 3) A performance-based payment adjustment to the DCMP; 4) A payment for GUIDE Respite Services; and 5) A one-time infrastructure payment for safety net providers in the new program track (if eligible).
Shared losses?	Yes Beginning July 1, 2024, the DCMP and respite payments made to a GUIDE Participant for an aligned beneficiary will count towards the shared savings/losses in the Medicare Shared Savings Program. In future years, GUIDE payments may be included in ACO benchmark and expenditure calculations
Attribution terms	Voluntary alignment process - participants must document that a beneficiary (or their legal representative if applicable) consents to align to the participant. Eligible beneficiaries: • Medicare and/or Medicaid eligible; • Has dementia, based on an attestation from clinician practicing within a participating GUIDE dementia care program; • Enrolled in Medicare as primary payer; • Not enrolled in Medicare Advantage, including Special Needs plans;

	Guiding and Improved Dementia Experience Guide (GUIDE) Model
	• Not residing in Long-Term Nursing Home; AND • Has not elected the Medicare hospice benefit and is not enrolled PACE.
Costs considered	Total Cost of Care
Permitted repayment mechanisms	Forthcoming
CMS recovery mechanisms for shared losses	Forthcoming
Public disclosure obligations?	CMS will consider publicly reporting performance data as part of our Innovation Center model data sharing initiative
Events requiring CMS notice	Participant withdrawal. GUIDE Request for Applications, "Participant Withdrawal Policy."
CMS events of termination	Poor performance, program integrity issues, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act. GUIDE Request for Applications, "Participant Monitoring, Auditing, and Termination Strategy."
Fraud and abuse flexibilities?	The Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation
Data Sharing	At least annual reporting to CMS of the following: • Beneficiary and Caregiver Assessment Data • Quality Data • Care Delivery Reporting • Sociodemographic Data • Health-related social needs
Data Sharing Limitations	Comply with all applicable laws and each participant must submit a HIPAA-Covered Data Disclosure Request and Attestation (DRA)

	Home Health Value-Based Purchasing Model
Official or alternate names (if applicable)	Home Health Value-Based Purchasing Model
Common acronym	HHVBP
Objective	This model aimed to improve the quality and delivery of home health care services to Medicare beneficiaries by providing incentives for better quality care with greater efficiency, studying new potential quality and efficiency measures for appropriateness in the home health setting, and enhancing the public reporting process.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/home-health-value-based-purchasing-model
Start date	January 1, 2016
End date	December 31, 2021; HHVBP Model was expanded nationwide in 2022.
Performance Year	CY
Core documents setting out model terms	CY 2016 HH PPS: https://www.federalregister.gov/documents/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home
Accepting new applications?	No. When the model was expanded in 2022, all Medicare-certified home health agencies became required to participate.
Eligible parties	Medicare-certified home health agencies.
Focused beneficiary population	Medicare beneficiaries receiving home health services.
Intermediate entities between	None

	Home Health Value-Based Purchasing Model
CMS and provider	
Where are changes communicated?	Annual Medicare payment rules; CMS Innovation Models website
Brief description of the financial arrangement	Home health providers received adjusted payments based on quality performance. CMS calculates a total performance score (TPS) for the participating home health agencies. The TPS is comprised of (1) a set of outcome and process measures already reported via the Outcome Assessment Information Set (OASIS) data collection process or determined from claims data; (2) a set of consumer satisfaction measures from the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) for all patients serviced by the agency; and three new measures that the agencies will report via the HHVBP portal.
Shared losses?	No
Attribution terms	N/A
Costs considered	Total cost of care.
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	N/A
CMS events of termination	N/A
Fraud and abuse flexibilities?	None. See CY 2016 HH PPS Final Rule Section IV(A).

	Home Health Value-Based Purchasing Model
Data Sharing	The expanded HHVBP Model measure set uses data already reported through the Home Health Quality Reporting Program (HH QRP) requirements, or Medicare claims, and HHCAHPS surveys.
Data Sharing Limitations	N/A

	Medicare Acute Care Episode (ACE) Demonstration
	Medicare Acute Care Episode Demonstration
Official or alternate names (if applicable)	N/A
Common acronym	ACE
Objective	The goal of this model was to test the use of a global payment for an episode of care (i.e., all Part A and Part B services pertaining to a Medicare fee-for-service beneficiary's inpatient stay) as an alternative approach to payment for service delivery.
Relevant statutory and regulatory provisions	Section 1866C of the Social Security Act, as added by Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/ace
Start date	2009
End date	2012
Performance Year	Varied, based on each participant.
Core documents setting out model terms	• Fact Sheet (PDF) • Solicitation (PDF)
Accepting new applications?	No, inactive.
Eligible parties	Physician-hospital organizations (PHOs), with at least one physician group and at least one hospital that routinely provide at least one of the two main procedures included in the demonstration: hip/knee replacement surgery and/or coronary artery bypass graft (CABG) surgery. Also, applicants must meet particular procedure volume thresholds, have established quality improvement mechanisms, and be located in Medicare Administrative

	Medicare Acute Care Episode (ACE) Demonstration
	Contractor (MAC) Jurisdiction 4 (comprising Texas, Oklahoma, New Mexico, and Colorado).[46]
Focused beneficiary population	Individuals in need of cardiovascular and/or orthopedic procedures.
Intermediate entities between CMS and provider	PHOs
Where are changes communicated?	During the active period of the ACE Demonstration, changes were communicated on the Model website.
Brief description of the financial arrangement	ACE tested the use of a global payment for an episode of care as an alternative approach to payment for service delivery. An episode of care is defined as Part A and Part B services provided during an inpatient stay for Medicare fee-for-service (FFS) beneficiaries for selected procedures.
Shared losses?	No
Attribution terms	Global payments are tied to certain cardiac and orthopedic Medicare severity diagnostic related groups (MS-DRGs or simply DRGs), as set forth in detail in Section 3.2, Table 1 of the ACE Demonstration Solicitation.
Costs considered	Applicants submit proposals for a global payment under the demonstration for one or both of the categories (cardiac and/or orthopedic MS-DRGs).
Permitted repayment mechanisms	The bundled payment amounts bid by demonstration applicants and agreed to by CMS were processed by the Part A/Part B Medicare Administrative Contractor (MAC) serving the demonstration site. The PHO submitted a bill as per usual in the electronic data entry system. Physicians and hospital departments involved in the demonstration then distributed payment according to their agreed-upon methodology. PHOs were required to accept the single bundled payment as payment in full.

[46] https://www.cms.gov/priorities/innovation/files/migrated-medicare-demonstration-x/acesolicitation.pdf, pg. 1

	Medicare Acute Care Episode (ACE) Demonstration
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	None.
Events requiring CMS notice	N/A; no longer active
CMS events of termination	N/A; no longer active
Fraud and abuse flexibilities?	None.
Data Sharing	Administrators employed monthly physician report cards on cost and quality data to increase the transparency of information. Physician report cards served as a driver for discussions among physicians and between physicians and administrators. In many instances, the report cards allowed a direct connection of the outcome measures to gainsharing, which led to some peer pressure among physicians to achieve quality goals at the physician and facility level (a pre-requisite for gainsharing in some sites).[47]
Data Sharing Limitations	N/A
Misc.	CMS shared up to 50 percent of the Medicare savings in the form of payments to beneficiaries to offset their Medicare cost-sharing obligations.[48]

[47] https://downloads.cms.gov/files/cmmi/ACE-EvaluationReport-Final-5-2-14.pdf, pg. 11 of 302

[48] https://www.cms.gov/priorities/innovation/files/migrated-medicare-demonstration-x/acesolicitation.pdf, pg. 4

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
Official or alternate names (if applicable)	N/A
Common acronym	MDPP
Objective	The Medicare Diabetes Prevention Program expanded model is a structured intervention with the goal of preventing type 2 diabetes in individuals with an indication of prediabetes.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program
Start date	March 30, 2020
End date	December 31, 2027
Performance Year	CY
Core documents setting out model terms	MDPP Expanded Model Fact Sheet CMS MDPP Billing and Claims Fact Sheet Medicare Enrollment Application, Medicare Diabetes Prevention Program (MDPP) Suppliers
Accepting new applications?	Yes.
Eligible parties	The three key groups that participate in the program are suppliers, coaches, and beneficiaries.[49] Eligible Beneficiaries must have:[50]

[49] Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet.

[50] Medicare Diabetes Prevention Program (MDPP) Beneficiary Eligibility Fact Sheet.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
	• Medicare Part B coverage through Original Medicare (Fee-for-Service) or a Medicare Advantage (MA) plan • Results from one of three blood tests conducted within one year before the first core session • Hemoglobin A1c test with a value of 5.7-6.4% • Fasting plasma glucose test with a value of 110-125 mg/dl • Oral glucose tolerance test with a value of 140-199 mg/dl • A body mass index (BMI) of at least 25, 23 if self-identified as Asian. MDPP suppliers must:[51] • Have and maintain full or preliminary CDC Diabetes Prevention Recognition Program (DPRP) recognition • Maintain at least one administrative location and report all other administrative locations and community settings on its enrollment application • Maintain a primary business telephone, listed with the name of the business in public view • Not currently have billing privileges terminated for cause or be excluded by a state Medicaid agency. • Not knowingly sell or allow other individuals or entities to use its supplier billing number • Allow CMS to conduct on-site inspections or recordkeeping reviews • Report on their application any changes of ownership, changes to their coach rosters, and final Adverse Legal Action (ALA) history within 30 days. All other changes must be reported within 90 days. ALAs are certain legal actions like convictions and suspensions that

[51] Medicare Diabetes Prevention Program (MDPP) Supplier Requirements Checklist.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
	disqualify individuals and organizations from becoming MDPP suppliers. • Not deny MDPP beneficiaries access to MDPP services on the basis of weight, height, health status, or achievement of performance goals with certain exceptions listed in 42 C.F.R., section 424.205(d)(8) • Offer an MDPP beneficiary all services for which they are eligible, with the same exceptions listed above • Not coerce an MDPP beneficiary's decision to change or not change to a different MDPP supplier • Provide MDPP beneficiaries, before the first MDPP session, with disclosure information including eligibility requirements, the once-per-lifetime limit, minimum coverage requirements, and MDPP supplier standards • Answer MDPP beneficiaries' questions about MDPP services and respond to MDPP related complaints within a reasonable timeframe • Implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier (MBI) of the beneficiary, a summary of the complaint, notes of actions taken, and the names and/or National Provider Identifiers (NPIs) of individuals who took such action on behalf of the MDPP supplier. MDPP Coaches must:[52] • Obtain and maintain NPI numbers • Not currently have their Medicare billing privileges revoked and be currently subject to the reenrollment bar • Not currently have Medicaid billing privileges terminated for cause or be excluded by a state Medicaid agency • Not currently be excluded from any other federal health care program

[52] Medicare Diabetes Prevention Program (MDPP) Supplier Requirements Checklist.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
	• Not be currently debarred, suspended, or excluded from participating in any other federal procurement or non-procurement program • Not have one of the following convictions, guilty pleas, or adjudicated pretrial diversions in the previous 10 years: o Crimes against persons, such as murder, rape, assault, and other similar crimes o Financial crimes such as extortion, embezzlement, insurance fraud, and other similar crimes o Any felony that placed Medicare or its beneficiaries at immediate risk, such as a malpractice conviction o Any other felonies that result in mandatory exclusion.
Focused beneficiary population	The MDPP program builds on the CDC's National Diabetes Prevention Program and is intended for adults at high risk of developing type 2 diabetes.[53] The MDPP Expanded Model is a structured behavior change intervention that aims to prevent the onset of type 2 diabetes among Medicare beneficiaries with prediabetes.[54]
Intermediate entities between CMS and provider	For suppliers furnishing services to beneficiaries of Original Medicare, they may submit claims via a billing agent to manage billing and claims processes on their behalf, or submit claims directly to their MAC contractor.[55] MDPP suppliers who furnish services to Medicare Advantage (MA) program beneficiaries must request payment from the Medicare Advantage Organization (MAO) with whom they are contracted, not Medicare, but submitting encounter data or a claim for payment to the appropriate MA plan.[56]

[53] Centers for Disease Control and Prevention Diabetes Prevention Recognition Program.

[54] Medicare Diabetes Prevention Program (MDPP) Expanded Model.

[55] Medicare Diabetes Prevention Program (MDPP) Billing and Claims Fact Sheet.

[56] Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
Where are changes communicated?	For MDPP, updates are provided via the Medicare Diabetes Prevention Program listserv,[57] the MDPP Bulletin Newsletter,[58] the Federal Register, and the MDPP Expanded Model supplier list.[59]
Brief description of the financial arrangement	Medicare pays organizations and providers that are enrolled as MDPP suppliers for furnishing MDPP services to eligible beneficiaries using a performance-based payment structure that incentivizes positive health outcomes for beneficiaries.[60] Medicare will cover participation only once-per-lifetime.[61] Organizations must be separately enrolled in Medicare as an MDPP supplier to bill for MDPP services. If you are already enrolled in Medicare as a different provider type, you must also enroll as an MDPP supplier to bill for MDPP services.[62] The MDPP program is split into three phases: Core Sessions, Core Maintenance Sessions, and Ongoing Maintenance Sessions; payment differs based on which phase the beneficiary is in and whether they have achieved the program goal of 5% weight loss.[63] For claims for services provided on or before December 31, 2023, billing must begin with Core Session 1.[64] All eligible beneficiaries can participate in core and core maintenance sessions in the first 12 months. In months 1 to 6, payments are allowed for one in-person or distance learning session every week up to a maximum of 16 sessions. In months 7 to 12, payments are allowed for one in-person or distance learning session every month up to a maximum 6 sessions.[65] Medicaid will pay for a maximum of 22 sessions.[66]

[57] Medicare Diabetes Prevention Program listserv.

[58] The MDPP Bulletin.

[59] Alternative Payments – Medicare Diabetes Prevention Program.

[60] Medicare Diabetes Prevention Program (MDPP) Expanded Model.

[61] Medicare Diabetes Prevention Program (MDPP): A Business Case for Prospective Suppliers.

[62] Medicare Diabetes Prevention Program (MDPP) Billing and Payment Fact Sheet.

[63] Medicare Diabetes Prevention Program (MDPP) Quick Reference Guide to Payment and Billing.

[64] Medicare Diabetes Prevention Program (MDPP) - Frequently Asked Questions.

[65] Medicare Diabetes Prevention Program (MDPP) Beneficiary Eligibility Fact Sheet.

[66] Medicare Diabetes Prevention Program (MDPP): A Business Case for Prospective Suppliers.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
	Core Sessions – A supplier can be paid based on the beneficiary's attendance, regardless of the beneficiary's weight loss. Core Maintenance Sessions – Payments are made in two 3-month intervals; a supplier is paid if a beneficiary meets attendance goals; supplier is paid **more** if the beneficiary **also** meets the 5% weight loss goal during the interval. Ongoing Maintenance Sessions – Payments are made in four 3-month intervals; a supplier is **only** paid if the beneficiary attends two ongoing maintenance sessions **and** meets the 5% weight loss goal during the interval.
Shared losses?	No.
Attribution terms	N/A
Costs considered	CMS remits payment based on the number of sessions the beneficiary attends and the weight loss performance goal.[67]
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	N/A
Events requiring CMS notice	N/A
CMS events of termination	N/A

[67] Medicare Diabetes Prevention Program (MDPP) Quick Reference Guide to Payment and Billing.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
Fraud and abuse or other regulatory flexibilities?	There are no fraud and abuse waivers associated with this program, but the following regulatory flexibilities were extended through December 31, 2027:[68] • MDPP suppliers may pause or delay the delivery of the MDPP set of services and resume services on a delayed schedule. • MDPP beneficiaries receiving the MDPP set of services as of March 1, 2020, and whose sessions were paused or cancelled due to the PHE may receive the set of MDPP services more than once per lifetime. • The 5% weight loss and most in-person attendance requirements were waived during the PHE for MDPP beneficiaries who were receiving the MDPP set of services as of March 1, 2020. • The limit on virtual sessions was waived for MDPP suppliers who can provide the MDPP set of services virtually, as long as the virtual sessions are furnished in a manner that is consistent with the CDC Diabetes Prevention Recognition Program (DPRP) standards for virtual sessions, and all other requirements specified at § 410.79(e)(3)(iv) are satisfied.
Data Sharing	MDPP suppliers must:[69] • Maintain a crosswalk file relating beneficiary identifiers used for claims with those used for CDC data and submit this file to CMS six months after they start delivering MDPP services and quarterly thereafter, **and** • Submit performance data for ongoing maintenance sessions with data elements consistent with CDC DPRP standards. For ongoing maintenance services delivered on or before December 31, 2023, MDPP suppliers must continue to submit performance data for any beneficiaries who attend ongoing maintenance sessions in a manner and form as specified by CMS. This performance data must align with the performance data elements as required by CDC for the DPRP standards. MDPP suppliers are required to submit session-level data, consistent with

[68] Medicare Diabetes Prevention Program (MDPP) - Frequently Asked Questions.

[69] Medicare Diabetes Prevention Program (MDPP) Supplier Requirements Checklist.

	Medicare Diabetes Prevention Program (MDPP) Expanded Model
	performance data MDPP suppliers are already providing to CDC, for ongoing maintenance sessions.[70]
Data Sharing Limitations	MDPP suppliers are required to maintain and handle any personally identifiable information (PII) and protected health information (PHI) in compliance with applicable law, including HIPAA, other applicable state and federal privacy laws. MDPP suppliers will also be expected to comply with the MDPP program standards and other applicable CMS policies and standards. For a discussion of our privacy policies including HIPAA, see pages 53323-4 of the CY 2018 PFS final rule. CMS recommends that MDPP suppliers consult with counsel to determine whether they qualify as a HIPAA-covered entity, and how to manage and transfer data appropriately based on applicability of HIPAA, other applicable state and federal privacy laws, and CMS standards.[71]

[70] Medicare Diabetes Prevention Program (MDPP) - Frequently Asked Questions.

[71] Medicare Diabetes Prevention Program (MDPP) - Frequently Asked Questions.

	Radiation Oncology Model
Official or alternate names (if applicable)	Radiation Oncology Model
Common acronym	RO Model
Objective	RO Model aims to improve the quality of care for cancer patients receiving radiotherapy and move toward a simplified and predictable patient system. This mandatory model tests whether changing the way that radiotherapy services are currently paid (i.e., fee-for-service) to prospective, site-neutral, modality-agnostic, episode-based payments will incentivize physicians to deliver higher-value care and reduce Medicare expenditures.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act 42 C.F.R. § 512.100 *et seq.*
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/radiation-oncology-model
Start date	Not yet available. CMS has delayed the start of the RO Model to a date to be determined in future rulemaking. *See* 87 Fed. Reg. 52698 (August 29, 2022).
End date	Not yet available.
Performance Year	CY
Core documents setting out model terms	RO Model is primarily governed by applicable regulations. *See* 42 C.F.R. § 512.100 *et seq.* Additional RO Model guides, technical documents, and user manuals are available on the CMS website.
Accepting new applications?	Not applicable. RO Model is a mandatory model for providers and suppliers within randomly selected Core-Based Statistical Areas ("CBSAs").
Eligible parties	Medicare-enrolled physician group practices, freestanding radiation therapy centers, and hospital outpatient departments that furnish radiation therapy services in applicable CBSAs.

	Radiation Oncology Model
Focused beneficiary population	Medicare beneficiaries receiving radiation therapy services for specified cancers.
Intermediate entities between CMS and provider	Not applicable.
Where are changes communicated?	Dedicated federal rules and related rulemaking (*See, e.g.*, 42 C.F.R. § 512.100 *et seq.*), the CMS website for RO Model, and RO Administrative Portal.
Brief description of the financial arrangement	RO Model is a prospective, episode-based payment model, which pays eligible providers rendering radiation therapy services a predetermined rate per cancer type for a 90-day episode of treatment. RO Model episodes are subject to an annual reconciliation against the sum of FFS amounts that would have been paid to the RO participant outside the model to determine whether CMS is owed a net reconciliation repayment amount or must pay a net reconciliation payment amount to the RO Participant. *See* 42 C.F.R. § 512.285, RO Model FAQs, and RO Model Billing Guide.
Shared losses?	Yes. RO participants may owe CMS "reconciliation repayments" upon reconciliation of RO episodes for a given performance year. *See* 42 C.F.R. § 512.285.
Attribution terms	Attribution is based on the RO participant's initiation of an episode. RO Model episodes are triggered when an RO participant furnishes an initial radiation therapy treatment planning service.
Costs considered	Costs for RO Model episodes based on the sum of all FFS amounts that would have been paid to the RO participant in the absence of the RO Model for any included radiation therapy services furnished during an episode.
Permitted repayment mechanisms	The regulations are silent.
CMS recovery mechanisms for shared losses	If RO model participants fail to pay amounts owed to CMS per a reconciliation report, CMS may recoup the repayment amount from any payments otherwise owned by CMS to the RO participant, including

	Radiation Oncology Model
	Medicare payments for items and services unrelated to the RO Model. 42 C.F.R. § 512.285.
Public disclosure obligations?	The regulations are silent.
Events requiring CMS notice	Notice of bankruptcy, notice of legal name change, notice of change in control, notice of change in TIN or CCN, and changes to individual practitioner list. *See* 42 C.F.R. §§ 512.180, 512.210, and 512.217.
CMS events of termination	CMS may require RO Model participants to terminate agreements with downstream participants if CMS determines one or more grounds for remedial action occur. *See* 42 C.F.R. § 512.160. Otherwise, the regulations are silent regarding RO Model participant termination.
Fraud and abuse flexibilities?	Silent.
Data Sharing	RO participants may ask to receive different types of data, including beneficiary line-level claims data, episode-level data, and participant-level data. *See* RO Model FAQs.
Data Sharing Limitations	Not yet available. RO participants must complete Data Request and Attestation ("DRA") form available on the RO Administrative Portal. Per RO Model FAQs, the DRA form has been removed from the RO Administrative Portal due to delays in implementing the model. RO Model regulations generally require that the RO participant comply with applicable laws regarding use of such data, including HIPAA, and contractually bind downstream recipients of CMS data to the same terms applicable to the RO participant. *See* 42 C.F.R. § 512.275.

State & Community-Based Models

	Accountable Health Communities Model
Official or alternate names (if applicable)	
Common acronym	"AHC"
Objective	This model promoted clinical-community collaboration through: • **Screening** of community-dwelling beneficiaries to identify certain unmet health-related social needs; • **Referral** of community-dwelling beneficiaries to increase awareness of community services; • Provision of **navigation** services to assist high-risk community-dwelling beneficiaries with accessing community services; and Encouragement of **alignment** between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act, authorized by Section 3021 of the Affordable Care Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/ahcm
Start date	May 1, 2017
End date	April 30, 2022
Performance Year	April 1 to March 31
Core documents setting out model terms	Accountable Health Communities Cooperative Agreement - Accountable Health Communities Implementation Plan: A Guide for Applicants
Accepting new applications?	No

	Accountable Health Communities Model
Eligible parties	Community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities.
Focused beneficiary population	Community dwelling Medicaid and Medicaid beneficiaries, including those who are dually eligible, regardless of age, who are not residing in a correctional facility or long-term care institution.
Intermediate entities between CMS and provider	A bridge organization that leads a consortium of participants. Bridge organizations may be community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, or for-profit or non-for-profit local and national entities with the capacity to develop and maintain relationships with clinical delivery sites and community service providers.
Where are changes communicated?	Amendments to cooperative agreements.
Brief description of the financial arrangement	CMS awards funding under cooperative agreements ranging from $1 million and $4.51 million each over a five-year period. Funds for this model supported the infrastructure and staffing needs of bridge organizations and did not pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, utilities, or transportation).
Shared losses?	No
Attribution terms	N/A
Costs considered	Funding categories include start-up costs, screening and referrals, program administration, navigation services, and quality improvement activities.
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No

	Accountable Health Communities Model
Events requiring CMS notice	Pursuant to the Cooperative Agreement and as stated in 45 CFR §75.113, award recipients must disclose, prior to an award, in writing to CMS or the pass-through entity all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Award recipients must also provide notice of any proceeding related to bankruptcy.
CMS events of termination	Pursuant to the Cooperative Agreement, CMS may terminate any award for material noncompliance. Material noncompliance includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity.
Fraud and abuse flexibilities?	The Secretary of Health and Human Services did not issue any waivers of the fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Social Security Act or of any other Medicare or Medicaid laws. The award recipients, sub-award recipients, and all other relevant individuals were required to comply with all applicable laws and regulations.
Data Sharing	Quarterly reporting on each intervention element and the program's progress towards goals.
Data Sharing Limitations	Data includes personally identifiable information that must be shared in a secure manner.

	Innovation in Behavioral Health (IBH) Model
Official or alternate names (if applicable)	Innovation in Behavioral Health (IBH) Model.
Common acronym	IBH
Objective	IBH is focused on improving quality of care and behavioral and physical health outcomes for Medicaid and Medicare populations with moderate to severe mental health conditions and substance use disorder (SUD).
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model
Start date	Announced - January 18, 2024 CMS announced IBH (here); April 26, 2024 CMS issued the Innovation in Behavioral Health (IBH) Model: Participation Benefits for State Medicaid Agencies (here)
End date	Implementation Period Q1 2028 – Q4 2032
Performance Year	Q4 2027 – Q3 2032 (here)
Core documents setting out model terms	Not yet available. There will be Cooperative Agreements between CMS and Medicaid agencies (up to 8 states, the District of Columbia, or U.S. territories).
Accepting new applications?	Q2 2024 for states
Eligible parties	States and BH practices that accept Medicaid in the selected states Eligible billing BH practices must: • Have at least one BH provider who is an employee, a leased employee, or an independent contractor:

	Innovation in Behavioral Health (IBH) Model
	1. Licensed by the state to deliver behavioral health services; ▪ Meet any state-specific Medicaid provider enrollment requirements; ▪ Eligible for Medicaid reimbursement. 2. Serve adult Medicaid beneficiaries (aged 18 or older) with moderate to severe behavioral health conditions. 3. Provide MH and/or SUD services at the outpatient level of care. Practices that participate in the IBH Model must serve a certain number of beneficiaries with moderate to severe behavioral health conditions.
Focused beneficiary population	Medicaid and/or Medicare adult beneficiaries with moderate to severe behavioral health conditions who are treated by a participating practice.
Intermediate entities between CMS and provider	State, District of Columbia and U.S. territories Medicaid agencies
Where are changes communicated?	IBH Website: Innovation in Behavioral Health (IBH) Model | CMS
Brief description of the financial arrangement	IBH is a state-based model, led by state Medicaid Agencies, with a goal of aligning payment between Medicaid and Medicare for integrated services. Practice participants in selected states who participate in the additional Medicare payment model will receive a per-beneficiary-per-month payment to support their implementation of the care delivery framework. These payments will be further supplemented with additional performance-based payments during the implementation period (model years 4-8). Additional information about eligibility to receive these payments will be provided in the Notice of Funding Opportunity (NOFO) to be issued in Spring of 2024.
Shared losses?	Details forthcoming.
Attribution terms	Prospective attribution – details forthcoming. *See* CMS, Innovation in IBH_Model Overview Webinar (Feb. 29, 2024) ("Practices receive list of

	Innovation in Behavioral Health (IBH) Model
	prospectively attributed members at least quarterly and use health IT data tools.")
Costs considered	Details forthcoming.
Permitted repayment mechanisms	Details forthcoming.
CMS recovery mechanisms for shared losses	Details forthcoming.
Public disclosure obligations?	Details forthcoming.
Events requiring CMS notice	Details forthcoming.
CMS events of termination	Details forthcoming.
Fraud and abuse flexibilities?	Details forthcoming.
Data Sharing	Details forthcoming.
Data Sharing Limitations	Details forthcoming.

	Integrated Care for Kids (InCK) Model
Official or alternate names (if applicable)	InCK Model
Common acronym	InCK
Objective	The InCK Model is a child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and the Children's Health Insurance Program (CHIP) through prevention, early identification, and treatment of priority health concerns like behavioral health challenges and physical health needs.
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/integrated-care-for-kids-model
Start date	January 2020 – Pre-Implementation Period begins January 2022 – Implementation Period begins
End date	December 31, 2026
Performance Year	CY
Core documents setting out model terms	Notice of Federal Opportunity InCK Award Fact Sheet
Accepting new applications?	No, applications were due 3/11/2019 and funding awards were issued in December 2019.[72]
Key Participants	State Medicaid Agencies (SMAs) – who are to support local implementation and provide population-level data for the geographic service area, support the development of information sharing arrangements and infrastructure and

[72] NOFO.

	Integrated Care for Kids (InCK) Model
	align support for the model across child-focused state agencies, and develop a pediatric Alternative Payment Model (APM). Lead Organization – these are Health Insurance Portability and Accountability Act (HIPAA) covered entities that receive funding to convene community partners to integrate coordination and management of the InCK Model's core child services for the attributed population. The Lead Organization is accountable for improving population level care quality and outcomes and for developing service integration protocols and processes. Partnership Council – these include representation from all core child services, community stakeholders and payers for the attributed population. These Partnership Councils, convened by the Lead Organization, are primarily responsible for devising strategies and processes to achieve the coordination of service types for the model.[73]
Focused beneficiary population	Medicaid and Children's Health Insurance Program (CHIP)-covered beneficiaries up to 21 years old in a defined geographic service area Awardees may also choose whether to include CHIP beneficiaries and Medicaid-covered pregnant women over the age of 21 in their attributed population.[74]
Intermediate entities between CMS and provider	N/A
Where are changes communicated?	InCK Website
Brief description of the financial arrangement	The state Medicaid agency will work with the Center for Medicare and Medicaid Innovation (CMMI), Center for Medicaid and CHIP Services (CMCS), and the Consortium for Medicaid and Children's Health (CMCHO) to develop and implement one or more child-focused alternative payment models (APMs) adherent to InCK Model requirements.

[73] See InCK Website.

[74] InCK Fact Sheet.

	Integrated Care for Kids (InCK) Model
	The state's APM(s) must meet the following requirements: 1. The APM(s) must include integrated care coordination, case management, and mobile crisis response services using the appropriate Medicaid and/or CHIP authorities to pay for these services with Medicaid and CHIP funds. 2. The APM(s) must utilize a clear method of patient attribution with a clear process for communicating patient attribution to providers. Ideally, the APM would use prospective patient attribution when feasible. 3. Downside financial risk sharing is not required, however, states that include a risk sharing element in an APM may not begin to utilize downside risk until model year 5. 4. The APM must conform to one of the following approaches: a. Fee-For-Service (FFS). States may design APMs that build on existing FFS architecture by providing mechanisms that connect payment to health care service quality and efficiency. Payments are based on performance against a cost target (and potentially, 28 utilization), and structured to encourage providers to deliver effective and efficient care through quality targets. Although cost (and/or occasionally utilization) performance is the distinguishing component of this payment arrangement, payments hold providers accountable for a wider range of activities and outcomes. Participating providers are paid on a FFS basis with retrospective reconciliation of the FFS payments (i.e. costs incurred) against the benchmark, or target, for the total cost of care during the period of performance. b. Population-Based Payment. Population-based payments compensate providers for caring for a defined patient population over a fixed period of time. States may design APMs that provide prospective, population-based payments for case management and care coordination services and encourage providers to deliver well-coordinated, high-quality, person-centered care. Population based payments must incorporate measures of appropriate care that serve as additional safeguards against incentives that limit necessary care; these payments must incentivize health and wellness throughout the care continuum by providing a single predominantly prospective payment that reflects the total cost of care for: (1) a broad array of pediatric services; (2) treating a primary (typically chronic)

	Integrated Care for Kids (InCK) Model
	condition; (3) a more limited set of specialty services (e.g., primary care or behavioral health); or (4) comprehensive pediatric care for the entire attributed population. States may design their APM(s) to target a subset of the population. For example, a state may design an APM such that a Service Integration Level (SIL) 1 attributed beneficiary is not covered under the APM unless they enter SILs 2 or 3.[75]
Shared losses?	Downside financial risk sharing is not required. States that include a risk sharing element in an APM may not begin to utilize downside risk until model year 5.[76]
Attribution terms	Each award recipient (AR) submits a retrospective attribution file (RAF) noting the number of individuals in the InCK Model population.[77] Population Attribution and Stratification[78] Level 1 – Medicaid/CHIP Beneficiaries, aged 0-21 Level 2 – Multiple sector needs with functional impairment Level 3 – At risk for out of home placement
Costs considered	Funding may only be used to support model planning and implementation activities, not to deliver services to beneficiaries. Examples of allowable expenses for model funding include staff time for training, infrastructure costs for data sharing, service integration process planning, and preparation for implementation.[79]
Permitted repayment mechanisms	N/A

[75] NOFO pages 27-28.

[76] NOFO page 27.

[77] InCK Model Evaluation – Report 1.

[78] InCK Overview slides – see slide 18.

[79] Fact Sheet page 5.

	Integrated Care for Kids (InCK) Model
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	None.
Events requiring CMS notice	Submission is required for all applicants, in writing, to the awarding agency and to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award.[80]
CMS events of termination	CMS may consider for corrective action, funding restrictions, or termination any Awardee that does not meet the model requirements outlined in the cooperative agreement Notice of Award, Terms and Conditions, or other federal award documentation.[81]
Fraud and abuse flexibilities?	The Secretary is not issuing any waivers of federal fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act or of any other Medicare or Medicaid laws as part of this Notice of Funding Opportunity[82]
Data Sharing	Lead Organizations will oversee the development and implementation of information technology to facilitate coordinated delivery of services, including 1) needs assessments, 2) eligibility determinations and stratification, 3) enrollment in services and programs, and 4) reduced duplication of similar services, assessments, and enrollment forms for each child. The purpose of this program requirement is to 1) improve information sharing among a range of providers to bring a complete picture of the child's health to their care team, 2) provide an integrated experience of care for the child and primary caregivers, and 3) reduce families' burden to navigate differing procedures and processes for the various organizations and programs that provide the Core Child Services (CCSs) and reduce their churn in and out of these programs. Applicants must include how their strategies achieve a streamlined experience for families while navigating privacy laws and regulations, the constraints of information exchange systems, and insufficient knowledge and coordination on the part of providers and other staff of the involved

[80] NOFO page 43.

[81] NOFO page 57.

[82] NOFO page 32.

	Integrated Care for Kids (InCK) Model
	programs. Examples of strategies include but are not limited to use of consumer/parent/caregiver online portals, custom built or existing data systems used by involved programs, including registries or health information exchanges, and cloud-based integrated record systems with user roles protecting privacy and controlling providers' ability to see and edit a child's record. Applicants must include a description of how their strategies achieve a streamlined experience for families while navigating privacy laws and regulations, addressing constraints of varied information exchange systems, and other known or potential impediments to data sharing, including insufficient knowledge and coordination on the part of providers and other staff of the involved programs. Examples of strategies include, but are not limited to, custom-built data systems that integrate existing data 26 systems used by involved programs, and cloud-based integrated record systems with user roles protecting privacy and controlling providers' ability to see and edit child's record. Possible strategies also include, but are not limited to,: a comprehensive enrollment process in which primary caregivers update information periodically and are enrolled in the appropriate programs simultaneously rather than separately; family-friendly access to services in which eligible siblings are enrolled simultaneously; periodic review of a family's enrollment profile to determine the appropriateness of enrollment in certain programs, and incorporate a mechanism for individual program disenrollment. Applicants should include a brief description of their intended approach to standardizing common data elements and supporting interoperability across state-level systems. Please refer to the Office of the National Coordinator's Interoperability Standards Advisory to review standards which might be appropriate (https://www.healthit.gov/isa/) . Consideration will be given to applicants who intend to develop or utilize reusable systems which support scalability and sustainability.[83] Data sharing across providers and beneficiaries and their caregivers to support SIL stratification; service integration and care coordination; and InCK Model program monitoring, auditing, and evaluation activities.[84] All award recipients have access to Medicaid data through their partnership with SMAs. State Medicaid data contains information for all award recipients' attributed populations and serves as the primary administrative

[83] NOFO page 25-26.

[84] InCK Report 2.

	Integrated Care for Kids (InCK) Model
	data source Award recipients use diagnosis, procedure, and service codes found in claims and encounter data to assess needs across CCS domains.[85] As part of the application process, CMS required ARs to certify that they would provide data to both CMS and its contractors for program monitoring, auditing, and evaluation purposes. ARs would provide data for the following domains: clinical care (depression screening), nonclinical care (food and housing), and CCS (including child welfare, foster care, and cash assistance). CMS also required that ARs would provide data in these domains for both the InCK Model and comparison populations and SIL screening data for 80 percent of the InCK Model population.[86] ARs invested considerable resources to establish Data Use Agreements (DUAs) to support information and data sharing for the purposes of reporting on model performance measures, SIL stratification, and care coordination. Almost all ARs were still working to successfully execute all required information sharing agreements at the end of the pre-implementation period.[87]
Data Sharing Limitations	As described in Evaluation Report 1, award recipients faced barriers in their attempts to access these data, such as the inability to develop data use agreements with other agencies or obtain individual-level rather than aggregated data.[88]
Affiliated or Companion Programs	The Maternal Opioid Misuse (MOM) Model is a Center for Medicare and Medicaid Innovation (Innovation Center) model designed to improve care delivery for vulnerable Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, particularly those affected by the nation's opioid crisis, while improving quality of care and reducing spending.[89]

[85] InCK Report 2 page 34.

[86] InCK – Report 1 page 39.

[87] InCK – Report 1 page 24.

[88] InCK – Report 2 page 40.

[89] InCK Press Release – Comparing InCK and MOM Models.

	Maternal Opioid Misuse (MOM) Model
Official or alternate names (if applicable)	Maternal Opioid Misuse (MOM) Model
Common acronym	MOM Model
Objective	
Relevant statutory and regulatory provisions	Section 1115A of the Social Security Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/maternal-opioid-misuse-model
Start date	January 1, 2020
End date	December 31, 2024
Performance Year	CY
Core documents setting out model terms	MOM Model Notice of Funding Opportunity (no longer available; unofficial site: MOM NOFO Final 2019 0206_v2.pdf (govtribe.com)) https://www.cms.gov/priorities/innovation/innovation-models/maternal-opioid-misuse-model Cooperative Agreement (unable to locate)
Accepting new applications?	No
Eligible parties	States Medicaid agencies; care-delivery partners vary by state, but include hospital systems, Medicaid managed care plans (MCPs), and other entities
Focused beneficiary population	Pregnant Medicaid and Children's Health Insurance Program (CHIP) beneficiaries with opioid use disorder (OUD) who have elected to participate, during the prenatal, peripartum (i.e., surrounding labor and delivery), and postpartum periods.

	Maternal Opioid Misuse (MOM) Model
Intermediate entities between CMS and provider	States
Where are changes communicated?	Website: Maternal Opioid Misuse (MOM) Model | CMS
Brief description of the financial arrangement	Transition Funding will be unrestricted on a quarterly basis, i.e., made available to each awardee that conducts the following activities, as demonstrated in quarterly reports to CMS: • Complete intake, assessment, and creation of a treatment plan, which can be funded only one time per pregnancy per beneficiary; • Provide care-delivery activities (coordination, engagement, and referral) to enrolled beneficiaries, which can be funded for up to 12 months per beneficiary during the course of the Transition Period; and • Conduct substantial outreach to enrolled beneficiaries who are disengaged from care; i.e., beneficiaries who have not received a physical or behavioral healthcare service in a given calendar month. Substantial outreach can be funded for up to two consecutive months per beneficiary. Substantial outreach will be funded at a lower amount per beneficiary than actual provision of coordination, engagement, and referrals. The total funding available during the Full Implementation Period will be up to $37.2 million across up to 12 awardees. Funding during the Full Implementation Period (Years 3, 4, and 5) will be made up of a combination of Implementation Funding and Milestone Funding. During the Full Implementation Period (Years 3, 4, and 5), the annual available amount will include $600,000 (for Year 3 only) and $500,000 (for each of Years Four and Five) in Implementation Funding; plus an additional potential $1,500,000 of Milestone Funding (for Years 3, 4, and 5, collectively). Milestone Funding will be restricted and will be awarded only if the awardee demonstrates satisfactory performance on quality measures (refer to Section F., Reporting).
Shared losses?	Unclear

	Maternal Opioid Misuse (MOM) Model
Attribution terms	Unclear
Costs considered	Total cost of care
Permitted repayment mechanisms	Unclear
CMS recovery mechanisms for shared losses	Unclear
Public disclosure obligations?	All information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award.
Events requiring CMS notice	Unclear
CMS events of termination	Unclear
Fraud and abuse flexibilities?	Beginning July 1, 2021, the anti-kickback statute safe harbor for CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)(2)) is available to protect MOM Beneficiary Incentives furnished in accordance with a CMS-approved Incentive Implementation Plan, provided that such MOM Beneficiary Incentives satisfy all safe harbor requirements set forth at 42 CFR § 1001.952(ii)(2) and the requirements of Section 29(c) of the Program Terms and Conditions.
Data Sharing	Quarterly and annual progress-reporting requirements and data submission for performance milestones
Data Sharing Limitations	Unclear

	States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Official or alternate names (if applicable)	States Advancing All-Payer Health Equity Approaches and Development Model
Common acronym	"States Advancing AHEAD" or "AHEAD" Model
Objective	In this model, CMS aims to collaborate with states to slow health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes by increasing investment in primary care, providing financial stability for hospitals, and supporting beneficiary connection to community resources.
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act.
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/ahead
Start date	The Pre-Implementation Period for Cohorts 1 and 2 will begin on July 1, 2024. Cohort 1 will begin the Model Implementation Period on January 1, 2026, and Cohort 2 will begin on January 1, 2027. The Pre-Implementation Period for Cohort 3 will begin on January 1, 2025, with the Model Implementation Period beginning on January 1, 2027.
End date	December 31, 2034
Performance Year	CY
Core documents setting out model terms	The Notice of Funding Opportunities (NOFO) for Model includes eligibility requirements and additional model detail and is available at https://www.grants.gov/search-results-detail/349644. The CMS webpage for the AHEAD Model contains FAQs, Fact Sheet, Webinar Slides and Transcripts.
Accepting new applications?	Yes. Cohorts 1 and 2 applications were due Monday, March 18, 2024 at 3:00 p.m. EST.

	States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
	For Cohort 3, the application period opens on June 12, 2024 and are due Monday, August 12, 2024 at 3:00 p.m. EST.
Eligible parties	State Medicaid agencies, state public health agencies, and other state agencies may apply to participate in AHEAD on behalf of their states if they have at least 10,000 Medicare fee-for-service (FFS) beneficiaries enrolled in Medicare Parts A and B residing in the state or selected sub-state region.
Focused beneficiary population	Beneficiaries in the states selected for participation.
Intermediate entities between CMS and provider	States will be required to establish a model governance structure to guide implementation of the model. Through this structure, states will convene individuals and organizations with a wide range of perspectives to inform model activities and build partnerships between the state, providers, payers, and the community to support model goals.
Where are changes communicated?	To be determined. Currently, information is posted to the AHEAD Model webpage.
Brief description of the financial arrangement	AHEAD is a voluntary Total Cost of Care (TCOC) initiative focused on primary care with multi-payer (including Medicare, Medicaid, and commercial) alignment among the participating state agencies and their provider communities. CMS will provide cooperative agreement funding for up to $12 million dollars (for up to six years) to eight applicants or "award recipients." AHEAD will use hospital global budgets and a primary care program (Primary Care AHEAD) to assist states in achieving higher quality care delivery, increasing investment in primary care, and supporting the delivery of advanced primary care - all while controlling overall growth in health care costs. Each participating state will be assessed and responsible for state-specific Medicare FFS and all-payer cost growth and primary care investment targets.
Shared losses?	Cost sharing is not applicable for this program.

	States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Attribution terms	For the Enhanced Primary Care Payment, the NOFO includes a preliminary indication of the attribution model where beneficiaries are attributed to Participating Primary Care Practices prior to the start of each quarter in a PY.
Costs considered	Total Cost of Care. Payment adjustments will be made to AHEAD-Specific Medicare FFS Hospital Global Budgets to reflect data such as TCOC Performance Adjustment, Effectiveness Adjustment, Quality Adjustments and Clinical and Social Adjustment. Many of these will be phased in over time and implementation will be delayed for CAHs.
Permitted repayment mechanisms	Not addressed at this time.
CMS recovery mechanisms for shared losses	None
Public disclosure obligations?	CMS encourages states to make their state-designed Medicare FFS hospital global budget methodologies publicly available to foster transparency and accountability.
Events requiring CMS notice	Not addressed at this time.
CMS events of termination	The NOFO notes that CMS may terminate an award for material noncompliance, which includes, but is not limited to, violation of the terms and conditions of the award; failure to perform award activities in a satisfactory manner; improper management or use of award funds; or fraud, waste, abuse, mismanagement, or criminal activity. CMS may terminate an award if a recipient does not meet defined milestones within the indicated timeframe. At any time in the award cycle, recipients could receive decreased funding, or their award could be terminated in accordance with 45 C.F.R. § 75.372.
Fraud and abuse flexibilities?	No dedicated waivers at this time.

	States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
Data Sharing	Participant Hospitals and participating Primary Care Practices ("Participant Primary Care Practices") will be required to collect and report standardized self-reported patient demographic data to CMS. Each recipient will be required to submit quarterly progress reports, annual progress reports, and a final progress report.
Data Sharing Limitations	Not addressed at this time.

	Transforming Maternal Health (TMaH) Model
Official or alternate names (if applicable)	Transforming Maternal Health (TMaH) Model
Common acronym	TMaH Model
Objective	The TMaH Model is designed to focus exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP).
Relevant statutory and regulatory provisions	Section 3021 of the Affordable Care Act
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model
Start date	The model was announced on December 15, 2023. The Notice of Funding Opportunity (NOFO) for state Medicaid agencies will be released in Spring 2024. Applications will be due in Summer 2024. The pre-implementation period is from January 2025 – December 2027. The implementation period is January 2028 – December 2034.
End date	The program is anticipated to run for 10 years, December 2034.
Performance Year	CY
Core documents setting out model terms	The Notice of Funding Opportunities (NOFO) is scheduled to be published in the spring 2024. Currently, the CMS webpage for TMaH contains information about the model with a Fact Sheet, Technical Assistance Fact Sheet, Payment Design Fact Sheet, Press Release, FAQ document and a MHaH Model Overview Webinar.
Accepting new applications?	Application period opens Spring 2024 and will be due in Summer 2024.
Eligible parties	State Medicaid agencies are eligible to apply. These SMAs will work with managed care plans (where applicable) and maternal health providers and supports to implement the TMaH Model.

	Transforming Maternal Health (TMaH) Model
Focused beneficiary population	Focused exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP).
Intermediate entities between CMS and provider	The State Medicaid Agencies (SMAs) will directly interact with CMS for this model. Participating Managed Care Entities (MCEs) in selected states will collaborate with SMAs to create and implement a plan to participate.
Where are changes communicated?	To be determined. Currently, information is posted to the TMaH Model webpage.
Brief description of the financial arrangement	TMaH's required and optional elements are structured around three key areas designed to improve maternal health care and birth outcomes while reducing health disparities in Medicaid and Children's Health Insurance Program (CHIP). 1- Access to care, infrastructure, and workforce capacity 2- Quality improvement and safety 3- Whole-person care delivery TMaH is designed to build a supportive structure for participating SMAs to develop an infrastructure that supports a whole-person approach to pregnancy, childbirth, and postpartum care. CMS will select up to 15 state Medicaid agencies (SMAs) to receive support and carry out TMaH elements by partnering with managed care plans, maternal health providers and supports, CBOs, hospitals, health systems, and additional agencies within the implementation region(s) or statewide. Each awarded SMA will be eligible for up to $17 million during the model's 10-year period.
Shared losses?	Cost sharing is not applicable for this program.
Attribution terms	Details have not been provided regarding attribution at this time.
Costs considered	The final details have not been made public at this time. The model will progress through several stages throughout its implementation.

	Transforming Maternal Health (TMaH) Model
	Initially, Technical Assistance will be provided to SMAs to develop and implement the TMaH Model. In subsequent years, Provider Infrastructure Payments and then upside-only Quality & Performance Incentive Payments will be made to providers in Model Year 4. In subsequent years SMAs will transition to a value-based model.
Permitted repayment mechanisms	Not addressed at this time.
CMS recovery mechanisms for shared losses	Not addressed at this time.
Public disclosure obligations?	Not addressed at this time.
Events requiring CMS notice	Not addressed at this time.
CMS events of termination	Not addressed at this time.
Fraud and abuse flexibilities?	Not addressed at this time.
Data Sharing	Not addressed at this time.
Data Sharing Limitations	Not addressed at this time.

Statutory Models

	Rural Community Hospital Demonstration
Official or alternate names (if applicable)	Rural Community Hospital Demonstration
Common acronym	RCHD
Objective	This model aims to test the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be Critical Access Hospitals.
Relevant statutory and regulatory provisions	Section 410A of the Medicare Modernization Act (MMA) of 2003; Sections 3123 and 10312 of the Affordable Care Act (ACT); Section 15003 of the 21st Century Cures Act (Cures Act).
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/rural-community-hospital
Start date	October 1, 2004
End date	December 31, 2026, unless another 5-year extension is authorized.
Performance Year	Corresponds with cost reporting year.
Core documents setting out model terms	RCHD Program New Solicitation of Participants
Accepting new applications?	No. CMS has conducted 4 solicitations for applications, with the most recent being 2017.
Eligible parties	A hospital must: • Be located in a rural area; • Have fewer than 51 acute care beds (not including beds in a psychiatric or rehabilitation unit that is a distinct part of the hospital), as reported on its most recent cost report;

	Rural Community Hospital Demonstration
	• Make available 24-hour emergency services; and • Not be eligible for designation or be designated as a Critical Access Hospital.
Focused beneficiary population	Medicare beneficiaries in rural areas receiving inpatient hospital services.
Intermediate entities between CMS and provider	None
Where are changes communicated?	CMS Innovation Model website
Brief description of the financial arrangement	Hospitals in the RCHD will receive payment for inpatient hospital services provided to Medicare beneficiaries in the following way: For discharges occurring in the first cost reporting period (base year) on or after the implementation of the extension, their reasonable costs of providing covered inpatient hospital services. For discharges occurring during subsequent cost reporting periods, the lesser of their reasonable costs or a target amount. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the Inpatient Prospective Payment System (IPPS) update factor. The target amount subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that cost reporting period. (https://www.cms.gov/priorities/innovation/files/x/rch-faqs.pdf)
Shared losses?	No
Attribution terms	N/A
Costs considered	Reasonable costs of care.

	Rural Community Hospital Demonstration
Permitted repayment mechanisms	N/A
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	Failing to meet the requirements in the authorizing legislation.
CMS events of termination	Failing to meet the requirements in the authorizing legislation. See https://www.cms.gov/priorities/innovation/files/x/rch-faqs.pdf.
Fraud and abuse flexibilities?	No
Data Sharing	Yearly report to Congress using de-identified data.
Data Sharing Limitations	N/A

	Value in Opioid Use Disorder Treatment Demonstration Program
Official or alternate names (if applicable)	Value in Treatment Demonstration
Objective	The goal of this model is to increase access of applicable beneficiaries to opioid use disorder treatment services, improve physical and mental health outcomes for such beneficiaries, and to the extent possible, reduce [Medicare program expenditures].
Common acronym	ViT Demonstration
Relevant statutory and regulatory provisions	Section 1866 F of the Social Security Act, which was added by Section 6042 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ("SUPPORT Act").
CMS website	https://www.cms.gov/priorities/innovation/innovation-models/value-in-treatment-demonstration
Start date	April 1, 2021
End date	December 31, 2024
Performance Year	CY (after Year 1). Year 1 began on the later of April 1, 2021 or the Effective Date (the date the Value in Treatment Participation Agreement was signed by the last party to sign it) and lasted through December 31, 2021.
Core documents setting out model terms	Value in Treatment Participation Agreement - https://omb.report/icr/202007-0938-012/doc/104483902 Value in Treatment Participation Agreement – Amendment to Section VI and Appendix B – 2022 Amendment 1 https://omb.report/icr/202305-0938-016/doc/132288100
Accepting new applications?	No.
Eligible parties	Entities and individuals enrolled in Medicare, who applied for and are selected to participate in the demonstration program under an application and selection process established by CMS, who establish an OUD (Opioid Use Disorder) care team and uses such team to furnish or arrange for OUD

	Value in Opioid Use Disorder Treatment Demonstration Program
	treatment services in the outpatient setting under the demonstration, and who are one of the following types of individuals or entities: • Physician • Group practice comprised of at least one physician • Hospital outpatient department • FQHC • RHC • Community mental health center • Clinic certified as a certified community behavioral health clinic pursuant to section 223 of the Protecting Access to Medicare Act of 2014 • Opioid treatment program (entity specified by the Secretary) • Critical Access Hospital (entity specified by the Secretary)
Focused beneficiary population	The following applicable beneficiaries and eligible participants are eligible to participate in the demonstration: • Is entitled to, or enrolled for, benefits under Medicare Part A and enrolled for benefits under Medicare Part B; • Is not enrolled in a Medicare Advantage plan under Medicare Part C; and • Has a current diagnosis for an opioid use disorder. Applicable beneficiaries include dually eligible individuals if the above criteria are also met.
Intermediate entities between CMS and provider	Participants must submit claims for the care management fee (CMF) under ViT to the Medicare Administrative Contractor (MAC) appropriate to the Participant using the ViT-specific G-code specified by CMS (ViT Code). No other billing or procedure codes may be included on the claim.
Where are changes communicated?	Posting to ViT website and/or through the Federal Register.

	Value in Opioid Use Disorder Treatment Demonstration Program
Brief description of the financial arrangement	ViT creates two new Medicare payments for participating providers and suppliers for OUD treatment services furnished to applicable beneficiaries participating in the demonstration program: 5. **A per beneficiary per month care management fee ("CMF")**, which the participant may use to "deliver additional services to applicable beneficiaries, including services not otherwise eligible for payment under [Title XVIII]"; and 6. **A performance-based incentive**, that will be payable based on the participant's performance with respect to criteria specified by CMS, which may include evidence-based medication-assisted treatment ("MAT"), as well as patient engagement and retention in treatment. Services furnished under ViT must be based on an applicable beneficiary's individualized OUD treatment plan, aligned with OUD treatment services defined in statute and with other services furnished to the beneficiary for purposes of treating his or her OUD, and have a reasonable expectation of improving or maintaining the health or overall function of applicable beneficiaries. CMS shall pay the CMF to the Participant in addition to any amount that may otherwise be made under Medicare, including: 1. Payment for existing care management codes in the Medicare Physician Fee Schedule, unless the Participant is an FQHC or RHC, in which case the Participant is prohibited from billing HCPCS codes G0511 (general care management) or G0512 (psychiatric collaborative care model) within a calendar quarter period of having billed the ViT Code for the same beneficiary; and 2. Bundled payments for opioid use disorder treatment services furnished by opioid treatment programs made pursuant to 42 C.F.R. § 410.67.
Shared losses?	No.
Attribution terms	N/A
Costs considered	Total cost of care, Medicare program expenditures on OUDs, costs of increased access to OUD treatment services.

	Value in Opioid Use Disorder Treatment Demonstration Program
Permitted repayment mechanisms	Under the ViT Participation Agreement, if CMS determines that a payment was made in error, CMS shall send the Participant a demand letter for the amount of such payment. The Participant shall pay any such amount within 30 Days of the date of the demand letter. If CMS does not receive payment of the full amount owed by the date specified in the demand letter, CMS may assess interest at the rate applicable to other Medicare debts pursuant to 42 C.F.R. §405.378 on any outstanding unpaid amounts. Interest will be calculated in 30-Day periods and assessed for each 30-Day period that payment is not made in full. If the Participant fails to pay CMS the full amount owed by the date specified in the demand letter, CMS will recoup monies owed from present and future Medicare payments otherwise owed to the Participant. If CMS is unable to recoup the full amount owed via Medicare payments, CMS will invoke all legal means to collect the debt, including referral of the remaining debt to the United States Department of Treasury, pursuant to 31 U.S.C. 3711(g).
CMS recovery mechanisms for shared losses	N/A
Public disclosure obligations?	No
Events requiring CMS notice	Any noncompliance or deficiencies that would result in the Participant losing eligibility to participate in ViT within 15 days of discovery; any administrative or other action that may the affect the Participant's Medicare enrollment status, or the Medicare enrollment status of a member of the Participant's OUD Care Team, within 30 days of the Participant's receipt of notice of such action. (Section III A – Value in Treatment Participation Agreement).
CMS events of termination	See Section XV of the Value in Treatment Participation Agreement.
Fraud and abuse flexibilities?	N/A
Data Sharing	See Section VII.B of the Value in Treatment Participation Agreement.
Data Sharing Limitations	Must omit individually identifiable data for each Participating Beneficiary who has not agreed for CMS to share his or her data with the Participant and for each Participating Beneficiary who has elected to terminate his or her

	Value in Opioid Use Disorder Treatment Demonstration Program
	consent for CMS to share his or her data with the Participant. The Participant shall not require an Applicable Beneficiary to agree to share his or her data with the Participant in order to participate in ViT and receive OUD Treatment Services from the Participant.

