United States Government Accountability Office

Report to Congressional Requesters

March 2018

CMS INNOVATION CENTER

Model Implementation and Center Performance

GAO-18-302

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Model Implementation and Center Performance

GAO Highlights

Highlights of GAO-18-302, a report to congressional requesters

Why GAO Did This Study

The Patient Protection and Affordable Care Act created the Innovation Center within CMS to test new approaches to health care delivery and payment—known as models—for use in Medicare, Medicaid, or CHIP. The Innovation Center became operational in November 2010. In 2012, GAO reported on the early implementation of the Innovation Center. GAO found that, during the first 16 months of operations, the Innovation Center focused on implementing 17 new models and developed preliminary plans for evaluating the effects of each model and for assessing the center's overall performance.

GAO was asked to update its previous work. In this report, GAO: (1) describes the status of payment and delivery models implemented and the resources used; (2) describes the center's use of model evaluations; and (3) examines the center's assessment of its own performance. GAO reviewed available documentation, such as model fact sheets and frequently asked questions, and evaluation reports for models that have been implemented. GAO reviewed obligation data and performance information for the time period for which complete data or information were available. GAO also interviewed officials from the Innovation Center and CMS's Office of the Actuary.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-18-302. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

As of March 1, 2018, the Center for Medicare and Medicaid Innovation (Innovation Center) had implemented 37 models that test new approaches for delivering and paying for health care with the goal of reducing spending and improving quality of care. These models varied based on several characteristics, including the program covered—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or some combination of the three—and the nature of provider participation—voluntary or mandatory. Going forward, the Innovation Center indicated that the center plans to continue focusing on the use of voluntary participation models and to develop models in new areas, including prescription drugs, Medicare Advantage, mental and behavioral health, and program integrity. Through fiscal year 2016, the Innovation Center obligated $5.6 billion of its $10 billion appropriation for fiscal years 2011 through 2019.

The Innovation Center has used evaluations of models (1) to inform the development of additional models, (2) to make changes to models as they are implemented, and (3) to recommend models for expansion. For example, Innovation Center officials noted that, for some instances where evaluations have shown reduced spending with maintained or improved quality of care, the center has developed new models that build upon the approaches of earlier models, but with adjustments intended to address reported limitations. In addition, the Innovation Center used evaluations to recommend two models to the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary for certification for expansion. According to CMS officials, a model evaluation and a certification for expansion differ in that a model evaluation assesses the impact of a delivery and payment approach for model participants only, while a certification for expansion assesses the future impact on program spending more broadly across all beneficiaries, payers, and providers who would be affected by the expanded model. As a result, the Office of the Actuary used the results of the evaluation and other information, such as Medicare claims data and published studies, to certify the expansion of both models.

To assess the center's overall performance, the Innovation Center established performance goals and related measures and reported meeting its targets for some goals in 2015, the latest year for which data were available (see table below).

Center for Medicare and Medicaid Innovation Reported Results for 2015 Performance Goals

Performance goal	Performance targets met
Reducing the growth of health care costs while promoting better health and healthcare quality through delivery system reform	Partially met
Identifying, testing, and improving payment and delivery models	Met
Accelerating the spread of successful practices and models	Partially met

Source: Center for Medicare & Medicaid Services. | GAO-18-302

Innovation Center officials told GAO that the center also recently developed a methodology to estimate a forecasted return on investment for its model portfolio. The center is in the early stages of refining the methodology and applying it broadly across its models.

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Abbreviations

ACO	Accountable Care Organization
APRN	Advanced Practice Registered Nurse
BPCI	Bundled Payments for Care Improvement
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CJR	Comprehensive Care for Joint Replacement
Diabetes Prevention Program	YMCA of the USA Diabetes Prevention Program
FQHC	Federally Qualified Health Center
HHS	Department of Health and Human Services
ICIP	Innovation Center Investment Proposal
OMB	Office of Management and Budget
Innovation Center	Center for Medicare and Medicaid Innovation
PPACA	Patient Protection and Affordable Care Act

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March 26, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Federal spending on health care in the United States—driven primarily by Medicare and Medicaid expenditures—is expected to reach over $1 trillion in 2018 and to continue increasing and exerting pressure on the federal budget.[1] At the same time, studies have found that higher levels of spending do not reliably lead to enhanced quality of care.[2] The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), has sought to both reduce spending and improve quality of care for beneficiaries enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) by testing new ways

[1]Medicare is the federal health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is a joint federal-state health care financing program for certain low-income individuals and medically needy individuals.

[2]See for example, Sirovich, Brenda E., Daniel J. Gottlieb, H. Gilbert Welch, and Elliott S. Fisher. "Regional Variations in Health Care Intensity and Physician Perceptions of Quality of Care." *Annals of Internal Medicine,* vol. 144, no. 9 (2006); Landrum, M. B., Meara, E. R., Chandra, A., Guadagnoli, E., & Keating, N. L. "Is Spending More Always Wasteful? The Appropriateness Of Care And Outcomes Among Colorectal Cancer Patients." *Health Affairs, vol.* 27, no. 1 (2008); Yasaitis, L., Fisher, E. S., Skinner, J. S., & Chandra, A. "Hospital Quality And Intensity Of Spending: Is There An Association?" *Health Affairs, vol. 28, no.4*, (2009); and Rothberg MB, Cohen J, Lindenauer P, Maselli J, Auerbach A. "Little Evidence Of Correlation Between Growth In Health Care Spending And Reduced Mortality." *Health Affairs*, vol. 29, no.8 (2010).

for delivering and paying for health care services.[3] To further such testing, the Patient Protection and Affordable Care Act (PPACA) established the Center for Medicare and Medicaid Innovation (Innovation Center) within CMS under section 1115A of the Social Security Act.[4]

In establishing the Innovation Center, the law provided CMS with additional authority when testing new health care delivery and payment approaches, known as models.[5] For example, CMS may expand the duration and scope of models tested by the Innovation Center through rulemaking instead of needing the enactment of legislation, which was required to expand the demonstrations that CMS frequently conducted in the past. In addition, the law provided a dedicated appropriation for testing models—$10 billion for the Innovation Center's activities for the period of fiscal years 2011 through 2019 and $10 billion per decade beginning in fiscal year 2020.

In November 2012, we reported on the early activities of the Innovation Center. We found that, during the first 16 months of operations, the Innovation Center focused on implementing 17 new models while assuming responsibility for 20 demonstrations that CMS began before the start of the center. We also reported that the Innovation Center developed preliminary plans for evaluating the effects of each model on spending and quality of care and assessing the center's overall performance.[6]

At the time of our 2012 report, however, it was too early to consider certain questions raised by members of Congress about Innovation

[3]CHIP is a federal-state program that provides health care coverage to children 18 years of age and younger living in low-income families whose incomes exceed the eligibility requirement for Medicaid.

[4]The Innovation Center was established by section 1115A of the Social Security Act, as added by section 3021 of PPACA. See Pub. L. No. 111-148, §§ 3021, 10306. 124 Stat. 119, 389, 939 (Mar. 23, 2010) (codified at 42 U.S.C. § 1315a).

[5]Historically, CMS's efforts to test new approaches to health care delivery and payment have been referred to as "demonstrations." In this report, we will use the term "models" when discussing approaches initiated by the Innovation Center, and "demonstrations" when discussing approaches that were initiated prior to the establishment of the center.

[6]We also found that the Innovation Center had initiated implementation of a process to review and eliminate unnecessary duplication in the contracts awarded in one of its models. We recommended completing the implementation expeditiously. Implementation was completed in August 2013. See GAO, *CMS Innovation Center: Early Implementation Efforts Suggest Need for Additional Actions to Help Ensure Coordination with Other CMS Offices*, GAO-13-12 (Washington, D.C.: November 15, 2012).

Center operations, including the use of its dedicated funding, the impact of the models tested, and the center's overall performance. Given the amount of time that has passed—the Innovation Center has been in operation for over 7 years—you asked us to update our previous work to provide information on the activities of the center and to report on any results of the testing. This report examines

1. the status of the Innovation Center's testing of models and the resources used for such activities;
2. the use of model evaluations; and
3. the Innovation Center's assessment of its performance.

To determine the status of model testing and the resources used by the Innovation Center for such activities, we reviewed Innovation Center documentation, including information on models the center was implementing or had announced, as well as web pages, model fact sheets, and frequently asked questions. We obtained and analyzed Innovation Center data on the amounts of the Innovation Center's appropriations obligated. We also interviewed and obtained written responses from Innovation Center officials. Our work focused on models tested and funded through appropriations under section 1115A of the Social Security Act, as enacted by PPACA, which established the center and provided its dedicated appropriations. In general, our work covered the period during which the Innovation Center first became operational (fiscal year 2011) through the most recent time period for which complete information was available. For the status of model testing, we considered information through March 1, 2018. For the resources used, we analyzed data on the amounts of the Innovation Center's appropriations obligated through fiscal year 2016. We assessed the reliability of the obligation data by comparing it to publicly reported amounts and discussing the data with center officials. We determined these data were sufficiently reliable for the purposes of our objectives.

To determine how the Innovation Center used evaluations of models, we interviewed officials from the center, CMS's Office of the Actuary, evaluation contractors, and subject matter experts to discuss the use of

evaluations, in general, as well as for five selected models specifically.[7] We selected models based on a nonprobability sample that included both Medicare and Medicaid models; ongoing and completed models; models that fell under the responsibility of different Innovation Center staffing groups; and one model evaluated for expansion. Because we used a nonprobability sample, our results are not generalizable beyond the models we reviewed; however, they provide insight into how CMS uses the evaluations of its models. We also analyzed publicly available evaluation reports and other model documentation publicly available from the Innovation Center and the Office of the Actuary.

To describe the Innovation Center's assessment of its performance, we reviewed information reported on the center's targeted and actual performance available in CMS's Congressional Budget Justifications for fiscal years 2012 through 2018. Information on the center's targets was available for performance years 2014 through 2018. Complete information on the center's actual performance was available for 2015. Partial information was available for 2014 and 2016, and no information was available for 2017 and 2018. We also interviewed Innovation Center officials regarding the assessment of performance.

We conducted this performance audit from February 2017 to March 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7]The five models selected were the Bundled Payments for Care Improvement Model 2; the Comprehensive Primary Care Initiative; the Health Care Innovation Awards; the Pioneer Accountable Care Organization model; and the Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care model.

Background

Requirements for Innovation Center Models Implemented under Section 1115A

Section 1115A establishes certain requirements for the Innovation Center that relate to the selection of models, use of resources, and evaluation of models. These requirements include:

- consulting with representatives of relevant federal agencies, as well as clinical and analytical experts in medicine or health care management, when carrying out its duties as described in the law;
- ensuring models address deficits in care that have led to poor clinical outcomes or potentially avoidable spending;
- making no less than $25 million of the Innovation Center's dedicated funding available for model design, implementation, and evaluation each fiscal year starting in 2011;
- evaluating each model to analyze its effects on spending and quality of care, and making these evaluations public; and
- modifying or terminating a model any time after testing and evaluation has begun unless it determines that the model either improves quality of care without increasing spending levels, reduces spending without reducing quality, or both.

Under section 1115A, certain requirements applicable to previous CMS demonstrations are inapplicable to models tested under the Innovation Center. For example, while prior demonstrations generally required congressional approval in order to be expanded, section 1115A allows CMS to expand Innovation Center models—including on a nationwide basis—through the rulemaking process if the following conditions are met: (1) the agency determines that the expansion is expected to reduce spending without reducing the quality of care, or improve quality without increasing spending; (2) CMS's Office of the Actuary certifies that the expansion will reduce or not increase net program spending; and (3) the agency determines that the expansion would not deny or limit coverage or benefits for beneficiaries.[8] In addition, certain requirements previously cited by the Medicare Payment Advisory Commission as administrative

[8]In addition, the law provides that demonstrations conducted under 42 U.S.C. § 1395cc-3, Medicare's Health Care Quality Demonstration Program, may also be expanded under the same conditions. 42 U.S.C. § 1315a(c).

barriers to the timely completion of demonstrations are inapplicable.[9] Specifically, section 1115A provides the following:

- HHS cannot require that an Innovation Center model initially be budget neutral—that is, designed so that estimated federal expenditures under the model are expected to be no more than they would have been without the model—prior to approving a model for testing.
- Certain CMS actions in testing and expanding Innovation Center models cannot be subject to administrative or judicial review.
- The Paperwork Reduction Act—which generally requires agencies to submit all proposed information collection efforts to the Office of Management and Budget (OMB) for approval and provide a 60-day period for public comment when they want to collect data on 10 or more individuals—does not apply to Innovation Center models.[10]

Innovation Center Staffing and Organization

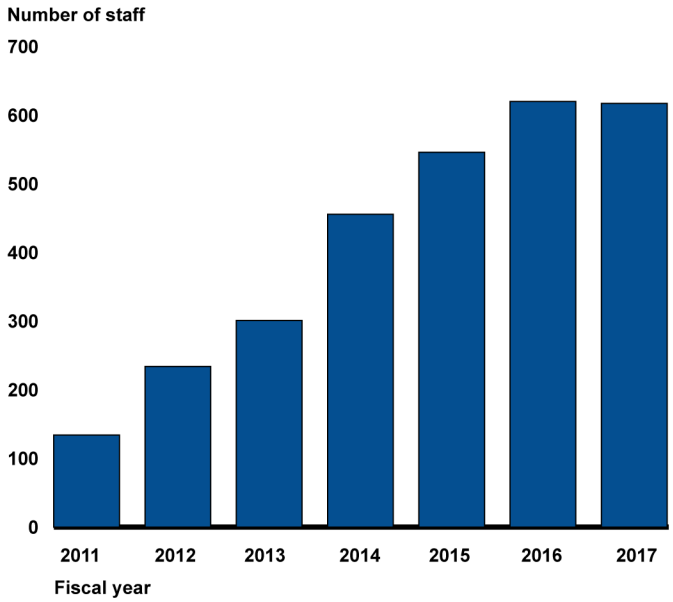
The Innovation Center uses a combination of staff and contractors to test models. Since the center became operational in November 2010, the number of staff increased steadily through the end of fiscal year 2016.[11] (See fig. 1.) As of September 30, 2017, there were 617 staff—a slight decrease in the number of staff from the end of the prior fiscal year. Officials indicated that, in the future, changes in the model portfolio may require additional staff to manage and support model development and implementation. However, officials do not anticipate needing to increase staffing levels at the same pace as they did between fiscal years 2011 and 2016. Additionally, the Innovation Center uses third-party contactors to perform functions related to the implementation of models and to perform evaluations of the changes in the quality of care furnished and program spending under a model.

[9]See Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare*, (Washington, D.C.: 2010).

[10]44 U.S.C. §§ 3501-3520. OMB assists the President in overseeing the preparation of the federal budget and in supervising its administration in executive branch agencies. OMB also oversees and coordinates the administration's procurement, financial management, information, and regulatory policies.

[11]We previously reported that, as of March 31, 2012, the Innovation had 184 staff. See GAO-13-12. Staff are primarily funded through appropriations under section 1115A of the Social Security Act.

Figure 1: Center for Medicare and Medicaid Innovation Staffing Levels, Fiscal Years 2011-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

The Innovation Center has organized its 617 staff members primarily into eight groups and the Office of the Director. Four of the eight groups are responsible for coordinating the development and implementation of models.[12] Staff in these four groups primarily lead efforts in developing model designs and obtaining approval for their models from CMS and HHS. Once a model is approved, staff coordinate the remaining implementation steps, including soliciting and selecting participants and overseeing the model during the testing and evaluation period. The other four groups perform key functions that support model development and implementation, such as reviewing ideas submitted for consideration as possible models, overseeing the evaluations of models, providing feedback to model participants about their performance, disseminating

[12]We previously reported that as of March 31, 2012, the groups that implement models included the Medicare Demonstration Group, which was responsible for implementing models required by authorities other than section 1115A of the Social Security Act and CMS demonstrations that existed prior to the establishment of the Innovation Center. See GAO-13-12. According to Innovation Center officials, the responsibility for these models and demonstrations was reassigned to other model groups.

lessons learned across models, and monitoring budget resources.[13] The Office of the Director, in general, has oversight responsibilities for the models led by these groups. Table 1 provides information on the staffing groups within the Innovation Center.

Table 1: Description of Center for Medicare and Medicaid Innovation (Innovation Center) Staffing Groups

Group	Purpose
Groups that coordinate model development and implementation	
Patient Care Models Group	Develop and coordinate the implementation of models designed to improve care for clinical groups of patients, such as patients needing heart bypass surgery
Prevention and Population Health Group	Develop and coordinate the implementation of models designed to improve the health of different populations of beneficiaries.
Seamless Care Models Group	Develop and coordinate the implementation of models designed to improve coordination of care for a general patient population across care settings.
State Innovations Group	Develop and coordinate the implementation of models designed to use states' policy and regulatory levers to accelerate health care transformation in multi-payer environments.
Groups that support model development and implementation	
Business Services Group	Provide administrative support to the Innovation Center in areas such as budgeting, contracting, project management, information technology support and maintenance.
Learning and Diffusion Group	Facilitate learning within models and disseminate the lessons learned across models so that participants can benefit from the experiences of other models.
Policy and Programs Group	Manage ideas for consideration as possible models and seek to ensure a balanced portfolio of different types of models and manage stakeholder engagement for the Innovation Center.[a]
Research and Rapid Cycle Evaluation Group	Coordinate the evaluation of models and provide ongoing feedback to participants.

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

Notes: We previously reported that the groups under which the Innovation Center organized staff included the Medicare Demonstration Group and the Stakeholder Engagement Group. See GAO-13-12. The Medicare Demonstration Group, which previously was responsible for implementing

[13]We previously reported that as of March 31, 2012, the groups that support model implementation included the Stakeholder Engagement Group, which conducted outreach to potential stakeholders, to gain support and solicit ideas for innovative models, and to potential participants—such as physician groups and hospitals—to inform them of the opportunity to participate in models. See GAO-13-12. According to Innovation Center officials, this group was incorporated into the Policy and Programs Group in 2016. The Policy and Programs Group is also responsible for developing and implementing a portion of the Quality Payment Program—a new payment framework for Medicare intended to reward providers for efficient, high-quality care, instead of a higher volume of services. This program includes two tracks: (1) the Merit-based Incentive Payment System and (2) Advanced Alternative Payment Models.

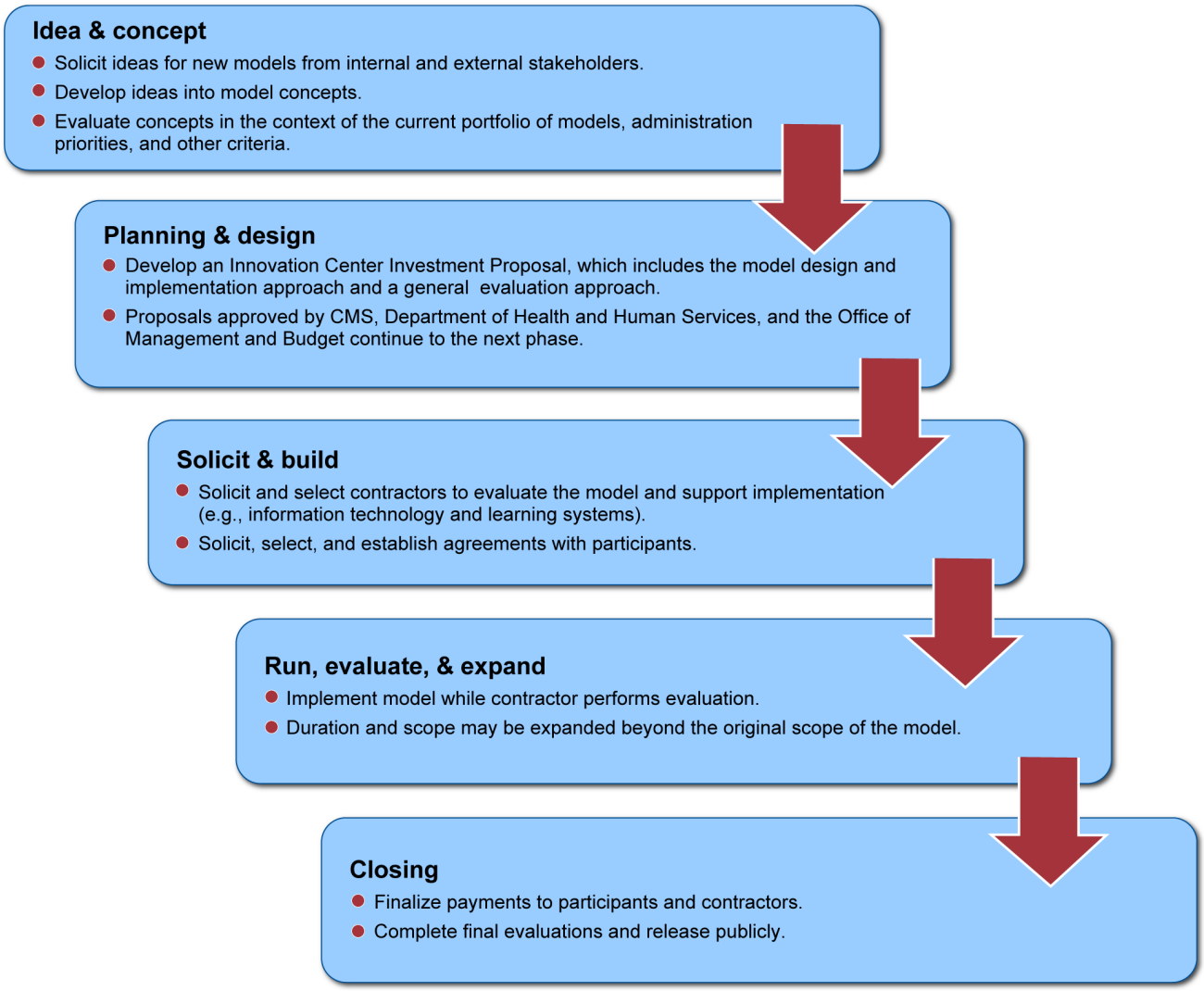
certain models and demonstrations, was eliminated, and its responsibilities were reassigned to other groups. The Stakeholder Engagement Group was incorporated into the Policy and Programs Group.

[a]The Policy and Programs Group is also responsible for developing and implementing a portion of the Quality Payment Program—a new payment framework for Medicare intended to reward health care providers for efficient, high-quality care, instead of a higher volume of services. This program includes two tracks: (1) the Merit-based Incentive Payment System and (2) Advanced Alternative Payment Models.

Innovation Center Process for Model Development and Implementation

The Innovation Center has developed internal agency guidance that outlines a general process used by the four model groups for developing and implementing models. (See fig. 2.) Appendix I provides additional information about the general process for implementing models.

Figure 2: Center for Medicare and Medicaid Innovation (Innovation Center) Process for Model Development and Implementation



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-18-302

Innovation Center Categories for Models

The Innovation Center has organized its models into seven categories based on delivery and payment approaches tested and program beneficiaries covered. The seven categories are as follows:

- **Accountable Care.** This category includes models built around accountable care organizations (ACOs)—groups of coordinated health care providers who are held responsible for the care of a group of patients. The models are designed to encourage ACOs to invest in infrastructure and care processes for improving coordination, efficiency, and quality of care for Medicare beneficiaries.
- **Episode-based payment initiatives.** This category includes models in which providers are held accountable for the Medicare spending and quality of care received by beneficiaries during an "episode of care," which begins with a health care event (e.g., hospitalization) and continues for a limited time after.
- **Initiatives Focused on Medicare-Medicaid Beneficiaries.** This category includes models focused on better serving individuals eligible for both Medicaid and Medicare in a cost-effective manner.
- **Initiatives Focused on Medicaid and CHIP Populations.** This category includes models administered by participating states to lower spending and improve quality of care for Medicaid and CHIP beneficiaries.
- **Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models.** This category includes models where the Innovation Center works with participants to test state-based and locally developed models, covering Medicare beneficiaries, Medicaid beneficiaries, or both.
- **Initiatives to Speed the Adoption of Best Practices.** This category includes models in which the Innovation Center collaborates with health care providers, federal agencies, and other stakeholders to test ways of disseminating evidence-based best practices that improve Medicare spending and quality of care for beneficiaries.
- **Primary Care Transformation.** This category includes models that use advanced primary care practices—also called "medical homes"—to emphasize prevention, health information technology, care coordination, and shared decision-making among patients and their providers.

For certain categories, the Innovation Center assigns primary responsibility for developing and implementing models to a single model group; for some other categories, the responsibility is shared across different groups. For example, the center assigned responsibility for models in the ACO and the Primary Care Transformation categories to the Seamless Care Model Group, whereas the responsibility for models in the Initiatives to Accelerate the Development and Testing of New

Payment and Service Delivery Models categories were assigned across all four model groups. Appendix II provides a summary of the number of models organized under each category and a description of each model.

The Innovation Center Implemented 37 Models That Test Varying Delivery and Payment Approaches, and Obligated over $5.6 Billion

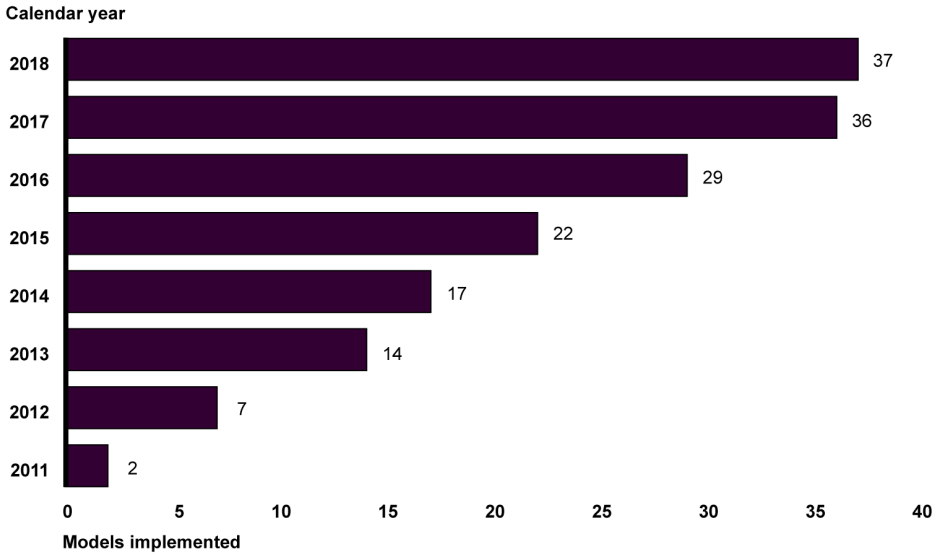
The Innovation Center Implemented 37 Models and Announced an Additional 2; Models Varied by Delivery and Payment Approaches Tested, Beneficiaries Covered, and Other Characteristics

As of March 1, 2018, the Innovation Center had implemented 37 models under section 1115A of the Social Security Act.[14] (See fig. 3.) Of those 37 models, the testing period has concluded for 10 of them.[15] In addition, the Innovation Center has announced two models to begin testing in 2018.

[14]In addition to these models, we previously reported that the Innovation Center was responsible for implementing 6 models required by other provisions of PPACA, as well as 20 CMS demonstrations that existed prior to the establishment of the Innovation Center. See GAO-13-12. The testing periods for 4 of the 6 models required by other provisions of PPACA and 19 of 20 demonstrations have ended. See appendix III for more information on the 6 models required by other provisions of PPACA.

[15]These ten models are the Advance Payment ACO Model, the Bundled Payments for Care Improvement Model 1 (Retrospective Acute Care Hospital Stay Only), the Comprehensive Primary Care Initiative, the Federally Qualified Health Center Advanced Primary Care Practice Demonstration, the Health Care Innovation Awards Round 1, the Health Care Innovation Awards Round 2, the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents: Phase One, Pioneer ACO, Partnership for Patients, and State Innovation Models Initiative: Round One.

Figure 3: Cumulative Number of Models Implemented by the Center for Medicare and Medicaid Innovation, 2011-2018



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

Note: Models were implemented between January 1, 2011 and March 1, 2018. Of the 37 models, the testing period ended in calendar year 2017 or before for 10 models.

Innovation Center models varied based on several characteristics, including delivery and payment approaches tested and program(s) covered. Delivery and payment approaches varied across all implemented and announced models—even models organized by the Innovation Center under the same model category. For example, the six models that tested an episode-based payment approach varied in terms of how episodes were defined, including the clinical and surgical episodes to which models applied. In addition, some models included multiple approaches for achieving changes in health care delivery or payment. Models also differed in terms of the programs covered, with 22 models covering Medicare only, 9 models covering Medicare and Medicaid, one model covering Medicaid and CHIP, and 7 models covering all three programs. Other characteristics by which models varied include the nature of model participation for providers (voluntary or mandatory) and the source of innovation (i.e., federal, state, or local initiatives). See table 2 for a breakdown of models across selected characteristics. Appendix II provides a full description of all models implemented and announced by the Innovation Center.

Table 2: Selected Characteristics of the Center for Medicare and Medicaid Innovation Implemented and Announced Models, as of March 1, 2018

Model characteristic	Description of models implemented or announced
Program covered	• Twenty-two models covered Medicare only—one of which specifically focused on Medicare Advantage. • Nine models covered Medicare and Medicaid. • One model covered Medicaid and the Children's Health Insurance Program (CHIP). • Seven models covered Medicare, Medicaid, and CHIP.
Nature of provider participation	• Thirty-seven models had voluntary participation. • One model had a combination of mandatory and voluntary participation.[a] • One model had mandatory participation.
Innovation source	• Thirty-one models tested a delivery and payment approach designed by the Innovation Center. • Six models tested approaches designed and implemented by or in partnership with states. • Two models tested a variety of delivery and payment approaches designed and implemented by individual cooperative agreement awardees.
Other	• Eight models were considered advanced alternative payment models—payment approaches that gave incentive payments to provide high-quality and cost-efficient care allowing providers to earn more for taking on some risk related to patient outcomes. • Two models tested delivery and payment approaches designed to prevent the development of specific diseases in at-risk beneficiaries. • Two models focused on specialty care services— orthopedic surgeries and chemotherapy—to test payment arrangements in which hospitals received additional payments or made recoupment payments if total spending for Medicare services provided during an "episode of care" was over or under a predetermined target price.

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

[a]On December 1, 2017, a final rule was issued making provider participation in select geographic areas voluntary for this model, effective January 1, 2018. Prior to the final rule, provider participation was mandatory in all geographic areas included in this model.

In September 2017, the Innovation Center provided some insight into its future plans when it issued an informal "request for information" that identified guiding principles under which models will be designed going forward, described focus areas for new models, and requested feedback from stakeholders. One of the guiding principles focused on voluntary models—a principle consistent with a final rule published in December 2017 canceling four mandatory participation models in development and making participation in a fifth mandatory model voluntary for some

geographic areas.[16] Other guiding principles included promoting competition based on quality, outcomes, and costs; empowering beneficiaries, their families, and caregivers to take ownership of their health; and using data-driven insights to ensure cost-effective care that also leads to improvements in beneficiary outcomes. In addition, the Innovation Center indicated the following focus areas for new model development: additional advanced alternative payment models; consumer-directed care and market-based innovation models; physician specialty models; prescription drug models; Medicare Advantage innovation models; state-based and local innovation, including Medicaid-focused models; mental and behavioral health models; and program integrity.

The Innovation Center Obligated over 55 Percent of Its Initial Multiyear Appropriation through Fiscal Year 2016

According to Innovation Center documentation, through September 30, 2016, the center obligated over $5.6 billion of the $10 billion appropriated for fiscal years 2011 through 2019 under section 1115A of the Social Security Act.[17] The obligated amounts for individual models during this period ranged from $8.4 million to over $967 million, and varied based on model scope and design.[18] For example, a model where the Innovation Center used its waiver authority to provide additional flexibility to participants (rather than additional funding) required only $8.4 million in obligations for the evaluation of the model and implementation activities. In contrast, a model where the Innovation Center awarded funding to a

[16]See 82 Fed. Reg. 57,066 (Dec. 1, 2017). The final rule canceled the Episode Payment Models—the Surgical Hip/Femur Fracture Treatment Model, the Acute Myocardial Infarction Model, and the Coronary Artery Bypass Graft Model—and the Cardiac Rehabilitation Incentive Payment Model, all of which were scheduled to begin on January 1, 2018. The Comprehensive Joint Replacement model was implemented in April 2016 in 67 geographic areas. When implemented, participation was mandatory in all areas. The final rule made participation voluntary in 33 of the 67 geographic areas and for all low volume and rural hospitals.

[17]An obligation is a definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty on the part of the United States that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States. Payment may be made immediately or in the future.

[18]Obligated amounts for individual models reflect payments made to model participants (including health care providers, states, and others) as well as other payments to support model development and testing. Amounts do not include Medicare, Medicaid, and CHIP payments that health care providers or others receive for services provided to the beneficiaries. For models selected by the Innovation Center for development and implementation, the center obtains approval from CMS, HHS, and OMB for the amount it expects will be required to test and evaluate models.

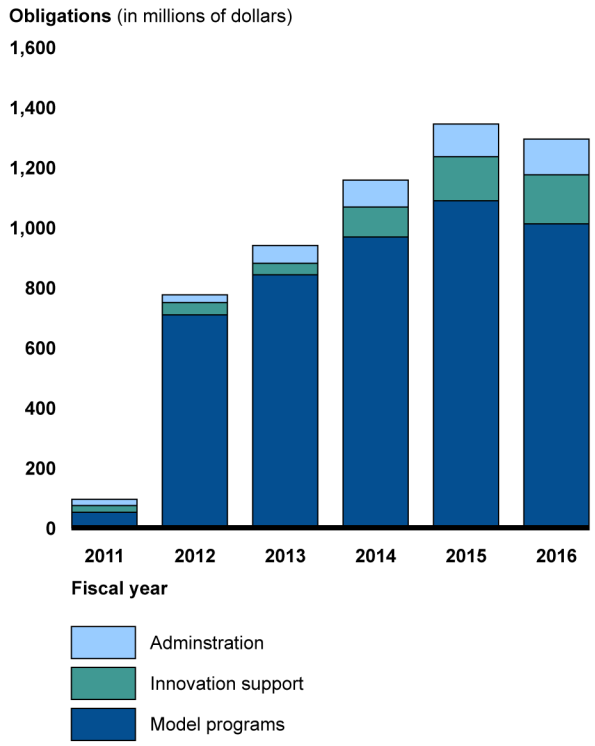
broad set of partners, including providers, local government, and public-private partnerships, to test their own care delivery and payment models required more than $870 million in obligations for payments to awardees and used over $95 million for contractor evaluations and other activities that supported model development and implementation.

Innovation Center spending falls into three categories: model programs, innovation support, and administration.

- Model programs include obligations that directly support individual models and delivery system reform initiatives.
- Innovation support includes center-wide operational expenses that are not directly attributable to a single model.
- Administration includes permanent federal full-time equivalent payroll expenses, administrative contracts, administrative interagency agreements, and general administrative expenses.

As the Innovation Center implemented additional models each year, total annual obligations increased steadily from approximately $95 million in fiscal year 2011 to more than $1.3 billion in fiscal year 2015, but decreased slightly in fiscal year 2016. (See fig. 4) Most of these total obligations were for model programs, which followed a similar pattern, increasing from $51 million in 2011 to about $1.1 billion in fiscal year 2015, with a slight decrease in fiscal year 2016. According to officials, the 2016 decrease in obligations for model programs was due in part to some of the earlier, expensive models ending and to newer models being less costly than the older models. Officials noted, for example, that a number of newer models incorporated basic program infrastructure used in previously implemented models, which allowed for reduced model costs. Officials also indicated that the decrease in obligations may be due to newer models using payment approaches that are funded by the Medicare Trust Fund, rather than funded by the Innovation Center's dedicated appropriation. The center's obligations for both innovation support and administration increased from around $20 million for each category in fiscal year 2011 to about $163 million for innovation support and $119 million for administration in fiscal year 2016. Officials told us that as obligations for model programs grew, so did obligations for innovation support and administration, which includes indirect costs and contractor assistance.

Figure 4: Center for Medicare and Medicaid Innovation Annual Obligations, Fiscal years 2011-2016



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

Evaluations Inform the Development of Models and Decisions to Certify Certain Models for Expansion

The Innovation Center Has Used the Results from Evaluations to Inform the Development of Additional Models and to Make Changes to Implemented Models

The Innovation Center has used the results from model evaluations to generate ideas for new models. For some of the early implemented models, evaluation results showed reduced spending and maintained or improved quality of care, but also identified model design limitations that could affect those results. According to officials, in some of these instances, the Innovation Center has developed new models that build upon the approaches of earlier models, but include adjustments intended to address identified limitations (see text box).

Evaluations of Implemented Models

The evaluation of each model is performed by a third-party contractor, who generally determines the effect of a model on quality of care and program spending by comparing data for model participants to those of a comparison group of providers and beneficiaries with characteristics similar to model participants. For purposes of the evaluation, the Innovation Center has the authority to require the collection and submission of necessary data by model participants. Accordingly, the third-party contractor collects both quantitative and qualitative data. The quantitative data are used to assess program spending and quality of care and the qualitative data are used to provide the context needed to understand the quantitative results.

Source: GAO | GAO-18-302

Example of A Model That Tests the Same General Delivery and Payment Approach of a Previously Implemented Model While Addressing Limitations

Bundled Payment for Care Improvement (BPCI) Model 2 tested an episode-based delivery and payment approach in which the Innovation Center set a benchmark, or target, price for all Medicare services a beneficiary might receive during a clinical episode—defined by BPCI Model 2 as the initial hospital stay and all services received up to 90 days after discharge. If the total spending for Medicare services during an episode was lower than the target price, participating hospitals would receive payments in addition to the normal fee-for-service payments. If the total spending for Medicare services during an episode was higher than the target price, participating hospitals would have to reimburse Medicare. Participants could select up to 48 different clinical episodes under the model.

The evaluation of BPCI Model 2 found that orthopedic surgery episodes—of which approximately 90 percent were hip and knee joint replacement surgeries—may have resulted in reduced program spending and improved quality of care. However, the evaluation also identified limitations affecting those results. For example, the target prices for hip and knee replacement surgeries did not account for potential differences in Medicare spending between elective surgeries and surgeries required after a fracture. As a result of this limitation, hospitals could attempt to control spending by limiting the number of episodes associated with higher cost beneficiaries (i.e., those requiring surgery due to a fracture).

In part to address the design issue identified under BPCI Model 2, Innovation Center officials told us they developed the Comprehensive Care for Joint Replacement (CJR) model. Implemented in April 2016, the CJR model tests the same general delivery and payment approach used in BPCI Model 2, but focuses specifically on hip and knee joint replacement surgical episodes and adjusts the target price to account for the higher spending related to hip and knee joint replacement surgeries following a fracture. As of March 1, 2018, no evaluations of the CJR model have been publicly released.

Source: GAO. | GAO-18-302

The Innovation Center has also used the results from evaluations as one way to improve the operational and participant support for new models. According to officials, evaluations have helped them identify lessons learned regarding support systems, such as which types of systems work well with which types of models, and then the center incorporated those lessons when designing the systems for new models. For example, officials noted that the experience with the learning system from the Bundled Payments for Care Improvement (BPCI) models informed the learning system for the Comprehensive Care for Joint Replacement (CJR) model.[19] The lessons learned helped the Innovation Center better identify where participants would need additional support and the learning activities—such as webinars and implementation guides—to provide the needed support during the early stages of model implementation. Innovation Center officials told us that these lessons from evaluations helped ensure that each successive model built upon the collective experience of models implemented by the center.[20]

The Innovation Center also has used evaluation results to make periodic changes to models during the testing period. According to officials, these changes include adjustments to the delivery and payment approaches tested, such as refining the target population, broadening the geographic focus, and refinements of spending calculations. Innovation Center officials noted that, in general, such changes were limited to minimize their effects on the evaluation of program spending and quality of care. Officials also identified changes to operational and participant support systems, which have included changes to the timing of participant data reporting, revisions to how data are collected from participants, and changes to the way learning materials are delivered to participants. According to officials, these types of changes are generally intended to help improve the experience of participants.

[19]The Innovation Center uses learning systems to help participants achieve success under its models by articulating the aim and drivers of success, providing technical assistance and feedback, and facilitating peer-to-peer exchange of ideas, among other functions.

[20]Another way in which the evaluations inform the development of additional models relates specifically to primary care redesign models. The Innovation Center initiated a systematic review of the evaluation results for six primary care redesign models implemented by the center. The review, in part, identified common themes to consider when developing new models. See https://innovation.cms.gov/Files/reports/primarycare-finalevalrpt.pdf (accessed March 7, 2018).

According to Innovation Center officials, evaluation results may also be used in making a decision to terminate a model prior to the end of its planned testing period. However, officials stated that the Innovation Center has not terminated any models prior to the conclusion of their testing periods, either based on the results of an evaluation or for other reasons.[21]

Evaluations Informed Innovation Center Decisions to Recommend Two Models be Certified for Expansion

The Innovation Center used evaluation results in recommending two models be certified for expansion. According to Innovation Center officials, the evaluation of each model adequately demonstrated that the delivery and payment approach tested reduced Medicare spending while maintaining or improving quality of care. Based on these results, the Innovation Center formally requested that CMS's Office of the Actuary analyze the financial impact of a potential expansion of each model. The two models were:

- **Pioneer ACO.** Pioneer ACO tested an ACO delivery and payment approach that gave providers an opportunity to be paid a relatively greater share of savings generated, compared to participants in other ACO models, in exchange for accepting financial responsibility for any losses. In year 3 of the model, ACOs that met certain levels of savings in the first two years could elect to receive a portion of their Medicare fee-for-service payments in the form of predetermined, per beneficiary per month payments.
- **YMCA of the USA Diabetes Prevention Program (Diabetes Prevention Program).** The Diabetes Prevention Program applied a lifestyle change program recognized by the Centers for Disease Control and Prevention to reduce to the risk of Type 2 diabetes for at-risk Medicare beneficiaries. The Diabetes Prevention Program was a part of the Health Care Innovation Awards Round One model.

When assessing the Pioneer ACO and Diabetes Prevention Program models for expansion, the officials from the Office of the Actuary considered the model evaluation results that were available and information from other sources.[22] For example, the assessment of Pioneer ACO used historical shared savings calculations and beneficiary

[21]Innovation Center officials told us that some models have been canceled prior to the start of testing due to lack of interest in participation.

[22]The Office of the Actuary conducted its assessments prior to the availability of final evaluations for both models.

attribution data from ACOs in the Medicare Shared Saving Program and Pioneer ACO; Medicare claims and enrollment data; and published studies. According to CMS officials, a model evaluation and a certification for expansion differ in that a model evaluation assesses the historical impact of a delivery and payment approach for model participants only, while a certification for expansion assesses the future impact on program spending across all beneficiaries, payers, and providers who would be affected by the expanded model.

Based on its assessments, the Office of the Actuary certified both models for expansion and steps have been taken to expand them. In certifying Pioneer ACO, the Office of the Actuary concluded that because ACOs, in general, have been shown to produce savings relative to Medicare fee-for-service, an expansion of Pioneer ACO would generate further savings to the Medicare program.[23] According to officials, CMS expanded Pioneer ACO by incorporating elements of the model—through rulemaking—as one of the options that providers may choose under the Medicare Shared Savings Program.[24] For the Diabetes Prevention Program, the Office of the Actuary concluded that certain changes considered as part of the expansion would, in the near term, improve upon the original savings achieved as part of the Health Care Innovation Awards as well as savings achieved in similar diabetes prevention programs. The Innovation Center has expanded—through rulemaking—the Diabetes Prevention Program under a new, nationwide model to be implemented in April 2018.

In addition, officials from the Innovation Center and the Office of the Actuary discussed potentially assessing whether Partnership for Patients should be certified for expansion. Partnership for Patients is a model that leveraged federal, state, local, and private programs to spread proven practices for reducing preventable hospital-acquired conditions and readmissions across acute care hospitals. According to officials, the Innovation Center shared the results for Partnership for Patients—which showed improved quality of care in the form of reduced preventable hospital-acquired conditions and readmissions—with the officials from the

[23]In order for the requirements for expansion to be met, the Secretary must also determine that expansion is expected to reduce spending without reducing the quality of care or improve the quality of care without increasing spending and that expansion would not deny or limit the coverage or provisions of benefits.

[24]The Medicare Shared Savings Program is a permanent Medicare ACO program. The program includes different participation options that allow ACOs to assume various levels of risk.

Office of the Actuary. After discussing these issues, Innovation Center officials decided not to request a formal analysis for certification of expansion.[25]

The Innovation Center Established Performance Goals and Related Performance Measures and Reported Meeting Its Targets for Some Goals

To assess is own performance, the Innovation Center established three center-wide performance goals and related measures.[26]

Goal 1: Reduce the growth of healthcare costs while promoting better health and health care quality through delivery system reform. This goal has three performance measures that focus on ACOs. As shown in table 3, the Innovation Center has reported mixed results in achieving the targets set. According to agency reported data, the Innovation Center met the targets for 2 of its 3 Goal 1 performance measures for 2015. For the remaining measure—the percentage of ACOs that shared in savings—the center did not meet its target during either of the two years for which data were available. According to officials, when results fall short of targets, they examine the causes and make appropriate adjustments to the program. Officials stated that the missed target was driven by the high growth in the number of ACOs that were new—and therefore would not yet be expected to achieve a level of savings in which they could share—and not by ACO performance deficits. As a result, officials decided that no adjustments were required to the Medicare Shared Savings Program or other ACO Models to help improve performance. However, as shown in table 3, the Innovation Center set a target for 2016 that was lower than the 2015 target. For 2017, the Innovation Center lowered the expectation for growth compared to previous years, setting a target that was 1 percent higher than the 2016 target. Moving forward, CMS believes that as more ACOs gain experience, more will share in savings. Additionally, the agency expects that with additional performance years, the targets for the measure will become more refined.

[25]According to Innovation Center officials, the evidence of improvements under the model was sufficient for the model approach to be incorporated in the Quality Improvement Organization program—a program under which CMS contracts with organizations to improve quality of care of Medicare beneficiaries in nursing homes and other settings.

[26]We previously reported that the Innovation Center's initial plans for evaluating its own performance included aggregating data on cost and quality measures developed for individual models, in conjunction with its third-party contractors. See GAO-13-12. According to center officials these measures could not be aggregated because of differences in the target populations and participating providers across models.

Table 3: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Reduce the Growth of Health Care Costs While Promoting Better Health and Health Care Quality through Delivery System Reform

Performance measure	Performance year				
	2014	2015	2016[a]	2017[a]	2018[a]
Increase the number of Medicare beneficiaries who have been aligned with accountable care organizations (ACOs)	✔ (Target: 5,425,000) (Actual: 5,954,342)	✔ (Target: 7,090,000) (Actual: 7,731,655)	n/a (Target: 8,710,000) (Actual: n/a)	n/a (Target: 9,920,000) (Actual: n/a)	n/a (Target: 11,245,000) (Actual: n/a)
Increase the number of physicians participating in an ACOs	✘ (Target: 150,000) (Actual: 132,148)	✔ (Target: 178,000) (Actual: 195,212)	n/a (Target: 266,600) (Actual: n/a)	n/a (Target: 275,200) (Actual: n/a)	n/a (Target: 331,200) (Actual: n/a)
Increase the percentage of ACOs that share in savings	✘ (Target: 35 percent) (Actual: 34 percent)	✘ (Target: 37 percent) (Actual: 34 percent)	n/a (Target: 36 percent) (Actual: n/a)	n/a (Target: 37 percent) (Actual: n/a)	n/a (Target: n/a) (Actual: n/a)

Legend: ✔– met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

[a]CMS has not released performance data for 2016 through 2018 for this performance measure.

Goal 2: Identify, test, and improve payment and service delivery models. This goal has one performance measure, which identifies the number of models that currently indicate (1) cost savings while maintaining or improving quality or (2) improving quality while maintaining or reducing cost. As of September 30, 2016, the Innovation Center reported that four section 1115A model tests have met these criteria (see table 4). [27]

[27]The four models that have met the criteria of the Innovation Center's goal 2 are: Pioneer ACO, the Diabetes Prevention Program, the Initiative to Prevent Avoidable Hospitalizations among Nursing Facilities Residents Phase 1, and lower-extremity joint replacement under the BPCI.

Table 4: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Identify, Test, and Improve Payment and Service Delivery Models

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Increase the number of model tests that currently indicate (1) cost savings while maintaining or improving quality, and/or (2) improving quality while maintaining or reducing cost	n/a	✔ (Target: 3 models) (Actual: 3 models)	✔ (Target: 4 models) (Actual: 4 models)	n/a (Target: 5 models) (Actual: n/a)	n/a (Target: 6 models) (Actual: n/a)

Legend: ✔– met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for fiscal year 2017 or 2018 for this performance measure.

Goal 3: Accelerate the spread of successful practices and models. For this goal, the first performance measure focuses on the number of states developing and implementing a health system transformation and payment reform plan.[28] The second measure focuses on increasing the percentage of active model participants who are involved in Innovation Center or related learning activities. As shown in table 5, the Innovation Center reported meeting its target for the first measure for both fiscal years 2015 and 2016, but not meeting its target for the second measure. For the second measure, the Innovation Center noted in its report to Congress that although the results for fiscal year 2016 showed a slight decrease in overall participation in Innovation Center or related learning activities, the majority of models performed higher than their individual targets. Several models underperformed, however, bringing down the overall percentage rate.

[28]The Innovation Center provides funding and technical assistance to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP.

Table 5: Reported Results of the Center for Medicare and Medicaid Innovation's Performance Measures for Its Goal to Accelerate the Spread of Successful Practices and Models

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Number of States developing and implementing a health system transformation and payment reform plan	n/a	✔ (Target: 38 states) (Actual: 38 states)	✔ (Target: 38 states) (Actual: 38 states)	n/a (Target: 17 states) (Actual: n/a)	n/a (Target: 12 states) (Actual: n/a)
Increase the percentage of active model participants who are engaged in Innovation Center or related learning activities	n/a	✘ (Target: 61 percent) (Actual: 58.6 percent)	✘ (Target: 64.5 percent) (Actual: 56.9 percent)	n/a (Target: 59.7 percent) (Actual: n/a)	n/a (Target: 60 percent) (Actual: n/a)

Legend: ✔– met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for fiscal year 2017 or 2018 for this performance measure.

In addition to the Goal 3 performance measures, the Innovation Center identifies two related contextual indicators—which according to officials are measures that provide supporting information to help understand trends or other information related to the goal. The first contextual indicator provides a snapshot of Medicare beneficiary participation at a given point in time for all models operational for more than 6 months. In fiscal year 2016, CMS reported that over 3.6 million Medicare fee-for-service beneficiaries participated in models, representing approximately 9 percent of Medicare fee-for-service beneficiaries. The second contextual indicator provides information to help understand the level of interest and participation among providers in the Innovation Center's model portfolio. In fiscal year 2016, the Center estimates that 103,291 providers participated in Innovation Center payment and service delivery models.

In addition to the three goals established by the Innovation Center, CMS has established an agency-wide goal related to the center's performance. In 2015, CMS announced goals to help drive Medicare, and the health care system at large, toward rewarding the quality of care instead of the quantity of care provided to beneficiaries. One of these goals was to shift Medicare health care payments from volume to value using alternative payment models established under the Innovation Center. This agency-wide goal has one performance measure, which is to increase the

percentage of Medicare fee-for-service payments tied to alternative payment models, such as ACOs or bundled payment arrangements. As shown in table 6, CMS reported meeting its target for 2015 and 2016.

Table 6: Reported Results of Center for Medicare & Medicaid Services' Performance Measures for Its Goal to Shift Medicare Health Care Payments from Volume to Value

Performance measure	Performance year				
	2014	2015	2016	2017[a]	2018[a]
Increase the percentage of Medicare Fee-for-Service Payments Tied to Alternative Payment Models	n/a	✔ (Target: 26 percent) (Actual: 26 percent)	✔ (Target: 30 percent) (Actual: 30 percent)	n/a (Target: 40 percent) (Actual: n/a)	n/a (Target: 50 percent) (Actual: n/a)

Legend: ✔ – met or exceeded performance target; ✘ – did not meet performance target; n/a – data not available

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: The goal and related performance measure were established in 2014. A target for performance was established in 2015.

[a]CMS has not released performance data for 2017 or 2018 for this performance measure.

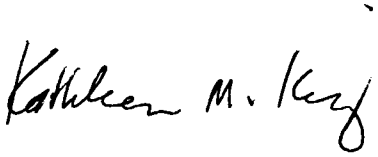
Looking forward, officials told us that the Innovation Center has developed a methodology to estimate a forecasted return on investment for the model portfolio, and is in the early stages of refining the methodology and applying it broadly across the portfolio in 2018. As part of the development efforts, the Innovation Center expects to utilize standard investment measures used in the public and private sectors.

Agency Comments

We provided a draft of this report to HHS for comment. The Department provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



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Appendix I: Center for Medicare and Medicaid Innovation's General Process for Implementing Models

Table 7: Description of the Center for Medicare and Medicaid Innovation's (Innovation Center) General Process for Model Implementation

Idea & concept	
Identify ideas for new models	• Internally, the Innovation Center receives ideas for different payment and care delivery approaches from the administration and leadership of the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS). • Externally, the Innovation Center solicits and receives ideas for different payment and care delivery approaches through listening sessions, its web-based idea-submission tool, informal requests for information inviting the public to provide information to CMS for information and planning purposes, and other mechanisms.[a] • As part of this step, the Innovation Center considers model types suggested in its authorizing law, and seeks input from across CMS; HHS; other federal partners, including the Physician-Focused Payment Model Technical Advisory Committee (PTAC); and an array of external stakeholders.[b]
Develop promising ideas into concepts for new models	• The Innovation Center reviews details of the ideas that have been submitted—such as the health care services addressed; providers, beneficiaries, and stakeholders involved; and the resources needed— to assess the potential for developing the idea into a working model. • A small collaboration team is formed from across the Innovation Center to further develop promising model concepts. A model concept includes preliminary model design, evaluation plans, budget information, and estimates of potential savings to be achieved. • The Innovation Center evaluates concepts in the context of the current portfolio of models, administration priorities, and other criteria such as the potential impact on Medicare and Medicaid beneficiaries, the concept's ability to improve how care is delivered nationally, and the degree to which the concept would meet the needs of the most vulnerable beneficiaries.
Planning & design	

Develop an Innovation Center Investment Proposal (ICIP)	• Once the Innovation Center decides to move forward with a concept, it develops an ICIP, which typically includes
	  • a proposed design for the model, including the size and scope of testing, the population and programs involved, and duration;
	  • a summary of prior evidence and supporting research;
	  • a preliminary evaluation plan, including research questions, proposed measures related to spending and quality, and discussion of the model's expected impact; and
	  • an implementation plan, including the application and selection process, an analysis of whether the model overlaps or complements other initiatives, and an analysis of the potential for expansion of the model.
	• The Innovation Center prepares separate documents for approval that are related to funding requests and solicitations associated with the model.

Obtain approval from CMS, HHS, and the Office of Management and Budget (OMB) and announce model	• The Innovation Center seeks approval for the model. This includes separate approval processes for the ICIP, model funding, and any solicitations that would be issued to potential participants. • The approval process includes a sequence of reviews within CMS, within HHS, and finally within OMB. During these reviews, revisions may be made on the basis of input from individuals in other CMS centers and offices, in other related HHS programs, and from OMB. • Once the ICIP is approved, the Innovation Center issues an announcement and other information about the model to the public.
Solicit & build	
Solicit and select contractors for evaluating and implementing model	• The Innovation Center solicits and hires contractors to evaluate the model. Applicants are asked to propose specific evaluation approaches to the preliminary evaluation plans that the Innovation Center has identified. Contractors are selected through a competitive process. Once a contractor is selected, it works with the Innovation Center to complete a design phase and reach agreement on the final evaluation plan for the model. • The Innovation Center also engages contractors for other purposes that are part of implementation, such as data collection and provider recruitment.
Solicit, select, and establish agreements with participants	• The Innovation Center issues information about how to apply for participation in the model, including information about which types of providers or organizations are eligible to participate, the process for submitting applications, and the selection process. The Innovation Center may also organize webinars or learning sessions open to the public and interested participants to share information and answer questions. • Innovation Center models vary by the type of participant that is involved—for example, physician group practices, health plans, and state Medicaid programs. • Models also vary in terms of the type of agreement that is established with participants—for example, whether it is a grant, a cooperative agreement, a contract, or a provider agreement. • The selection process for participants is generally competitive. The criteria used in the selection process may vary by model. For example, selection criteria may include such factors as organizational capabilities and plans for ensuring quality of care. In other cases, eligible participants may be selected in order to achieve a mix and balance of certain characteristics for evaluation purposes, for example geographic location (urban, rural) and whether the participant uses electronic health records

Build operational and participant support	• The Innovation Center and contractors create systems or plans that support the implementation of each model, including:
	  • information technology systems that collect, maintain, and provide access to data;
	  • a learning system that consists of a combination of educational approaches that focus on collaboration and group-based activities, as well as known improvement strategies that support participants in achieving the goals of the model's learning activities;
	  • a communication plan that establishes communication channels between participants and the Innovation Center, as well as for information released to the general public;
	  • a monitoring system that establishes requirements for participant reporting and, if applicable, corrective action plans; and
	  • an operational plan that establishes steps—including training—to help ensure the Innovation Center and participants understand how the model will operate once it is implemented.

Run, evaluate, & expand	
Run model implementation	• The innovations that models are testing—changes to health care delivery or payment—are put into effect by CMS and by participants. • The testing period for Innovation Center models is typically set for 3 to 5 years. However, monitoring may indicate that the model should be modified, terminated, or expanded before this period ends (see below). The Innovation Center may choose to shorten the test period for a model for such reasons.
Conduct evaluation of model to assess its impact on cost and quality	• Data are collected for cost and quality measures. Using a variety of statistical techniques, these data are generally compared to data for a comparison group representing patients or providers that are not participating in the model to determine the model's impact on cost and quality. When comparison groups are not possible, data for model participants are compared to "baseline" data that represent a period prior to the test period. Qualitative information on the different strategies participants may use to deliver care under each model is also collected and analyzed. • During the testing period information collected is shared on a regular basis with participants. The purpose of this "rapid cycle" feedback is to provide timely information so that participants can make improvements during the testing period.

Determine whether to terminate, modify, or recommend expanding model	• The Innovation Center regularly reviews each model's impact on the quality and cost of care to determine whether the payment or delivery approach is successful and should be recommended for expansion. • The Secretary is required to terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary certifies with respect to program spending), after testing has begun, that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. • The Secretary may expand the duration and scope of a model if (1) the CMS Chief Actuary certifies that expansion would reduce or not result in any increase in net program spending, (2) the Secretary determines that expansion is expected to reduce spending without reducing the quality of care or improve the quality of patient care without increasing spending, and (3) the Secretary determines that expansion would not deny or limit the coverage or provision of benefits.
Closing	
Participant, contract, and administrative closeout	• The Innovation Center makes final payments to participants and contractors, final evaluations are completed and publicly released, lessons learned are documented and, if applicable, continuity of model operations is coordinated with CMS.

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

[a]An agency may issue a request for information for planning purposes.

[b]PTAC was chartered by the Secretary of HHS in January 2016. PTAC evaluates stakeholder proposals for physician-focused payment models, and submits comments and makes recommendations on the models to the Secretary of HHS, who is required to respond to PTAC's recommendations.

Appendix II: Models Implemented or Announced by the Center for Medicare and Medicaid Innovation under Section 1115A

As of March 1, 2018, the Center for Medicare and Medicaid Innovation (Innovation Center) organized its models into seven categories based on delivery and payment approaches tested and program beneficiaries covered. Table 8 provides the number of models implemented and announced, organized under each category.

Table 8: Number of Section 1115A Center for Medicare and Medicaid Innovation Models Implemented and Announced by Category, as of March 1, 2018

Model category	Models implemented	Models announced	Total
Accountable Care	7	0	**7**
Episode-based Payment Initiatives	6	1	**7**
Initiatives Focused on Medicare-Medicaid Enrollees	3	0	**3**
Initiatives Focused on the Medicaid and Children's Health Insurance Program Population	1	0	**1**
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	14	0	**14**
Initiatives to Speed the Adoption of Best Practices	2	1	**3**
Primary Care Transformation	4	0	**4**
Total	**37**	**2**	**39**

Source: GAO analysis of Centers for Medicare & Medicaid Services information. | GAO-18-302

The Innovation Center organized seven of its models under the Accountable Care category. (See table 9.)

Table 9: Descriptions and Other Information for Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Accountable Care

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Advance Payment Accountable Care Organization (ACO) Model – Tested the effectiveness of providing physician-based and rural Medicare Shared Savings Program ACOs with upfront and monthly payments that they could use to invest in care coordination activities.[c]	Implemented - testing period ended (2012-2015)	35 ACOs	$73.8 million ($110.1 million)
Pioneer ACO – Tested the effectiveness of allowing experienced ACOs to take on greater financial risk than ACOs that participated in the Medicare Shared Savings Program.[d] In exchange, participating ACOs are eligible for a greater percentage of any savings achieved. In year 3 of the model, providers that met certain levels of savings in the first two years were eligible to receive prospective per beneficiary per month payments.	Implemented - testing period ended (2012-2016)	Began with 32 ACOs and concluded with eight.	$96.9 million ($244.3 million)
Comprehensive End-Stage Renal Disease Care Model – Tests the effectiveness of an ACO delivery and payment approach for providing care to end-stage renal disease beneficiaries.	Implemented (2015-2020)	37 end-stage renal disease seamless care organizations	$56.5 million (n/a)
ACO Investment Model – Tests the effectiveness of pre-paid shared savings in encouraging new Medicare Shared Savings Program ACOs to form in rural and underserved areas and in encouraging current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.[d]	Implemented (2016-tbd)	45 ACOs	$62.0 million ($10.9 million)
Next Generation ACO Model – Tests the impact of strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management. ACOs participating in the Next Generation ACO Model must assume greater risk and can earn greater rewards than in other Centers for Medicare & Medicaid Services' (CMS) ACO initiatives.	Implemented (2016-2020)	44 ACOs	$44.5 million ($11.8 million)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Vermont All-Payer ACO Model – Tests a model in which Medicare, Medicaid, and commercial health care payers in Vermont will coordinate to have similar design requirements for ACOs. Under the arrangement, Vermont commits to meeting statewide quality of care and financial targets. CMS will also provide funding to Vermont to support care coordination and improve collaboration between providers.	Implemented (2017-2022)	1 state	n/a (n/a)
ACO Track 1 Plus – Tests the effectiveness of offering an advanced alternative payment model with a more limited risk track than currently available in the Medicare Shared Savings Program to encourage more Medicare Shared Savings Program ACOs, especially ACOs composed solely of small physician practices and small rural hospitals, to take on financial risk.	Implemented[e] (2018-tbd)	n/a	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017 with the exception of the status for ACO Track 1 Plus, which was updated as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reported reflect obligations through fiscal year 2016.

[c]An ACO refers to a group of providers and suppliers of services, such as hospitals and physicians, that work together to coordinate care for the patients they serve.

[d]The Medicare Shared Savings Program is an ACO program enacted as an ongoing part of the Medicare program and not an Innovation Center model. See 42 U.S.C. § 1395jjj. The program includes different participation options that allowed ACOs to assume various levels of risk.

[e]ACO Track 1 Plus was implemented on January 1, 2018.

The Innovation Center organized seven of its models under the Episode-Based Payment Initiatives category. (See table 10.)

Table 10: Descriptions and Other Information for Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Episode-Based Payment Initiatives

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Bundled Payments for Care Improvement (BPCI) Model 1, Retrospective Acute Care Hospital Stay Only – Tested the effectiveness of a payment arrangement in which hospitals received discounted payments for Medicare services provided during an inpatient hospital stay and in which physicians who provided services during the inpatient stay were paid their standard rates under the physician fee schedule. Hospitals were able to share cost-savings they generated under the model with physicians as a means of encouraging them to participate in redesigning the care process to become more efficient. Hospitals were also held financially responsible for the cost of all Medicare services provided 30 days after discharge that exceeded historical trends.	Implemented – testing period ended (2013-2016)	Began with 24 hospitals and concluded with nine.	$75.7 million, includes BPCI Models 1-4 (n/a)
BPCI Model 2, Retrospective Acute & Post-Acute Care Episode – Tests the effectiveness of a payment arrangement in which acute care hospitals and physician group practices receive additional payments or make recoupment payments if the total costs for Medicare services provided during an inpatient hospital stay and up to 90 days after discharge are over or under a pre-determined target price.	Implemented (2013-2018)	335 hospitals and 204 physician group practices	See BPCI Model 1
BPCI Model 3, Retrospective Post-Acute Care Only – Tests the effectiveness of a payment arrangement in which post-acute care providers—such as a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency—or physician group practices receive payments or make recoupment payments if total costs for certain Medicare services are over or under a predetermined target price. These services are those provided during a clinical episode that begins with post-acute care services and include all services up to 90 days after the hospital discharge that preceded the post-acute care services.	Implemented (2013-2018)	620 skilled nursing facilities, 81 home health agencies, 9 inpatient rehab facilities, and 48 physician group practices	See BPCI Model 1

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
BPCI Model 4, Prospective Acute Care Hospital Stay Only – Tests the effectiveness of making a single, predetermined payment in advance for all Medicare services furnished by a hospital, physicians, and other practitioners during an inpatient stay in an acute care hospital. Physicians and other practitioners submit "no-pay" claims to Medicare and are paid by the hospital out of the advance, bundled payment.	Implemented (2013-2018)	2 hospitals	See BPCI Model 1
Comprehensive Care for Joint Replacement Model – Tests the effectiveness of a payment arrangement in which acute care hospitals receive additional payments or make recoupment payments if the total costs for certain Medicare services are over or under a predetermined target price. These services are those provided during a clinical episode that includes an inpatient hospital stay related to a hip or knee replacement surgery and all services up to 90 days after discharge.	Implemented (2016-2020)	Participation required for about 800 hospitals in 67 randomly selected geographic areas[c]	$25.7 million (n/a)
Oncology Care Model – Tests the effectiveness of a payment arrangement in which providers receive a monthly payment for each Medicare beneficiary during a 6-month episode of care following the administration of chemotherapy and can earn additional performance-based payments if the total costs for Medicare services provided during the episode are under a predetermined target price. Starting in 2017, practices could receive higher performance-based payments by taking on risk for costs that exceed the target price.	Implemented (2016-2021)	192 practices and 14 payers	$58.3 million (n/a)
BPCI Advanced[d] – Will test the effectiveness of a payment arrangement in which acute care hospitals and physician group practices receive additional payments if the total costs for Medicare services provided are under a pre-determined target price and performance is maintained or improved on specific quality measures. Services are those to be provided during a clinical episode that will include either an inpatient hospital stay or outpatient procedure and all services for 90 days after discharge or the procedure. This model will qualify as an advanced alternative payment model.	Announced (2018-2023)	tbd	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017 with the exception of information for BPCI Advanced, which was updated as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

[c]On December 1, 2017, a final rule was issued making provider participation in 33 geographic areas voluntary for this model, effective January 1, 2018. Participation will remain mandatory for 34 geographic areas.

[d]BPCI Advanced was announced on January 9, 2018.

The Innovation Center organized three of its models under the Initiatives Focused on Medicare-Medicaid Enrollees category. (See table 11.)

Table 11: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives Focused on Medicare-Medicaid Enrollees

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase One – Tested effectiveness of partnerships between independent organizations and long-term care facilities to enhance on-site services to reduce hospitalizations for Medicare-Medicaid beneficiaries.	Implemented – testing period ended (2012-2016)	Seven Enhanced Care and Coordination Provider organizations and 143 long-term care facilities	$124.7 million (n/a)
Financial Alignment Initiative for Medicare-Medicaid Enrollees – Tests two models to integrate primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees and better aligns the financing of the Medicare and Medicaid programs.	Implemented (2013-2020)	Model tests are operating in 13 states, with two demonstrations operating in New York.	$234.2 million ($7.2 million)
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two – Tests whether a new payment model for a new set of long-term care facilities, as well as long-term care facilities that participated in the initial phase of the model and continue to offer enhanced on-site services, will improve quality of care by reducing avoidable hospitalizations, while also lowering combined Medicare and Medicaid spending.	Implemented (2016-2020)	Six Enhanced Care and Coordination Provider organizations	$18.8 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized one of its models under the category, Initiatives Focused on the Medicaid and Children's Health Insurance Program Population. (See table 12.)

Table 12: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives Focused on the Medicaid and Children's Health Insurance Program Population

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models - Tests three approaches to enhance the current care delivery and address the medical, behavioral and psychosocial factors that may be present during pregnancy and contribute to preterm-related poor birth outcomes.	Implemented (2013-2018)	27 awardees with more than 200 sites including hospitals, health plans, community-based providers, Federally Qualified Health Centers, nationally-certified birth centers, Indian Health services clinics, local health departments, and physician groups	$96.2 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized 14 of its models under the category, Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models. (See table 13.)

Table 13: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Partnership for Patients – Tested whether a coordinated, goal-directed, national collaborative approach for systematically spreading known best practices in patient safety could make acute care hospitals safer, more reliable, and less costly by reducing hospital acquired conditions and readmissions.	Implemented – testing period ended (2011-2016)	3,700 short stay acute care hospitals	$559.4 million (n/a)
Health Care Innovation Awards Round One – Tested the effectiveness of providing funding to a broad set of partners, including providers, local government, and public-private partnerships, to test new care delivery and payment models for beneficiaries enrolled in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).	Implemented – testing period ended (2012-2015)	108 awardees including academic medical centers, not-for-profit organizations, provider organizations, managed care organizations, integrated health systems, health clinics, hospitals, and local and state agencies.	$967.4 million (n/a)
State Innovation Models Initiative: Round One – Tested the effectiveness of financial, technical, and other support to states that were either prepared to test or were committed to design and test new payment and service delivery models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented – testing period ended (2013-2016)	Six test states, 16 design states	$326.7 million (n/a)
Health Care Innovation Awards Round Two – Tested the effectiveness of providing funding to awardees to test new care delivery and payment models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented – testing period ended (2014-2017)	39 awardees including academic medical centers, not-for-profit organizations, provider organizations, managed care organizations, integrated health systems, health clinics, hospitals, and local and state agencies.	$397.7 million (n/a)
Maryland All-Payer Model – Tests the effectiveness of an all-payer system for hospital payment on quality of care and cost.	Implemented (2014-2019)	One state	$12.6 million (n/a)
Repetitive Scheduled Non-Emergent Ambulance Transport Model (Prior Authorization) – Tests the effectiveness of prior authorization of repetitive scheduled non-emergent ambulance transport.	Implemented (2014-2018)	Nine states	$28.9 million (n/a)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
State Innovation Models Initiative: Round Two – Tests the effectiveness of financial, technical, and other support to states that are either prepared to test or are committed to designing and testing new payment and service delivery models for beneficiaries enrolled in Medicare, Medicaid, or CHIP.	Implemented (2015-2018)	11 test states, 17 design states, plus America Samoa, District of Columbia, Commonwealth of the Northern Mariana Island, and Puerto Rico	$373.7 million (n/a)
Hyperbaric Oxygen Therapy Model (Prior Authorization) – Tests the effectiveness of prior authorization of non-emergent hyperbaric oxygen therapy.	Implemented (2015-2018)	Three states	$5.7 million (n/a)
Home Health Value-Based Purchasing Model – Tests the effectiveness of tying payments for Medicare-certified home health agencies to the quality of care provided.	Implemented (2016-2022)	Nine states	$18.0 million (n/a)
Medicare Care Choices Model – Tests the effectiveness of providing Medicare, Medicaid, or dual-eligible beneficiaries the option to receive hospice-like support services from certain hospice providers while concurrently receiving curative services.	Implemented (2016-2020)	141 hospices	$16.5 million (n/a)
Part D Enhanced Medication Therapy Management Model – Tests the effectiveness of providing basic, stand-alone prescription drug plans with the regulatory flexibility to design and implement innovative medication therapy management programs with the goal of optimizing medication use.	Implemented (2017-2021)	Six Part D sponsors	$10.7 million (n/a)
Pennsylvania Rural Health Model – Tests whether multi-payer global budgets will enable participating rural hospitals to invest in quality and preventive care and to tailor the services they deliver to better meet the needs of their local communities.	Implemented (2017-2023)	One state	n/a (n/a)
Medicare Advantage Value-Based Insurance Design Model – Tests the effectiveness of offering Medicare Advantage plans the flexibility to design and offer reduced cost-sharing and/or additional supplemental benefits to enrollees with chronic conditions with the goal of incentivizing beneficiaries to use high-value services. Eligible Medicare Advantage plans in seven states, upon approval from the Centers for Medicare & Medicaid Services (CMS), can offer varied plan benefit designs for enrollees who fall into certain clinical categories identified and defined by CMS.	Implemented (2017-2021)	11 Medicare Advantage and Medicare Advantage prescription drug plans[c]	$8.4 million (n/a)

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Accountable Health Communities Model – Tests the effectiveness of systematically identifying and addressing the health-related social needs of beneficiaries through improved clinical-community linkages.	Implemented (2017-2022)	32 organizations including hospitals, university health systems, and local health departments	n/a (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

[c]In 2017, participation was limited to eligible plans in 7 states. CMS expanded the model into 3 additional states in 2018 and will expand into 15 more in 2019. The Bipartisan Budget Act of 2018 requires that the model covers all states effective no later than January 1, 2020.

The Innovation Center organized three of its models under the category, Initiatives to Speed the Adoption of Best Practices. (See table 14.)

Table 14: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Initiatives to Speed the Adoption of Best Practices

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Health Care Payment Learning and Action Network – Facilitates the national learning collaborative to accelerate the adoption of advanced payment models that include private payers, purchasers, health care providers, consumers, and states.	Implemented (2015-tbd)	Over 600 organizations	$11.7 million (n/a)
Million Hearts®: Cardiovascular Disease Risk Reduction Model – Tests the effectiveness of providing financial incentives for health care providers to reduce the patients' risk of heart attack and stroke on outcomes and accountability for costs among Medicare beneficiaries.	Implemented (2017-2022)	516 organizations	$13.8 million (n/a)
Medicare Diabetes Prevention Program Expanded Model – Will test the effectiveness of an evidence-based intervention targeted to prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes.	Announced (2018-tbd)	tbd	n/a (n/a)

Legend: n/a – not applicable; tbd – to be determined

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-18-302

Note: Information in this table is as of December 1, 2017 with one exception. We excluded the Direct Decision Support model, which was cancelled by the Innovation Center on February 2, 2018, as of March 1, 2018.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

The Innovation Center organized four of its models under the category, Primary Care Transformation. (See table 15.)

Table 15: Descriptions and Other Information for the Center for Medicare and Medicaid Innovation (Innovation Center) Models Organized under Primary Care Transformation

Model Description	Status (Years tested)	Participants	Obligations funded under section 1115A[a] and titles XVIII and XIX[b] of the Social Security Act
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration – Tested the effectiveness of the advanced primary care practice model—referred to as a patient-centered medical home—for health centers that have received a FQHC designation from the Centers for Medicare & Medicaid Services. FQHCs provide comprehensive community-based primary and preventive care services in medically underserved areas or to medically underserved populations. As part of the model, FQHCs were paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services.	Implemented – testing period ended (2011-2014)	434 FQHC sites	$64.2 million (n/a)
Comprehensive Primary Care Initiative – Tested the impact of enhanced primary care services, including care coordination, prevention, and 24-hour access for Medicare and Medicaid beneficiaries. The initiative included multiple payers and participating providers received a monthly care management fee and an opportunity to share in any net savings to the Medicare program.	Implemented – testing period ended (2012-2016)	442 primary care practices	$397.0 million ($0.6 million)
Comprehensive Primary Care Plus – Tests the impact of multi-payer enhanced primary care services for Medicare and Medicaid beneficiaries, including care coordination, prevention, and 24-hour access for Medicare and Medicaid beneficiaries. This model includes greater financial resources and flexibility to make appropriate investments to improve quality and efficiency of care. The initiative included multiple payers and participating providers received a monthly care management fee, performance-based incentive payments, and payments under the Medicare physician fee schedule.	Implemented (2017-2022)	2,816 primary care practices	$66.7 million (n/a)
Transforming Clinical Practice Initiative – Tests the effectiveness of providing support to outpatient clinical practices to move from volume to value-based delivery systems within the Quality Payment Program by sharing, adapting, and developing comprehensive quality improvement strategies to facilitate large-scale practice transformation.	Implemented (2015-2019)	29 practice transformation networks and 12 support and alignment networks	$328.7 million (n/a)

Legend: n/a – not applicable

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Note: Information in this table is as of December 1, 2017.

[a]Obligations funded under section 1115A reflect payments to participants in the testing of models, such as health care providers of services, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through Innovation Center funds as appropriated under section 1115A of the Social Security Act. Amounts reflect obligations made for fiscal years 2012 through 2016.

[b]Obligations funded under Titles XVIII or XIX reflect payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. This column does not include Medicare, Medicaid, and Children's Health Insurance Program payments to health care providers or others for services provided to beneficiaries. Amounts reflect obligations made through fiscal year 2016.

Appendix III: Models Required by Different Provisions of the Patient Protection and Affordable Care Act

In addition to models required by section 1115A of the Social Security Act, as added by the section 3021 of Patient Protection and Affordable Care Act, the Center for Medicare and Medicaid Innovation implemented six models under different provisions of the Patient Protection and Affordable Care Act. (See table 16.)

Table 16: Models Implemented by the Center for Medicare and Medicaid Innovation Required by Different Provisions of the Patient Protection and Affordable Care Act

Model Description	Status (Years tested)	Participants	Obligations through September 30, 2016
Incentives for Prevention of Chronic Diseases in Medicaid – Tested the impact of providing incentives to Medicaid beneficiaries to participate in prevention programs such as those that address tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and managing or avoiding the onset of diabetes. The final evaluation was unable to directly measure whether the programs prevented chronic diseases, but found programs focusing on tobacco cessation increased cessation rates.	Implemented – testing period ended (2011-2015)	10 states	$71.1 million
Medicaid Emergency Psychiatric Demonstration – Tested the extent to which reimbursing private psychiatric hospitals for inpatient services needed to stabilize psychiatric emergency medical conditions in adult Medicaid beneficiaries ages 21 to 64 (which is generally prohibited under Medicaid) improved access to and quality of care for these beneficiaries and reduced overall Medicaid spending and utilization. The final evaluation was unable to make definitive conclusions about whether the demonstration improved access to and quality of care while reducing spending and utilization.	Implemented – testing period ended (2012-2015)	27 private psychiatric hospitals in 11 states and the District of Columbia	$74.2 Million
Medicare Independence at Home Demonstration – Tests the effectiveness of delivering an expanded scope of primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions.	Implemented (2012-2019)	14 primary care practices and consortia	$16.1 million

Model Description	Status (Years tested)	Participants	Obligations through September 30, 2016
Community Based Care Transitions Program – Tested approaches to reduce unnecessary hospital readmissions by improving the transition of Medicare beneficiaries from the inpatient hospital setting to home or other care settings. The final evaluation was unable to make definitive conclusions on the impact of the model, but found some evidence that suggested the potential for the program to reduce hospital readmissions.	Implemented – testing period ended (2012-2017)	Began with 101 community-based organizations and concluded with 44.	$291.5 million
Certain Complex Diagnostic Lab Tests – Tested the effect of making separate payments for certain complex diagnostic laboratory tests on access to care, quality of care, health outcomes, and expenditures. The final evaluation found that the Demonstration did not have a significant impact on the care received, health outcomes, or expenditures among the Medicare beneficiary population as a whole.	Implemented – testing period ended (2012-2014)	Not applicable	$400,000
Graduate Nurse Education – Tests the effect of offsetting the costs of clinical training for Advanced Practice Registered Nurses (APRN) on the availability of graduate nursing students enrolled in APRN training programs. The final evaluation found that the model had a positive impact on APRN student growth, and helped transform clinical education within participating schools of nursing.	Implemented (2012-2018)	5 hospitals partnering with 19 schools of nursing	$153 million

Source: Centers for Medicare & Medicaid Services. | GAO-18-302

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

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