

# Safety Net Representation in Federal Payment and Care Delivery Reform Initiatives

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## ABSTRACT

**OBJECTIVES:** Safety net organizations face challenges under new value-driven payment models. More than 70 payment reform programs were created through the CMS Center for Medicare and Medicaid Innovation (CMMI). These programs were analyzed to determine the extent to which they target safety net organizations.

**STUDY DESIGN:** Systematic review of publicly available CMMI program descriptions.

**METHODS:** We reviewed all CMMI programs' stated goals, eligibility criteria, participating organizations (if applicable), and all other relevant information publicly available on the CMMI website. We classified each program as (1) specifically targeting the safety net, (2) applying to the safety net but not specifically targeting it, or (3) not applying to the safety net. For safety net initiatives, we also reviewed each program to determine which portion(s) of the safety net it was relevant to.

**RESULTS:** Only 13 CMMI programs directly targeted safety net providers, 32 included safety net providers, and 22 programs did not apply to or target the safety net. No trends were found to suggest that this proportion was increasing over time. Safety net-relevant programs tended to target critical access hospitals rather than primary care or behavioral health.

**CONCLUSIONS:** Programs that specifically target the safety net may represent an important opportunity to overcome unique payment reform challenges facing this portion of the healthcare sector. However, safety net organizations are inconsistently represented in CMMI programs. There is currently no expedient approach to determine whether CMMI programs apply to specific safety net subsectors. Additional clarity regarding safety net relevance may help organizations understand and participate in relevant CMMI programs.

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One potentially promising approach to improving value in healthcare is the use of alternative payment models (APMs) to fee-for-service (FFS)-based models.<sup>1</sup> APMs include FFS payments that are linked to quality and value, gain sharing and/or downside risk, condition-specific population-based payment, and comprehensive population-based payment.<sup>2</sup> Success under an APM requires transforming the manner in which care is delivered in a healthcare organization.<sup>1,3</sup>

Payment and care delivery reform pose significant technical and operational challenges for healthcare delivery organizations.<sup>4,5</sup> However, not all healthcare delivery organizations are equally well positioned to respond to such challenges.<sup>6,9</sup> Study results suggest that safety net organizations may not be well positioned to succeed under new payment models.<sup>6,9-11</sup> A safety net healthcare organization is one that provides a significant level of care to low-income, uninsured, and vulnerable populations and has a legal mandate to serve patients regardless of their ability to pay.<sup>12</sup> The safety net sector provides care to Americans who live in underserved areas.<sup>6,12</sup>

Safety net organizations face unique challenges that limit the success of payment reform initiatives. In addition to the challenges of patient attribution and risk adjustment, safety net organizations also have exceptionally high-cost patients.<sup>13-15</sup> These challenges are further complicated by policy changes, such as Disproportionate Share Hospital funding streams that changed substantially for many safety net hospitals with the passage of the Affordable Care Act.<sup>9,11,16</sup>

These and other payment reform initiatives have traditionally put pressure on safety net hospitals owing to their unique missions, patient populations, and funding streams.<sup>7</sup> Despite declining uninsured rates, safety net providers persist as an integral source of care for many.<sup>17</sup> Understanding the challenges and opportunities that payment reform presents for safety net organizations is of immense importance due to the size and scope of the safety net sector.<sup>6,12</sup>

Payment reform presents significant opportunities for achieving improved population health outcomes, improved patient experience of care, and decreased per capita costs.<sup>18</sup> However, new payment models often carry high financial, technological, and personnel needs.<sup>11</sup> Safety net organizations tend to have more difficulty meeting these needs compared with non-safety net organizations, especially the large start-up costs for new programs.<sup>6,9-11</sup> Furthermore, advanced payment models often rely on strong, interoperable data systems, which may not exist in safety net organizations.<sup>19,20</sup> Advanced payment models frequently place greater demands on personnel who may already be operating at maximum capacity within safety net organizations.<sup>13,21,22</sup> Complex programs also require qualified staff, and safety net organizations often have limited access to the needed talent pool because of budget restrictions and geographic location.<sup>11</sup> Because of these challenges, safety net organizations stand to benefit most from advanced payment models that not only apply to the safety net sector but are also specifically designed with these organizations in mind.<sup>23</sup>

Little empirical evidence has been compiled regarding systemwide trends in payment reform across the safety net.<sup>17</sup> Safety net organizations generally derive large proportions of their revenues from public payers, such as state Medicaid programs, so recent payment reform initiatives from large private payers may not directly apply to safety net organizations.<sup>24</sup> Likewise, the last remaining members of the recently concluded Pioneer Accountable Care Organization (ACO) program were not safety net organizations. Research suggests that although ACOs may be establishing new linkages with specific safety net providers, as of 2014 only 28% of ACOs included community health centers within their care networks.<sup>25</sup> A centerpiece of payment reform efforts in the United States is CMS' Center for Medicare and Medicaid Innovation (CMMI), which is home to some 70 payment reform programs. However, the overall extent to which safety net organizations are represented in these programs is not known, nor is it clear which of these programs are relevant for or directly target safety net organizations.

Given the large role that the safety net plays in delivering care to a range of underserved populations in the United States, it is crucial to consider how payment reforms may or may not be targeting safety net organizations. CMMI payment reforms are particularly relevant to safety net organizations because of these organizations' strong linkages with public programs. However, no summary evidence is available to guide policy makers' ability to determine whether current payment

reform efforts generally target or include safety net organizations at levels that are comparable with their role in the US healthcare delivery system. Likewise, safety net organizations themselves may benefit from a comprehensive review of the applicability of all CMMI programs to their organizations. The goal of this analysis is to explore the landscape of CMMI payment reform initiatives to better understand the range of payment reform efforts currently under way and the implications for how safety net organizations are funded in the future.

## METHODS

### Defining the Safety Net

Safety net providers organize and deliver a significant level of health-care and other health-related services to the uninsured, Medicaid enrollees, and other vulnerable patient populations.<sup>12</sup> Although there is a lack of consensus on what specifically constitutes a safety net organization,<sup>26</sup> we identified the safety net as including organizations serving vulnerable or underserved patients across 6 distinct but inter-related subsectors: federally qualified health centers (FQHCs), critical access hospitals, public teaching hospitals, community mental health centers, tribal health centers, and oral health providers who care for the underserved. The 6 subsectors are outlined in **Table 1**. These are not the only safety net organizations (others would include, for example, freestanding charity clinics), but they represent the largest portion of safety net providers.

### Data Sources and Approach

To identify federal payment reform opportunities available to safety net organizations, we identified all CMMI payment reform initiatives. We carefully reviewed each program and its stated goals, eligibility criteria, terms and conditions, and other relevant information available on the CMMI public website. We then classified the program according to a 3-level, mutually exclusive categorization: (1) specifically targeting the safety net, (2) applying to the safety net but not specifically targeting it, or (3) not applying to the safety net. Second, we classified each initiative as past (no longer active as of 2017), current, or future (under development, announced, accepting applications, applications under review, or participants announced). Third, for initiatives that applied to or specifically targeted the safety net, we reviewed the full description of the initiatives to determine which safety net subsector the payment reform initiative was relevant to.

To ensure the reliability of our categorizations, 2 members of the research team (N.C. and M.G.) each independently reviewed and coded all programs. When assessments differed, a third member of the research team (J.M.M.) reviewed the program and adjudicated resolution for whether that program specifically targeted, applied to, or did not apply to the safety net. For programs that applied to or specifically targeted safety net organizations, we again reviewed the program eligibility criteria, functions, and targeted stakeholders.

**Table 1. Healthcare Safety Net Subsectors, Number of Organizations, and Annual Patient Volume<sup>a</sup>**

Safety Net Subsector	National Advocacy Organization	Number of National Advocacy Organization Members	National Advocacy Organization Members' Annual Patient Volume
Community mental health centers	The National Council for Behavioral Health	2900	10,000,000
Critical access hospitals	American Hospital Association	1341	8,000,000
Federally qualified health centers	National Association of Community Health Centers	1375	25,000,000
Oral health safety net providers	National Network for Oral Health Access	850	14,900,000
Public county hospitals	America's Essential Hospitals	365	13,800,000
Tribal health centers	National Indian Health Board	691	6,600,000

<sup>a</sup>Organization membership and annual patient volume statistics retrieved from respective national advocacy organizations (The National Council for Behavioral Health, American Hospital Association, National Association of Community Health Centers, National Network for Oral Health Access, America's Essential Hospitals, and National Indian Health Board).

We then classified applicable programs as applying to 1 or more of the 6 safety net sectors.

**Data Analysis**

We conducted univariate and bivariate analyses to assess the breadth and identify patterns of CMMI payment reform programs applicable to safety net organizations. We specifically examined (1) whether the proportion of payment reform programs applicable to the safety net differed for past, current, and future CMMI programs and (2) whether any individual safety net subsector was over- or underrepresented in CMMI payment reform programs. All analyses were performed using Excel (Microsoft; Seattle, Washington) and Stata 13.1 (StataCorp; College Station, Texas).

**RESULTS**

Our review of CMMI initiatives revealed a total of 76 programs. Nine programs that were not directly related to payment reform (ie, initiatives to improve quality of care that did not incorporate any payment reform components) were excluded. The final sample size was 67 CMMI payment reform initiatives.

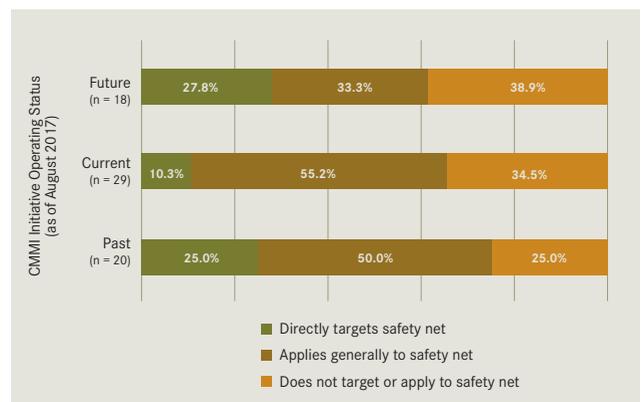
A total of 45 (67%) of these initiatives applied to safety net organizations, whereas 22 (33%) did not apply. Of the 45 initiatives that applied to safety net organizations, 13 (19%) specifically targeted safety net providers; the remaining 32 (48%) did not directly target safety net providers and only included safety net organizations more generally. Complete, initiative-by-initiative findings can be seen in the **eAppendix** (available at [ajmc.com](http://ajmc.com)).

Of the 67 CMMI payment reform initiatives, we also identified 20 as past (no longer active) initiatives, 29 as current initiatives, and 18 as planned or anticipated initiatives. The **Figure** shows that the proportion of initiatives targeting the safety net has not varied

over time and that the change in the proportion of programs that targeted, applied to, or did not involve the safety net was not statistically significant ( $P = .41$ ).

As shown in **Table 2**, CMMI payment reform initiatives most commonly targeted safety net hospitals, whereas far fewer initiatives targeted oral health safety net providers. Of the 45 initiatives that applied to safety net organizations, 11 were applicable to safety net hospitals but to no other safety net subsectors (data not shown in table). There were 26 initiatives that included multiple safety net subsectors (eg, hospitals plus FQHCs or community mental health providers). Of the 22 initiatives not applicable to the safety net, most were determined to be targeted to either hospitals ( $n = 8$ ) or nursing homes/home health care ( $n = 8$ ).

**Figure. Proportion of CMMI Payment Reform Initiatives Applicable to the Safety Net Over Time**



CMMI indicates Center for Medicare and Medicaid Innovation.

## DISCUSSION

Reimbursement models that link payment to quality or value are becoming increasingly common and important in the US health-care delivery system. In 2015, HHS set a goal of tying 30% of traditional FFS Medicare payments to quality or value through APMs by 2016 and 50% by 2018.<sup>27</sup> The Health Care Payment Learning & Action Network, an organization sponsored by HHS, has since expanded this goal to encompass the entire US health system, including public and private sectors.<sup>2</sup> However, the extent to which organizations serving vulnerable populations are represented in these initiatives is unknown. This analysis quantified past, current, and future CMMI payment reform initiatives relevant to the safety net.

We found that two-thirds of CMMI initiatives were applicable to safety net organizations, but the majority of these initiatives did not directly target the safety net. This could mean, for example, that only a single safety net hospital or FQHC participated in the initiative. Additionally, several large initiatives included safety net organizations, but the designs of these initiatives were not explicitly tailored to address the challenges that safety net organizations face in caring for underserved populations, nor were these programs tailored to the specific features of various safety net organization payment models. Initiatives that directly target safety net organizations are far less common, representing less than 20% of all CMMI payment reform programs. Among initiatives that are applicable to the safety net, nearly half included organizations from only a single portion of the safety net (eg, safety net hospitals, FQHCs, or behavioral health clinics). This is despite the well-known importance of integrating care across settings and coordinating among inpatient providers, outpatient providers, and community resources for service delivery.<sup>10,28</sup>

Results from previous studies have shown that safety net hospitals may not be well positioned to succeed under APMs.<sup>6,7,9-11</sup> Safety net organizations may therefore require more specialized or targeted support, including opportunities such as CMMI programs that enable healthcare delivery organizations to test and refine innovative payment reform approaches. However, we did not find evidence that CMMI initiatives disproportionately target the safety net or that the number of programs targeting safety net organizations is increasing over time. Although the majority of CMMI initiatives considered allowing safety net organizations to participate, these programs do not account for the challenges that safety net organizations must confront. Limited financial resources may make it difficult for safety net organizations to invest in the up-front costs, such as data systems or care coordination resources, that are required to successfully undertake the shift toward value-based care.<sup>29</sup>

Payment reform can provide safety net organizations with the opportunity to improve the health of the nation's most vulnerable populations, but a one-size-fits-all approach to the diffusion of APMs across the entire healthcare system may not be ideal.

**Table 2. CMMI Payment Reform Initiatives Relevant to or Targeting Specific Safety Net Subsectors<sup>a</sup>**

Safety Net Subsector	Number of Applicable CMMI Payment Initiatives
Public county hospitals	31
Critical access hospitals	27
Federally qualified health centers	23
Tribal health centers	17
Community mental health centers	14
Oral health safety net providers	9

CMMI indicates Center for Medicare and Medicaid Innovation.

<sup>a</sup>Initiatives may have 1 or more applicable safety net subsectors.

Specifically, different safety net sectors need different types of support to succeed in value-based reimbursement approaches, given the unique financing mechanisms for each sector. Particularly at the outset, implementing payment reform programs may require additional financial and labor inputs.<sup>30</sup> In the safety net, these resources are typically in shorter supply in comparison with non-safety net organizations.<sup>29,31</sup>

Our findings also reveal that certain safety net sectors appear to be disproportionately targeted by payment reform programs. For example, public county hospitals and critical access hospitals, 2 settings that provide mainly acute care, were eligible for the largest number of CMMI programs. In contrast, FQHCs and community mental health centers, 2 settings that provide mainly primary care, were eligible for participation in fewer payment reform programs. Given the importance of coordinating care across settings,<sup>32</sup> linking acute with primary care under new payment models,<sup>3,33</sup> and continuing to strengthen the primary care system in the United States,<sup>34-36</sup> the underrepresentation of primary care settings in CMMI programs is an area of specific concern for policy makers. Improving quality and reducing costs are important goals in all sectors, but this imbalance could fuel the mismatch between primary and preventive care compared with acute care.

Some non-CMMI payment reform initiatives are also under way within the safety net. For example, as of 2016, Medicaid ACOs and Delivery System Reform Incentive Payment programs had each been established in 8 states.<sup>37</sup> However, it appears that CMMI represents the greatest opportunity for safety net payment reform work. CMMI plays a vital role in providing opportunities to address the challenges that these safety net organizations face under new payment and care delivery models. Payment reform models that include or specifically target the safety net sector should address the unique challenges presented by underserved patients, such as lack of resources to hire specialized, highly trained administrative and clinical personnel and to implement and coordinate data infrastructure systems.

In this study, our team carefully reviewed each CMMI program to assess its relevance to the safety net; this required more than 100 hours to analyze published CMMI programs in order to determine their relevance to the safety net in general and to specific subsector(s) therein, and additional time would be necessary to determine how to apply for upcoming programs. Programs that are applicable to the safety net should be easily identifiable. Safety net organizations already face resource constraints and may not have spare personnel resources to dedicate to identifying appropriate programs. Clearly highlighting applicable programs could concretely support the safety net in participating in payment reform initiatives.

### Limitations

Our findings should be viewed in light of our study's limitations. First, there is not a specific universal acknowledgment of what constitutes the safety net. We operationalized the most widely used definition—that of the Institute of Medicine—yet this definition may be broader or narrower than others.<sup>12</sup> We categorized which subsector(s) of the safety net each CMMI program fit into in order to facilitate further reanalysis of safety net sector applicability if desired. Second, our review reflects applicability of CMMI payment reform programs only. Given the involvement of state-level funding sources across the safety net, additional work to categorize the full extent of safety net payment reform programs may generate different point estimates for the number of relevant programs that are active or planned. Our findings can still be interpreted to reflect federal initiatives that reach safety net populations that span multiple states (eg, Medicare–Medicaid enrollees) or underserved populations in hospital referral regions that span multiple states.

### CONCLUSIONS

Changing healthcare payment to emphasize value and de-emphasize volume presents an important opportunity to improve performance of the healthcare system. However, the safety net sector may face challenges in transitioning to value-based payment approaches, and it is likely to need special consideration and focus if HHS and private payers are to achieve ambitious targets for widespread dissemination of value-based payments. To date, very little summary evidence is available to guide policy makers and practitioners with respect to the extent to which the safety net is involved in payment reform initiatives.

Our analysis reveals that although the safety net is broadly eligible for some two-thirds of CMMI payment reform programs, less than 20% of these programs directly target the safety net. This is in spite of the fact that the safety net, broadly defined, serves more than 100 million patients annually. Safety net–relevant CMMI payment reform programs tend to be focused more on hospitals than on primary care settings, and the proportion of

safety net–relevant CMMI programs is not increasing over time. Moreover, there is no expedient approach to determine the relevance of each CMMI program to specific subsectors of the safety net. Additional consideration of ways to enhance the clarity of safety net relevance may help provider organizations to more fully understand and participate in relevant CMMI programs. Programs that specifically target the safety net may represent an important opportunity to overcome unique payment reform challenges that this portion of the healthcare sector must face. The safety net sector is underaddressed by past, current, and future CMMI payment reform programs.

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### REFERENCES

- Porter ME. What is value in health care? *N Engl J Med.* 2010;363(26):2477-2481. doi: 10.1056/NEJMp1011024.
- Alternative payment model (APM) framework refresh. Health Care Payment Learning & Action Network website. [hcp-lan.org/apm-refresh-white-paper](http://hcp-lan.org/apm-refresh-white-paper). Published July 11, 2017. Accessed April 21, 2018.
- Rittenhouse DR, Shortell SM, Fisher ES. Primary care and accountable care—two essential elements of delivery-system reform. *N Engl J Med.* 2009;361(24):2301-2303. doi: 10.1056/NEJMp0909327.

4. Miller HD. From volume to value: better ways to pay for health care. *Health Aff (Millwood)*. 2009;28(5):1418-1428. doi: 10.1377/hlthaff.28.5.1418.
5. Fisher ES, McClellan MB, Safran DG. Building the path to accountable care. *N Engl J Med*. 2011;365(26):2445-2447. doi: 10.1056/NEJMp1112442.
6. Andrulis DP, Siddiqui NJ. Health reform holds both risks and rewards for safety-net providers and racially and ethnically diverse patients. *Health Aff (Millwood)*. 2011;30(10):1830-1836. doi: 10.1377/hlthaff.2011.0661.
7. Gilman M, Adams EK, Hockenberry JM, Wilson IB, Milstein AS, Becker ER. California safety-net hospitals likely to be penalized by ACA value, readmission, and meaningful-use programs. *Health Aff (Millwood)*. 2014;33(8):1314-1322. doi: 10.1377/hlthaff.2014.0138.
8. Mohan A, Grant J, Batalden M, McCormick D. The health of safety net hospitals following Massachusetts health care reform: changes in volume, revenue, costs, and operating margins from 2006 to 2009. *Int J Health Serv*. 2013;43(2):321-335. doi: 10.2190/HS.43.2.h.
9. Cole ES, Walker D, Mora A, Diana ML. Identifying hospitals that may be at most financial risk from Medicaid disproportionate-share hospital payment cuts. *Health Aff (Millwood)*. 2014;33(11):2025-2033. doi: 10.1377/hlthaff.2014.0109.
10. Katz MH. Future of the safety net under health reform. *JAMA*. 2010;304(6):679-680. doi: 10.1001/jama.2010.1126.
11. Felland L, Cunningham P, Doubleday A, Warren C. *Effects of the Affordable Care Act on Safety Net Hospitals*. Washington, DC: Mathematica Policy Research; 2016. [aspe.hhs.gov/system/files/pdf/255491/SafetyNetHospital.pdf](https://aspe.hhs.gov/system/files/pdf/255491/SafetyNetHospital.pdf). Accessed April 21, 2018.
12. Lewin ME, Altman S, eds; Institute of Medicine. *America's Health Care Safety Net: Intact but Endangered*. Washington, DC: The National Academies Press; 2000. doi: 10.17226/9612.
13. Blegen MA, Goode CJ, Spetz J, Vaughn T, Park SH. Nurse staffing effects on patient outcomes: safety-net and non-safety-net hospitals. *Med Care*. 2011;49(4):406-414. doi: 10.1097/MLR.0b013e318202e129.
14. Friedberg MW, Chen PG, White C, et al. Effects of health care payment models on physician practice in the United States. *Rand Health Q*. 2015;5(1):8.
15. Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. *JAMA*. 2011;305(7):675-681. doi: 10.1001/jama.2011.123.
16. Neuhausen K, Davis AC, Needleman J, Brook RH, Zingmond D, Roby DH. Disproportionate-share hospital payment reductions may threaten the financial stability of safety-net hospitals [erratum in *Health Aff (Millwood)*]. 2014;33(7):1304. doi: 10.1377/hlthaff.2014.0688]. *Health Aff (Millwood)*. 2014;33(6):988-996. doi: 10.1377/hlthaff.2013.1222.
17. Ku L, Shin P, Regenstein M, Mead H. Promoting the integration and coordination of safety-net health care providers under health reform: key issues. The Commonwealth Fund website. [commonwealthfund.org/publications/issue-briefs/2011/oct/promoting-integration-and-coordination-safety-net-health-care](https://www.commonwealthfund.org/publications/issue-briefs/2011/oct/promoting-integration-and-coordination-safety-net-health-care). Published October 13, 2011. Accessed January 29, 2019.
18. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769. doi: 10.1377/hlthaff.27.3.759.
19. Adler-Milstein J, DesRoches CM, Kralovec P, et al. Electronic health record adoption in US hospitals: progress continues, but challenges persist. *Health Aff (Millwood)*. 2015;34(12):2174-2180. doi: 10.1377/hlthaff.2015.0992.
20. Torda P, Han ES, Scholle SH. Easing the adoption and use of electronic health records in small practices. *Health Aff (Millwood)*. 2010;29(4):668-675. doi: 10.1377/hlthaff.2010.0188.
21. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573-576. doi: 10.1370/afm.1713.
22. Vahey DC, Aiken LH, Sloane DM, Clarke SP, Vargas D. Nurse burnout and patient satisfaction. *Med Care*. 2004;42(suppl 2):II57-II66. doi: 10.1097/01.mlr.0000109126.50398.5a.
23. Medicare value-based payment models: participation challenges and available assistance for small and rural practices. US Government Accountability Office website. [gao.gov/products/GAO-17-55](https://www.gao.gov/products/GAO-17-55). Published December 9, 2016. Accessed April 24, 2018.
24. Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: the 'alternative quality contract.' *Health Aff (Millwood)*. 2011;30(1):51-61. doi: 10.1377/hlthaff.2010.0980.
25. Lewis VA, Colla CH, Schoenherr KE, Shortell SM, Fisher ES. Innovation in the safety net: integrating community health centers through accountable care. *J Gen Intern Med*. 2014;29(11):1484-1490. doi: 10.1007/s11606-014-2911-0.
26. Phillips RL Jr, Bazemore A, Miyoshi TJ. Mapping tools for monitoring the safety net. In: Weinick RM, Billings J, eds. *Tools for Monitoring the Health Care Safety Net*. Rockville, MD: Agency for Healthcare Research and Quality; 2003.
27. Better care. Smarter spending. Healthier people: paying providers for value, not volume [news release]. Washington, DC: CMS; January 26, 2015. [cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-paying-providers-value-not-volume](https://www.cms.gov/newsroom/fact-sheets/better-care-smarter-spending-healthier-people-paying-providers-value-not-volume). Accessed April 24, 2018.
28. Cunningham P, Felland L, Stark L. Safety-net providers in some US communities have increasingly embraced coordinated care models [erratum in *Health Aff (Millwood)*]. 2012;31(10):2356. doi: 10.1377/hlthaff.2012.0983]. *Health Aff (Millwood)*. 2012; 31(8):1698-1707. doi: 10.1377/hlthaff.2011.1270.

29. Katz MH, Brigham TM. Transforming a traditional safety net into a coordinated care system: lessons from Healthy San Francisco. *Health Aff (Millwood)*. 2011;30(2):237-245. doi: 10.1377/hlthaff.2010.0003.
30. McGinnis T, Small DM. Accountable care organizations in Medicaid: emerging practices to guide program design. Center for Health Care Strategies, Inc, website. [chcs.org/resource/accountable-care-organizations-in-medicaid-emerging-practices-to-guide-program-design](http://chcs.org/resource/accountable-care-organizations-in-medicaid-emerging-practices-to-guide-program-design). Published February 2012. Accessed January 29, 2019.
31. Lewin ME, Baxter RJ. America's health care safety net: revisiting the 2000 IOM report. *Health Aff (Millwood)*. 2007;26(5):1490-1494. doi: 10.1377/hlthaff.26.5.1490.
32. Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA*. 2009;301(6):603-618. doi: 10.1001/jama.2009.126.
33. Porter ME, Pabo EA, Lee TH. Redesigning primary care: a strategic vision to improve value by organizing around patients' needs. *Health Aff (Millwood)*. 2013;32(3):516-525. doi: 10.1377/hlthaff.2012.0961.
34. Donaldson MS, Yorody KD, Lohr KN, Vanselow NA, eds; Institute of Medicine. *Primary Care: America's Health in a New Era*. Washington, DC: The National Academies Press; 1996. doi: 10.17226/5152.
35. Davis K, Schoenbaum SC, Audet AM. A 2020 vision of patient-centered primary care. *J Gen Intern Med*. 2005;20(10):953-957. doi: 10.1111/j.1525-1497.2005.0178.x.
36. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x.
37. Chokshi DA, Chang JE, Wilson RM. Health reform and the changing safety net in the United States. *N Engl J Med*. 2016;375(18):1790-1796. doi: 10.1056/NEJMp1608578.

Family	Program Title	Stage and Start/End	Current, Past, Present	Function	Organizations Involved	Applies to Safety Net?	Sectors Included	Source
ACO	ACO Investment Model	Ongoing	Current	For ACOs participating in Shared Savings Program (MSSP). Use pre-paid savings to encourage new ACOs to form in rural and underserved areas; encourage Shared Savings Program ACOs to take on more financial risk. The AIM encourages ACO development in rural and underserved areas. Of the 45 participants, 36 have at least 65 percent of their delivery sites in rural areas.		45 Yes, Targeted	CAH, FQHC	CAH: Page says several ACOs include CAHs. FQHC: Coos County Family Health Services (NH). Several others participating via Rural ACOs.
ACO	Advance Payment ACO Model	No Longer Active. April 2012-December 2015.	Past	Provided upfront and monthly payments to 35 ACOs in Shared Savings Program. Only ACOs that entered MSSP in April 2012, July 2012, and January 2013 were eligible.		35 Yes, Targeted	CAH, FQHC	Application info specifically says ACOs including only CAHs as inpatient facilities are eligible. Final report mentions FQHCs and at least two, Coos County Family Health Services and Indian Stream Health Center, participated via the North Country ACO.
ACO	Comprehensive ESRD Care Model	Ongoing, started in 2015, Announced	Current	Working with ESRD Seamless Care Organizations. Clinics, nephrologists, and other providers coordinate care and ESCOs are accountable for clinical quality and financial outcomes measured by Medicare A/B spending (including dialysis services). Non-large dialysis organizations (fewer than 200 facilities) can opt to receive shared savings payments but will not be liable for payment of shared losses; can also have higher risk and potential for shared losses.		37 No		Participants are kidney care clinics and nephrology physician practices. In request for applications "Include safety net providers that care for indigent populations" as part of criteria for selection but didn't end up including any safety net orgs.
ACO	Medicare Health Care Quality Demonstration	Ongoing, began in 2009, year 3 data available, scheduled to end 2014	Current	Examine the extent to which major, multi-faceted changes to traditional Medicare's health delivery and financing systems lead to improvements in the quality of care provided to Medicare beneficiaries, without increasing total program expenditures.		4 No		Hospitals included are not AEH or CAH
ACO	Next Generation ACO Model	Announced, applications under review	Future	For ACOs who have participated before; can assume higher levels of risk and reward compared to Pioneer Model. Providers coordinate care of aligned beneficiaries.		44 Yes	AEH, CAH, FQHC	Methodology doc mentions CAHs and FQHCs. Request for applications also says CAHs and FQHCs are eligible. Several AEHs participating, including Henry Ford (MI) and Indiana University Hospital (IN).
ACO	Nursing Home Value-Based Purchasing Demonstration	Ongoing	Current	Financial incentives for nursing homes with high quality or improvement in care. Quality is 30% staffing related, 30% appropriate hospitalizations, 20% MDS Outcomes, 20% Survey Deficiencies. Incentive payments based on state payment pool (calculated); budget neutral		182 No		Only includes nursing homes (AZ: 41, NY: 79, WI: 62)
ACO	Physician Group Practice Transition Demonstration	No Longer Active	Past	First pay-for-performance initiative for physicians under the Medicare program. Under the PGP Demonstration, physician group practices continued to be paid under regular Medicare fee schedules, but earned incentive payments for offering patients high-quality, coordinated healthcare that resulted in Medicare savings for the patient population they served. Had to meet benchmarks.		6 Yes	CAH	Billings Clinic includes Beartooth Billings Clinic, a CAH.

ACO	Pioneer ACO Model	No Longer Active	Past	Population-based payment. Coordinate with private payers and providers to achieve shared savings and higher standard of care. In order to receive savings or owe losses in a given year, ACO expenditures must be outside a minimum corridor set by the ACO's minimum savings rate (MSR) and minimum loss rate (MLR). If savings/loss is within this corridor, no payment is made to the ACO or owed to CMS. If the Gross Savings/Losses percentage is outside this corridor, then the ACO splits the overall savings/loss with CMS.	32	Yes	CAH, FQHC, CMH	CAH: New Ulm Medical Center and River Falls Area Hospital via Allina Health ACO. Franciscan Alliance also included CAH. FQHC and CMH: mentioned in selectee descriptions document.
ACO	Private, For-Profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE)	No Longer Active	Past	Study to compare the costs, quality, and access to services provided by for-profit entities to those of nonprofit PACE providers. PACE=provide integrated care and services to the frail elderly at risk of institutionalization to enable them to remain in the community.	6	No		Program is for PACE providers.
ACO	Vermont All-Payer ACO Model	Announced	Future	Offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state, and will provide Vermont a funding opportunity announcement for \$9.5M in start-up investment to assist Vermont providers with care coordination and bolster their collaboration with community-based providers. Medicaid also incorporated. Goal is or 70% of Vermont insured residents to be attributed to ACO by 2022. Participation in the ACO is voluntary.	TBA	Yes	AEH, CAH, FQHC, CMH, Oral	Participants are not yet announced, but program is meant to include all providers in Vermont. Vermont does not appear to have Tribal Health facilities.
Episode-Based Payment	Acute Myocardial Infarction (AMI) Model	Announced	Future	Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to AMI treatment and recovery, beginning with a hospitalization for AMI treatment and extending for 90 days following hospital discharge. Under the AMI Model, the hospital is financially accountable for the quality and cost of an AMI episode of care, which incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.	1,095	Yes	AEH, CAH, Tribal Health	AEH= University of Missouri Health Care, East Alabama Medical Center, Yuma Regional Medical Center, Mt. Sinai Hospital (IL). CAH= Lost Rivers District Hospital (ID). Tribal= Sells Indian Health Service Hospital.
Episode-Based Payment	BCPI Model 1: Retrospective Acute Care Hospital Stay Only	No Longer Active	Past	Pertains to inpatient stay in acute care hospital. Medicare pays hospital discounted amount based on payment rates from Inpatient Prospective Payment System (automatic predetermined discount). Financial risk after 30 days of episode for Part A and B costs. Medicare pays physicians separately under Medicare Phys Fee Schedule. Applies to all MS-DRGs unless excluded by participant. Aims to reduce redundancies, improve processes, and save costs internally. Includes quality and activity reporting requirements.	24	Yes	AEH	AEH= St. Joseph's Regional Medical Center (NJ).

Episode-Based Payment	BCPI Model 2: Retrospective Acute & Post Acute Care Episode	Ongoing, started 2013, until at least 2018	Current	Participants can choose from 48 episodes (e.g. major joint replacement of lower extremity). The most comprehensive bundle, which includes the triggering hospital stay (i.e., the anchor hospitalization), all concurrent professional services and post-discharge services, including hospital readmissions, delivered within the chosen episode length of 30, 60, or 90 days (with certain exclusions). Individual providers are paid on a fee-for-service basis and total episode payments are reconciled retrospectively against the established target price.	AEH	AEH: UC Irvine, UCSD.	519	Yes	
Episode-Based Payment	BCPI Model 3: Retrospective Post Acute Care Only	Ongoing, started 2013, until at least 2018	Current	Includes services after the anchor hospital discharge, including professional services and readmissions within the chosen episode length of 30, 60, or 90 days (with certain exclusions). The episode starts when a beneficiary is admitted to a participating skilled nursing facility (SNF), home health agency (HHA), inpatient rehabilitation facility (IRF), or long-term care hospital (LTCH) following a hospitalization for a chosen clinical episode, or when a beneficiary is admitted to a post-acute care (PAC) setting by a physician who is in a participating physician group practice (PGP). Individual providers are paid on a fee-for-service basis and total episode payments are reconciled retrospectively against the established target price.		Applies to rehab centers, SNFs, home health agencies, etc.	735	No	
Episode-Based Payment	BCPI Model 4: Prospective Acute Care Hospital Stay Only	Ongoing, started 2013, until at least 2018	Current	Includes the anchor hospitalization, all concurrent professional services, and any readmissions and associated professional services that occur within 30 days of discharge that are not explicitly excluded from the bundle. Awardees are paid a prospectively determined amount and they, in turn, pay the providers involved in the episode.	10: 9 acute care hospitals; 9 Awardees and 1 EI involved in care redesign	Program is for acute care hospitals, no participants are AEH or CAH		No	
Episode-Based Payment	Comprehensive Care for Joint Replacement Model	Ongoing. Final rule issued Nov 2015. Expected to go on for about 5 years.	Current	Better/more efficient care for beneficiaries undergoing hip and knee replacements (i.e. lower extremity joint replacements, LEJR). 400,000 procedures costing over \$7 bil in 2014; lots of variation in cost and outcome. Program holds hospitals financially accountable for quality/cost of CJR episode, promote coordination between hospital, physician, and post-acute care provider. Starts with admission to participant hospital, ends 90 days post-discharge. Providers and suppliers are paid normally at first via Part A and B, and then at the end of the year, spending is compared to Medicare's target episode price for the hospital. Depending on quality and spending, hospital may get additional payment or be required to repay Medicare.	67 MSAs; almost 800 hospitals	AEH	America's Essential Hospitals: Participants include Alameda Hospital (CA), Bellevue Hospital (NY), Broward Health Coral Springs/Imperial Point/Medical Center/North, Bon Secours Community Hospital (NJ), Coney Island (NY), DCH Regional Medical Center (AL), Denver Health Medical Center (CO).	Yes	
Episode-Based Payment	Coronary Artery Bypass Graft (CABG) Model	Announced	Future	Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to CABG treatment and recovery, beginning with a hospitalization for CABG treatment and extending for 90 days following hospital discharge.		AEH, CAH, Tribal Health	AEH= Yuma Regional Medical Center (AZ). CAH= Guthrie County Hospital (IA). Tribal= Alaska Native Medical Center, Sells Indian Health Service Hospital.	1096	Yes

Episode-Based Payment	Medicare Acute Care Episode (ACE) Demonstration	No Longer Active, 2009-2012	Past	Tested global payment for an episode of care as an alternative approach to FFS. Covered all Part A and Part B services. For specified cardiovascular and/or orthopedic procedures.	5	No		5 participants were not AEH members or CAHs.
Episode-Based Payment	Medicare Hospital Gainsharing Demonstration	No Longer Active, 2008-2011	Past	Something of a preliminary ACO concept. Designed to test gainsharing as a way for hospitals and physicians to align incentives.	2	No		CAHs were not eligible. Only 2 participants, neither were AEHs or Tribal.
Episode-Based Payment	Oncology Care Model	Ongoing	Current	Incentivizes high-quality, coordinated care for participating practices. Incorporates a two-part payment system for participating practices, creating incentives to improve the quality of care and furnish enhanced services for beneficiaries who undergo chemotherapy treatment for a cancer diagnosis. Paid through \$160 PMPM Monthly Enhanced Oncology Services payment as well as potential for performance-based payment for chemotherapy episodes.	190 practices and 16 payers	Yes	AEH	AEHs include East Alabama Medical Center, University of Chicago Medicine, Henry Ford Health Systems, SUNY Upstate Medical University, University of Cincinnati, OSHU Knight Cancer Institute, United Hospital Center.
Episode-Based Payment	Physician Hospital Collaboration Demonstration	No Longer Active, 2009-2012	Past	Gainsharing program based on quality (short and long term outcomes) and net savings.	12	No		Hospitals included were not AEH, CAH, or Tribal. Physician participants were part of New Jersey Care Consortium.
Episode-Based Payment	Surgical Hip and Femur Fracture Treatment (SHFFT) Model	Announced	Future	Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to SHFFT and recovery, beginning with a hospitalization for SHFFT and extending for 90 days following hospital discharge.	865	Yes	AEH	AEH= Coney Island Hospital (NY), Jackson Memorial Hospital (FL). Based around MSAs.
Primary Care Transformation	Comprehensive Primary Care Initiative	No Longer Active	Past	Multipayer program that offers population-based care management fees and shared savings opportunities. Targeted towards five primary care functions: risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood.	7 CPC regions including 442 sites, 38 public and private payers, 2.7 million patients, including 410,777 Medicare/Medicaid beneficiaries	Yes	Tribal Health	May not concurrently participate in MSSP, Pioneer ACO, FQHC Advanced Primary Care Practice Demonstration, Independence at Home, Medicare High Cost Demonstration, Multi-payer Advanced Primary Care Practice Demonstration, or Physician Group Practice Demonstration. Cherokee Nation participated.
Primary Care Transformation	Comprehensive Primary Care Plus	Ongoing	Current	Builds upon CPC. Multipayer program beginning in January 2017; Advanced APM under MACRA. Payment elments: Care Management Fee (PBPM), performance-based incentive payment, Medicare physician fee schedule (track 1= normal FFS, track 2= reduced FFS payments with Comprehensive Primary Care Payments paid on quarterly basis). Track 2 pays more on average but has more requirements/expectations than Track 1.	2893 Primary Care Practices. Program begins Jan 2017 and runs for 5 years.	Yes	Tribal Health	Mainly targeted at physician practices. Accepting up to 2,500 practices for each track in 14 regions. Cherokee Nation is participating.
Primary Care Transformation	FQHC Advanced Primary Care Practice Demonstration	No Longer Active. Ended Oct 2014.	Past	3-year demonstration to test patient-centered medicale home for Medicare beneficiaries served by FQHCs. FQHCs had to pursue Level 3 PCMH recognition from NCQA by end of demonstration. 69% achieved this. Program will not have cost savings compared to non-program FQHCs. Final report in progress.	434	Yes, Targeted	FQHC	Program specifically designed for FQHCs. No oral health apparent.

Primary Care Transformation	Frontier Extended Stay Clinic Demonstration	No Longer Active. Ended April 2013 after 3 years.	Past	Program was designed to test new type of provider, the FESC. The FESC addressed the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, could not be transferred to acute care hospitals, or patients who needed monitoring and observation for a limited period of time, but did not require hospitalization. At the time, payment for this service was often complicated or not provided.	5 Yes, Targeted	FQHC, Tribal Health	Cross Road Medical Center and Iliulik Family & Health Services are FQHCs, Alicia Roberts Medical Center and Haines Health Center are Tribal facilities.
Primary Care Transformation	Graduate Nurse Education Demonstration	Ongoing	Current	Provide qualified training to advanced practice registered nurse (APRN) students in order to increase the supply of APRNs to provide better access to the increasing number of Medicare beneficiaries. Program provides reimbursement to hospitals for cost of providing training.	5 No		Non-AEH hospitals.
Primary Care Transformation	Independence at Home Demonstration	Ongoing. Began June 2012.	Current	Provide home-based primary care to chronically ill beneficiaries, track quality. If practices meet quality measures while generating savings, they have the opportunity to receive incentive payments after meeting a minimum savings requirement.	14 Yes	AEH	AEH= Boston Medical Center, Virginia Commonwealth
Primary Care Transformation	Medicare Coordinated Care Demonstration	No Longer Active. 2002-2008.	Past	Tested care coordination programs in Medicare FFS settings; wanted to see if it would reduce number of hospitalizations and improve health status while reducing costs. Included both urban and rural settings.	15 No		Did have some attention to rural, but no participants fell into designated categories. Note that CAH was a very new designation at the time the program was designed.
Primary Care Transformation	Multi-Payer Advanced Primary Care Practice	Ongoing. Began July 2011.	Current	Includes Medicare, Medicaid, and private payers. Pays monthly care management fee for beneficiaries receiving primary care from APC practices. Each participating state PCMH is implemented by a state agency as part of a state-sponsored reform initiative. Participants are states.	5 states currently, 8 total over the course of the program, approximately 1200 medical homes Yes	CAH, FQHC, CMH	Third evaluation report mentions several FQHCs and CAHs. Rhode Island included community mental health.
Primary Care Transformation	Transforming Clinical Practice Initiative	Ongoing	Current	Composed of Practice Transformation Networks (groups of physician practices) and Support and Alignment Networks. Funding goes towards technical assistance to help improve care. Round two awardees will participate in Sept. 2016-2019.	41 Yes	AEH, CAH, FQHC, CMH	AEH= UW Medicine (WA). National Rural AC Consortium includes FQHCs and CAHs. Health-e Arizona includes FQHC and mental health. National Council for Behavioral Health and American Psychological Association are awardees.
Initiatives Focused on the Medicaid and CHIP Population	Medicaid Emergency Psychiatric Demonstration	No Longer Active. 2012-2015.	Past	Medicaid doesn't reimburse psychiatric institutions for enrollees 21-64. Patients are referred to hospital Eds which don't provide the right kind of care. Tested reimbursing private psychiatric hospitals for services that aren't typically covered. Recommend that future programs incorporate more settings.	12 states Yes, Targeted	AEH, CMH	Rhode Island used CMH Centers as a resource. Also used in Missouri. AEH: Butler Hospital (RI).
Initiatives Focused on the Medicaid and CHIP Population	Medicaid Incentives for the Prevention of Chronic Diseases Model	Ongoing	Current	States run evidence-based program for one or more of the following goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving management of the condition. Uses various types of rewards directly to Medicaid enrollees.	10 states No		Interventions take place in the patient's home, not facilitated by safety net providers.

Initiatives Focused on the Medicaid and CHIP Population	Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models	Ongoing	Current	Test new approaches to prenatal care to reduce preterm births, improve outcomes, and reduce costs; for mothers in Medicaid or CHIP. Can't use funds to supplement or supplant any funding sources, including Medicaid or CHIP reimbursement.	27 awardees	Yes	AEH, FQHC AEH :Univ. of Alabama at Birmingham, Univ. of South Alabama, Univ. of Tennessee, Medical Univ. of South Carolina, Maricopa, LA county department of health services, Harris county hospital district, Grady health system, Einstein Healthcare network. FQHC: United Neighborhood Health Service.
Initiatives Focused on the Medicare-Medicaid Enrollees	Financial Alignment Initiative for Medicare-Medicaid Enrollees	Ongoing	Current	Align incentives for Medicare-Medicaid beneficiaries by pursuing a capitated model (three-way contract between State, CMS, and health plan) or managed fee-for-service model where State and CMS enter agreement where State can benefit from savings resulting from initiatives designed to improve quality and reduce costs for Medicare and Medicaid	13 states	Yes	AEH, CAH, FQHC, CMH, Oral AEH and CAH: Multiple states included coordination between hospitals and PCPs-- no specific participants mentioned, but given scale of the program, both of these sectors are probably included. FQHC: included in Washington program. CMH: Washington includes community mental health. Oral: Incorporated in Massachusetts program.
Initiatives Focused on the Medicare-Medicaid Enrollees	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	No Longer Active	Past	CMS supports organizations that each partner with a group of LTC facilities to implement evidence-based clinical and educational interventions that both improve care and lower costs. The initiative is focused on long-stay LTC facility residents who are enrolled in both the Medicare and Medicaid programs, with the goal of reducing potentially avoidable inpatient hospitalizations. This initiative was launched in 2012.		7 No	Takes place in nursing facilities
Initiatives Focused on the Medicare-Medicaid Enrollees	Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two	Announced	Future	New funding opportunity for orgs currently participating in initiative to apply to test whether a new payment model for LTC will improve quality of care by reducing avoidable hospitalizations.		6 No	Takes place in nursing facilities
Initiatives Focused on the Medicare-Medicaid Enrollees	Medicare-Medicaid Accountable Care Organization (ACO) Model	Announced, accepting letters of intent	Future	Medicare-Medicaid beneficiaries are sometimes attributed to Medicare ACOs, but no accountability for Medicaid costs. States apply for initiative and new or existing Shared Savings Program ACOs wishing to take on full accountability for Part A, B, Medicaid costs, and quality measures can participate. ACOs may be eligible for shared savings. First deadline (state application) January 20, 2017.	TBA	Yes, Targeted	Specifically mentions "Safety Net ACOs." Still under development, only accepting applications from states at this time. "CMS has included several model design elements that are intended to encourage participation from ACOs with safety-net providers. First, the MMACO Model is intended to align incentives across Medicare and Medicaid. Providers that see a large number of Medicare-Medicaid enrollees, or patients covered by one of these two payers may find this model appealing because it encourages symmetry across payer types. Second, CMS intends to offer specific learning system activities focused on care for high-risk, high-need populations that are served by safety-net providers. CMS believes this will offer ACOs an important opportunity to learn from other providers. Third, CMS intends to offer pre-payment of Medicare shared savings to participating ACOs.

<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Accountable Health Communities Model</p>	<p>Participants Announced</p>	<p>Future</p>	<p>Addresses gap in clinical care and community services by addressing health-related social needs of beneficiaries. Looking at total health care costs, improving health, and quality of care. Will use screenings, referring beneficiaries to community services, navigation services for high-risk community-dwelling beneficiaries, and encouragement of alignment between clinical and community services to ensure that community services are available and responsive. Funded through cooperative agreements with CMS, lump sum depending on track.</p>	<p>32 Yes, Targeted</p>	<p>AEH, CAH, FQHC, Tribal Health</p>	<p>AEH: OHSU, Bon Secours via Baltimore City Health Department. CAH: Allina Health System (River Falls Area Hospital, WI). FQHC: via Baltimore City Health Department. Tribal Health: included in MyHealth Access Network (OK).</p>
<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Cardiac Rehabilitation (CR) Incentive Payment Model</p>	<p>Under Development</p>	<p>Future</p>	<p>Acute care hospitals in certain selected geographic areas participate in retrospective incentive payments for Beneficiary utilization of cardiac rehabilitation/intensive cardiac rehabilitation (CR/ICR) services for the first 90 days following an acute myocardial infarction (AMI) episode of care or a coronary artery bypass graft (CABG) episode of care. Increasing the use of cardiac rehabilitation services has the potential to improve patient outcomes and help keep patients healthy and out of the hospital. Initial payment of \$25 per cardiac rehabilitation service for each of first 11 services; after 11, payment would increase to \$175 per service.</p>	<p>1114 Yes</p>	<p>AEH, CAH, Tribal Health</p>	<p>AEH= East Alabama Medical Center, CAH= Hu Hu Kam (AZ), Tribal= Phoenix Indian Medical Center</p>
<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Frontier Community Health Integration Project Demonstration</p>	<p>Participants Announced</p>	<p>Future</p>	<p>This program will test whether enhanced payments for ambulance services, SNF/NF beds, and telehealth services will enhance access to care for patients, increase the integration and coordination of care among providers within the community, and reduce avoidable hospitalizations, admissions, and transfers, therefore improving the quality of care for Medicare beneficiaries and lowering costs. A specific objective is to support the CAH and local delivery system in keeping patients within the community who might otherwise be transferred to distant providers.</p>	<p>10 Critical Access Hospitals Yes, Targeted</p>	<p>CAH</p>	<p>Program designed for CAHs</p>

<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Health Care Innovation Awards</p>	<p>No Longer Active</p>	<p>Past</p>	<p>Provides funding awards up to \$1 billion to organizations that are implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare/Medicaid/CHIP; high health needs.</p>	<p>107 Yes, Targeted</p>	<p>AEH, CAH, FQHC, Tribal Health, CMH, Oral</p>	<p>Majority of the programs target underserved populations such as people living in rural areas and the homeless. "CMS intends to fund projects in communities with a wide variety of geographic and socioeconomic characteristics, including underserved urban and rural areas." <b>AEH:</b> University of Alabama at Birmingham and University of Arkansas received awards. <b>CAH:</b> One Iowa project includes 10 CAHs. <b>FQHC:</b> Several mentioned as partners in Year 1 and Year 3 Behavioral Health &amp; Substance Abuse annual reports. <b>Tribal Health:</b> Delta Dental of SD conducted an oral health program for American Indian children. <b>CMH:</b> Multiple community mental health centers involved in various behavioral health-focused projects, as mentioned in the Behavioral Health &amp; Substance Abuse annual reports. <b>Oral:</b> Delta Dental of SD conducted an oral health program</p>
<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Health Care Innovation Awards Round 2</p>	<p>Ongoing</p>	<p>Current</p>	<p>Round two of Health Care Innovation Awards; see above</p>	<p>39 Yes, Targeted</p>	<p>AEH, CAH, FQHC, CMH, Oral</p>	<p>CMS chose to fund projects that improved care for populations with specialized needs and improved health of populations, defined by socioeconomic class and other factors, among other aspects. <b>AEH:</b> University of Illinois is a convener for one project. UC San Diego is conducting a project. Boston Medical Center is conducting a project. <b>CAH:</b> Catholic Health Initiatives project in Iowa includes CAHs. <b>FQHC:</b> Several FQHCs mentioned in first evaluation report. <b>CMH:</b> Clifford Beers Clinic had a project. <b>Oral:</b> Columbia University project focuses on oral health, and some care is provided at affiliated sites. Altarum project also implemented value-based purchasing for oral health providers.</p>
<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Home Health Value-Based Purchasing Model</p>	<p>Ongoing</p>	<p>Current</p>	<p>Improve quality and efficiency and promote higher quality care to Medicare beneficiaries-- pay for performance and HHAs in participating states compete on value.</p>	<p>HHAs in 9 states</p>	<p>No</p>	<p>Home Health Agencies only</p>
<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<p>Maryland All-Payer Model</p>	<p>Announced</p>	<p>Future</p>	<p>Maryland uses an all-payer model where all payers pay the same price for services at a certain hospital. This program limits the limit the per capita hospital growth to 3.58% and will implement quality measures.</p>	<p>1 Yes</p>	<p>AEH</p>	<p>Program includes all hospitals in Maryland, including Bon Secours hospital.</p>

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Medicare Advantage Value-Based Insurance Design Model	Applications Under Review	Future	Structures cost sharing and other elements to encourage beneficiaries to consume high-value services (i.e. most likely to positively impact health). MA plans can offer varied plan benefit design for enrollees with diabetes, CHF, COPD, past stroke, hypertension, coronary artery disease, mood disorders, and combinations of the above. Plans cannot have higher cost sharing or fewer benefits as a result of the program		11	No	Program includes MA payers
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Medicare Choices Model	Ongoing	Current	Allows Medicare beneficiaries to receive hospice-like services from hospice providers while also receiving curative services. Participating hospices receive \$200-\$400 PBP when delivering services.		141	No	Program is designed for hospice providers
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Medicare Demonstrations	Ongoing	Current	Variety of CMS programs to improve care and reduce costs. Most are complete.	N/A		No	
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Medicare Intravenous Immune Globulin (IVIg) Demonstration	Accepting Applications	Future	Beneficiaries and their doctors may apply to receive payment and items for services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIgD).	4,000 beneficiaries		No	Program applies to patients and doctors, provides bundled payment for items and services to administer IVIG in home.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Part D Enhanced Medication Therapy Management Model	Announced	Future	Tests whether providing Part D sponsors with additional payment incentives and regulatory flexibilities promotes enhancements in the MTM program, leading to improved therapeutic outcomes, while reducing net Medicare expenditures.		6	No	Program participants are Part D sponsors (commercial payors).
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Pennsylvania Rural Health Model	Announced	Future	Participating rural hospitals would be paid based on all-payer global budgets—a fixed amount that is set in advance for inpatient and outpatient hospital-based services, and paid monthly by Medicare fee-for-service and all other participating payers. In addition, the rural hospitals would deliberately redesign the delivery of care to improve quality of care and meet the health needs of their local communities.	At least 6 (TBA)		Yes, Targeted	CAH Applies to critical access hospitals in rural PA
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Regional Budget Payment Concept	Under Development	Future	CMS is interested in implementing a multi-payer concept similar to the Maryland All-Payer Model at a regional level and requested comments in April 2016. This concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas.	TBA		Yes, Targeted	AEH, CAH "This concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas." Program is still under development, but it is based on the Maryland All-Payer Model which covers all hospitals. Other sectors could be included in new programs.

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Rural Community Hospital Demonstration	Ongoing, started in 2004	Current	Participants must be rural hospitals in AK, AZ, AR, CO, ID, IA, ME, MN, MI, MT, NE, NV, NM, ND, OK, OR, SD, UT, WY. CAHs excluded. Under 51 beds, 24 emergency care. Test the feasibility and advisability of cost based reimbursement for small rural hospitals that are too large to be Critical Access Hospitals. The demonstration is aimed at increasing the capability of the selected rural hospitals to meet the needs of their service areas.	22	Yes, Targeted	Tribal Health	Program takes place in 20 states with lowest population density. Tribal: Includes Alaska and Oklahoma. CAHs excluded.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Model Design Awards Round One	Ongoing	Current	CMS awarded up to \$30 million through Model Design cooperative agreements. States interested in developing transformative payment and delivery reforms were invited to apply for Model Design awards. States created a Health Care Innovation Plan that inform their applications for a Model Test Award or another Model Design Award under the second round of this initiative and support statewide transformation efforts.	16 states	Yes	AEH, CAH, FQHC, Tribal Health, CMH, Oral	AEH: University of Utah involved in Utah program. CAH: Included in Utah program. FQHC: Included in Connecticut program. Tribal Health: Included in Idaho program. CMH: Included in Washington program. Oral: included in Hawaii program.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Model Design Awards Round Two	Ongoing	Current	\$43 million in awards to design or further refine State Health Care Innovation Plans.	21 states/territories/DC	Yes	AEH, CAH, FQHC, Tribal Health, CMH, Oral	CAH: Incorporated in Nevada program. AEH: University of Kentucky participated. FQHC: Incorporated in Oklahoma program. Tribal Health: Incorporated in New Mexico program. CMH: Incorporated in New Mexico program. Oral: Incorporated in Hawaii program.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Model Pre-Test Awards	No Longer Active	Past	Three states received pre-testing assistance and funding to continue to work on a comprehensive State Health Care Innovation Plan. States that received pre-testing awards under the State Innovation Models initiative whad six months to submit their State Health Care Innovation Plans to CMS.	3 states	Yes	AEH, FQHC, Tribal Health, CMH	CO, NY, and WA received pre-test awards. FQHC: Part of Washington program. AEH: Harborview Medical Center and University of Washington participated in WA program. Tribal Health: incorporated in Colorado and Washington programs. CMH: incorporated in Colorado and Washington programs.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Model Test Awards Round One	Ongoing	Current	The CMS Innovation Center invested over \$250 million in Round 1 Model Test awards to support six states in implementing their State Health Care Innovation Plans. A State Health Care Innovation Plan is a proposal that describes a state's strategy to use all of its available levers to transform its health care delivery system through multi-payer payment reform and other state-led initiatives.	6 states: Arkansas, Maine, Mass, Minn, Oregon, Vermont	Yes	AEH, CAH, FQHC, CMH, Oral	Minnesota program was explicitly directed towards the safety net. <b>AEH:</b> Hennepin Health Care System, which includes Hennepin County Medical Center, participated in Year 2. <b>CAH:</b> Southern Prairie Community Care participated in Year 2, includes Redwood Area Hospital, a CAH. <b>FQHC:</b> Participated in Vermont and Maine programs. <b>CMH:</b> incorporated in Arkansas program. <b>Oral:</b> Included in Minnesota and Oregon programs.
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Model Test Awards Round Two	Ongoing	Current	The State Innovation Models Initiative Model Test Awards provide financial and technical support for states to test and evaluate multi-payer health system transformation models. States must implement a proposal capable of creating statewide health transformation for the majority of care within the state.	11 states	Yes	AEH, CAH, FQHC, Tribal Health, CMH, Oral	AEH: Henry Ford Health System (MI) incorporated in Michigan program. Broadlawns Medical Center (IA) in Iowa program. CAH: Incorporated in Iowa program. FQHC: Incorporated in Michigan program. Tribal Health: Incorporated in Idaho program. CMH: Incorporated in Michigan program. Oral: Incorporated in Idaho program.

Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Round One	Ongoing	Current	Incorporates all "Round One" initiatives; see above (Design, Pre-Test, and Test).	19 states	Yes	See above	See above
Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	State Innovation Models Initiative: Round Two	Ongoing	Current	Incorporates all "Round Two" initiatives; see above (Design and Test).	32 states	Yes	See above	See above
Initiatives to Speed the Adoption of Best Practices	Beneficiary Engagement and Incentives: Direct Decision Support (DDS) Model	Applications Under Review	Future	Program is designed to engage beneficiaries about their overall health and specific clinical conditions outside the clinical care setting and will enable beneficiaries to become more informed, empowered, and engaged health care consumers and have a positive impact on their health care decision making, utilization patterns, and cost of care. Each DSO will provide decision support for a core set of preference-sensitive conditions, in addition to proposing a broader range of acute and chronic conditions. The DSOs will receive a fixed per beneficiary per month (PBPM) payment for each beneficiary in the geographic region assigned to them. Twenty-five percent of this amount will be withheld as a performance incentive, which DSOs will be eligible to receive on an annual basis if they meet performance metrics as specified in their Model Participant Agreements.	Up to 7 DSOs, about 700,000 Medicare beneficiaries	No		Program participants are Decision Support Organizations
Initiatives to Speed the Adoption of Best Practices	Beneficiary Engagement and Incentives: Shared Decision Making (SDM) Model	Applications Under Review	Future	The Shared Decision Making Model (SDM Model) will test a specific approach to integrate a structured Four Step shared decision making process into the clinical practice of practitioners who are participating Accountable Care Organizations (ACOs). The shared decision making process is a collaboration between the beneficiary and the practitioner. Focuses on 6 preference-sensitive conditions. The SDM Model will pay participating ACOs \$50 for each SDM Service furnished by its SDM practitioners, as long as all required SDM Activities are completed.	N/A	Yes	AEH, CAH, FQHC	ACOs participating in Medicare Shared Savings or Next Gen ACO can participate. FQHCs and CAHs may participate in MSSP. These sectors may also participate in the Next Gen ACO program, as well as AEHs.
Initiatives to Speed the Adoption of Best Practices	Community-based Care Transitions Program	No Longer Active	Past	Community-based organizations (CBOs) will use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. Up to \$300 million in total funding is available for 2011 through 2015. The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. CBOs will only be paid once per eligible discharge in a 180-day period for any given beneficiary.		18	No	CAHs and America's Essential Hospitals may have been eligible, but none participated

Initiatives to Speed the Adoption of Best Practices	Medicare Diabetes Prevention Program (MDPP) Expanded Model	Announced	Future	The Diabetes Prevention Program is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. Payment structure TBD. Providers may enroll if their organizations meet the requirements.	About 1850 organizations participated in CDC program which Medicare is expanding	Yes	AEH, CAH, FQHC, Tribal Health	AEH: Temple University Hospital participated in CDC program. CAH: Grundy County Memorial Hospital (IA) participated in related CDC program that CMS is expanding. FQHC: Coal Country Community Health Center (ND) participated in CDC program. Tribal Health: Native American Community Clinic (MN) participated in CDC program.
Initiatives to Speed the Adoption of Best Practices	Medicare Imaging Demonstration	No Longer Active	Past	The goal of the demonstration is to collect data regarding physician use of advanced diagnostic imaging services to determine the appropriateness of services in relation to medical specialty guidelines. The demonstration will test whether the use of decision support systems (DSS) can improve quality of care and reduce unnecessary radiation exposure by promoting appropriate ordering of advanced imaging services. Data collection program, not payment reform.		5	AEH	Included Henry Ford Health System, an AEH member.
Initiatives to Speed the Adoption of Best Practices	Million Hearts Cardiovascular Disease Risk Reduction Model	Participants Announced	Future	The Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model is a randomized controlled trial that seeks to bridge a gap in cardiovascular care by providing targeted incentives for health care practitioners to engage in beneficiary CVD risk calculation and population-level risk management. Instead of focusing on the individual components of risk, participating organizations will engage in risk stratification across a beneficiary panel to identify those at highest risk for atherosclerotic cardiovascular disease (ASCVD). The Million Hearts® CVD Risk Reduction Model will use data-driven, widely accepted predictive modeling approaches to generate individualized risk scores and mitigation plans for eligible Medicare fee-for-service beneficiaries. Uses incentive payment structure.		516	AEH, CAH, FQHC, Tribal Health	FAQ indicates that CAHs and FQHCs are eligible. Several Tribal Health clinics are participating. AEH: UC Irvine is participating.
Initiatives to Speed the Adoption of Best Practices	Partnership for Patients	Ongoing	Current	Includes Hospital Improvement Innovation Networks, Hospital Engagement Networks, Community-Based Care Transitions Program, Patient and Family Engagement. Main goals are to make care safer and improve care transitions.	4000 hospitals in hospital engagement networks	Yes	AEH, CAH, Tribal Health	AEH= Minnesota Hospital Association includes Hennepin County Medical Center. CAH= Washington State Hospital Association includes Cascade Medical Center in Leavenworth, WA. Tribal Health= Gallup Indian Medical Center (NM) is part of HIN