The Center for Medicare & Medicaid Innovation (CMS Innovation Center) at the Centers for Medicare & Medicaid Services (CMS) has embarked on an ambitious set of initiatives to test new payment and delivery models that have helped to galvanize transformation in medicine. The CMS Innovation Center was created by the Affordable Care Act to test innovative models of payment and service delivery to reduce expenditures while preserving or enhancing the quality of care provided to Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries.

Opportunities exist today to align strategies between public and private payers to achieve system-wide innovation, thus accelerating the impact of certain models and interventions beyond the world of federal payment. All of our models are tests designed to be potentially scaled up. As a result, all of our models include rapid cycle evaluation built into them from the very beginning and also create ways to accelerate the spread of knowledge gained from the delivery system model tests.

The CMS Innovation Center currently supports models in a number of important areas, spanning the spectrum of population-based prevention down to the level of improvements in the delivery of specific clinical services and procedures. For example, in the Seamless Care Models Group, which I lead, our charge is to focus on initiatives that follow patients across time and settings, resulting in a coordinated and patient-centered care experience. One of our divisions focuses on accountable care models, and the other focuses on advanced primary care models.

The Accountable Care Organization (ACO) Models
The Innovation Center announced the Pioneer ACO Model in May 2011. In December 2011, 32 organizations were selected to participate in the testing of the Pioneer ACO Model, which began in January 2012. The model complements the Medicare Shared Savings Program—the ACO program established by the Affordable Care Act—by offering some provider organizations payment arrangements with higher risk and reward and a transition to population-based payments (or partial capitation) in performance year 3. The model is also intended to test new program features that could be incorporated into the Shared Savings Program in the future.

The Pioneer ACO Model offers providers several payment options with varying and escalating levels of risk and reward. The model also tests among other things: 1) a novel expenditure benchmark methodology that is consistent with prospective patient alignment and that reduces reliance on risk-adjustment methods; 2) a requirement that ACOs eventually commit to deriving the majority of their revenues (Medicare and non-Medicare) from similar outcomes-based contracts; 3) the effectiveness of timely data sharing with appropriate technical assistance; and 4) infrastructure to support intensive shared learning activities.

But not every health care organization was ready to become a Pioneer. For entities such as small physician-led organizations or those in rural areas that would like to participate in the Medicare Shared Savings Program but may lack access to the capital they need to get started, the Innovation Center announced the Advance Payment ACO model in October 2011. This model was available to eligible ACOs that had been accepted into the Medicare Shared Savings Program in either the April or July 2012 or January 2013 application periods and also applied for the Advance Payment model, a process that included describing their organizational structure and plans for investing the funds. Available funds were paid as an “advance” on the savings it is hoped these organizations will realize in the Shared Savings Program relative to traditional Medicare fee-for-service care. There are currently 20 ACOs participating in the Advance Payment Model.

The Comprehensive Primary Care Initiative
Many in primary care practices agree that the biggest barrier to transformation in practice is transformation in payment. The model of “usual primary care,” supported by usual fee-for-service visit-based payments, does not reliably offer some of the high-value services that could be offered in a primary care practice, including care coordination, proactive intervisit care for at-risk patients, or risk stratification and customized care management based on identified risk factors. Many experts agree that strengthening and augmenting primary care capacity—not to do more of what we do now but to do something related but different—is critical to having a high performing delivery system. The Comprehensive Primary Care initiative (http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html) tests a new model for delivery of primary care.
care in collaboration with other public and private payers that rests on three foundational elements: enhanced payment, robust use of electronic health records (EHRs), and continuous improvement driven by data. The model defines five core functions of high-value comprehensive primary care: 1) risk-stratified care management, 2) 24/7 access to a clinician with access to information, 3) proactive management of chronic disease and prevention, 4) patient and family engagement, and 5) care coordination across the medical neighborhood. CMS will pay a monthly care management fee—on average, $20 per Medicare beneficiary per month in the first two years—and offers an opportunity for practices to share in savings achieved for their Medicare beneficiaries—net of the Innovation Center’s investment in the initiative—generated as a result of practices’ participation in the program.

When the Innovation Center released the initiative, it invited public and private payers across the country to propose an enhanced non-visit-based support strategy aligned with the one offered by the CMS Innovation Center, to commit to an aligned data sharing strategy on quality and cost, and to declare where in the country they would be prepared to offer it. We learned that insurers, employers, and state Medicaid agencies across the country were interested in attaining higher value primary care. Ultimately, 44 separate payers agreed to offer increased revenue to selected primary care practices in seven markets across the country (Hudson Valley region of New York; the states of New Jersey, Arkansas, Colorado, and Oregon; the greater Cincinnati-Dayton Ohio/Northern Kentucky region; and the greater Tulsa, OK, region).

Having identified the areas of overlapping interest, the Innovation Center invited primary care practices in those markets to apply. We set very high selection criteria standards. Because effective use of health information technology is key to the success of the primary care model we are seeking to test, one important focus for the selection criteria was participation in the Medicare and Medicaid EHR Incentive Programs and attesting to meaningful use of EHRs. We have now selected 500 practices, including more than 2,000 individual clinicians. Roughly one third are general internists, and two thirds are family physicians.

The five “primary care functions” have been “operationalized” as a set of nine practice milestones that practices need to achieve by the end of program year 1. The operating assumption is that more can be done to empower and support participating practices to provide them the resources to realize our shared goal of better patient health at lower cost. We plan an ambitious curriculum delivered through a national and local learning community to help them achieve the milestones and position themselves to be successful at improving quality while decreasing total cost of care.

**Conclusion**

We are very hopeful that, given the Innovation Center’s statutory authority to test models that could be expanded to test on a nationwide basis, these models will succeed in contributing both to payment reform and development of newer high-value models of accountable care and of primary care practice. The models being tested represent decades of experience and thoughtful leadership by those who have fought tirelessly for a system where physicians can be better supported in delivering the kind of patient-centric care that we all know will lead to improved outcomes and long-term sustainability. We hope SGIM members will get involved with those in their community engaged in these programs, studying the initiatives and/or continuing to develop the knowledge base on which effective models of care delivery need to be built.