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The innovation center is focused on three major goals

The Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI) develops and tests new healthcare payment and service delivery models to:

- Improve patient care.
- Lower costs.
- Better align payment systems to promote patient-centered practices.

Within the Innovation Center portfolio, there are three models that focus on community transformation

The Accountable Health Communities (AHC) Model

Tests whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

Community Health Access and Rural Transformation (CHART) Model

Tests a model to address disparities by providing a way for rural communities to transform their health care delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities.

Geographic Direct Contracting (Geo) Model

Tests whether a geographic-based approach to care delivery and value-based care can improve health and reduce costs for Medicare beneficiaries across an entire geographic region.

There are multiple tools in the toolbelt to create the incentives to lower cost, improve quality and improve alignment

	Funding	Capitation	Risk	Flexibilities
The Accountable Health Communities (AHC) Model	✕			✕
Community Health Access and Rural Transformation (CHART) Model	✕	✕	✕	✕
Geographic Direct Contracting (Geo) Model		✕	✕	✕

Funding enables organizations to invest in infrastructure and activities that may have longer returns on investment

Funding | Capitation | Risk | Flexibilities

The **AHC model** will provide funding to organizations to implement universal screening of all community-dwelling beneficiaries who seek care from participating clinical delivery sites referral to community services and intensive community service navigation.

The **CHART Community Transformation Track** will provide Lead Organizations with funding to establish partnerships with community stakeholders to develop a health care delivery system redesign strategy, recruit Participant Hospitals, and procure technical support.

Capitation provides flexibility for participants and providers to efficiently allocate resources outside of a fee for service framework

Funding | **Capitation** | Risk | Flexibilities

The **CHART Community Transformation Track** will provide participating Hospitals with capitated payments. Capitated payments provide hospitals with a stable revenue stream and incentivize reductions in fixed costs and avoidable utilization.

The **Geo Model** will provide participating providers with the option to enter capitated payment arrangements, which may be used to support population health, value based payment arrangements with its downstream providers, or to invest in health care management tools, such as health care technologies.

Risk aligns the incentives for participants and providers to implement interventions that lower cost and increase quality

Funding | Capitation | **Risk** | Flexibilities

The **CHART ACO Transformation Track** will provide the opportunity for rural ACO to receive payments as part of joining the Medicare Shared Savings Program (Shared Savings Program). Building on the success of the ACO Investment Model (AIM), the advanced shared savings payments are expected to help CHART ACOs engage in value-based payment efforts that will improve outcomes and quality of care for rural beneficiaries.

The **Geo Model** will require participants to take full risk with percent shared savings / shared losses, with risk corridors, for Medicare Parts A and B services for aligned Medicare FFS beneficiaries in a defined target region.

Flexibilities enable participants and providers to provide additional services beyond traditional Medicare

Funding | Capitation | Risk | **Flexibilities**

The **CHART** and **Geo Models** both provide a suite of benefit enhancements and beneficiary engagement incentives to increase flexibilities for participating entities.

- Vouchers for transportation services to and from an appointment with a health care provider
- Vouchers for those with malnutrition to access meal programs
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Statute specifies the Innovation Center evaluate quality of care and changes in spending in each model

It is scalable?

- Can the model be scaled to more providers and more patients?
- What infrastructure (tools, data, etc), would be needed to enable it to scale?

Is it generalizable?

- Will the model have the same results if expanded to other communities?
- What are the aspects of the model that may make it unique to specific communities?

Does it improve quality and lower cost?

- What were the interventions within the model that led to improved quality and lower costs?
- How did those interventions vary across providers or specific sub-populations?