Center for Medicare and Medicaid Innovation (CMMI) Initiatives

MGMA Government Affairs Department

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**Medicare Shared Savings Program (ACO)**

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<td>Section 3022 of the Patient Protection Affordable Care Act requires the Centers for Medicare and Medicaid Services (CMS) to establish a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. The program is designed to improve beneficiary outcomes and increase value of care by: • Promoting accountability for the care of Medicare FFS beneficiaries • Requiring coordinated care for all services provided under Medicare FFS • Encouraging investment in infrastructure and redesigned care processes Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization, also called an ACO</td>
<td>Applicants had to Submit a Notice of Intent (NOI) between Nov 1, 2011 - Jan 6, 2012 • After submitting your NOI, CMS will assign you an ACO ID which is required in order to fill out the actual application. <em>You must have an ACO ID to apply to participate in the Medicare Shared Savings Program</em> • If you plan to apply electronically, you will need a CMS User ID to access the automated application system. To get a CMS User ID, follow the instructions at the NOI instruction page • Applications for both 2012 start dates can be found at <a href="http://www.cms.gov/sharedsavingsprogram/">http://www.cms.gov/sharedsavingsprogram/</a></td>
<td>For April 1, 2012 Start Date: Notice of Intent (NOI): Nov. 1, 2011- Jan. 6, 2012 Applications Accepted: Dec. 1, 2011-Jan. 20, 2012 Approval/Denial Decision: March 16, 2012 For April 1, 2012 Start Date: Notice of Intent (NOI): Nov. 1, 2011- Feb. 17, 2012 Applications Accepted: March 1, 2012-March 30, 2012 Approval/Denial Decision: May 31, 2012</td>
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**Advance Payment ACO Model**

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| This initiative is **only** available to ACOs participating in the Medicare Shared Savings Program (MSSP). It will test whether advance, upfront payments will increase participation in MSSP and whether advance payments will allow ACOs to improve care and generate Medicare savings more quickly. | To apply for the Advance Payment ACO Model, interested parties must both apply for the Shared Savings Program and complete a separate application for the Advance Payment ACO Model. For an April 1, 2012 start date applications will be accepted between Jan. 3 and Feb.1. For a July 1 start date applications will be accepted between March 1 and March 30. *Only ACOs that enter the Shared Savings Program in April 2012 or July 2012 will be eligible for advance payments.* | **For April 1, 2012 Start Date:**
Applications Accepted: Dec. 1, 2011-Jan. 20, 2012
Approval/Denial Decision: March 16, 2012

**For July 1, 2012 Start Date:**
Applications Accepted: March 1, 2012-Feb. 17, 2012
Approval/Denial Decision: May 31, 2012 |

For more details, deadlines and application inquiries regarding the Advance Payment ACO Model visit [www.innovations.cms.gov](http://www.innovations.cms.gov)
## ACO Initiatives

### Pioneer ACO Model

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<td>This initiative complements the Medicare Shared Savings Program (MSSP) by testing more advanced ACO models that may already have experience in coordinating care for patients across settings. ACOs spending 1 percent over or under historical core spending (determined from historical per capita payments) will either acquire their savings or pay back overspent funds. Thus, the Pioneer Model is a shared savings payment policy with generally higher levels of shared savings and risk than levels currently proposed in MSSP.</td>
<td>Applications were due in 2011. December 19, 2011 CMS announced 32 applicants they selected for the Pioneer ACO Model. For a complete list of chosen organizations, including region, for the Pioneer ACO visit <a href="http://www.innovations.cms.gov">www.innovations.cms.gov</a></td>
<td>The Pioneer ACO Model is a three year initiative. The first performance period began Jan. 1, 2012 2012-2014: test shared savings and shared losses at higher levels than MSSP 2014-2015: those who have shown savings the first two years will be eligible to move to a population-based payment model</td>
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The 32 organizations participating in the Pioneer ACO Model:

1. Allina Hospitals & Clinics
2. Atrius Health
3. Banner Health Network
4. Bellin-Thedacare Healthcare Partners
5. Beth Israel Deaconess Physician Organization
6. Bronx Accountable Healthcare Network (BAHN)
7. Brown & Tolan Physicians
8. Dartmouth-Hitchcock ACO
9. Eastern Maine Healthcare System
10. Fairview Health Systems
11. Franciscan Alliance
12. Genesys PHO
13. Healthcare Partners Medical Group
14. Healthcare Partners of Nevada
15. Heritage California ACO
16. JSA Medical Group
17. Michigan Pioneer ACO
18. Monarch Healthcare
19. Mount Auburn Cambridge
20. North Texas ACO
21. OSF Healthcare System
22. Park Nicollet Health Services
23. Partners Healthcare
24. Physician Health Partners
25. Presbyterian Healthcare Services – Primecare Medical Network
26. Renaissance Medical Management
27. Seton Health Alliance
28. Sharp Healthcare System
29. Steward Health Care System
30. TriHealth, Inc.
31. University of Michigan
Bundled Payments for Care Improvement

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| On Aug. 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments: • Model 1 covers inpatient hospital service • Model 2 covers inpatient hospital and postacute services • Model 3 covers postacute services • Model 4 covers inpatient hospital and physician services. Applicants would propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the traditional fee-for-service (FFS) system. After the conclusion of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings. For more details on the four models visit the Bundled Payments CMS website. | Applicants for Model 1 had to submit a Letter of Intent (LOI) by Sep. 22, 2011 and a completed application by Oct. 21, 2011. Applicants for Models 2-4 had to submit a LOI by Nov 4, 2011. CMS announced applications for Models 2-4 are now due on April 30, 2012. For Models 2-4: CMS will provide historical Medicare claims data to potential applicants. In order to receive the data applicants must submit a Research Study Protocol along with their LOI, and will later be expected to submit and comply with a Data Use Agreement (DUA.). For a general fact sheet, frequently asked questions and application materials visit the CMS website. | Model 1:  
Application by: Oct. 31, 2011  
target date for supplying Limited Data Sets: Feb. 28, 2012  

Model 2-4:  
Letter of Intent (LOI): Nov. 4, 2011  
Application by: April 30, 2012  
target date for supplying Limited Data Sets: Feb. 28, 2012 |
### Comprehensive Primary Care (CPC) Initiative

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<td>Multipayer initiative fostering collaboration between public and private healthcare payers to strengthen primary care. CMS will pay a risk-adjusted, monthly care management fee averaging $20 per beneficiary, per-month (PBPM) for the first two years; $15 PBPM for years three and four. After year two, market Medicaid savings will be available to practices. The CPC initiative will test two models simultaneously, a service delivery model and a payment model. The service delivery model will test comprehensive primary care, which is characterized as having the following five functions: 1. Risk-stratified care management 2. Access and continuity 3. Planned care for chronic conditions and preventative care 4. Patient and caregiver engagement; 5. Coordination of care across the medical neighborhood.</td>
<td>Applicants had to submit a nonbinding letter of intent and a completed Geographic Service Area Worksheet by Nov. 15, 2011 via email. Final applications must be received on or before Jan. 17, 2012. Once CMS evaluates these proposals and selects the markets, a second solicitation will be issued for primary care practices in those markets. For more information and application materials visit the CPC initiative website.</td>
<td>Letter of Intent (LOI): Nov. 15, 2011 Applications by: Jan. 17, 2012 <em>Award date unknown</em></td>
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*CMS has yet to announce when monthly payments for chosen applicants will begin.*
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration

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<td>Operated by CMS, in partnership with the Health Resources and Services</td>
<td>Applicants have already been selected for this initiative - 500 FQHCs chosen</td>
<td>- Oct. 24, 2011- CMS announces chosen applicants for demonstration</td>
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<td>Administration (HRSA), will show how the patient-centered medical home (PCMH)</td>
<td>FQHCs are required to update their Readiness Assessment Survey every 6 months; first deadline is May 1, 2012</td>
<td>- This initiative will be conducted from Nov. 1, 2011 through Oct. 31, 2014</td>
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<td>model can improve quality of care, promote better health, and lower costs.</td>
<td>Upcoming Readiness Assessment Survey Update Deadlines:</td>
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<td>The program will test the effectiveness of doctors and other health</td>
<td>- May 1, 2012</td>
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<td>professionals working in teams to coordinate and improve care for up to</td>
<td>- Nov. 1, 2012</td>
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<td>195,000 Medicare patients.</td>
<td>- Other Dates TBD</td>
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<td>To determine the value of providing financial and technical assistance to a</td>
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<td>select cohort of FQHCs in achieving Level 3 PCMH recognition through the</td>
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<td>National Committee for Quality Assurance (NCQA). Goal is to have 90 percent</td>
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<td>of participants achieve Level 3.</td>
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<td>Five hundred community health centers in 44 states across the country will</td>
<td>10 percent of FQHC participants will be randomly selected for audit after each</td>
<td>Nov. 17, 2011- CMS held the first FQHC Primary Care Practice Demonstration conference call in which they discussed the Quarterly Care Management Fee Payment Schedule and other program details. For more information on this program and slides from the conference call visit this CMS demonstration website.</td>
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<td>receive approximately $42 million over three years. Chosen applicants will</td>
<td>Readiness Assessment Survey Update First audit: May 2012</td>
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<td>be paid a monthly care management fee for each eligible Medicare beneficiary</td>
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<td>receiving primary care services. In return, FQHCs agree to adopt care</td>
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<td>coordination practices that are recognized by the NCQA.</td>
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**Multipayer Primary Care**

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<td>Under this demonstration, CMS will participate in multipayer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness and efficiency of healthcare, increase patient decision-making and increase the availability and delivery of care in underserved areas. Purpose: to allow Medicare to join Medicaid and private insurers in state-based health reform initiatives aimed at improving the delivery of primary care.</td>
<td>Past- Solicitation Period Closed/Ongoing Demonstrations</td>
<td>Sep. 2009- HHS announced demonstration The demonstration will be fully operational by midyear 2011 and operate for 3 years Nov. 2011- HHS announced 8 states to participate in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota</td>
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## Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

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<td>CMS will test two models to encourage states to align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and long-term services and supports.</td>
<td>Past</td>
<td>July 2011- HHS announced its adding a Technical Assistance Resource Center available to states, in light of this initiative.</td>
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<td>The Medicare-Medicaid Coordination Office and CMMI are collaborating on this initiative. These two models include:</td>
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<td>To participate in the financial alignment model demonstration, CMS will require that states demonstrate their ability to meet or exceed certain standards and conditions. In order for CMS to determine whether these criteria have been met, each state must submit a proposal that describes the proposed approach for the selected model(s).</td>
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<td>• <em>Capitated Model:</em> A state, CMS and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.</td>
<td><em>States interested in the new financial alignment opportunities were required to submit a letter of intent (LOI) by Oct. 1, 2011</em></td>
<td>The 15 states that received design contracts under the State Demonstrations to Integrate Care for Dual Eligible Individuals may chose to pursue these models and use their planning contract and stakeholder processes to support the development of the demonstration proposal, described below.</td>
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<td>• <em>Managed Fee-for-Service Model:</em> A state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.</td>
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**State Demonstrations to Integrate Care for Dual Eligible Individuals**

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<td>In cooperation with the Medicare-Medicaid Coordination Office, the Innovation Center selected 15 states with design contracts of up to $1 million to develop new ways to meet the often complex and costly medical needs of the approximately 9 million Americans who are eligible for both the Medicare and Medicaid programs, known as “dual eligibles.” The goal of the program is to eliminate duplication of services for these patients, expand access to needed care, and improve the lives of dual eligibles, while lowering costs. The 15 states are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.</td>
<td>Past</td>
<td>April 14, 2011- HHS announced the 15 states that will receive federal funding. These chosen states will receive up to $1 million to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals. States will work with beneficiaries, their families and other stakeholders to develop their demonstration proposals. After federal review of the proposals, CMS will work with states to implement the plans that hold the most promise. For more information visit <a href="#">this initiatives website</a>.</td>
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### Healthcare Innovation Challenge

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| This initiative will award up to $1 billion in grants (each about $1 million to $30 million) to engage a broad set of innovation partners to identify and test new care delivery and payment models that produce better care, better health, and reduced cost. A focus will be on new models of workforce development and on innovators who can rapidly deploy care improvement models (within six months of award). | Letter of Intent (LOI) was due Dec. 19, 2011  
All applications must be sent electronically.  
Interested applicants should use the Funding Opportunity Announcement (FOA) CMS released Nov. 14, 2011 for more information and application criteria.  
The selection process will comprise independent review panels of non-CMMI and non-government leaders. | Letter of Intent (LOI): Dec. 19, 2011  
Applications Due: Jan. 27, 2012  
Anticipated Award Date: March 30, 2012 |
### Innovations Advisors Program

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<td>The program will create a network of experts in improving the delivery system for Medicare, Medicaid, and CHIP beneficiaries. Selected members will receive a $20,000 stipend for their home organization or group. To broadly help individuals refine, apply and sustain managerial and technical skills necessary to drive the delivery system reform to improve the delivery system for beneficiaries. Program designed to deepen several key skill sets, including: • Healthcare economics and finance • Population health • System analysis • Operations research</td>
<td>In Dec. 2011, CMS selected 73 individuals out of 920 applications to participate in the initiative. The first group of Innovation Advisors will start their six-month intensive orientation and applied research period in Jan. 2012. It is anticipated that applications will be reopened in spring 2012 and that the remaining advisors will be selected by June 2012. <em>Applicants who were not selected for the first group do not have to reapply and will automatically be considered when applications are reopened</em></td>
<td>1st applicants chosen: Dec. 2011 1st research period: Jan. 2012 - July 2012 2nd round of applications: June 2012</td>
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For more information on this program visit the [Innovation Advisors Program website](#).
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<td>A nationwide public-private partnership that offers support to physicians, nurses and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other settings. This initiative seeks to decrease, by 40 percent, preventable hospital conditions and reduce by 20 percent readmissions due to preventable complications during a transition from one care setting to another. CMS will dedicate as much as $500 million in funds to test different models to achieve these goals. <em>To date, over 6,000 organizations, including more than 3,000 hospitals, have joined. Launched in April 2011</em></td>
<td>This program is ongoing and those interested may join at anytime. Visit the Partnerships for Patients website. to join your respective partnership pledge. Those that can join: -Hospitals -Clinician or other care providers -Consumer -Community -Patient Organization -Employer -Union -Health Plan -State</td>
<td>As the program grows, there will be more ways to get involved, learn how to improve patient safety, and share results. Check this page frequently to find out about new opportunities. May 2011- Secretary of Health and Human Services (HHS) Kathleen Sebelius and other HHS officials have embarked on a national tour to applaud hospitals and medical centers that are being proactive about making their facilities safer and more effective in treating patients with fewer complications. The Secretary kicked off the Partnership for Patients tour in Texas, where she visited Seton Medical Center in Austin where the birth injury rate has been dramatically dropped to nearly zero by following best practices. Additionally, HHS is launching a series of patient safety webinars. The webinars are free, and available to all stakeholders who want to make strides in improving patient safety. For more information visit the Partnerships for Patients website.</td>
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