



Centers for Medicare & Medicaid Services  
Center for Medicare and Medicaid Innovation

# **REPORT TO CONGRESS**

**DECEMBER 2014**

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# **The Center for Medicare and Medicaid Innovation**

## **REPORT TO CONGRESS**

### **1. Executive Summary**

The Center for Medicare and Medicaid Innovation (referred to herein as “the CMS Innovation Center”) was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures... while preserving or enhancing the quality of care” provided to those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The CMS Innovation Center’s mandate gives it flexibility within the parameters of section 1115A to select and test the most promising innovative payment and service delivery models. Section 1115A provides a total of \$10 billion in direct funding for these purposes over the fiscal years 2011 through 2019.

Section 1115A requires the Secretary of the Department of Health and Human Services to submit to Congress a report on the CMS Innovation Center’s activities under section 1115A at least once every other year beginning in 2012. This is the second report to Congress, and it focuses on activities between November 1, 2012 and September 30, 2014. As of September 30, 2014, the CMS Innovation Center has launched 22 payment and service delivery initiatives under section 1115A authority (Appendix).<sup>1</sup> There has been significant interest in these initiatives and a high level of public and provider engagement.

The CMS Innovation Center’s portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. We estimate that over 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in CMS Innovation Center payment and service delivery models. Beyond the impact for these beneficiaries, CMS Innovation Center models are impacting tens of millions of additional Americans by engaging thousands of other providers, payers, and states in model tests and through quality improvement efforts that extend across the country. As required by section 1115A, these models are expected to reduce program expenditures in Medicare, Medicaid, and CHIP, while preserving or enhancing the quality of care received by beneficiaries.

Since its inception in 2010, the CMS Innovation Center has partnered with stakeholders across the country, other federal agencies, and Centers for Medicare & Medicaid Services

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<sup>1</sup> This number includes only activities that are considered payment or delivery system initiatives. Bundled Payments for Care Improvement represents four separate models; Health Care Innovation Awards and State Innovation Models are each considered two separate models. Million Hearts®, Strong Start Strategy One, and the Innovation Accelerator are not included in this count.

(CMS) components, including the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior Authorization models), and the Center for Clinical Standards and Quality (for the Partnership for Patients), to enable our health system to achieve better health, improved care, and lower costs.

CMS Innovation Center models have supported providers and health care organizations in the testing of alternative care delivery and payment models. These models focus on three core strategies for improving our health system: improving the way providers are paid, improving the way care is delivered, and increasing the availability of information to guide decision-making. Several of the models being tested include other payers in order to align financial incentives across payers when possible. The participation of multiple payers in alternative delivery and payment models increases support for delivery system transformation and encourages efficiencies for health care organizations.

Rates of some hospital-acquired conditions and hospital readmission rates have declined meaningfully. These improvements reflect policies and an unprecedented public-private collaboration made possible by the Affordable Care Act. Two of the first models launched by the CMS Innovation Center, Pioneer Accountable Care Organizations and Partnership for Patients, have released early findings showing favorable impacts on cost and quality. These findings are detailed later in this report.

This report conforms to the requirements of section 1115A and describes the models launched under this authority. Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President's budget request.

## **2. Introduction**

The CMS Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care” for those individuals who receive Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) benefits. The statute provided the Secretary of the Department of Health and Human Services (HHS) with the authority under section 1115A(c) to expand through rulemaking the duration and scope of a model being tested or a demonstration project under section 1866C, including implementation on a nationwide basis. In order for the Secretary to exercise this authority, an expansion must either reduce spending without reducing quality of care or improve quality of care without increasing spending, CMS’ Chief Actuary must certify that expansion of the model would reduce (or not increase) net program spending, and the model must not deny or limit the coverage or provision of benefits under Medicare, Medicaid, or CHIP. The Secretary’s expansion determinations are made based on evaluations performed by CMS under section 1115A(b)(4).

The law also requires that the Secretary terminate or modify models tested under section 1115A, at any time after testing has begun and before completion, unless the Secretary determines that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing quality of care, or improve quality of care and reduce spending. The CMS Chief Actuary must make a certification in support of the Secretary’s determinations with respect to spending.

The CMS Innovation Center is organized to support the development and testing of new payment and service delivery models, as well as to support demonstrations and other projects. To better coordinate these models and demonstration projects and to avoid duplication of effort and expense, the former Office of Research, Development and Information was merged with the CMS Innovation Center in early 2011. As a result, the CMS Innovation Center oversees not only initiatives that are authorized under section 1115A, but also activities under several other authorities, including other provisions of the Affordable Care Act and other laws and certain projects authorized by section 402 of the Social Security Amendments of 1967 as amended. Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination and more efficient operations. However, each demonstration or model is associated with its own funding stream, as appropriate. For example, demonstrations authorized by section 402 of the Social Security Amendments of 1967 as amended are not funded under section 1115A.

The CMS Innovation Center works directly with other CMS components and with colleagues throughout the federal government in developing and testing new payment and service delivery models. The CMS Innovation Center has partnered with the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior

Authorization Models), and the Center for Clinical Standards and Quality (for Partnership for Patients) for the joint development and administration of these models. Other CMS components, and other federal agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Office of the National Coordinator of Health Information Technology, Administration for Community Living, Department of Housing and Urban Development, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration, have assisted in design and testing activities for multiple models. These collaborations help the CMS Innovation Center effectively test new models and execute mandated demonstrations.

### **CMS Innovation Center Priorities: 2011 - 2014**

CMS published a Statement of Organization, Functions, and Delegations of Authority for the CMS Innovation Center in the November 17, 2010 *Federal Register* (75 FR 70274). Since that time, the CMS Innovation Center has focused on four main priorities as it carries out its statutory responsibilities:

- a. testing new payment and service delivery models,
- b. conducting congressionally mandated or authorized demonstrations and related activities,
- c. evaluating results and advancing best practices, and
- d. engaging stakeholders.

#### **a. Testing New Payment and Service Delivery Models**

The CMS Innovation Center develops new payment and service delivery models in accordance with the requirements of section 1115A and in consideration of the opportunities and factors set forth in section 1115A(b)(2) of the Act. During the development of models, the CMS Innovation Center builds on ideas received from stakeholders and consults with clinical and analytical experts, as well as with representatives of relevant federal and state agencies. For example, as is typical in other projects, during the development, announcement, and solicitation phases of the Comprehensive End-Stage Renal Disease (ESRD) Care Model, the CMS Innovation Center

- held open door phone calls with small dialysis organizations, large dialysis organizations, nephrologists, ESRD advocacy groups, and other interested stakeholders;
- consulted with representatives from other federal agencies,
- assembled and consulted a technical expert panel;
- staged webinars on the Request for Application, Building Effective Partnerships, and Making the Accountable Care Organization Business Case; and
- posted proposed quality measures for public consideration and comment.

The CMS Innovation Center solicits organizations to participate in model tests through an open process that includes competitive Funding Opportunity Announcements and Requests for Applications. The selection process follows established protocols to ensure that it is fair and transparent, provides opportunities for potential partners to ask questions regarding the CMS Innovation Center's expectations, and takes into account stakeholder input to inform selection of the most qualified partners. The CMS Innovation Center does not fund unsolicited proposals, but does use ideas from partners and stakeholders to inform model development.

**b. Conducting Congressionally Mandated or Authorized Demonstrations and Related Activities**

The CMS Innovation Center has taken on responsibility for implementing a number of specific demonstration projects authorized and funded by statute. For example, the Independence at Home Demonstration was authorized by section 3024 of the Affordable Care Act and the Medicaid Emergency Psychiatric Demonstration was authorized by section 2707 of the Affordable Care Act. The findings from these demonstrations will inform possible changes in health care payment and policy, as well as the development and testing of new models, if appropriate.

The CMS Innovation Center has managed 20 demonstrations authorized by statute (in addition to the 22 authorized under section 1115A authority) during the period between November 1, 2012 and September 30, 2014. A list of all demonstrations active during this time period is included in the Appendix.

**c. Evaluating Results and Advancing Best Practices**

Section 1115A(b)(4) requires the CMS Innovation Center to conduct an evaluation of each new model. Section 1115A(b)(4) also specifies that each evaluation must include an analysis of the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria, as well as changes in spending. As noted above, the Secretary shall take the evaluation into account in decisions to expand the duration and scope of a model or demonstration project under section 1866C.

The CMS Innovation Center's Research and Rapid Cycle Evaluation Group assesses routinely and rigorously the impact of each model on quality and cost. To evaluate models, the evaluation group employs advanced statistical methods and carefully defines and selects comparison groups, as appropriate, to ensure that programs deemed to be successful represent high-value investments of taxpayer dollars.

Central to this evaluation approach is the recognition that evaluators must not only assess results, but also understand the context that allows for those results. For each model, the CMS Innovation Center collects qualitative information about provider practices, organizational characteristics, and their systems of practice. This information also includes participants' perceptions regarding the opportunities and challenges they have faced and their experiences in addressing them. These data are merged with performance metrics to allow evaluators to assess which features of interventions are associated with

successful outcomes. The CMS Innovation Center also provides data to states to help its state partners monitor outcomes and facilitate care coordination for Medicare-Medicaid enrollees.

Learning and adaptation are essential to enable providers and health systems to achieve the greatest efficiencies and improvements possible in each new model. In addition to the rigorous evaluation of the impact of each model on outcomes of interest, the CMS Innovation Center supports continuous quality improvement by providing frequent feedback to model participants. The CMS Innovation Center leverages claims data to deliver actionable feedback to providers about their performance and encourages participating providers to use their own performance data to drive continuous improvement in their outcomes.

Every test of a new service delivery or payment model developed by the CMS Innovation Center also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both public programs and the health care system at large. The CMS Innovation Center has created learning collaboratives for providers in our models that promote broad and rapid dissemination of evidence-based best practices that have the potential to deliver higher quality and lower cost care for Medicare, Medicaid, and CHIP beneficiaries.

#### **d. Engaging Stakeholders**

Since its inception, the CMS Innovation Center has actively sought input from a broad array of stakeholders across the country to identify promising new payment and delivery models. The CMS Innovation Center has held regional meetings and frequent “listening sessions,” engaging thousands of innovators from around the country. In addition, hundreds of ideas for improving health care have been shared through the CMS Innovation Center website. The result is a growing portfolio of innovative payment and service delivery models.

The CMS Innovation Center invites input in the design of individual models using vehicles that are open to all stakeholders, including Requests for Information (RFI), surveys, and “open door” phone conferences. Guidance from leading authorities is also sought through interviews, consultation, and technical evaluation panels.

#### **Requests for Information and comments issued in the past two years:**

From 2013 to 2014, the CMS Innovation Center issued four RFIs seeking input from stakeholders on possible models and initiatives under consideration. Information collected through these RFIs may be used to test new payment and service delivery models. CMS also requested comments on a model through the CY 2015 proposed rule for the Medicare Home Health Prospective Payment System.

#### ***Accountable Care Organizations (ACOs)***

On December 20, 2013, the CMS Innovation Center issued an RFI to obtain input on policy considerations for the next generation of ACO initiatives. Topics of particular

interest included approaches for increasing participation in the current Pioneer ACO model through a second round of applications, and suggestions for new ACO models that encourage greater care integration and financial accountability. The submission period for the RFI concluded on March 1, 2014.

***Specialty Practitioner Payment Model Opportunities***

On February 11, 2014, the CMS Innovation Center issued an RFI seeking information in relation to the development of models that will focus on specific diseases, patient populations, and specialty practitioners in the outpatient setting to incentivize improved care, better health, and lower costs. The submission period for the RFI concluded April 10, 2014.

***Transforming Clinical Practice Initiative***

On March 5, 2014, the CMS Innovation center issued an RFI to obtain input on policy considerations related to large-scale transformation of clinician practices to accomplish the aims of better care and better health at lower costs. The submission period for the RFI concluded on April 8, 2014. The CMS Innovation Center has used this input in the design and development of an initiative supporting large-scale transformation of clinical practices and, as of September 30, 2014, anticipates the release of a Funding Opportunity Announcement.

***Beneficiary Engagement Model Opportunities***

On August 15, 2014, the CMS Innovation Center issued an RFI to seek input from stakeholders on the possibility of testing innovative models to increase the engagement of Medicare beneficiaries, Medicaid beneficiaries, Medicare-Medicaid enrollees, and/or CHIP beneficiaries in their health and health care. The submission period for the RFI concluded on September 22, 2014.

***Home Health Value-Based Purchasing***

In the CY 2015 proposed rule for the Home Health Prospective Payment System issued in July 2014 (79 FR 38408-38409), CMS requested comments regarding a possible Home Health Agency Value-Based Purchasing (HHA VBP) model that would build on other related demonstrations and programs, including the Hospital Value-Based Purchasing (HVBP) program.<sup>2</sup> The model presents an opportunity to test whether larger incentives than have been previously tested will lead to even greater improvement in the quality of care furnished to beneficiaries. CMS will consider the comments it received as it makes further decisions about implementing an HHA VBP model in CY 2016. If CMS decides to move forward with the implementation of an HHA VBP model in CY 2016, it intends to invite additional comments on a more detailed model proposal to be included in future rulemaking.

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<sup>2</sup> The Medicare Home Health Prospective Payment System final rule released in October 2014 summarizes these comments (79 FR 66105-66106)

***RFIs Under Consideration***

In April 2014, the Advance Notice of Methodological Changes for CY 2015 Call Letter signaled CMS' interest in partnering with private payers to test innovations in health plan design for CMS beneficiaries, including but not limited to value-based arrangements, beneficiary engagement and incentives, and/or care coordination. The Call Letter also indicated CMS' intent to issue a formal RFI in the coming months.

**Stakeholder solicitations and communications:**

In addition, the CMS Innovation Center has conducted hundreds of interviews and consultations with technical experts and leading providers, payers, and researchers to learn from their innovations and experiences, and has held scores of webinars each year to announce and explain initiatives and increase stakeholder engagement.

In designing the Comprehensive Primary Care initiative, for example, the CMS Innovation Center solicited input from numerous provider organizations, primary care thought leaders, payers, and advocacy groups. In the design of the Medicare Care Choices Model, CMS held an open door call for providers, beneficiary advocacy groups, and other interested parties and engaged stakeholders from the National Hospice and Palliative Care Organization and representatives from leading palliative care programs.

The CMS Innovation Center interacts with people across the country interested in service delivery and payment innovation through its website, social media outreach, and an e-mail listserv. Since 2012, the listserv audience has grown from 30,000 to over 55,000 and Twitter followers have increased from 5,000 to 16,000. The CMS Innovation Center website and listserv continually update innovators in the field on new funding and learning opportunities. The site includes search-driven interactive maps that allow state-level views of organizations participating in CMS Innovation Center models.

The CMS Innovation Center has also developed an online network that supports collaboration among awardees, grant recipients, and other CMS Innovation Center partners. The site allows CMS Innovation Center partners to share documents and tools and to interact online. The network is used by participants in various CMS Innovation Center models, including Accountable Care Organizations, the Comprehensive Primary Care initiative, and the Health Care Innovation Awards. There are currently 8,000 registered users and more than 50 active affinity groups collaborating on improvement activities on topics such as pediatric asthma, community health workers, and the care of complex patients. The site is a key tool in the CMS Innovation Center's efforts to capture and disseminate lessons learned to accelerate the spread of innovations that enhance care, improve health, and lower costs.

### **3. Review of CMS Innovation Center Activities**

During the past 4 years, the CMS Innovation Center has launched 22 new payment and service delivery initiatives aimed at reducing expenditures under Medicare, Medicaid, and CHIP and enhancing the quality of care that beneficiaries receive. Collectively these initiatives are providing services to Medicare, Medicaid, and/or CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. The CMS Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders.

The CMS Innovation Center estimates that over 2.5 million beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in these CMS Innovation Center models. Millions of additional Americans are or will be receiving care from the CMS Innovation Center's models through multi-payer model tests such as the Comprehensive Primary Care initiative, the Pioneer ACOs, and the Health Care Innovation Awards, and through quality improvement initiatives like Partnership for Patients and Million Hearts<sup>®</sup>. These other engagements also reach thousands of other health care providers. Comprehensive state health care transformation efforts driven by the State Innovation Models (SIM) initiative are affecting a steadily increasing percentage of providers nationwide. The states engaged in SIM represent over half of the U.S. population.

Model participants and partners include a broad cross section of health care providers, health organizations and systems, state and local governmental entities, academic institutions, and nonprofit and community organizations engaged in health system transformation. CMS Innovation Center models are testing approaches to improve outcomes and lower costs across the care continuum from prenatal to palliative care and from acute care to community settings. Under each CMS Innovation Center model, beneficiaries retain access to their regular Medicare, Medicaid, and CHIP benefits and the right to select the providers and services of their choice.

CMS Innovation Center models focus on improving care delivery and on realigning financial incentives so they reward providers and provider organizations who deliver better care at lower cost. These models also offer providers the financial support, skills, and information they need to improve the care of individual beneficiaries and the health of populations. The CMS Innovation Center has engaged private and other governmental payers in testing new care delivery and payment models. CMS Innovation Center models also support delivery system transformation at the state level.

The initiatives highlighted in this section include only models authorized and funded by section 1115A of the Social Security Act.<sup>3</sup> However, the CMS Innovation Center will implement and thoroughly evaluate both the section 1115A models and initiatives authorized under other authorities to determine their impact on quality and costs. A table

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<sup>3</sup> Million Hearts is authorized by section 1115A of the Social Security Act, but has not received direct funding from the CMS Innovation Center.

identifying all of the activities under the purview of the CMS Innovation Center and their specific statutory authority is provided in the Appendix.

CMS Innovation Center initiatives are grouped into the following categories:

- Primary Care Transformation,
- Accountable Care ,
- Bundled Payments for Care Improvement,
- Initiatives Focused on Medicaid and CHIP Populations,
- Initiatives Focused on Medicare-Medicaid Enrollees,
- Initiatives to Speed the Adoption of Best Practices, and
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models.

### **Primary Care Transformation**

Primary care serves as an entry point and coordinating mechanism for many patients, including those with chronic illness. Achieving better outcomes and lower costs across the health care system requires more efficient and effective models for delivering and paying for primary care. New approaches, including enhanced primary care and the patient-centered medical home, are expanding the capacities needed to allow primary care to manage the health of populations, to coordinate care, and to integrate health information technology within the practice. Under its section 1115A authority, the CMS Innovation Center is testing two primary care transformation models employing these new approaches: the Comprehensive Primary Care initiative and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration.

#### ***Comprehensive Primary Care Initiative***

The Comprehensive Primary Care (CPC) initiative is a multi-payer collaboration between public and private health care payers to strengthen primary care. As of September 30, 2014, 2,528 providers are serving an estimated 396,000 Medicare beneficiaries at 483 practice sites. Of the initially selected 502 practices, 96 percent continued into the second year of the model, a highly favorable persistency rate. The CPC practice sites are distributed across seven regional or statewide markets:

- Arkansas: statewide
- Colorado: statewide
- New Jersey: statewide
- New York: Capital District-Hudson Valley Region
- Ohio/Kentucky: Cincinnati-Dayton Region
- Oklahoma: Greater Tulsa Region
- Oregon: statewide

The CPC model period of performance began in October 2012 and will end in December 2016. The CPC initiative tests whether multi-payer participation in a payment model

encompassing upfront care management fees and potential shared savings can result in primary care practices delivering better care.

The initiative includes both a new delivery and a new payment model designed to support improved care, better health for populations, and lower costs through the provision of a core set of five “comprehensive” primary care functions. The functions are: 1) risk-stratified care management; 2) access and continuity; 3) planned care for chronic conditions and preventive care; 4) patient and caregiver engagement; and 5) coordination of care across the medical neighborhood. The initiative is testing whether these functions, coupled with payment reform, the use of data to guide improvement, and meaningful use of health information technology, can achieve better care, improved health, and reduced costs and can inform future Medicare and Medicaid policy.

The seven CPC regions were chosen after soliciting interest from payers nationally. Regions with the highest collective market penetration of payers willing to align their payment models to support the five CPC functions were selected. The seven regions encompass 38 public and private payers spanning commercial, Medicare Advantage, Medicaid managed care, and Third Party Administrator/Administrator Services Only lines of business, as well as four state fee-for-service (FFS) Medicaid agencies (Arkansas, Colorado, Ohio, and Oregon). The CMS Innovation Center is funding the enhanced payment models offered by state FFS Medicaid agencies. Other CPC payers receive no payment from the CMS Innovation Center for participation in the model.

CPC practices were selected through a competitive process in each designated region. Participating practices receive a monthly care management fee for each Medicare FFS beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. Practices also receive monthly fees from other participating CPC payers and are expected to combine CPC revenues across payers to develop a whole-practice transformation strategy.

The CMS Innovation Center guides development of the five CPC functions through a framework of Milestones, including the provision of care management for high-risk patients, 24/7 access to medical records, assessment and improvement of patient experience of care, the use of data to guide improvement, and improvement in patient shared decision-making capacity. CPC aligns with the Office of the National Coordinator of Health Information Technology (ONC) by requiring providers to achieve Meaningful Use standards and to use ONC-certified electronic health records in their quality measurement and improvement activities. Practices routinely report their progress through a web portal. The CMS Innovation Center supports practices in attaining the CPC Milestones through national and regional learning networks, online collaboration opportunities, and access to local academic and clinical faculty under contract with CMS, who provide hands-on assistance. To support learning across payers, the CMS Innovation Center convenes CPC payers on both a regional and national basis to review and discuss data, trends, and strategies for improvement.

The evaluation plan for the Comprehensive Primary Care initiative has been designed to provide a robust assessment of implementation and impacts using mixed-methods techniques. The evaluation will use site visits, key informant interviews, observations of technical assistance, surveys, and program data to establish how the intervention was implemented and received. Building on this analysis, the evaluation will use additional survey data and administrative claims to analyze the intervention's impact on beneficiaries and the primary care workforce. Key outcome and quality measures will include total Medicare and Medicaid expenditures per beneficiary, hospitalization rates, emergency department visit rates, claims-based process of care outcomes, readmission rates, beneficiary experience of care, and beneficiary health-related quality of life. These analyses will be performed at the program and regional level, looking at both the entire beneficiary population attributed, as well as key subgroups, such as Medicare-Medicaid enrollees. Finally, the impact and implementation analyses will be synthesized to attempt to identify the key factors that drive positive impacts.

***Federally Qualified Health Center Advanced Primary Care Practice Demonstration***

The Federally Qualified Health Center Advanced Primary Care Practice Demonstration (FQHC APCP) tests both the feasibility of incentivizing the adoption of National Committee of Quality Assurance (NCQA) Level 3 Patient Centered Medical Home (PCMH) standards within FQHCs and whether the application of these standards ultimately improves quality of care and reduces costs for Medicare beneficiaries. As of May 2014, FQHCs operating under the demonstration had provided services to more than 207,000 Medicare FFS beneficiaries and had received approximately \$45 million in care management fees from CMS. CMS collaborates with the Health Resources and Services Administration to assist participating FQHCs in achieving Level 3 NCQA recognition as a PCMH. 73 percent of FQHCs participating in the demonstration have achieved NCQA Level 3 PCMH recognition, with large increases in final quarters. The demonstration is a 3-year model that began on November 1, 2011 and concludes on October 31, 2014. The original goal was to have 90 percent of participating FQHCs achieve PCMH recognition by the end of the demonstration.

A PCMH is a patient-centered or community-centered model of primary care that delivers accessible, comprehensive, and coordinated care using a systems-based approach to quality and safety. FQHCs that have achieved PCMH recognition provide enhanced services to patients through the following:

- team-based care that maximizes efficiency and quality,
- improved access to care that both attracts new patients and retains current patients,
- use of Electronic Health Record systems to facilitate the coordination and continuity of care,
- a systematic approach to medication management and reconciliation with the goal of reducing adverse drug events and unnecessary readmissions,
- adherence to documented policies and evidenced-based procedures to ensure quality, and
- improved staff retention to prevent practice disruption.

The goals of the FQHC evaluation are to assess the impact of the demonstration on FQHCs' attainment of NCQA Level 3 PCMH recognition, to determine whether the rate of PCMH recognition accelerated under the model, and to assess whether there were resulting improvements on a range of quality, utilization, and cost outcomes for Medicare beneficiaries seeking care at demonstration FQHCs. The evaluation will also examine the impact of the model on beneficiary experience. The final evaluation report will include analyses based on linked Medicare data files and the use of beneficiary-level information to assess impact on quality, utilization, and spending.

### **Accountable Care**

The CMS Innovation Center is currently testing three Accountable Care Organization (ACO) models: the Pioneer ACO, Advance Payment ACO, and Comprehensive End Stage Renal Disease Care Model. These models were developed to incentivize health care providers to become accountable for the quality and cost of care for an entire patient population and to invest in infrastructure and redesigned care processes that achieve high-quality and efficient service delivery.

#### ***Pioneer ACO Model***

The Pioneer Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. The Pioneer ACO Model was launched in 2012 with 32 ACOs. Organizations agree to an initial 3-year performance period with the option to extend for 2 additional option years. At present, 19 Pioneer ACOs are participating and plan to enter their fourth performance year in 2015. Of those Pioneer ACOs that made the decision to exit the model, each organization did so based on its particular business priorities and concerns. Three of the withdrawing organizations generated shared losses. Other Pioneer ACOs that generated losses made the decision to remain in the model and a number of others transitioned into the Medicare Shared Savings Program to continue healthcare transformation with a slower transition to downside risk. More than 625,000 Medicare beneficiaries are aligned to Pioneer ACOs. The model has reported favorable results on both cost and quality measures for its first 2 performance years. It is scheduled to end in February 2017.

The model tests payment arrangements that hold providers accountable for cost, quality, and patient experience outcomes for a defined population of beneficiaries. It uses a shared savings payment methodology with generally higher levels of shared savings and risk than levels currently in use in the Medicare Shared Savings Program and is assessing the ability of hospital and physician organizations experienced in care and risk management to achieve savings for Medicare while sustaining or improving the quality of care for beneficiaries. Pioneer ACOs that demonstrated savings during the first 2 performance years and met other criteria are able to transition to a monthly population-based payment starting in performance year 3. The performance of Pioneer ACOs on both financial and quality metrics, including patient experience ratings, is publicly reported by CMS.

On July 16, 2013, CMS announced positive results indicating higher quality of care from the first performance year of the Pioneer ACO Model

(<http://innovation.cms.gov/Files/x/PioneerACOQualmsrpy1.pdf>). Financial results, including lower Medicare expenditures, were discussed in a subsequently released report (<http://innovation.cms.gov/files/reports/pioneeracoevalreport1.pdf>).

Quality of Care and Patient Experience:

- All 32 Pioneer ACOs that participated in the first year achieved the maximum reporting rate in their first year and eligible professionals participating in the ACOs earned incentive payments for successfully reporting quality measures. Overall, Pioneer ACOs performed better than comparable providers in Medicare FFS on all 15 clinical quality measures for which comparable data are available.

Medicare Expenditures and Savings:

- Pioneer ACOs generated total program savings of \$87 million in their first year of operation with savings to the Medicare Trust Funds of nearly \$33 million.
- According to an independent evaluation, on average, Medicare spending per beneficiary per month was about \$20 less than if beneficiaries had not been aligned with an ACO in their market.
- 13 Pioneer ACOs earned shared savings and one generated shared losses which were paid to CMS. The rest of the Pioneer ACOs generated neither savings nor losses.

After the first performance year, nine ACOs withdrew from the model. Of those nine ACOs, seven transitioned to the Medicare Shared Savings Program and their organizations continue to invest in care delivery and intervention strategies for accountable care.

Preliminary results for the second performance year of the Pioneer ACO Model were released on September 16, 2014 (<http://innovation.cms.gov/Files/x/PioneerACOQualmsrpy2.pdf>, <http://innovation.cms.gov/Files/x/PioneerACO-FncI-PY1PY2.pdf> ) and showed higher quality of care and lower Medicare expenditures.

Quality of Care and Patient Experience:

- The mean quality score among Pioneer ACOs increased from 71.8 percent in 2012 to 85.2 percent in 2013.
- The organizations showed improvements over 2012 in 28 of the 33 quality measures and experienced average improvements of 14.8 percent across all quality measures. These measures included screening for future fall risk, screening for tobacco use and cessation, patient experience in health promotion and education, and controlling high blood pressure.

The Pioneer ACOs improved the average performance score for patient and caregiver experience in six out of seven measures compared with 2012. These results suggest that Medicare beneficiaries who obtain care from a provider participating in Pioneer ACOs report a positive patient and caregiver experience.

Medicare Expenditures and Savings:

- In the second performance year, there were 23 Pioneer ACOs. During the second performance year, Pioneer ACOs generated estimated total model savings of over \$96 million and savings to the Medicare Trust Funds of approximately \$41 million. Model savings and other financial results are based on preliminary results and are subject to revision.
- Pioneer ACOs achieved lower per capita growth in spending for the Medicare program at 1.4 percent, which is about 0.45 percent lower than Medicare FFS per capita growth.
- 11 Pioneer ACOs earned shared savings, three generated shared losses, and three elected to defer reconciliation until after the completion of performance year three. The remaining six Pioneer ACOs did not earn shared savings or generate losses.

Four Pioneer ACOs withdrew from the model after the second performance year. Of the Pioneer ACOs that withdrew, two are transitioning into the Medicare Shared Savings program.

While it is too early to draw conclusions about the success of the Pioneer ACO Model in its ability to improve beneficiary quality and reduce Medicare costs, several insights have begun to emerge. ACOs that showed savings more often had higher expenditures than their local markets in the year before the model began. In addition, ACOs with diverse organizational arrangements and incentive structures for physicians achieved savings in the first 2 years, suggesting that many different types of ACOs are capable of high performance. An independent evaluation for the first 2 performance years is being undertaken.

***Advance Payment ACO Model***

In the Medicare Shared Savings Program, groups of providers and suppliers meeting criteria specified by the Secretary may form ACOs to improve care management for beneficiaries. ACOs participating in the Advance Payment Model receive an upfront payment and ongoing monthly payments which they can use to make important investments in their care management infrastructure. The Advance Payment ACO Model is testing whether pre-paying a portion of future shared savings allows more entities to participate successfully in the Medicare Shared Savings Program and generate savings for Medicare.

The Advance Payment ACO Model was designed to help entities such as smaller ACOs with less access to capital participate in the Medicare Shared Savings Program, in which ACOs are eligible to share in savings as long as they meet or exceed quality and financial

performance standards. The CMS Innovation Center developed the Advance Payment ACO Model in response to input received from stakeholders on the proposed rule for the Shared Savings Program and comments received on its initial Funding Opportunity Announcement in May 2010. There are currently 35 Advance Payment ACOs encompassing a total of 301,000 aligned Medicare beneficiaries. Five ACOs began participation in April 2012, 15 joined in July 2012, and 16 more were added in January 2013. All but one of these ACOs, which voluntarily terminated because of an organizational buyout, are still in the Advance Payment Model and will complete their initial period of performance in the Medicare Shared Savings Program on December 31, 2015. All Advance Payment ACOs had a minimum 3-year performance period and early starters had additional months in their first performance “year”.

Advance payments are structured to acknowledge that new ACOs will have both fixed and variable start-up costs. ACOs receive three types of advance payments during their agreement period:

- *An upfront, fixed payment:* each ACO receives a fixed payment.
- *An upfront, variable payment:* each ACO receives a payment based on the number of beneficiaries prospectively assigned to it on a preliminary basis.
- *A monthly payment of varying amounts depending on the size of the ACO:* each ACO receives a monthly payment based on the number of beneficiaries prospectively assigned to it on a preliminary basis.

The Medicare Shared Savings Program has released financial and quality data for the first performance year (<https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ytuq5-65xt>). Nine Advance Payment ACOs earned gross savings. Eight of the nine Advance Payment ACOs that earned gross savings successfully reported quality data and earned shared savings sufficient to fully repay the funds received from the Advance Payment Model. Overall, 33 of the 36 Advance Payment ACOs submitted quality data. Results showing year-over-year performance on financial and quality measures will be reported after completion of the second performance year.

As of June 2014, the Advance Payment Model completed its disbursement of advance payments to participating ACOs. The model will continue to provide trainings and forums for Advance Payment ACOs to identify and share best practices and lessons learned that will contribute to their success until the model ends on December 31, 2015.

### ***Comprehensive End Stage Renal Disease Care Model***

The purpose of the Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model is to improve outcomes for Medicare beneficiaries with ESRD and reduce per capita Medicare expenditures. Under the CEC Model, CMS will partner with ESRD Seamless Care Organizations (ESCOs)—accountable care collaborations of dialysis facilities, nephrologists, and other providers and suppliers—to address the needs of beneficiaries with ESRD and complex medical needs.

The Request for Applications to participate in the CEC Model was issued in the spring of 2014 and included two application rounds. The first application round for ESCOs

included Large Dialysis Organizations (LDOs), defined as organizations with more than 200 dialysis facilities, closed in June 2014. It is expected that these LDO ESCOs will begin their initial 3-year period of performance in July 2015. The second application round for ESCOs focused on non-LDOs; it closed in September 2014. The 3-year period of performance for these non-LDO ESCOs is also expected to begin in July 2015. An additional 2 performance years may be offered, subject in part to the ESCOs meeting financial and quality performance targets.

The CMS Innovation Center expects a total of 10 to 15 unique ESCOs to participate in the CEC Model, with broad representation from dialysis facilities, and geographic areas. An ESCO is required to have a minimum of 350 matched beneficiaries to qualify for the model. Medicare beneficiaries will be prospectively matched to the ESCO if they meet the eligibility requirements and receive dialysis services from a dialysis facility participating in the ESCO. The model will be implemented as a 3-year agreement with 2 option years for each ESCO, contingent on performance.

This model is based on the hypothesis that appropriately aligned financial incentives will encourage providers to work together and improve care coordination for ESRD beneficiaries, resulting in improved health, better health care, and lower expenditures. Specifically, the CMS Innovation Center is testing whether this model will:

- improve key care processes such as chronic disease management;
- improve clinical outcomes, including transplantation rates, mortality rates, and disease complications;
- improve beneficiary experiences of care, quality of life, and functional status;
- improve management of care transitions;
- reduce excess utilization of services such as emergency department visits; hospitalizations, and readmissions; and
- reduce total Medicare Parts A and B per capita expenditures.

The core operational elements of the model are:

- respect for Medicare FFS beneficiaries' freedom to continue to seek the services and providers of their choice;
- selection of a diverse group of ESCOs willing to commit to transformation of their business and care delivery models;
- payment arrangements that, over time, escalate the degree of the ESCO's financial accountability;
- standardized quality performance metrics and other parameters across ESCOs to allow for rigorous evaluation;
- provision of monthly and quarterly data reports to ESCOs for purposes of supporting care improvement;
- strong beneficiary protections and comprehensive and frequent monitoring;
- formative and summative evaluation; and
- shared learning that is continuous and data-driven.

The quality measure set for the CEC Model was developed in collaboration with CMS Innovation Center partners with input from stakeholders. The CMS Innovation Center developed its approach working with the Center for Clinical Standards and Quality and with the input of the CMS Quality Measures Taskforce. A preliminary set of measures was reviewed and evaluated by a Technical Expert Panel and released for Public Comment in February 2014. The measure set will be made available to participants in November 2014.

The CMS Innovation Center will closely monitor the utilization of services for beneficiaries through data analysis and the use of audits and other actions as necessary. Beneficiaries will be surveyed each year to assess their experience with the model.

The evaluation for the CEC Model will identify comparison groups and assess the impact of the initiative on the quality of care, health outcomes, and Medicare expenditures of beneficiaries with ESRD. The evaluator will perform rigorous quantitative analysis of claims, clinical, and survey data to determine if the CEC Model resulted in improvements in care, health outcomes and cost. The evaluation will also include qualitative analyses to capture participant, provider, and beneficiary perceptions, key success factors, and lessons learned.

### **Bundled Payments for Care Improvement**

The Bundled Payments for Care Improvement (BPCI) initiative was announced in August 2011. Currently, it tests four models for bundling payment for acute and/or post-acute care by episode of care. The four models offer participating organizations options for the clinical conditions to be tested, the length and composition of an episode, and the level of financial risk. The initiative is projected to serve 130,000 Medicare beneficiaries.

The four BPCI models are the following:

**Retrospective Acute Care Hospital Stay Only (Model 1):** Under this model, the episode of care is the acute inpatient stay. Hospitals are permitted to “gainshare” savings from coordinating and improving care, if quality targets and certain other conditions are met. All Medicare FFS beneficiaries admitted to a participating acute care hospital initiate an episode regardless of the Medicare Severity Diagnosis Related Group (MS-DRG). Beginning 6 months after the start of the performance period, Medicare pays a discounted amount based on payment rates established under the Inpatient Prospective Payment System.

**Retrospective Acute Care Hospital Stay Plus Post-Acute Care (Model 2):** This model extends the episode of care beyond the acute care inpatient hospitalization to include care in a post-acute period that is clinically related to the hospitalization. The episode of care is specific to the clinical condition being treated; each beneficiary who is assigned a selected MS-DRG will initiate an episode. The episode includes services furnished by the hospital, physicians, and post-acute care providers as well as other Medicare-covered items and services furnished during the inpatient hospital

stay and during the post-acute period following discharge. Awardees must offer Medicare a discount based on the episode's historical cost, which is used to determine a target price for the episode.

After the episode of care concludes, the aggregate Medicare FFS expenditures for items and services included in the episode are reconciled against the predetermined target price for the episode. If aggregate Medicare FFS expenditures are less than the target price, Medicare pays the difference to the awardee. Gains may be shared among participating providers if quality targets and certain other conditions are met. If aggregate Medicare FFS expenditures for items and services included in the episode exceed the target price, the awardee must repay Medicare. Medicare performs reconciliation for each performance quarter during which awardees bear risk in BPCI. Recent changes to the program have limited the range of awardee payments/repayments to +/- 20 percent of the sum of the target price and Medicare discount, aggregated across all episodes of care that initiate for the awardee in each performance quarter. In addition, Medicare waived the requirement to repay negative amounts at the episode initiator level for the fourth quarter of 2013 and all four quarters of 2014.

**Retrospective Post-Acute Care (Model 3):** Under this model, an episode of care consists of services furnished in a post-acute care period following an acute care inpatient hospitalization. The initial inpatient hospital stay is not included. The episode begins with the initiation of post-acute care services following discharge from an acute care hospital for selected MS-DRGs. The episode of care includes physician services, hospital readmissions, services furnished by post-acute care providers, and other Medicare-covered items and services during the episode. Awardees must offer Medicare a discount based on the episode's historical cost, which is used to determine a target price for the episode.

As with Model 2, after the episode concludes, the aggregate Medicare FFS expenditures for items and services included in the episode are reconciled against the predetermined target price for the episode, and gains may be shared if quality targets and other conditions are met.

**Prospective Acute Care Inpatient Hospital Stay Only (Model 4):** The episode of care in this model covers all acute care inpatient hospital and physician services provided during the hospital stay. It also includes all acute care hospital and physician services provided during clinically related readmissions for a period after an initial hospitalization for beneficiaries assigned the selected MS-DRGs. CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services and incorporates a discount. In most cases, physicians and other practitioners are not paid directly by Medicare for covered services furnished as part of the episode, but are paid directly by the hospital from the bundled payment. Participants are permitted to share gains derived from better coordination of care, provided quality targets and certain other conditions are met.

Models 1–3 are administered retrospectively with Medicare continuing to pay each provider participating in the episode under the applicable FFS payment system. Model 4 is administered prospectively with Medicare making a single bundled payment.

For Model 1, interested providers were invited to apply in late 2011. Selected providers began participation in April 2013. There was also an additional application period in mid-2013, which resulted in one additional provider joining the model in January 2014. In total, 14 hospitals are currently participating in Model 1.

For Models 2–4, the initial application period was in 2012, with additional open periods for new providers to join in late 2013 and early 2014. Subsequent submissions expanded the current BPCI participants and added new entities representing approximately 4,000 additional hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long term care hospitals, physician group practices, and convening organizations.

Models 2–4 are structured in two phases. Phase 1 is a preparation period, in which model participants receive additional data from CMS and prepare to assume financial risk. In Phase 2, entities that are offered an agreement by CMS fully participate in the model and bear financial risk. As of October 2014, 220 awardees, concentrated in Models 2 and 3, have shifted at least one episode to Phase 2 and begun a period of performance in BPCI. There are over 6,500 entities currently in the preparatory phase—Phase 1. These may enter the risk-bearing phase if offered an agreement with CMS. The transition period to the risk-bearing phase will conclude in October 2015. At that point, all episodes remaining in BPCI must be in Phase 2. The table below summarizes the entities by model type, entering Phase 2 as of October 2014.

***Table 1: As of October 2014, bundled payment entities starting to assume risk.***

<b>BUNDLED PAYMENT ENTITIES STARTING TO ASSUME RISK</b>		
<b><i>Data from October 2014</i></b>	<b>Entities in Phase 1 (Preparatory Phase) Only</b>	<b>Entities Shifting at Least One Episode to Phase 2 (Risk Bearing Phase)</b>
<b>Model 2</b>	2,046	117
<b>Model 3</b>	4,637	94
<b>Model 4</b>	8	9

Awardees that entered into agreements with the CMS Innovation Center between October 2013 and January 2014 have begun the risk-bearing phase for some or all of their episodes. In BPCI, the period of performance is at the episode level for 3 years. Awardees may move episodes into a period of performance on a quarterly basis, and not all episodes selected by an Awardee will have the same performance period.

Participating entities continue to receive significant technical and educational support, along with Medicare patient data to support successful transition to the risk bearing phase. Participants are monitored for adverse outcomes, including stinting of necessary patient care.

Each of the four bundled payment models will be rigorously evaluated for its impact on total cost and quality of care. The evaluation and monitoring plan for BPCI is designed to guide the implementation, monitoring, and summative evaluation of the initiative. The goals of the evaluation are to assess the initiative's impact on a range of quality, utilization, and cost outcomes. The evaluation will also examine the impact of the initiative on beneficiary experience including access to care and functional outcomes. The evaluation plan includes monitoring the implementation of the initiative to identify any unintended consequences, such as reduced quality and patient or cost shifting. Results will be examined during the period of time covered by the defined episode as well as within a more extended window to assess possible cost shifting and outcomes. Annual and quarterly reports will include analyses based on a combination of qualitative and quantitative sources including Medicare and Medicaid claims, patient surveys, awardee reports, interviews, and site visits.

### **Initiatives Focused on Medicaid and Children's Health Insurance Program Populations**

#### ***Strong Start for Mothers and Newborns***

The Strong Start for Mothers and Newborns initiative (Strong Start) was announced in February 2012 and is serving Medicaid and CHIP enrollees in sites across 20 states and the District of Columbia, and Puerto Rico. The initiative uses two complementary strategies to improve birth outcomes.

Strategy 1 builds on the work of Partnership for Patients (detailed later in this report) and tests a learning collaborative model to encourage the adoption of best practices to reduce early elective deliveries prior to 39 weeks.

Preterm birth—defined as a gestational age of less than 37 weeks—is a growing public health problem with significant health and financial consequences for families. Nationwide, approximately 12 percent of infants are preterm, a 36 percent increase over the last 20 years. Despite long-established evidence that delivery prior to full term (defined as 39 weeks to 40 weeks, 6 days) significantly increases the risk of complications, up to 15 percent of all babies are electively delivered prior to full term without medical indication. To address these risks, Strategy 1 uses three distinct activities: spreading best practices, increasing awareness, and promoting transparency.

To expedite the adoption of best practices that reduce early elective deliveries, Strong Start builds on the efforts and infrastructure of the Partnership for Patients initiative, including the engagement of nearly 4,000 participating institutions. The CMS Innovation Center has worked with the Partnership for Patients' 26 Hospital Engagement Networks to establish and report progress towards measurable goals for participating hospitals, and is providing technical assistance to implement proven strategies and practices for reducing early elective deliveries.

The CMS Innovation Center is also supporting broad-based awareness efforts for Strong Start through visible partnerships with leading organizations that share its goals, including the March of Dimes and the American Congress of Obstetricians and Gynecologists, as well as other professional and advocacy organizations. In addition to supporting industry efforts to develop and publish data on early elective deliveries, the Hospital Engagement Networks are reinforcing participating hospitals' efforts to collect data, measure success, and promote quality improvement and transparency. In May 2014 a reduction of 64.5 percent in early elective deliveries (using a standard Joint Commission measure) was announced (in conjunction with other improvements in Partnership for Patients measures), reflecting the collaborative efforts of providers, private sector organizations, and government toward the shared goal of improved birth outcomes.

Strategy 2 tests three enhanced prenatal care interventions to reduce preterm births for women covered by Medicaid or CHIP who are at high risk for preterm birth. In February 2013, CMS awarded 27 cooperative agreements to test approaches to enhanced prenatal care under Strategy 2. Awarded sites are located in Alabama, Arizona, California, District of Columbia, Florida, Georgia, Illinois, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Missouri, New Jersey, Nevada, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Puerto Rico.

Awardees and sites began enrolling women in Year 2 of the initiative, with large enrollment increases reported in the second quarter. Through June 2014, cumulative enrollment for all three models in Strong Start Strategy 2 is estimated at 11,108 with a total of 1,725 live births. Because women are enrolled early in their pregnancy, a similar increase in births, reflective of the Year 2 enrollment increase, is anticipated by the end of 2014. Awardees comprise a wide range of providers and organizations, across rural and urban areas, including university systems, hospital systems, community health centers, and nonprofit health organizations. Awards are for a 4-year performance period, with continuation contingent upon awardee performance and demonstrated progress toward reducing preterm births.

Strategy 2 provides an opportunity for funding to obstetric providers to test three specific, evidence-based maternity care interventions in the Medicaid program that have shown the potential to reduce preterm birth:

- Enhanced Prenatal Care through Centering/Group Visits: Group prenatal care that incorporates peer-to-peer interaction in a facilitated setting for health assessment, education, and additional psycho-social support.
- Enhanced Prenatal Care at Birth Centers: Comprehensive prenatal care facilitated by teams of health professionals, including allied health professionals and peer counselors. Services include collaborative care, intensive case management, counseling, and psycho-social support.
- Enhanced Prenatal Care at Maternity Care Homes: Comprehensive prenatal care emphasizing care coordination and management that includes psycho-social support, education, and health promotion in addition to traditional prenatal care. This intervention offers expanded access to care, improved care coordination, and a broader array of health services.

An evaluation will assess the impact of Strong Start programs and models of care provided to Medicaid and CHIP beneficiaries on pregnancy outcomes (particularly gestational age at birth and birth weight) and health costs for mother and infant in the year following birth. The evaluation will have three components: case studies of all awardees, participant level data as measured through three surveys and clinical reports, and an impact analysis based on Medicaid/CHIP claims and vital records data. The analysis will be conducted at the site and awardee level—by model, by services provided, by risk levels, and by demographic characteristics of sites and participants.

While findings will be based on the evaluation, the CMS Innovation Center has identified several lessons learned during the first year of implementation of the Strategy 2 enhanced prenatal care approaches. These include: the effectiveness of electronic medical records in identifying women at high risk for preterm birth early in pregnancy; the value of creating and utilizing “opt out” policies to facilitate program participation and retention; and the need for award recipients to establish program policies and infrastructure that facilitate program startup and operations. These lessons learned are informing the technical assistance provided to award recipients and will be used for future program operations and infrastructure planning.

### **Initiatives Focused on Medicare-Medicaid Enrollees**

The Medicare and Medicaid programs were designed to serve distinct purposes. As a result, there are often barriers that prevent beneficiaries enrolled in both programs (often called dual eligible or Medicare-Medicaid enrollees) from receiving coordinated, high-quality, and cost-efficient care. Currently, there are over 10 million low-income seniors and people with disabilities who are Medicare-Medicaid enrollees. These individuals must deal with multiple rules, benefits, providers, and insurance cards to access care across the different parts of the Medicare and Medicaid programs. Many of these beneficiaries have complex health care needs and, as a result, account for a disproportionate share of the programs’ expenditures.

Opportunities exist to enhance the Medicare and Medicaid programs for enrollees who are dually eligible. A fully integrated, person-centered system of care that ensures all of a beneficiary’s needs are met—primary, acute, long-term care, prescription drug,

behavioral, and social—could serve this population in an improved, high-quality, and cost-effective manner.

Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination Office) to integrate program benefits more effectively and improve coordination between the federal government and states for Medicare-Medicaid enrollees. Working together, the CMS Innovation Center and the Medicare-Medicaid Coordination Office have created new opportunities to develop and test innovative care models for the Medicare-Medicaid enrollee population.

The Medicare-Medicaid Coordination Office Fiscal Year 2013 Report to Congress provides additional detail on the Office's efforts to develop policies, programs, and initiatives that promote coordinated, high-quality, cost-effective care for all Medicare-Medicaid enrollees (<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html>). The Financial Alignment Initiative and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents are designed to reduce inefficiencies in care delivery and improve both the coordination of services and overall experience of care for Medicare-Medicaid enrollees.

***Financial Alignment Initiative and State Demonstrations to Integrate Care for Dual Eligible Individuals***

In July 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to establish innovative models of care for Medicare-Medicaid enrollees. Under this initiative and through related work, CMS is partnering with states to test both a capitated model and a managed fee-for-service (MFFS) model. Under the capitated model, the state and CMS enter into a three-way contract with a health plan, which receives a prospective blended payment to provide comprehensive, coordinated care. Under the MFFS model, the state and CMS enter into an agreement by which the state may benefit from a portion of savings from initiatives that improve quality and reduce costs in the FFS delivery system. Although the approaches differ in each state demonstration, beneficiaries are eligible to receive all the standard Medicare and Medicaid services and benefits that they are entitled to, as well as additional care coordination, beneficiary protections, and access to enhanced services. As of October 2014, approximately 200,000 beneficiaries are currently enrolled in the combined Financial Alignment Initiative & State Demonstrations to Integrate Care for Dual Eligible Individuals. Model tests are operated in 11 states.

The Financial Alignment Initiative builds upon and, for some states, incorporates funding from its precursor, the State Demonstrations to Integrate Care for Dual Eligible Individuals, through which CMS awarded design contracts to 15 states (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin) in April 2011 to design new approaches to better coordinate care for beneficiaries enrolled in both the Medicare and Medicaid programs.

Eight of these states are now part of the Financial Alignment Initiative, but continue to receive implementation funding under the State Demonstrations to Integrate Care for Dual Eligible Individuals. Seven of these eight states have signed Memoranda of Understanding (MOUs) to test new models under the Financial Alignment Initiative. In Minnesota, the eighth state from the State Demonstrations, CMS has signed an MOU to test an alternative model, building on the longstanding Minnesota Senior Health Options program.

As of September 2014, under the Financial Alignment Initiative, CMS has entered into MOUs with a total of 11 states: seven states that received awards from the State Demonstrations (California, Colorado, Massachusetts, Michigan, New York, South Carolina, and Washington) and four additional states (Illinois, Ohio, Texas, and Virginia) to integrate care for Medicare-Medicaid enrollees. Nine of these states (California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia) are implementing capitated model demonstrations. Colorado is implementing a MFFS model demonstration and Washington is implementing both a MFFS model and a capitated model demonstration in separate regions of the state. Each model is scheduled to serve beneficiaries for approximately 3 years.

Approved demonstrations are at different stages of implementation. The Washington and Colorado MFFS demonstrations began in July 2013 and September 2014, respectively. The Minnesota demonstration became effective in September 2013. Medicare-Medicaid Plans (MMPs) in Massachusetts started serving beneficiaries in October 2013. Plans participating in the Illinois demonstration began beneficiary services in March 2014; plans in California and Virginia initiated services in April 2014; and MMPs in Ohio began in May 2014. In other states with signed MOUs, beneficiary enrollment will begin at various times in early 2015.

As more demonstrations move toward implementation, CMS and the states have invested in new monitoring and oversight activities designed to protect beneficiary rights and maximize the benefits of integrated care. These activities include the following:

- *Readiness Reviews:* Plans participating in capitated model demonstrations and states participating in MFFS model demonstrations must complete readiness reviews prior to the start of the demonstration. These comprehensive reviews help ensure that each plan or state is ready to accept enrollments, provide the required continuity of care, ensure access to the full spectrum of providers, and fully meet the diverse needs of the Medicare-Medicaid population.
- *Implementation Funding:* States that previously received design contracts for a Demonstration to Integrate Care for Dual Eligible Individuals and also have signed an MOU for demonstrations are eligible for additional funding for implementation activities, especially those activities that promote beneficiary engagement and the protection of beneficiary rights. As of September 2014, CMS had made such awards to California, Colorado, Massachusetts, Michigan, Minnesota, New York, South Carolina, and Washington.

- *Contract Management Teams:* For each capitated model demonstration, CMS and the state establish a joint Contract Management Team (CMT), which monitors plan compliance with a three-way contract. The CMT is responsible for day-to-day monitoring of the demonstration and conducts contract management activities related to access, beneficiary protections, quality, program integrity, and financial solvency.
- *Funding for Ombudsman Services:* Through funding from CMS and technical support from the Administration for Community Living, the Demonstration Ombudsman Programs do the following: 1) provide beneficiaries in states with approved Financial Alignment demonstrations with access to person-centered assistance in answering questions and resolving issues; 2) monitor the beneficiary experience; and 3) offer recommendations to CMS, the states, and participating plans. As of September 2014, CMS had made awards to California, Colorado, Illinois, Massachusetts, Ohio, Virginia, and Washington through this funding opportunity.
- *Funding for State Health Insurance Counseling and Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs):* This funding supports local SHIPs and ADRCs in providing beneficiary outreach and one-on-one “options counseling” to states participating in the demonstrations. As of September 2014, CMS had made awards to California, Illinois, Massachusetts, Virginia, and Washington.

An aggregate evaluation plan has been designed to guide the overall evaluation and individual state evaluation plans are in development. The goals of the evaluation are to monitor demonstration implementation in each state and assess the demonstration’s impact on a range of quality, utilization (including changes in the balance between home and community-based services and nursing facility use), and cost outcomes. Evaluations will also examine the impact of the demonstrations on the beneficiary experience. Results will be measured for the eligible populations as a whole and for subpopulations of interest in each demonstration (such as persons with mental and/or substance use disorders or long term services and supports recipients). The final state-specific reports and the final aggregate evaluation report will include analyses based on linked Medicare and Medicaid data files to provide beneficiary-level information on total Medicare and Medicaid quality, utilization, and spending.

***Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents***

Under the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, seven organizations operating under cooperative agreements are partnering with approximately 146 nursing facilities in seven states. Focused on improving the quality of care in nursing facilities by reducing avoidable hospitalizations, the initiative has served an estimated 24,000 Medicare-Medicaid enrollees each year.

Nursing facility residents are subject to frequent avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities. Approximately 45 percent of hospitalizations

among Medicare-Medicaid enrollees are avoidable, costing the federal government billions in unnecessary expenditures each year.

To address this situation, the CMS Innovation Center launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents in March 2012. Under this initiative, CMS has entered into cooperative agreements with seven organizations functioning as Enhanced Care and Coordination Providers (ECCPs) to test strategies to reduce unnecessary hospitalizations of Medicare-Medicaid enrollees who are long-stay residents of nursing facilities, while at the same time maintaining or improving quality of care. The selected organizations and their partners will test evidence-based interventions designed to accomplish this goal. They will implement and operate these interventions over a 4-year performance period. The model began serving Medicare-Medicaid enrollees in February 2013.

Implementation of the project was staggered, starting in February 2013 and continuing until September 2013, by which time the ECCPs had started operations at all participating nursing facilities under the terms of the model test. During the fourth quarter of 2013, the population served by the model included 15,946 long-stay nursing facility residents in the intervention group. The CMS Innovation Center has worked closely with the participating organizations to support and monitor implementation of the model, providing learning and diffusion activities that facilitate collaboration between model participants and carefully tracking beneficiaries' experience of care.

An independent evaluator is monitoring each ECCP's implementation of the interventions and will evaluate the impact of interventions after they have been operational for several years. The independent evaluator is using comparison groups located in close proximity to partnering nursing facilities in each state to assess the effectiveness of the overall initiative and of the separate components of each ECCP intervention.

### **Initiatives to Speed the Adoption of Best Practices**

#### ***Partnership for Patients***

In April 2011, CMS announced the Partnership for Patients, an initiative designed to make hospital care safer, more reliable, and less costly. The program contracts were awarded in December 2011, and the period of performance includes a 2-year base period and a 1-year option period. The option period was exercised and the contracts end in December 2014. The Partnership for Patients has two goals:

**Making Care Safer:** By the end of 2014, decrease preventable hospital-acquired conditions by 40 percent compared to 2010. This decrease would represent approximately 1.8 million fewer injuries to patients.

**Improving Care Transitions:** By the end of 2014, decrease preventable complications during a transition from one care setting to another so that all hospital readmissions would be reduced by 20 percent as compared to 2010. Achieving this goal would mean

that more than 1.6 million patients will recover from illness without suffering a preventable complication requiring readmission within 30 days of discharge.

Preliminary data for Partnership for Patients show positive results on measures of reduced harm and readmissions. Although the precise causes of the decline in patient harm are not fully determined, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events, spurred in part by Medicare payment incentives, and catalyzed by HHS' Partnership for Patients initiative that is led by CMS.<sup>4</sup>

- For example, based on 2011 and 2012 data from the independent National Scorecard Evaluation, conducted by the Agency for Healthcare Research and Quality (AHRQ), there has been a 9 percent reduction since 2010 in overall harm rates. The reduction in harm rates equates to preventing an estimated 560,000 harms to patients and averting more than 15,000 deaths. The estimated cost savings from these reductions are approximately \$4 billion for 2011 and 2012 combined. These preliminary results and estimated cost savings do not yet include the impact of work in 2013 and 2014. The preliminary quarterly data from the AHRQ National Scorecard continues to trend significantly in the direction of further decreases in harm.
- There has been an 8 percent reduction in the Medicare FFS all-cause, 30-day readmission rate, which represents 150,000 fewer hospital readmissions between January 2012 and December 2013.
- Data from other national leading indicator datasets and from a preliminary independent evaluation provide further evidence of significant national improvements. In the preliminary evaluation report, posted on the CMS Innovation Center website in July 2014 (<http://innovation.cms.gov/Files/reports/PFPEvalProgRpt.pdf>), five areas of focus are showing clear evidence of improvement; Ventilator Associated Pneumonia (VAP), reduction in Early Elective Deliveries (EED), Adverse Drug Events (ADE), Central Line-Associated Bloodstream Infections (CLABSI), and Readmissions.

To make care safer and improve care transitions, through Partnership for Patients, CMS is collaborating with more than 8,000 individuals and organizations in a shared effort to save thousands of lives, prevent millions of injuries, and take critical steps toward a more dependable and affordable health care system. These organizations include the following:

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<sup>4</sup> Preliminary estimates for 2013, released in December 2014 (<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html>), show a further 9 percent decline in the rate of hospital-acquired conditions from 2012 to 2013. From 2010 to 2013, there was a 17 percent decline from 145 to 121 hospital-acquired conditions per 1,000 discharges. A cumulative total of 1.3 million fewer hospital-acquired conditions were experienced by hospital patients over the 3 years (2011, 2012, and 2013) relative to the number of hospital-acquired conditions that would have occurred if rates had remained steady at the 2010 level.

- hospitals and national organizations representing physicians, nurses, and other frontline health care and community-based social services providers committed to improving care processes and systems, and enhancing coordination to prevent inpatient harm;
- patient and consumer organizations committed to raising public awareness and developing information, tools, and resources to help patients and families effectively engage with their providers and avoid preventable complications; and
- employers and states committed to providing the incentives and support that will enable clinicians and hospitals to deliver high-quality health care to their patients.

The 26 Hospital Engagement Networks (HENs) created through the Partnership for Patients represent approximately 3,700 hospitals, or 70 percent of the nation's total general acute-care medical centers and over 80 percent of the total admissions in the United States. HENs are made up of a diverse group: wholly-owned systems, state-based hospital organizations, and other regional or national entities. HENs help identify solutions already working and disseminate them to other hospitals and providers. They work to:

- develop learning collaboratives for hospitals,
- provide a wide array of initiatives and activities to improve patient safety,
- conduct intensive training programs to help hospitals make patient care safer,
- provide technical assistance to help hospitals achieve quality measurement goals,
- establish and implement a system to track and monitor hospital progress in meeting quality improvement goals, and
- identify high performing hospitals and their leaders to coach and serve as national faculty to other hospitals committed to achieving the Partnership goals

The HEN efforts are dedicated to 10 core patient safety areas of focus that include nine hospital-acquired conditions: adverse drug events, catheter-associated urinary tract infections, central line associated blood stream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia as well as the area of readmissions. The Partnership will not limit its work to these areas, but the 10 areas of focus are important places to begin.

Six of the HENs are pursuing Leading Edge Advanced Practice Topics (LEAPT). This project, launched in September 2013, is designed to rapidly test and develop practices to reduce harm from 11 advanced practice topics of concern, including sepsis, clostridium difficile (C-diff), and other clinical conditions where there is less consensus about the measures and practices necessary to eliminate harm. HENs participating in the LEAPT project are committed to the aims of the Partnership for Patients and are working to identify best practices and lessons learned that can be spread quickly at national scale.

Beginning in late 2013, the Center for Clinical Standards and Quality assumed management of the HEN work from the CMS Innovation Center. Partnership for Patients, furthermore, is partnering with other federal entities and quality improvement

programs to align efforts across federal programs in support of progress towards its goals of preventing inpatient harm and reducing readmissions. Federal collaborators include agencies working across the spectrum of care delivery, quality reporting, quality improvement, and provider engagement. Partnership for Patients coordinates a weekly federal partners meeting to improve collaboration across the government.

The relationship between health care providers and their patients (and patients' families) is critical in preventing inpatient harm and reducing complications through improved care transitions. The National Quality Strategy (NQS, <http://www.ahrq.gov/workingforquality/about.htm#aims>), published in 2011, is an effort led by AHRQ to drive improvement on three aims: better care, healthier people, and affordable cost. From the NQS priority area of Person- and Family-Centered Care, Partnership for Patients has defined as one of its program goals better patient and family engagement. To meet this goal, Partnership for Patients is strengthening partnerships among patients, families, and health care providers by engaging patients and families in organizational design and governance, driving adoption of patient-preferred practices at the system level, and anchoring health care in patient and family preferences. In addition, Partnership for Patients is working with a network of many patient advocacy groups as well as a network of patients, families, and 200 patient advocates who are systematically defining best practices for patient and family engagement across the country.

### ***Million Hearts<sup>®</sup>***

The Million Hearts<sup>®</sup> initiative brings together communities, health care professionals, health systems, nonprofit organizations, federal agencies, and private-sector organizations around a common goal: preventing 1 million heart attacks and strokes by 2017. Million Hearts<sup>®</sup> calls attention to a small set of changes that can be made in communities and health care systems that support long-term reductions in heart attacks and strokes. Million Hearts<sup>®</sup> also emphasizes the importance of coordination between public health organizations and clinical systems.

CMS does not fund Million Hearts<sup>®</sup> but supports the Million Hearts<sup>®</sup> objectives in several other ways. CMS has adopted the Million Hearts<sup>®</sup> measure set and embedded it across quality reporting programs and models such as Accountable Care Organizations, the Physician Quality Reporting System, and the Comprehensive Primary Care Initiative. CMS also supports Million Hearts<sup>®</sup> goals by encouraging clinicians who lead CMS Innovation Center models to deploy their electronic health record systems to assess and improve their performance, adopt evidence-based tools like hypertension treatment protocols and patient registries, and reach out to patients to address gaps in care. All of these actions are focused on improving health—especially cardiovascular health—for all Americans. The report “Turning Point for Impact” ([http://millionhearts.hhs.gov/Docs/MH\\_Mid-Course\\_Review.pdf](http://millionhearts.hhs.gov/Docs/MH_Mid-Course_Review.pdf)) summarizes Million Hearts<sup>®</sup> progress to date.

## **Initiatives to Accelerate the Development & Testing of New Payment & Service Delivery Models**

### ***Health Care Innovation Awards***

Innovation in service delivery and payment reform is occurring throughout the country. The Health Care Innovation Awards (Innovation Awards) were created to accelerate the development and testing of innovations originating in the field. The Innovation Awards fund organizations proposing new payment and service delivery models that hold promise of delivering better care, lower costs, and improved health for people enrolled in Medicare, Medicaid and CHIP, particularly those with the greatest health care needs.

The CMS Innovation Center has issued two solicitations for the Innovation Awards, each receiving a robust response. Collectively, the Innovation Awards fund interventions in urban and rural areas in all 50 states, the District of Columbia, and Puerto Rico.

Awardees encompass a diverse set of organizations, including clinicians, hospitals and health systems, academic medical centers, information technology entrepreneurs, community and faith-based organizations, state and local governmental entities, non-profit organizations, and advocacy groups.

Round One, announced in November 2011, was a broad solicitation that encouraged applicants to focus on high-risk populations and to include new models of workforce development. There were 107 Round One awards announced in two groups, in May 2012 and June 2012.<sup>5</sup> The period of performance is 3 years. Round One models are enhancing primary care, coordinating care across multiple settings, deploying new types of health care workers, helping patients and providers make better decisions, and testing new service delivery technologies. Approximately 575,000 Medicare, Medicaid, and CHIP beneficiaries are being served directly through Round One models.

Round One awards were made in seven general areas. Model tests have been grouped together accordingly, so that evaluation can be more model-specific and data can be aggregated:

1. **Complex/High Risk Patient Targeting group:** comprised of 23 awards with a shared focus on patients with medically complex conditions at high risk for hospitalization or readmission. Awardees employ diverse approaches to improve the care of these populations including care coordination, redesign of clinical care workflow, patient education and support, financial incentives, and workforce development.

The evaluation plan for the Complex/High Risk Patient Targeting group will include individual awardee evaluations as well as evaluation of measures that apply across this entire group of model tests. The goal of the evaluation is to assess impact on a range of quality, utilization, and cost outcomes, including beneficiary experience, for each award individually and for this group of awards as a whole. Results will be

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<sup>5</sup> One of the awards encompasses two separate initiatives that will be evaluated separately. Accordingly, there are 107 awards and 108 evaluations.

measured for the eligible populations as a whole and for subpopulations of interest. The final evaluation report will include analyses based on awardee-provided self-monitoring data and linked Medicare and Medicaid data files and use beneficiary-level information to assess impact on quality, utilization, and spending.

2. Disease Specific group: includes 18 awards targeting patient populations with specific diseases or diagnostic profiles. These patients are medically fragile, living in the community, and suffering from specific chronic conditions. Their treatment may involve multidisciplinary care teams across various care settings for long durations.

The goal of the evaluation of the Disease Specific group is to assess the impact of awardee interventions on participants with specific health conditions, including cancer, heart disease, dementia, end stage renal disease, diabetes, chronic pain, and pediatric asthma. The evaluation will include intensive case studies of all awards and, for awards with available data and sufficient enrollment, quantitative analysis of claims using matched control groups. Outcomes of interest include hospitalizations and readmissions, emergency department visits, and costs. The evaluation will consider demographic characteristics and other contextual factors for sites and participants.

3. Behavioral Health and Substance Abuse group: includes 10 awards focusing primarily on mental health and substance abuse services using an array of interventions. Although their initiatives have similar themes (such as workforce development and care coordination), these model tests target different priority populations, such as individuals with schizophrenia or individuals with both a serious mental illness and a chronic physical condition.

Evaluation of Behavioral Health and Substance Abuse model tests will identify and assess strategies and outcomes that are common across the awardees' projects and compare findings. The final evaluation will include quantitative analyses of the impact on total Medicare and Medicaid utilization and spending based on Medicare, and Medicaid data files. This report will also include qualitative analyses to provide information on care quality, organizational characteristics, and workforce transformation. The synthesis of findings across awardees will increase the validity and generalizability of results, and their usefulness for policymakers and program administrators.

4. Hospital Setting group: encompasses 10 awardees providing acute care interventions in the hospital/inpatient setting. These awardees use improved screening, bundled services, workforce training, and technology to deliver better care. Some awardees work with specific subgroups, such as geriatric and intensive care unit patients and patients with delirium, sepsis, and mobility issues. The goal of these interventions is to reduce hospital admissions, readmissions, inpatient length of stay, and cost while improving patient care, experience, and outcomes.

The evaluation will assess whether and how the programs are redesigning acute care while improving health care utilization and patient outcomes in the hospital and

inpatient setting. Measures will include hospital admissions, readmissions, inpatient length of stay, and cost. The evaluation plan will utilize a mixed-methods approach which includes qualitative and quantitative data collection and analyses to examine implementation and program effectiveness, workforce issues, and the impact on priority populations. Quantitative analysis will be used to estimate the impact of the initiative on quality, utilization, and costs. Data sources will include Medicare and Medicaid claims and administrative data, as well as patient and clinician surveys.

Qualitative analyses will be used to address questions pertaining to the nature of program participants and identifying the care redesign strategies planned and implemented by providers. Qualitative data sources will include focus groups, interviews, and review of documents from the awardees and contractors. Each of the 10 awardees will be evaluated individually, with some potential for comparing those that are similar in terms of goals, populations (for example, awardees focusing on specific subgroups such as patients with delirium, sepsis, and mobility issues, as well as geriatric and ICU patients), and care delivery models.

5. Community Resource Planning, Prevention, and Monitoring group: includes 24 awardees. The goal of this group is to enhance care coordination and improve access to health care through the use of health information technology, care management, patient navigation, and the delivery of preventive and health promotion services.

Evaluation of the awardees in the Community Resource Planning, Prevention, and Monitoring group will include qualitative and quantitative components. The qualitative component will consist of analysis of narratives from quarterly reports, project officer observations, awardee site visits, and interviews and/or focus groups. The quantitative component will include an individual assessment of each awardee, including their development of a credible comparison group for total cost of care, their all-cause inpatient admission rate, their all-cause readmission rates, their hospital emergency department visit rates, and awardee-specific clinical and patient reported outcomes. Awardees with similar participant populations may be grouped for analysis. A cross-cutting analysis of all awardees in the Community Resource Planning, Prevention, and Monitoring group will identify underlying themes.

6. Medication Management and Shared Decision-Making group: comprised of nine awardees. Medication management initiatives are designed to optimize therapeutic outcomes and reduce adverse events through improved medication use. The Shared Decision-Making programs engage patients in discussion with care teams and case managers to actively participate in choosing the most appropriate health treatments or care management options for their individual needs, taking into account the best scientific evidence available, as well as the patient's values and preferences.

The evaluation of Medication Management and Shared Decision-Making model tests will use a mixed-methods approach to assess whether and how these programs reduce cost while improving or maintaining the standard of care, patient health and quality of life, and workforce satisfaction. To the extent that a particular approach is promising, this evaluation will describe the contextual factors needed to make success likely, and

the contextual factors that may present barriers. The evaluation will report program-specific measures, such as all-cause and preference-sensitive surgery rates and costs and the proportion of days covered, as well as mortality, inpatient admissions, readmissions, emergency department visits, and costs.

7. Primary Care Redesign group: includes 14 awardees that represent a wide range of intervention models, target populations, and organizational settings.

The evaluation will assess whether and how the initiatives are redesigning primary care practices and improving the coordination, efficiency, and quality of patient care. Site visits and key informant interviews will provide insight into what the intervention entails and how it is implemented. Outcome measures, based on analysis of administrative claims data, will include expenditures per beneficiary, hospitalization rates, emergency department visit rates, and readmission rates.

Round One incorporates a Learning System framework to capture, share, package, and disseminate strategies and resources to help Innovation Award recipients successfully implement their projects and make sustainable improvements in health care system design and delivery. Over 900 individuals have participated in aspects of the learning system in the past year. This multifaceted learning system includes all-awardee webinars and virtual meetings; small group interactions; written collaboration products; and a highly interactive CMS Innovation Center collaboration site. Activities and products have specifically tailored themes based on common issues, challenges, and awardee feedback. Topics have included development of driver diagrams to focus improvement, strategies for participant recruitment, measurement of cost savings, data management and reporting, and workforce development. Small group projects connect awardees with common areas of emphasis/populations and allow for ongoing collaboration and sharing of strategies and lessons learned.

Awards are for a 3-year cooperative agreement period, with continuation contingent upon meeting operational plan milestones. These may include the achievement of patient recruitment goals, the execution of contracts, the dissemination of information, and the application of new technology. The performance period for Round One began in July 2012 and extends through June 2015. Round One awardees completed the second year of the 3-year performance period in mid-2014. Project Officers monitor each award biweekly and review quarterly reports prepared by an independent evaluation contractor. In addition, technical assistance is provided to awardees as needed. A design for evaluation of the 107 awards was completed in early 2013. At the conclusion of the Round One Innovation Award models, the evaluation will assess the impact of interventions on care, cost, and patient outcomes for each award and across awardees.

It is too early to draw any conclusions about quality improvement or cost savings from the Innovation Awards Round One model tests.

Round Two, announced in May 2013, was a more targeted solicitation focused on defined categories and priority areas. Round Two awardees were announced in two groups in May 2014 and June 2014. The period of performance is 3 years. These models

include interventions that will improve care for children, the frail elderly, and those living with HIV/AIDS; enhance emergency care and the management of cardiovascular diseases; better coordinate care in rural areas; and provide support for aging in the community. As in Round One, awards are for a 3-year cooperative agreement period, with continuation contingent upon meeting operational plan milestones.

The second round of Health Care Innovation Awards funded applicants who proposed new payment and service delivery models with the greatest likelihood of driving health care system transformation and delivering better outcomes for Medicare, Medicaid, and CHIP beneficiaries. In Round Two, the CMS Innovation Center sought new payment and service delivery models in four broad categories described below. These categories were identified as gaps in the current CMS Innovation Center portfolio and as areas that could result in potentially usable models for changes in Medicare, Medicaid, and CHIP payment methods.

The four broad categories are as follows:

1. Models designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings.
2. Models that improve care for populations with specialized needs.
3. Models that test the means through which specific types of providers might transform their financial and clinical models.
4. Models that improve the health of populations through activities focused on prevention, wellness, and comprehensive care that extend beyond the clinical service delivery setting.

Round Two required each applicant to propose both an innovative care delivery model and a payment model that would support sustainability. Applicants were encouraged to focus on alternative payment models that did not simply expand FFS payments.

In Category One, three awards were made. Of these, one awardee will test a model to redirect patients with chronic illness and “super-utilizers” with non-emergent conditions from the emergency room to primary care medical homes. Another will test a combination of several proven tools designed to improve care and reduce hospital admissions for patients at 11 nursing facilities.

In Category Two, 11 awards were made. Examples include one awardee that will test a model using technology-enabled care management, virtual visits, and a peer support network to promote better care for people living with HIV/AIDS. Another awardee will test a model using a coach and support team to coordinate health and social services for young adults transitioning out of foster care.

In Category Three, there were 13 awards, including one awardee that will test a model for high-need families providing integrated medical, behavioral health, and community-based services, coordinated by a multidisciplinary team. Another awardee will test a model using a medical neighborhood of primary care and specialty providers designed to promote evidence-based practices and to avoid unnecessary services and imaging for patients with low back pain.

In Category Four, 12 awards were given. One of these awardees will create a statewide hospital telehealth system to provide optimal stroke care and avoid unnecessary transfer to tertiary care centers. Another will test a model to identify patients with Hepatitis C and provide comprehensive medical and behavioral care. Another will test a combination of LEAN process improvements, chronic disease management, and clinical-community integration across 25 critical access hospitals and 73 associated primary care clinics.

The performance period for Round Two began in September 2014 and extends through June 2017. Round Two awardees are testing new models in all categories and priorities. Lessons learned from Round One have been leveraged in the implementation and management of Round Two awards. These lessons include incorporating operational plans into the application process, soliciting payment models, and requesting financial and actuarial review.

### ***State Innovation Models***

In February 2013, the CMS Innovation Center announced funding to 25 states to participate in the State Innovation Models (SIM) initiative, an initiative intended to accelerate state-level health care transformation. Six states (Arkansas, Massachusetts, Maine, Minnesota, Oregon, and Vermont) received funding as Model Test states. These states are currently implementing transformation plans. Nineteen states (California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Maryland, Michigan, New Hampshire, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, and Washington) received Model Design awards to develop State Health Care Innovation Plans. The periods of performance were 9 months for Design states and 36-45 months for Test states.

In May 2014, a second round of SIM funding was announced. The CMS Innovation Center will fund up to 15 Model Design awards and up to 12 Model Test awards in Round Two. States, territories, and the District of Columbia are eligible to apply. Round Two awards will be announced by the end of 2014.<sup>6</sup> The periods of performance will be 1 year for Model Design awards and 3 years for Model Test awards.

States play a critical role in determining the effectiveness of the health care system and the health of their state's population. Not only are states health care payers for the Medicaid, CHIP, and state employee populations, they also impact care delivery through their licensing and public health activities. Moreover, successful health care

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<sup>6</sup> SIM Round Two awards were announced in December 2014 (<http://innovation.cms.gov/initiatives/State-Innovations-Round-Two/index.html>).

transformation design and implementation processes require partnering with the private and public sector at both a state and a national level. States are, therefore, uniquely positioned to partner with the CMS Innovation Center in health care reform.

Under this initiative, the CMS Innovation Center provides financial and technical support to states to help them design and test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP while maintaining or improving quality of care. States cannot use SIM funding to supplant funding levels for activities that are already provided by states or other payers, but they can use SIM funding to supplement existing efforts to enhance the broader transformation of the delivery system.

SIM supports two broad areas of activity:

- Model Design Awards: In Round One, the 19 states that received Model Design awards were charged with developing or enhancing a State Health Care Innovation Plan. These plans were intended to guide innovation and to be used to apply for an expected second round of Model Test awards. The 19 states submitted their State Health Care Innovation Plans to CMS in December 2013.
- Model Testing Awards: The six Round One Model Test states received awards to implement their State Health Care Innovation Plan. These states are expected to: 1) bring a wide range of stakeholders into the implementation process; 2) implement multi-payer payment and service delivery models that include Medicare, Medicaid, CHIP, and other payers; 3) utilize their authority to facilitate and support new health care delivery models that improve care and health while lowering cost; and 4) ensure that models complement and coordinate with other initiatives sponsored by CMS and HHS. The Model Testing award provides funds for the state to carry out and evaluate their transformative payment and service delivery model.

The six Round One Model Test states continue to strengthen, implement, and evaluate their State Health Care Innovation Plan based on finalized Operational Plans. They are receiving extensive guidance and support from the CMS Innovation Center regarding their accountability targets, milestones, self-evaluation plans, and progress reporting. These states are implementing innovative payment and delivery models including ACOs, patient-centered medical homes, and bundled payments. At this time, all test states have implemented innovative approaches to Medicaid and are expanding these approaches to include commercial payers.

The Funding Opportunity Announcement and subsequent terms and conditions of the SIM cooperative agreements required the Design state awardees to consider policy levers and strategies that could be applied to influence the structure and performance of the state's entire health care system and accelerate transformation. In developing their State Health Care Innovation Plan, the state awardees engaged a broad group of stakeholders in

the design process to review, identify, and collaboratively determine how to create multi-payer strategies to move away from payment based on volume and toward payment based on outcomes.

Over the course of the project period, the CMS Innovation Center played a significant role in supporting the states' design of their State Health Care Innovation Plans. All states were assigned a dedicated Project Officer to coordinate resources and monitor awardee progress. The Project Officers interacted regularly with the states, shared actions and activities, and worked collaboratively with other CMS and HHS staff and contractors to ensure the states received targeted support.

The CMS Innovation Center worked with contractors to provide technical assistance to the Design and Test state awardees. Specific topic areas included payment reform, financial analysis, actuarial modeling, behavioral health, substance abuse, dental and long-term services, and quality reporting and analysis. Design states also received assistance developing evaluation plans.

The CMS Innovation Center and the Centers for Disease Control and Prevention (CDC) facilitated a meeting of the SIM states in January 2014 to address the integration of population health strategies in service delivery system and payment reform efforts. During 2014, organizations such as the National Governor's Association, the National Association of State Health Policy, the Commonwealth Fund, the Milbank Memorial Fund, and the Catalyst for Payment Reform hosted or participated in virtual and in-person forums dedicated to supporting SIM states.

An internal review of all available Model Design State Health Care Innovation Plans reveals significant progress and effort in wide-ranging stakeholder engagement. Approximately 100 commercial payers (excluding Medicare and state Medicaid and CHIP agencies) were engaged across the Design and Pre-Test states. At last count, 5,283 stakeholders were engaged throughout the cumulative design deliberation process, encompassing the types of organizations and entities listed above. In addition, the states reported that more than 1,200 meetings were conducted throughout the design and engagement process. Three Design States engaged tribal communities and all states engaged with significant numbers of providers, consumers, and payers. Methods of engagement varied across states.

The six Round One Model Test states have made progress toward the State Health Care Innovation Plan goals. States worked with providers, payers, and CMS to support policy decisions and legislative plans needed to implement their Plans. State SIM teams also worked with physician practices, health systems, health plans, and hospitals to transition to value-based clinical models and to adopt a state's chosen strategy.

All six Round One Test states are using SIM funds to either build new or expand existing health information technology systems that will enable their State Health Care Innovation Plans to be implemented. These states continued to engage stakeholders through work groups or task forces that meet regularly to discuss particular, often technical, issues.

More than 50 stakeholder meetings took place in the last quarter of 2013 with more than 1,000 stakeholders engaged, including the full continuum of health care providers, Medicaid plans, commercial payers, public health agencies, and the general public.

Round Two SIM requirements were modified based on experiences in the initial round. Since states participating in Round One awards requested additional time to design plans, the performance period for second round SIM states will be extended to afford states more time to design and implement strategies. Larger states with diverse populations reported to CMS the need to develop region-specific efforts that require additional resources. In consideration of state variations as a factor in transformation, CMS increased funding for Round Two Model Test states based on the size and scope of the innovation plan. Finally, in recognition of the value of senior leadership engagement in Round One, the CMS Innovation Center required Round Two Model Test applicants to include Senior State Health Officials in the application process.

The CMS Innovation Center views partnerships with states through SIM as a critical channel to accelerate health care transformation. In the upcoming years, state-led innovations will provide valuable lessons that have the potential to identify scalable innovative delivery and payment models in health care across the nation.

***Medicaid Innovation Accelerator Program (IAP)***

In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP), a collaborative initiative with states to promote transformation in state Medicaid delivery systems and payment innovations. Investments will be made over 4 years to provide technical assistance to help states accelerate the development and testing of new state-led payment and service delivery innovations to achieve better care, better health, and lower costs for individuals enrolled in Medicaid.

CMS has been actively engaged with states and stakeholders on health care reform efforts. The Medicaid IAP will build on these discussions by focusing on targeted areas that will accelerate states' efforts to undertake Medicaid delivery system and payment reform.

While payment and service delivery innovation is already underway in states, opportunities for improvement remain. The Medicaid IAP will help strengthen state Medicaid program capabilities in technical areas such as data analytics, service delivery, financial modeling, quality measurement, and rapid cycle evaluation to improve payment and service delivery.

The IAP and its focus areas – data analytics, quality measurement, model development, disseminating best practices, and evaluation – were developed with input from states, including the National Governor's Health Care Sustainability Task Force, and surveys of states participating in the State Innovation Models initiative. Ongoing consultation and collaboration with states as well as consumer groups, health plans, and health care providers will be built into the IAP as it moves forward.

### ***Maryland All-Payer Model***

Maryland operates the nation's only all-payer hospital rate regulation system that applies in lieu of the Inpatient Prospective Payment System and Outpatient Prospective Payment System. Maryland sets rates for hospital services, and all third party payers pay the same rate. Maryland's all-payer system operated from 1977 until December 2013 under section 1814(b)(3) of the Social Security Act.

Effective January 2014, Maryland entered into a new agreement with CMS to implement the Maryland All-Payer Model, a 5-year hospital payment model. Under the terms of the agreement with CMS, Maryland will meet a number of quality targets and limit annual cost growth for all payers, including Medicare. The purpose of this model is to test the impact of transformation in the context of an all-payer rate setting system. Specifically, the model will test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health, and reduced costs.

The agreement between Maryland and CMS provides for the following:

- Maryland elects that specified Maryland hospitals will no longer be reimbursed by Medicare in accordance with its previous statutory waiver in section 1814(b)(3), which is based on Medicare payment per inpatient admission, in exchange for the new CMS model based on Medicare per capita total hospital cost growth;
- Maryland agrees to take measures intended to generate \$330 million in Medicare savings over a 5-year performance period, measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth;
- Maryland will limit its annual all-payer per capita total hospital cost growth to 3.58 percent, the 10-year compound annual growth rate in per capita gross state product;
- Maryland will shift virtually 100 percent of its hospital revenue over the 5-year performance period into global payment models;
- Maryland will take measures to achieve a number of quality targets that will improve the care for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries, such as the following:
  - Readmissions: Maryland will reduce its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate to the national rate over 5 years.
  - Hospital Acquired Conditions: Maryland will achieve an annual aggregate reduction of 6.89 percent in 65 Potentially Preventable Conditions over 5 years for a cumulative reduction of 30 percent.
  - Population Health: Maryland will submit an annual report demonstrating its performance along various population health measures.

- Maryland will transition Maryland hospitals over 2 years to the national Medicare payment systems, if for any reason the 5-year performance period of the model is terminated before its intended end date; and
- Maryland will develop a proposal for a new model based on a Medicare total per capita cost of care test before the start of the fourth year of the model, to begin no later than after the end of the 5-year performance period.

The CMS Innovation Center expects that this model will engage all Maryland acute-care hospitals, as well as other care providers, in innovation and payment reform. The model will work synergistically with other important delivery reform innovations in the state.

### **Medicare Care Choices Model**

The Medicare Care Choices Model provides a new option for beneficiaries with advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, and HIV/AIDS to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. This initiative represents a fundamental change in the delivery of care for persons with advanced illness.

Currently, Medicare beneficiaries are required to forgo curative care in order to receive access to palliative care services offered by hospices. The Medicare Care Choices Model will test whether Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit will elect to receive the palliative and supportive care services typically provided by a hospice if they can continue to seek services from their curative care providers. The CMS Innovation Center will study whether access to such services will result in improved quality of care and patient and family satisfaction, and whether there are any effects on use of curative services and the Medicare hospice benefit.

The Request for Application for the Medicare Care Choices Model was announced in March 2014. The deadline for applications was June 2014. The CMS Innovation Center received a robust response from Medicare certified and enrolled hospice organizations that spanned most of the United States and Puerto Rico. The CMS Innovation Center will select at least 30 rural and urban Medicare certified and enrolled hospices that have demonstrated experience with an established network of providers who have been referring patients to hospice. Preference will be given to hospices that demonstrate experience in developing, reporting, and analyzing quality assurance and performance improvement data. The CMS Innovation Center expects to announce selected participants by the end of 2014.

Through selected hospices, CMS expects to enroll 30,000 beneficiaries throughout the 3-year period of performance. Participants will begin delivering services under the model no later than 180 days after announcement.

### **Prior Authorization Models**

In May 2014, the CMS Innovation Center, in collaboration with CMS' Office of Financial Management, announced that it will begin testing two prior authorization models for repetitive scheduled non-emergent ambulance transport and non-emergent

hyperbaric oxygen therapy. The models, authorized under Section 1115A, build on an earlier prior authorization demonstration for power mobility devices. Repetitive, scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy are the focus of these models due to the high incidences of improper payments for these services as reported by the Department of Health and Human Services Office of Inspector General, as well as concerns about beneficiaries receiving services that are not medically necessary.

The objective of the models is to test whether prior authorization helps reduce improper payments and thereby lowers Medicare costs, while maintaining or improving quality of care. The models will not create additional documentation requirements; rather, they will require reporting the same information that is currently necessary to support Medicare payment, only earlier in the process. This will help ensure that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

The prior authorization model for repetitive scheduled non-emergent ambulance transport will be implemented in South Carolina, New Jersey, and Pennsylvania, and the non-emergent hyperbaric oxygen therapy model will be implemented in Illinois, Michigan, and New Jersey. These states were chosen because of their high Medicare expenditures for repetitive scheduled non-emergent ambulance transports and non-emergent hyperbaric oxygen therapy. The CMS Innovation Center expects to announce performance period dates by the end of 2014.

Both models will follow a similar prior authorization process. The provider or beneficiary will be encouraged to submit to their Medicare Administrative Contractor (MAC) a request for prior authorization along with all relevant documentation to support Medicare coverage of the service. The MAC will review the request and provide a provisional affirmative or non-affirmative decision within a specified timeframe. A claim submitted with an affirmative prior authorization will be paid as long as all other requirements are met, and a claim submitted with a non-affirmative decision will be denied (with appeal rights available). Unlimited resubmissions are allowed under the models. If a provider or supplier chooses to forego prior authorization and submits a claim without a prior authorization decision, the claim will undergo pre-payment review. The models will include an expedited review process to address circumstances where the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. However, we expect requests for expedited reviews to be extremely rare since both models apply only to non-emergent services.

In the repetitive scheduled non-emergent ambulance transport model, a provisional affirmative prior authorization decision will affirm a specified number of trips (up to 40 round trips), within a 60-day period. In the non-emergent hyperbaric oxygen therapy model, a provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in a year.

Outreach and education to participating providers, suppliers, and beneficiaries will begin prior to the start of both models and will continue throughout the performance periods.

Outreach and education will include Open Door Forums, frequently asked questions, operational guides, and updates through the model websites. In addition, the MACs will conduct in-person educational events and will post a letter to physicians explaining their role in the models.

Prior authorization supports ongoing efforts to safeguard beneficiaries’ access to medically necessary items and services, while reducing improper Medicare billing and payments. The initiative will improve access to services by giving Medicare beneficiaries greater confidence that their services are covered before they are rendered.

#### **4. Beneficiaries Participating in CMS Innovation Center Initiatives**

*Table 2: Estimated number of beneficiaries participating, or projected to participate in models authorized under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). A comprehensive listing of all initiatives currently administered by the CMS Innovation Center is contained in the Appendix.*

<b>BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)</b>	
<b>INITIATIVE</b>	<b>DIRECT BENEFICIARIES*</b>
<b>Primary Care Transformation</b>	
Comprehensive Primary Care Initiative	396,000
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	207,000
<b>Accountable Care</b>	
Pioneer Accountable Care Organization Model	625,000
Advance Payment Accountable Care Organization Model	301,000 <sup>†</sup>

<b>BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)</b>	
<b>INITIATIVE</b>	<b>DIRECT BENEFICIARIES*</b>
Comprehensive End-Stage Renal Disease Care Model (CEC)	Data Not Yet Available <sup>†</sup>
<b>Bundled Payments for Care Improvement</b>	
Model 1	78,000 <sup>§</sup>
Model 2	33,000 <sup>§</sup>
Model 3	15,000 <sup>§</sup>
Model 4	4,000 <sup>§</sup>
<b>Initiatives Focused on the Medicaid Population</b>	
Strong Start for Mothers and Newborns (Strategy 1)	16,000
Strong Start for Mothers and Newborns (Strategy 2)	11,000
<b>Initiatives Focused on Medicare-Medicaid Enrollees</b>	
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Included in Financial Alignment Initiative
Financial Alignment Initiative	200,000
Initiative to Reduce Preventable Hospitalizations Among Nursing Facility Residents	24,000

<b>BENEFICIARIES PARTICIPATING IN CMS INNOVATION CENTER INITIATIVES (Estimate as of September 30, 2014)</b>	
<b>INITIATIVE</b>	<b>DIRECT BENEFICIARIES*</b>
<b>Initiatives to Speed the Adoption of Best Practices</b>	
Partnership for Patients	Not Applicable**
Million Hearts®	Not Applicable**
<b>Initiatives to Accelerate New Service Delivery and Payment Model Testing</b>	
Health Care Innovation Awards (Round One)	575,000
Health Care Innovation Awards (Round Two)	Data Not Yet Available‡
State Innovation Models (Round One)	80% of test states' beneficiaries
State Innovation Models (Round Two)	Data Not Yet Available‡
Maryland All-Payer Model	830,000††
Medicare Care Choices Model	Data Not Yet Available‡
Medicaid Innovation Accelerator Program	Not Applicable**
Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy	Data Not Yet Available‡
Medicare Prior Authorization Models: Repetitive Scheduled Non- Emergent Ambulance Transport	Data Not Yet Available‡

\* Beneficiaries may be participating in more than one model.

† Source: Medicare Shared Savings Program

‡ Model is pre-operational

§ Projected

\*\* This is a national quality improvement initiative without direct beneficiary participants.

†† This number only includes Medicare Fee-for-Service beneficiaries.

‡‡ This initiative will provide federal tools and resources to support states in advancing Medicaid-specific delivery system reform and by sharing lessons and best practices, but it will not directly engage beneficiaries.

## **5. Payments Made on Behalf of Beneficiaries Participating in Models**

Table 3 below outlines the estimated payments made on behalf of beneficiaries participating in models authorized under section 1115A of the Social Security Act, as well as payments under Titles XVIII and XIX of the Social Security Act and CMS Innovation Center obligations to date to support each initiative. A comprehensive listing of all demonstrations and other initiatives administered by the CMS Innovation Center is included in the Appendix. In general, payments made under the applicable titles for services on behalf of beneficiaries assigned to CMS Innovation Center models continue to be made in accordance with existing payment provisions. This table does not include Medicare, Medicaid, and CHIP payment amounts that providers, suppliers, or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.

As required by the statute, each of these models was selected to address a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures, with a focus on models expected to reduce program expenditures while preserving or enhancing the quality of care received by beneficiaries. During the review of each model, the CMS Innovation Center will evaluate the models' evidence base by reviewing the potential cost and quality impact of the initiative. The CMS Innovation Center will also prepare estimates, typically with the participation of the CMS Office of the Actuary, of the financial impact of the proposed initiatives as well as an analysis of their potential impact on the quality of health care among beneficiaries. The strength of this evidence will be used to support decisions to advance a particular initiative.

The data included in this table are defined as follows:

- The column titled “CMS Innovation Center *payments made to model participants*” reflects payments to participants in the testing of models, such as providers of services, suppliers, states, conveners, and others. These payments may include care management fees and cooperative agreement awards and are paid through CMS Innovation Center funds as provided under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). These payments were made by September 30, 2014.

- The column titled “*Payments under Title XVIII or XIX made for services on behalf of beneficiaries*” reflects payments, such as shared savings payments, made from the Medicare Trust Funds, as well as any other payments made under Titles XVIII or XIX for model-related services on behalf of beneficiaries. For example, certain models (such as the Pioneer ACO Model) include opportunities to share in the savings that providers generate for Medicare through payment under Title XVIII. This column does not include Medicare, Medicaid, and CHIP payment amounts that providers, suppliers, or others receive for covered services provided to the beneficiaries under the applicable titles that would have occurred even in the absence of the models.
- The column titled “*Other CMS Innovation Center funds obligated to support model development and testing*” reflects the total CMS Innovation Center funds obligated as of the end of Fiscal Year 2014, September 30, 2014, such as contract awards for administrative and evaluation obligations, but excluding payments listed in other columns.

**Table 3: As of September 30, 2014, estimates of payments made to model participants (including providers, suppliers, states, conveners and others); shared savings or other payments under Title XVIII or XIX made on behalf of beneficiaries; and other CMS Innovation Center funds obligated to support model development and testing.**

<b>ESTIMATED PAYMENTS</b>			
<b>INITIATIVE</b>	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
<b>Primary Care Transformation</b>			
Comprehensive Primary Care Initiative	\$172,740,615	Payments Not Yet Made (expected in FY 2015)	\$57,609,096
Federally Qualified Health Center Advanced Primary Care Practice Demonstration	\$45,967,680	Not Applicable	\$22,868,754

<b>ESTIMATED PAYMENTS</b>			
<b>INITIATIVE</b>	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
<b>Accountable Care Organizations</b>			
Pioneer Accountable Care Organization Model	Not Applicable	\$80,719,585	\$87,048,657
Advance Payment Accountable Care Organization Model	\$67,801,572 <sup>§§</sup>	\$5,705,754 <sup>***</sup>	\$5,371,781
Comprehensive End-Stage Renal Disease Care Model	Not Applicable	Payments Not Yet Made	\$16,476,376 <sup>†††</sup>
<b>Bundled Payments for Care Improvement</b>			
Bundled Payments for Care Improvement (Models 1-4)	Not Applicable	Data Not Yet Available	\$40,399,579
<b>Initiatives Focused on the Medicaid Population</b>			
Strong Start for Mothers and Newborns (Strategies 1 & 2)	\$23,594,395	Not Applicable	\$47,649,930
<b>Initiatives Focused on Medicare-Medicaid Enrollees</b>			
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	\$70,509,361	Not Applicable	\$18,928,906

<b>ESTIMATED PAYMENTS</b>			
<b>INITIATIVE</b>	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Financial Alignment Initiative	\$5,207,996	Data Not Yet Available	\$79,839,514 <sup>***</sup>
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	\$78,900,786	Not Applicable	\$11,245,590
<b>Initiatives to Speed the Adoption of Best Practices</b>			
Partnership for Patients	Not Applicable	Not Applicable	\$451,352,024
Million Hearts <sup>®</sup>	Not Applicable	Not Applicable	Not Applicable
<b>Initiatives to Accelerate New Service Delivery and Payment Model Testing</b>			
Health Care Innovation Awards Round 1	\$879,640,554 <sup>\$\$\$</sup>	Not Applicable	\$60,477,074
Health Care Innovation Awards Round 2	\$120,033,340	Not Applicable	\$7,272,376
State Innovation Models (Round One)	\$181,418,835	Not Applicable	\$32,335,764
State Innovation Models (Round Two)	Payments Not Yet Made	Not Applicable	\$1,985,982 <sup>****</sup>
Medicaid Innovation Accelerator Program	Not Applicable	Not Applicable	Obligations Not Yet Made
Maryland All-Payer Model	Not Applicable	Not Applicable	\$5,608,084

<b>ESTIMATED PAYMENTS</b>			
<b>INITIATIVE</b>	CMS Innovation Center payments made to model participants	Payments under Title XVIII or XIX made for services on behalf of beneficiaries	Other CMS Innovation Center funds obligated to support model development and testing
Medicare Care Choices Model	Payments Not Yet Made	Not Applicable	\$1,857,149
Prior Authorization Model: Non-Emergent Hyperbaric Oxygen Therapy	Not Applicable	Not Applicable	Obligations Not Yet Made
Prior Authorization Model: Repetitive Scheduled Non-Emergent Ambulance Transport	Not Applicable	Not Applicable	\$4,338,941
<b>SUBTOTALS:</b>	\$1,645,815,124	\$86,425,339	\$952,665,577

<sup>§§</sup> Payments made to model participants in the Advance Payment ACO Model represent the advance payments given to ACOs as part of the model, which were distributed under the authority of section 1115A of the Social Security Act.

<sup>\*\*\*</sup> Payments to participants in the Advance Payment ACO Model under Title XVIII or XIX were distributed as shared savings payments under the authority of the Medicare Shared Savings Program.

<sup>†††</sup> Of this amount, \$1,321,039 was obligated as application support through the FY2013 pre-implementation budget.

<sup>†††</sup> Of this amount, \$1,495,660 was obligated for the Financial Alignment Initiative under the FY2011 budget for the State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees.

<sup>§§§</sup> This total reflects the full amount of grant funding provided to HCIA awardees for the 3-year period of performance. Funds are used by awardees to implement models, including payments to providers of services, and to suppliers.

<sup>\*\*\*\*</sup> This funding was used for the Medicaid Innovation Accelerator Program (IAP) Learning Collaborative in FY2014. The IAP program is budgeted separately in FY2015 and thereafter.

To date, total payments made to model participants (excluding payments under Title XVIII and XIX) and other obligations for CMS Innovation Center models, as detailed above, are estimated at \$2.600 billion (exclusive of administrative costs). Actual costs may vary based on the numbers of providers and beneficiaries participating, as well as changes in expected operational and evaluation costs.

## **6. Results and Recommendations**

### ***Results from evaluations***

The payment and service delivery models announced by the CMS Innovation Center under the authority of section 1115A of the Social Security Act, as well as the initiatives to speed the adoption of best practices, have not completed their respective periods of performance and many are in the early stages of implementation. Caution is urged in the interpretation of preliminary findings based on limited data from the early stages of model implementation. The findings from summative evaluations needed to assess the impact of new payment and service delivery models are not available. Interim results from two of the first models to be implemented, Partnership for Patients and Pioneer ACOs, have been included with their respective model descriptions in this report. The CMS Innovation Center will conduct summative evaluations of each model after the conclusion of its respective period of performance. As they become available, evaluation results will be included in future Reports to Congress, and will inform recommendations regarding model expansions or legislative action.

### ***Models chosen for expansion***

As of September 30, 2014, none of the models tested under section 1115A of the Social Security Act have been in the testing phase long enough to generate sufficient data to assess the impact of the model or to allow for a recommendation about its expansion.

### ***Recommendations for legislative action***

This report conforms to the requirements of section 1115A and describes the models launched under this authority. Any legislative recommendations related to CMS programs, including the CMS Innovation Center, would typically be included in the President's budget request.

## **7. Conclusion**

Over the past 4 years, the CMS Innovation Center has, in accord with its legislative charge, actively tested new payment and service delivery models that show promise for reducing program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries.

The CMS Innovation Center's portfolio of models has attracted participation from a broad array of health care providers, states, payers, and other stakeholders, and serves Medicare, Medicaid, and CHIP beneficiaries in all 50 states, the District of Columbia, and Puerto Rico. We estimate that over 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 60,000 providers participating in CMS Innovation Center initiatives. Because a number of these initiatives involve multiple payers or focus on broad areas of quality improvement, millions of other Americans are benefiting from the CMS Innovation Center's model testing activities.

The CMS Innovation Center has solicited input from stakeholders across the country and federal partners in the selection and design of new payment and delivery models to be tested. To implement these models, the CMS Innovation Center has collaborated with CMS components, including the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) (for the Financial Alignment Initiative), the Office of Financial Management (for the Prior Authorization Models), and the Center for Clinical Standards and Quality (for Partnership for Patients) for the joint development and administration of these models. Other CMS components, and other federal agencies such as the Centers for Disease Control and Prevention, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Office of the National Coordinator of Health Information Technology, Administration for Community Living, Department of Housing and Urban Development, Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration, have assisted in design and testing activities for multiple models.

Under section 1115A authority, the CMS Innovation Center is testing 22 initiatives intended to achieve better care, better health, and lower costs for Medicare, Medicaid, and CHIP beneficiaries. Models have been designed to align financial incentives with improved quality and efficiency and to promote multi-payer participation in payment and delivery system reform. New payment mechanisms are enabling providers to better coordinate treatment across the continuum of care, to manage the health of populations, and to redesign care to be more patient-centered, more effective, and ultimately less costly.

These CMS Innovation Center initiatives are being conducted in partnership with a broad array of providers, health and community organizations, and researchers. Model tests are routinely monitored on performance and quality measures. Continuous quality improvement in the model tests is supported through technical assistance, learning and diffusion resources, facilitated collaboration between participants, and rapid cycle feedback on monitoring and reporting. The CMS Innovation Center is further accelerating improvement and health care transformation by disseminating successful strategies and lessons learned from model testing among program participants and throughout the health care community. The evaluation of model tests is driven by the CMS Innovation Center's Research and Rapid Cycle Evaluation Group, which reviews the program design, research methodology, and the evaluability of all proposed models and oversees both intermediate and final evaluation of model tests, aimed respectively at improving model performance during the period of performance and at providing rigorous and valid summative assessments of a model's impact on the quality and cost of care.

The efforts of the CMS Innovation Center represent important steps forward in the transformation of the health care system. Models underway and in development will help providers, payers, states, and other stakeholders achieve a system in which beneficiaries, and eventually all Americans, receive comprehensive, integrated care driven by evidence, performance, and improving outcomes. The CMS Innovation Center looks forward to building on its existing work and continuing to advance improvements in health care delivery and the reduction of expenditures.

## 8. Appendix: The CMS Innovation Center Program Portfolio

(All Projects With Activity During the Period November 2012-September 2014)

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Advance Payment ACO Model</b>	Prepayment of expected shared savings to certain eligible ACOs to advance development of ACO infrastructure and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Bundled Payment for Care Improvement</b>	Evaluate 4 different episode payment models around inpatient hospitalization to incentivize care redesign Model 1: Retrospective Acute Care Model 2: Retrospective Acute Care Episode & Post-Acute Care Model 3: Retrospective Post-Acute Care Model 4: Prospective Acute Care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Comprehensive End Stage Renal Disease (ESRD) Care (CEC)</b>	An initiative to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Comprehensive Primary Care Initiative</b>	A public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Federally Qualified Health Center (FQHC) Advanced Primary Care Practice-Demonstration</b>	Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Financial Alignment Initiative</b>	Opportunity for states to partner with CMS to implement new integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Health Care Innovation Awards Round One</b>	A broad appeal for innovations with a focus on developing the workforce for new care models	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Health Care Innovation Awards Round Two</b>	A second appeal for innovations with a focus on payment and system delivery reform in 4 categories for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents</b>	Initiative to improve the quality of care and reduce avoidable hospitalizations among long-stay nursing facility residents through cooperative agreements with independent organizations partnering with nursing facilities to test enhanced on-site services and supports	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Maryland All-Payer Hospital Model</b>	To test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health and reduced costs	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Medicaid Innovation Accelerator Program</b>	Initiative providing states with technical assistance in such areas as data analytics, service delivery and financial modeling, quality measurement, and rapid cycle evaluation to accelerate the development and testing of state-led payment and service delivery innovations	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Medicare Care Choices Model</b>	To test whether Medicare beneficiaries who meet Medicare hospice eligibility requirements will achieve patient-centered goals if they receive hospice services with continuation of curative services	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Medicare Prior Authorization Models: Non-Emergent Hyperbaric Oxygen Therapy</b>	A prior authorization model for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Medicare Prior Authorization Models: Repetitive Scheduled Non-Emergent Ambulance Transport</b>	A prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina to test whether prior authorization helps reduce expenditures, while maintaining or improving quality of care	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Million Hearts<sup>®</sup></b>	National initiative to prevent 1 million heart attacks and strokes over 5 years; brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke; this initiative is not a payment and service delivery model for purposes of section 1115A, but rather is an initiative that is part of the infrastructure of the CMS Innovation Center	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) <sup>†††</sup>
<b>Partnership for Patients</b>	Efficacy of hospital engagement networks (and other interventions) in reducing hospital acquired conditions by 20 percent, and readmissions by 40 percent (Community-Based Care Transitions Program is covered in another row)	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Pioneer ACO Model</b>	Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees</b>	Support states in designing integrated care programs for Medicare-Medicaid enrollees	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>State Innovation Models Round One</b>	Provides financial, technical, and other support to states that are either prepared to test, or are committed to designing and testing new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>State Innovation Models Round Two</b>	Provides financial, technical, and other support to up to an additional 32 states to develop or implement state health care innovation plans	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Strong Start for Mothers and Newborns</b>	<p>Strategy I: Testing the effectiveness of shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women</p> <p>Strategy II: Testing and evaluating a new model of enhanced prenatal care to reduce preterm births (less than 37 weeks) in women covered by Medicaid and CHIP</p>	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
<b>Mandated Demonstrations and Other Initiatives Authorized Under Various Statutes</b>		
<b>Acute Care Episode (ACE) Demonstration</b>	Test the effect of bundling Part A and B payments for episodes of care to improve the coordination, quality, and efficiency of care	Section 1866C of the Social Security Act
<b>Community-Based Care Transitions Program (a part of the Partnership for Patients)</b>	Reduce readmissions by improving transitions of high-risk Medicare beneficiaries from the inpatient hospital setting to home or other care settings	Section 3026 of the Affordable Care Act

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Environmental Health Hazards (Libby)</b>	Pilot program provides certain environmental exposure affected individuals deemed eligible for Medicare, comprehensive, coordinated, and cost effective care (including coverage of certain benefits and services not normally authorized or covered under Medicare)	Section 1881A of the Social Security Act (section 10323 of the Affordable Care Act)
<b>Frontier Community Health Integration Program (F-CHIP)</b>	Develop and test new models of integrated, coordinated health care in the most sparsely-populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures	Medicare Improvements for Patients and Providers Act Section 123 and Affordable Care Act Section 3126
<b>Frontier Extended Stay Clinic Demonstration</b>	Allows remote clinics to treat patients for more extended periods of time than are usually provided in routine physician visits, including overnight stays	Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
<b>Graduate Nurse Education Demonstration</b>	Designed to increase the nation’s primary care workforce by supporting facilities that train Advanced Practice Registered Nurses (APRNs) through payments to eligible hospitals, helping them offset the costs of clinical training for APRN students	Section 5509 of the Affordable Care Act
<b>Independence at Home Demonstration</b>	Home-based care for Medicare beneficiaries with multiple chronic conditions	Section 1866E of the Social Security Act, as added by section 3024 of the Affordable Care Act
<b>Intravenous Immune Globulin (IVIG) Demonstration</b>	Evaluate the benefits of providing payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of primary immune deficiency disease (PIDD)	P.L. 112-242 Title I - Medicare IVIG Access Sec. 101

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Medicaid Emergency Psychiatric Demonstration</b>	Provides federal matching funds to States for emergency Medicaid admissions to private psychiatric hospitals for beneficiaries aged 21 to 64	Section 2707(e) of the Affordable Care Act
<b>Medicaid Incentives for Prevention of Chronic Diseases Demonstration</b>	Initiatives to provide incentives to Medicaid beneficiaries who successfully participate in a comprehensive, evidence-based, widely available, and easily accessible program, which has demonstrated success in helping individuals achieve ceasing use of tobacco, controlling or reducing their weight, lowering cholesterol, lowering blood pressure, and avoiding onset of diabetes, or in the case of a diabetic, improving the management of the condition	Section 4108 of the Affordable Care Act
<b>Medicare Coordinated Care Demonstration (Health Quality Partners)</b>	This project tests whether providing coordinated care services to Medicare beneficiaries with complex chronic conditions can yield better patient outcomes without increasing program costs	Section 4016 of the Balanced Budget Act of 1997
<b>Medicare Health Care Quality Demonstration</b>	Test major changes to improve quality of care while increasing efficiency across an entire health care system	Section 1866C of the Social Security Act
<b>Medicare Imaging Demonstration</b>	Collect data regarding physician use of advanced diagnostic imaging services in relation to appropriateness criteria which, for purposes of the demonstration, are medical specialty guidelines meeting specific conditions	Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Medicare Low Vision Rehabilitation Demonstration</b>	Examine the impact of coverage for vision rehabilitation services provided to Medicare beneficiaries with moderate to severe visual impairments that cannot be corrected through surgery or glasses	Appropriations Conference Report 2004 (H.R. 2673) and Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)
<b>Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)</b>	State-led, multi-payer collaborations to help primary care practices transform into advanced primary care practices	Section 402 of the Social Security Amendments of 1967 as amended (42 U.S.C. 1395b-1)
<b>Physician Group Practice (PGP) Transition Demonstration</b>	A precursor to the Medicare Shared Savings Program; rewards physician groups for efficient care and high quality	Section 1899(k) of the Social Security Act
<b>Physician Hospital Collaboration Demonstration</b>	Examines the effects of gainsharing aimed at improving the quality of care in a health delivery system	Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as amended by Section 3027 of the Affordable Care Act
<b>Private, For-Profit Demonstration Project for the Programs of All-Inclusive Care for the Elderly (PACE)</b>	Study of the quality and cost of private, for-profit entities providing PACE program services under the Medicare and Medicaid programs	Section 4804 of the Balanced Budget Act of 1997

<b>THE CMS INNOVATION CENTER PROGRAM PORTFOLIO</b>		
<b>Initiative Name</b>	<b>Description</b>	<b>Statutory Authority</b>
<b>Rural Community Hospital Demonstration</b>	Test the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals	Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as amended by sections 3123 and 10313 of the Affordable Care Act
<b>Treatment of Certain Complex Diagnostic Laboratory Tests</b>	Make separate payments for certain complex diagnostic laboratory tests, such as gene protein expression, typographic genotyping, or cancer chemotherapy sensitivity assay	Section 3113 of the Affordable Care Act

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\*\*\*\* The Million Hearts® initiative does not receive any funding from the CMS Innovation Center.

## **9. Glossary of Acronyms**

ACO	Accountable Care Organization
ADRC	Aging and Disability Resource Center
ADE	Adverse Drug Events
AHRQ	Agency for Healthcare Research and Quality
BPCI	Bundled Payments for Care Improvement
CDC	Centers for Disease Control and Prevention
CEC	Comprehensive ESRD Care
CHIP	Children’s Health Insurance Program
CLABSI	Central Line-Associated Bloodstream Infections
CMS	Centers for Medicare & Medicaid Services
CMT	Contract Management Team
CPC	Comprehensive Primary Care
ECCP	Enhanced Care and Coordination Provider
EED	Early Elective Deliveries
ESCO	ESRD Seamless Care Organization
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
FQHC ADCP	Federally Qualified Health Center Advance Primary Care Practice Demonstration
HEN	Hospital Engagement Network

HHA	Home Health Agency
HHA VBP	Home Health Agency Value-Based Purchasing
HIV/AIDs	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HHS	Department of Health and Human Services
HVBP	Hospital Value-Based Purchasing
IAP	Medicaid Innovation Accelerator Program
LEAPT	Leading Edge Advanced Practice Topics
LDO	Large Dialysis Organization
MAC	Medicare Administrative Contractor
MFFS	Managed Fee-for-Service
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
MS-DRG	Medicare Severity Diagnosis Related Group
NCQA	National Committee of Quality Assurance
NQS	National Quality Strategy
ONC	Office of the National Coordinator of Health Information Technology
PCMH	Patient-Centered Medical Home
RFI	Request for Information
SDO	Small Dialysis Organization
SHIP	State Health Insurance Counseling and Assistance Program

SIM	State Innovation Models
VAP	Ventilator Associated Pneumonia