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The Center for Medicare and Medicaid Innovation: A Year's Progress

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Background

Improving the quality of care delivery and reducing explosive growth in healthcare costs is a cornerstone of The Patient Protection and Affordable Care Act (ACA).¹ It reflects the shared understanding that the current silo-based approaches to care delivery that focus on settings of care (e.g., physician office, hospital) rather than care delivery across multiple providers and setting (e.g., episodic) are not working. Costs are increasing at an unsustainable pace, and evidence from leading researchers collectively points to serious deficiencies in health care quality and the disconnect between high spending and health care quality.²

To foster the development of more collaborative and coordinated approaches to care delivery, the ACA created the Center for Medicare and Medicaid Innovation (The Innovation Center) “for the purpose of testing health care delivery and payment systems, supporting care coordination, and disseminating best practices across the health care delivery system.”³ This new Center sits within The Center for Medicare & Medicaid Services (CMS) and is critical to the ACA and the Agency’s “three part aim of better health, better health care, and reduced expenditures.”⁴

We [first wrote](#) about the Innovation Center in the spring of 2010 shortly after Congress passed the ACA. Because CMS had yet to organize the Center, our initial GPS brief focused on the framework and issues raised by the authorizing legislation. Nearly a year and a half later, the Innovation Center is operational and making considerable progress on their mandated tasks. We explore this progress and key issues below.

Changes made by the Affordable Care Act (P.L. 111- 148, § 3021):

- The ACA directs the Innovation Center to test the ability of delivery and payment models to reduce Medicare and Medicaid costs and improve or maintain health quality in two phases. During Phase I, the Secretary has discretion to select models giving preference to models that focus on cost reduction and care improvement within the Medicare, Medicaid, and dual eligible populations where there is “evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” The Secretary also may consider models that involve the use of electronic health records and a team based approach to care. Only those models that improve or maintain health while reducing costs will be continued. In Phase II, “the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested” provided the Secretary determines that expansion will reduce costs and maintain or improve quality and the Chief Actuary of CMS certifies that expansion will reduce costs.⁵

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- The ACA authorizes the Innovation Center to relax the application of certain laws that govern financial relationships between and among providers (e.g., federal anti-kickback law, Stark physician self-referral law) while conducting testing. Consequently, providers participating in Innovation Center initiatives that focus on improved care coordination and team-based approaches to care will be allowed to share in any savings that may be generated by new payment and care delivery models (e.g., gainsharing).⁶
- The ACA grants the Innovation Center broad authority to waive Social Security Act requirements in order to conduct testing. In particular, the Secretary, acting through the Innovation Center, may waive any requirement under Title XI (“General Provisions, Peer Review, and Administrative Simplification”) and Title XVIII (Medicare) as well as certain Title XIV (Medicaid) requirements pertaining to statewideness, rate-setting processes, and contracted services.⁷

Implementation

CMS officially launched the Innovation Center on November 16, 2010 (prior to the required January 1, 2011 date).⁸ Since that time, the Innovation Center has actively pursued several significant initiatives, including:

- *Bundled Payments for Care Improvement*⁹
 - Through the Bundled Payments for Care Improvement Initiative, the Innovation Center will test the impact of linking payments for multiple related services that patients receive across an episode of care. For example, instead of a surgical procedure generating claims from the hospital, physician(s), and rehabilitation center, one provider will receive a “bundled” payment for all care related to the surgical procedure. The goal is to encourage providers to deliver health care services more efficiently while maintaining or improving quality
 - The Center plans to test prospective and retrospective bundled payment models in the following four settings: (1) Acute Care Hospital Stay; (2) Acute Care Hospital Stay plus Post-Acute Care; (3) Post-Acute Care only; and (4) Chronic Care. Applications for Model 1 are currently being reviewed and final applications for Models 2-4 are due by March 15, 2012.
- *Partnership for Patients*
 - The Partnership for Patients is a public-private initiative launched by the Department of Health and Human Services (HHS) and the Innovation Center. The Initiative seeks to achieve a 20% reduction in hospital readmissions and 40% reduction in hospital acquired conditions by 2013.¹⁰
 - The Partnership also will focus on working to reduce the hospitalization rate of nursing home residents by partnering with organizations that provide advanced clinical care to nursing home residents.¹¹
 - Hospitals, providers, consumers, unions, and other interested stakeholders may join the partnership by pledging their commitment to a safer and “more dependable” health care

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system on the HHS website.¹² More than 6,400 organizations, including more than 2,900 hospitals, have taken the Partnership for Patients pledge.¹³

- CMS will award 500 million dollars in grants to “Hospital Engagement Contractors” who will facilitate safer care by providing training and technical assistance to hospitals and providers.
- CMS is administering the Community Based Care Transition Program (CCTP) as part of the Partnership for Patients. This program will facilitate partnerships between community-based organizations (CBOs) and acute care facilities for the purpose of providing care transition services to discharged patients with the goal of preventing avoidable readmissions. CMS defines care transition services to include services such as “[t]imely and culturally and linguistically competent post-discharge education,” patient-centered support, and medication review.¹⁴
- *Initiatives to Support Accountable Care Organization (ACO) Development*
 - Accelerated Development Learning Sessions. The Innovation Center has conducted three “ACO Accelerated Development Learning Sessions” to help potential ACOs assess their “readiness to become an ACO,” establish goals, and develop an action plan. The Center will monitor the progress of participants to determine whether the ADLS improved their ability to manage care for Medicare beneficiaries as compared to those that did not participate.
 - Pioneer ACOs. The Innovation Center designed the Pioneer ACO model to help ease the transition for organizations interested in becoming ACOs and to test payment models that increase participant accountability, shift from FFS payment to population-based payment, and produce savings. The Innovation Center will share savings with participating ACOs that meet a certain benchmark during the first two performance periods. During the third performance period, ACOs will have the opportunity to receive population-based payments. Organizations may not participate in the both the Pioneer Model and the Medicare Shared Savings Program.¹⁵ Thirty-two healthcare organizations (20 health systems and 12 physician groups) have been selected to participate in this initiative. These organizations will have the opportunity to improve care for 860,000 Medicare beneficiaries and potentially generate savings up to \$1.1 billion over the next five years.¹⁶
 - Advanced Payment Initiative for ACOs. The Advanced Payment Initiative for ACOs (API) will test the efficacy of providing an advanced payment to ACOs participating in the Medicare Shared Savings Program to: (1) increase participation in the program; and (2) facilitate improved care while increasing the amount of shared savings and speed at which savings accrue.¹⁷ CMS will pay ACOs participating in the API both a fixed and variable upfront payment as well as a monthly payment in an amount dependent upon the ACO’s size. ACOs will remit advanced payments to CMS out of their shared savings per an agreement between the two entities.¹⁸
- *Initiatives Designed to Foster Primary and Patient-Centered Care*
 - Advanced Primary Care Practice Demonstration. The Innovation Center will test the impact of using the advanced primary care practice model, also referred to as a patient-centered medical home, on improving health, improving quality of care, and lowering costs for

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Medicare beneficiaries in 500 Federally Qualified Health Centers (FQHCs). CMS will pay FQHCs participating in the Advanced Primary Care Practice Demonstration (APCP) monthly and quarterly “care management fees” to assist with the costs of transitioning to a primary care practice and for patient-centered care management services.¹⁹

- Multi-payer Advanced Primary Care Initiative. The Innovation Center selected eight states (Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota) to design and test the impact that multi-payor supported APCPs have on the quality of care, variation in utilization and expenditures, patient participation, the provision of evidence-based care, and the use of, and expenditures on, Medicare and Medicaid services. The Multi-payer Advanced Primary Care Initiative (*MAPCP*) testing began in 2011 and will last three years.²⁰
- Comprehensive Primary Care Initiative. The Innovation Center will provide monthly case management fees to primary care providers for comprehensive care management, and after two years provide opportunities for primary care practices to share in any savings generated. CMS also will work with other local payers to implement similar programs supporting primary care practices. CMS will look to collaborate with other payers in local markets who will commit to similar changes to how they engage primary care practices. Five to seven localities will be selected for this Initiative. Final applications are due to the Innovation Center January 17, 2012.
- *State-based Initiatives for Dual Eligibles*
 - Funding and Technical Assistance. Through the Innovation Center and the Federal Office of Coordinated Health Care (referred to as the Medicare-Medicaid Coordination Office), CMS awarded fixed price, eighteen month contracts to fifteen states to design patient-centered delivery and payment models that coordinate “primary, acute, behavioral health, and long-term” care for dual eligibles. CMS is providing technical assistance to the selected states and will subsequently review the developed models to determine whether any are appropriate for implementation.²¹
 - State Medicaid Director Letter. In July 2011, CMS issued a State Medicaid Director (SMD) letter announcing that the Innovation Center, in concert with the Medicare-Medicaid Coordination Office, will test two financial alignment models designed to fully integrate delivery system and care coordination for dual eligibles.²² Thirty-eight states have indicated intent to participate.²³ Under the terms of the SMD letter, participating states may use a fully-capitated model, a managed fee-for-service model, or a combination of the two.²⁴ CMS has targeted implementation by the end of 2012.
- *Health Care Innovation Challenge*²⁵
 - In March 2012, the Innovation Center will award between \$1 million and \$30 million for projects that will rapidly implement new models of care that improve care and lower costs of care for Medicare, Medicaid, and CHIP enrollees, particularly those with the greatest health care needs. Applicants are encouraged to focus on models that focus on workforce development to support service delivery.

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- *Innovation Advisors Project*²⁶
 - The Innovation Center will select up to 200 Innovation Advisors to administer projects designed to achieve the three-part aim of improving health and health care while lowering cost. Innovation Advisors will administer these projects through their sponsoring organization and work with local organizations to reform delivery systems. Advisors will not receive compensation for their participation, but CMS will pay their sponsoring organization a \$20,000 “fellowship” to defray costs of participation.

Key Issues

- *Prioritization of Models.* The ACA gives the Innovation Center, through the HHS Secretary, considerable discretion to choose projects for testing. The Innovation Center is applying a “transparent” process to turn “ideas into actions”²⁷ and invites the public to submit testing proposals through the CMI website.²⁸ CMI evaluates these proposals based on the clarity of the hypothesis, amount of evidentiary support, scope of the project, and the populations, delivery systems, and conditions tested, but these criteria provide minimal insight into how CMI actually prioritizes the models.²⁹ For example, the Innovation Center has selected several ACO, bundled payment, and patient-centered models before testing a population and community health model.
- *Eligibility and Selection.* The Innovation Center has articulated highly specific eligibility and selection criteria for many of the initiatives, so that the Innovation Center can test models in a controlled environment. Will such limited selection give the Innovation Center sufficient information to allow for successful expansion during Phase II?
- *Budget.* Given ongoing budget concerns, will Congress reduce the Innovation Center’s funding? If so, how will the Center react to the reduced budget? Will the Center terminate existing initiatives or choose not to pursue future activities?
- *Sustainability.* Critical to the success of the work of the Innovation Center will be identifying and fostering new models of service delivery and payment that will be sustainable beyond the funded “testing” phase. The Center must work closely with all awardees to ensure that during the “testing” phase the necessary infrastructure is built to continue productive work.
- *Management and Evaluation.* The ACA has significantly increased the scope and complexity of CMS’s work by mandating the development of a high number of flexible and unique projects. This will result in the need for CMS staff to manage hundreds of unique models, including evaluating their impact. Further, the number of different initiatives operating simultaneously may make it difficult to isolate the impact of specific interventions for evaluation purposes.

Authorized Funding Levels

The ACA provides five million dollars for the “design, implementation, and evaluation of models” during fiscal year 2010 and ten billion dollars for the Innovation Center’s activities from 2011 to 2019.³⁰

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- ¹ Patient Protection and Affordable Care Act, Pub. L. 111-148 (2009), as amended by the Health Care and Education Affordability Reconciliation Act, Pub. L. 111-152 (2010).
- ² See, e.g., F. de Brantes, M. Rosenthal, M. Painter, “A Bridge from Fragmentation to Accountability — The Prometheus Payment Model,” *N Engl J Med* 2009; 361:1033-1036 (Sept. 10, 2009), E. Fisher, D. Goodman, J. Skinner, K. Bronner, “Health Care Spending, Quality and Outcomes: More Isn’t Always Better,” Dartmouth Atlas Project Topics Brief (Feb. 27, 2009); J. Wennberg, et al., “Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration,” Dartmouth Atlas White Paper (2008); E. Fisher, et al., “The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care,” *138 Annals Intern. Med.* 273-87 (2003); E. Fisher, et al.; “The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care,” *138 Annals Intern. Med.* 288-98 (2003). McGlynn, E., et al., “The Quality of Health Care Delivered to Adults in the United States,” *348 New Eng. J. Med.* 2635-45 (2003); J. Wennberg, E. Fisher, J. Skinner, “Geography and the Debate Over Medicare Reform,” *Health Affairs Web Exclusive* (Feb. 13, 2002).
- ³ Patient Protection and Affordable Care Act §3021(a), 124 Stat. 389 (2010).
- ⁴ CMS, Fact Sheet: Advance Payment Accountable Care Organization (ACO) Model 2 (2011), available at http://innovations.cms.gov/documents/payment-care/AdvancePaymentsFactSheet_10_20_2011.
- ⁵ Affordable Care Act §3021(a), 124 Stat. 390.
- ⁶ *Id.*
- ⁷ *Id.*
- ⁸ *Medicare chief urges push to make hospitals safer*, ASSOCIATED PRESS, Nov. 17, 2010, available at http://articles.boston.com/2010-11-17/news/29292336_1_medicare-patients-patient-safety-donald-berwick.
- ⁹ CENTER FOR MEDICARE AND MEDICAID INNOVATION, BUNDLED PAYMENTS FOR CARE INITIATIVE: REQUEST FOR APPLICATION 5 (2011), available at http://innovations.cms.gov/documents/payment-care/BundledPayments-Request_for_Application_v4.pdf
- ¹⁰ Press Release, Health and Human Services, Up to \$500 million in Affordable Care Act funding will help health providers improve care (June 22, 2011) available at <http://innovations.cms.gov/wp-content/uploads/2011/06/HHS-Press-Release-pfsolicitationrelease-Final-062211.pdf>.
- ¹¹ CMS, Reducing Preventable Hospitalizations Among Nursing Facility Residents, http://www.cms.gov/medicare-medicaid-coordination/09_ReducingPreventableHospitalizationsAmongNursingFacilityResidents.asp#TopOfPage (last visited Nov. 16, 2011).
- ¹² Join the Partnership, Healthcare.gov, <http://www.healthcare.gov/compare/partnership-for-patients/join/index.html> (last visited Nov. 6, 2011).
- ¹³ See <http://partnershippledge.healthcare.gov/> (last visited November 19, 2011).
- ¹⁴ CMS, COMMUNITY-BASED CARE TRANSITIONS PROGRAM, available at https://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FactSheet.pdf.
- ¹⁵ CENTER FOR MEDICARE AND MEDICAID INNOVATION, PIONEER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL Request for Application 2, available at <http://innovations.cms.gov/wp-content/uploads/2011/07/Pioneer-ACO-RFA.pdf>.
- ¹⁶ Press Release, Health and Human Services, Affordable Care Act helps 32 health systems improve care for patients, saving up to \$1.1 billion (December 19, 2011) available at <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.
- ¹⁷ CENTER FOR MEDICARE AND MEDICAID SERVICES, FACT SHEET: ADVANCE PAYMENT ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL 2 (2011), available at http://innovations.cms.gov/documents/payment-care/AdvancePaymentsFactSheet_10_20_2011.pdf.
- ¹⁸ *Id.* at 3.
- ¹⁹ CENTER FOR MEDICARE AND MEDICAID SERVICES, FACT SHEET: MEDICARE FEDERALLY QUALIFIED HEALTH CENTER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION (2011), available at http://innovations.cms.gov/documents/pdf/FQHC_Demo_Fact_Sheet_Oct_24_2011.pdf.
- ²⁰ CENTER FOR MEDICARE AND MEDICAID SERVICES, MULTI-PAYER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION SOLICITATION 3, https://www.cms.gov/DemoProjectsEvalRpts/downloads/mapcpdemo_Solicitation.pdf.
- ²¹ CENTER FOR MEDICARE AND MEDICAID SERVICES, RFP: STATE DEMONSTRATIONS TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS, http://www.cms.gov/medicare-medicaid-coordination/downloads/RFP_CMS2011_0009.pdf.
- ²² CENTERS FOR MEDICARE & MEDICAID SERVICES, SMDL #11-008, FINANCIAL MODELS TO SUPPORT STATE EFFORTS TO INTEGRATE CARE FOR MEDICARE-MEDICAID ENROLLEES (2011) [hereinafter “SMDL #11-008”].
- ²³ Centers for Medicare & Medicaid Services. States Submitting Letters of Intent-Financial Alignment Models, available at <https://www.cms.gov/medicare-medicaid-coordination/Downloads/StatesSubmittingLettersofIntentFinancialAlignmentModels.pdf>.
- ²⁴ SMDL #11-008 *supra* note 53.

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²⁵ CMI, Fact Sheet: We Can't Wait: Health Care Innovation Challenge Will Improve Care, Save Money, Focus on Health Care Jobs, *available at* <http://innovations.cms.gov/documents/pdf/innovation-challenge-fact-sheet.pdf>.

²⁶ CMI, Innovation Advisors Program, <http://innovations.cms.gov/innovation-advisors-program/> (last visited Nov. 16, 2011); CENTER FOR MEDICARE AND MEDICAID SERVICES, FACT SHEET: INNOVATION ADVISORS PROGRAM (2011), *available at* http://innovations.cms.gov/documents/pdf/Innovation_Advisors_FACT_SHEET_FINAL_for_CMS.pdf.

²⁷ CMI, FAQs, <http://innovations.cms.gov/about-us/faqs/> (last visited Nov. 7, 2011).

²⁸ CMI, Innovative Care and Payment Models, <http://innovations.cms.gov/partnerships/share-your-ideas/innovative-care-and-payment-models/> (last visited Nov. 7, 2011).

²⁹ CMI, Innovation Center Idea Assessment Factors (2011), *available at* http://innovations.cms.gov/wp-content/uploads/2011/03/Idea-Assessment-Factors-3_17_11.pdf.

³⁰ Affordable Care Act § 3021(f), 124 Stat. 394.