DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAY 07 2012

The Honorable Tom Coburn
United States Senate
Washington, D.C. 20510

Dear Senator Coburn:

Thank you for your letters about the operations of the Center for Medicare and Medicaid Innovation (Innovation Center). We apologize for the delay in responding to your inquiry. We share your goal of reducing health care costs and improving the fiscal solvency of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). We appreciate the opportunity to provide the attached information about the work of the Innovation Center to achieve this goal.

As specified in the Affordable Care Act, the purpose of the Innovation Center is to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care furnished to individuals under Medicare, Medicaid, and CHIP. In its first year of existence, the Innovation Center has begun to test multiple innovative models reflecting the diversity of approaches proposed by innovators from across the country. Data and information on model programs, administrative costs, and operations since the inception of the Innovation Center are contained in the enclosed documents.

We appreciate your support and share your concern for fiscal responsibility. I will also provide this response to the cosigners of your letter.

Sincerely,

Marilyn Tavenner

Marilyn Tavenner

Enclosures

1. **Provide an accounting of expenditures made to date by the Innovation Center to test payment and service delivery models. Identify all recipients of funding from the Innovation Center to date, including how much each entity received and for what purposes. This includes, but is not limited to, expenditures made under the Partnership for Patients, the Bundled Payments for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, the Medicare Shared Savings Program, the Pioneer Accountable Care Organization program, and the Physician Group Practice Transition Demonstration.**

   Response: To coordinate initiatives, demonstrations, and research projects at the Centers for Medicare & Medicaid Services (CMS) and to prevent duplication, the Innovation Center oversees initiatives that are authorized and funded under various authorities.

   - Section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) established the Innovation Center to test innovative payment and service delivery models to reduce expenditures while preserving or enhancing quality of care for Medicare, Medicaid, and CHIP beneficiaries. As of March 31, 2012, the Innovation Center announced 11 models under this authority.

   - The Affordable Care Act included other demonstration provisions that are also managed by the Innovation Center, such as the Independence at Home Demonstration (section 3024 of the Affordable Care Act) and the Medicaid Emergency Psychiatric Demonstration (section 2707(e) of the Affordable Care Act).

   - Other demonstrations and evaluations are conducted under the authority of other statutes, including section 402 of the Social Security Amendments of 1967, and may be funded through the CMS Program Management Account or other appropriations. For example, the Medicare Care Management Performance Demonstration was conducted under the authority of Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

   The obligations made through March 31, 2012 by the Innovation Center are summarized in Tables 1 and 2 below. The FY 2011 actual obligations were $149 million for all activities administered by the Innovation Center. The FY 2012 obligations as of March 31, 2012 are $274 million for all activities administered by the Innovation Center. Table 1 includes Social Security Act § 1115A funding and Table 2 includes funding from all other sources. The obligations reported in Tables 1 and 2 reflect orders placed, contracts awarded, or services rendered during a given period that requires payment to be made by CMS. In addition, in FY 2010 the Innovation Center obligated $104,062 in start-up administrative expenses.

Table 1
CENTER FOR MEDICARE AND MEDICAID INNOVATION
SOCIAL SECURITY ACT § 1115A(F) FUNDING
OBLIGATION SUMMARY
FISCAL YEARS 2011 -2012
(actual dollars in millions)

Activity	FY 2011 Actual Obligations	FY 2012 Obligations as of 03/31/2012
Models and Evaluations	$51	$244
Innovation Supports	$23	$17
Administrative Expenses	$21	$10
Total*, Social Security Act § 1115A(f) Funding	**$95**	**$270**

*Totals may not add due to rounding.

Table 2
CENTER FOR MEDICARE AND MEDICAID INNOVATION
FUNDING SOURCES OTHER THAN § 1115A(F)
OBLIGATION SUMMARY
FISCAL YEARS 2011 -2012
(actual dollars in millions)

Activity	FY 2011 Actual Obligations	FY 2012 Obligations as of 03/31/2012
Other Demonstrations and Evaluations (including demonstrations conducted under the Affordable Care Act or other statutory authorities)[1]	$50	$0.8
Administrative Expenses[2]	$5[3]	$4
Total*, Other Funding (not including Social Security Act § 1115A funding)	**$54**	**$4**

*Totals may not add due to rounding.

1/ Demonstrations and evaluations conducted under the authority of the Affordable Care Act (with the exception of funding under section 1115A of the Social Security Act), under section 402 of the Social Security Amendments of 1967, or under other statutory authority.

2/ The FY 2011 actual and FY 2012 obligations as of 03/31/2012 are the administrative costs associated with the staff from the former CMS Office of Research, Development and Information (ORDI).

3/Many of the staff from the former ORDI were reassigned to the Innovation Center in March 2011; therefore, FY 2011 reflects costs of these staff from March 2011 through September 2011 only. Please see the response to question 3 for more details on the organizational structure of the Innovation Center.

For those projects with contracts, awards, or obligations made in FY 2011, **Attachment 2** lists operational contractors or recipients, the purpose, and the amount of the contracts or agreements that support the Innovation Center's model, demonstration, and research activities. **Attachment 2** does not include contracts, agreements, awards, or grants to organizations participating in a particular initiative. Please see the response below for information on organizations participating in the initiatives.

As shown on Table 3, below, as of March 31, 2012, the Innovation Center has announced 11 models under the authority of section 1115A(f) of the Social Security Act.

Table 3

Innovation Center: Summary of Existing Models

The following is a list of models that are being tested by the Innovation Center under the authority of section 1115A(f) of the Social Security Act, along with the planned testing period, as of March 31, 2012.

Model Name	Testing Period
FQHC Advanced Primary Care Demonstration	2011—2014
Pioneer Accountable Care Organizations	2012—2017
Advance Payment Accountable Care Organizations	2012—2014
Bundled Payments for Care Improvement	2012—2016
Comprehensive Primary Care Initiative	2012—2016
State Demonstrations - Integrate Care for Medicare-Medicaid Enrollees	2011—2015
Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees	2012—2015
Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents	2012—2016
Partnership for Patients	2011—2014
Health Care Innovation Award	2012—2015
Strong Start for Mothers and Newborns	2012—2015

The Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration was announced in June 2011. The Demonstration will provide care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services. **Attachment 3** includes the selected FQHCs participating in the Demonstration.

The Pioneer Accountable Care Organization (ACO) model was announced in May 2011. Pioneer ACOs are experienced provider organizations taking on financial risk for improving quality and lowering costs for Medicare patients. **Attachment 4** includes the organizations participating in the testing of the Pioneer ACO model.

The Advance Payment ACO model prepays expected shared savings to support ACO infrastructure and care coordination for eligible organizations participating in the Medicare Shared Savings Program. The two application deadlines for the testing of the Advance Payment ACO model were February 1, 2012 and March 30, 2012.

The Bundled Payments for Care Improvement initiative was announced in August 2011. This initiative will make episodic payments around inpatient hospitalizations to incentivize care redesign. Four models will be tested. Applications for the first model were due on November 18, 2011 and applications for the remaining 3 models are due on June 28, 2012.

Announced in September 2011, the Comprehensive Primary Care initiative is a public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination. The application deadline for interested payers was January 17, 2012. Once both markets and payers are established, primary care providers will be invited to apply to participate. The Innovation Center announced the seven selected markets on April 11th.

In partnership with the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office), the Innovation Center announced the State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees in December 2010. Fifteen States were selected to receive design contracts to develop new ways to meet the often complex and costly needs of the approximately nine million Americans who are enrolled in both the Medicare and Medicaid programs, known as "Medicare-Medicaid enrollees." The 15 States are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin. Early work with these States confirmed that a key component of a fully integrated system would be testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs for Medicare and Medicaid.

As a result, in July 2011, the Innovation Center and the Medicare-Medicaid Coordination Office announced the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. These new models provide an opportunity for States to test cost-effective integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees.

Announced in 2011, the Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents aims to reduce costly and potentially dangerous avoidable hospitalizations by providing enhanced on-site services and supports for long-stay residents in nursing facilities. To improve quality and reduce costs, CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to residents of nursing facilities. Applications are due on June 14, 2012.

Launched in April 2011, the Partnership for Patients is a nationwide public-private partnership that offers support to physicians, nurses and other clinicians working in and out of hospitals to make patient care safer and to support effective transitions of patients from hospitals to other

settings. **Attachment 5** includes the 26 State, regional, national, or hospital system organizations that were selected to be Hospital Engagement Networks. As Hospital Engagement Networks, these organizations will help identify solutions already working to reduce health care acquired conditions and work to spread them to other hospitals and health care providers.

Launched in November 2011, the Health Care Innovation Award is a broad appeal for innovations to test models designed to deliver better health, improved care and lower costs for people enrolled in Medicare, Medicaid and CHIP, with a focus on developing the workforce for new care models. The selected applicants will be announced soon.

On February 8, 2012, the Innovation Center launched the Strong Start initiative to reduce the rate of early elective deliveries and improve prenatal care for women covered by Medicaid. This initiative brings together the activities of the Center for Medicaid and CHIP Services at CMS; the Health Resources and Services Administration; the Administration on Children and Families; and the Centers for Disease Control and Prevention, along with the efforts of outside groups devoted to the health of mothers and newborns including the March of Dimes, the American College of Obstetricians and Gynecologists, the National Partnership for Women and Families, the Society for Maternal and Fetal Medicine, the American College of Nurse Midwives, Childbirth Connections, Leapfrog Group, the National Priorities Partners, convened by the National Quality Forum, and others. Strong Start includes two components: (1) a test of a nationwide public-private partnership and awareness campaign to spread the adoption of best practices that can reduce the rate of early elective deliveries prior to 39 weeks; and 2) a funding opportunity for providers, States, and other applicants to test the effectiveness of enhanced prenatal care models to reduce preterm births in women covered by Medicaid.

In addition to the models listed in Table 3, the Innovation Center launched the Innovation Advisors initiative and is participating in the multi-agency Million Hearts campaign. Announced in October 2011, the goal of the Innovation Advisors initiative is to engage individuals to test and support models of payment and care delivery to improve quality and reduce cost through continuous improvement processes. The first 73 Innovation Advisors announced in December 2011 are included on **Attachment 6**. This initiative is not itself a model, but rather an important support for the Innovation Center's mission.

Announced in September 2011, the Million Hearts campaign aims to prevent one million heart attacks and strokes over the five years through community prevention and clinical care improvement by focusing, coordinating, and enhancing cardiovascular disease prevention activities across the public and private sectors. The Centers for Disease Control and Prevention and CMS are the co-leaders of the Million Hearts campaign. The Innovation Center is integrating the campaign's goals and strategies into each of the models, as appropriate.

Additional detail regarding the Innovation Center's full portfolio of announced initiatives as of March 31, 2012, including initiatives conducted under different legislative authority and current

demonstrations that began prior to the formation of the Innovation Center, is included in **Attachment 7**.

2. **Provide any strategic plan or operating strategy document that provides information on future initiatives funded by the current $10 billion appropriation for the Innovation Center. Please include any studies, analysis or supporting documentation that supports the need for those initiatives and the anticipated value they will add to the Medicare program.**

Response: The statutory mandate of the Innovation Center is to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for Medicare, Medicaid or CHIP beneficiaries. The Innovation Center has developed a Mission Statement (included as **Attachment 8**), Process Statement (included as **Attachment 9**), and Portfolio Criteria (March 2011) (included as **Attachment 10**) that collectively explain the Innovation Center's strategy. Newly proposed models follow this process.

The Innovation Center's mission is to help transform the Medicare, Medicaid and CHIP programs to deliver better health care, better health and reduced costs through improvement for CMS beneficiaries and in so doing, help to transform the health care system for all Americans. The Innovation Center carries out this mission by identifying, testing and fostering new models of service delivery and payment.

The Innovation Center has established a Process Statement and Portfolio Criteria for identifying, developing, and advancing a balanced portfolio of care delivery and payment initiatives consistent with its mission and authority. This process includes soliciting ideas for new models, selecting the models that show promise to improve quality and reduce costs, testing and evaluating the models, and expanding the use of the models as authorized under the statute. Two of the most important parts of the Innovation Center's process are obtaining ideas from the public through web site submissions and holding listening sessions to engage stakeholders and stimulate discussion about innovative ideas. The Innovation Center has met with hundreds of people and organizations, held 10 regional meetings with over 4,000 attendees, and received nearly 500 significant suggestions for improving health care payment and delivery through the "Innovation Pipelines" on our website. Staff are reviewing these ideas to determine the innovations with the most promise. The Innovation Center has made it a priority to meet with stakeholders from all around the country.

During the review of each potential model, the Innovation Center evaluates the model's evidence base to determine whether the model has an appropriate business case by reviewing the potential cost and quality impact of the initiative. The review includes an evaluation of the strength of the evidence and scalability of the model. For those initiatives with promise, the Innovation Center reviews the available literature, analysis, and documentation supporting the need for the initiative. Typically, in consultation with the CMS Office of the Actuary, the Innovation Center prepares estimates of the financial impact of the proposed initiatives, as well as an analysis of

their potential impact on the quality of health and health care among beneficiaries, an examination of current costs of the targeted health care service, an analysis of the potential savings, and a review of the prior research that supports testing the initiative.

Initiatives go through a structured clearance process to ensure that the initiative's premise is fiscally sound, that it meets the statutory requirements, and that it shows the promise of delivering better health care and lower costs.

3. **Provide an explanation of the organizational structure of the Innovation Center. List the individuals employed by the Innovation Center, including names, titles, job requirements, SES or grade level and salary. In addition, please describe the statutory or other authority under which these employees were hired and the Innovation Center's annual expenditures for salaries travel, training, office space, technology and all other costs associate with personnel. Please include a detailed description and/or visual representation of the organizational structure of the Innovation Center that details all groups, divisions or other hierarchies that exist. Also provide any information regarding pilot projects or other initiatives related to personnel within the Innovation Center.**

   Response: The organizational structure of the Innovation Center is presented in the organizational chart on **Attachment 11**. The Innovation Center comprises new staff and staff incorporated from the former Office of Research, Development, and Information (ORDI). The merger of the Innovation Center and ORDI prevents duplication in CMS and provides for efficient coordination of research projects and activities across CMS. **Attachment 12** includes the number of employees in each occupational series within each group in the Innovation Center as of January 14, 2012.

4. **Provide a detailed breakdown of the budget of the Innovation Center including all monies spent since the office's inception and future spending for FY 2012 that clearly delineates administrative and operational costs. Please also include a listing of all anticipated contract actions and actual awards made from the Innovation's inception through FY 2012.**

   Response: Information regarding the Innovation Center's FY 2011 and FY 2012 obligations is contained in the responses to questions 1 and 3.

5. **Provide any estimates of savings prepared by the CMS Office of the Actuary for programs developed by the Innovation Center to date or any evidence that participants in these programs are generating Medicare spending that is lower than the median fee-for-service (FFS) provider or lower than how the median FFS provider would have performed as a result of the Partnership for Patients, the Bundled Payments for Care Improvement Initiative, the Comprehensive Primary Care Initiative, the FQHC Advanced Primary Care Practice Demonstration, the Medicare Shared Savings Program, the Pioneer ACO program, the Physician Group Practice Transition Demonstration, and other Innovation Center programs.**

Response: During the review of each potential model under the authority of section 1115A(f) of the Social Security Act, the Innovation Center evaluates the model's evidence base by reviewing the potential cost and quality impact of the initiative. The review includes an evaluation of the strength of the evidence and scalability of the model. For those initiatives with promise, the Innovation Center reviews the available literature, analysis, and documentation supporting the need for the initiative.

Typically, in consultation with the CMS Office of the Actuary, the Innovation Center prepares estimates of the financial impact of the proposed initiatives, as well as an analysis of their potential impact on the quality of health and health care among beneficiaries, an examination of current costs of the targeted health care services, an analysis of the potential savings, and a review of the prior research that supports testing the initiative. The Office of the Actuary has participated in reviewing savings estimates and in some cases produced estimates. The Office of the Actuary's role varies by the initiative. For example, the Office of the Actuary developed a methodology for estimating the financial impact of the Pioneer ACO model and the Advance Payment ACO model. In other cases, such as the Comprehensive Primary Care initiative, the Office of the Actuary reviewed the estimate of the likely potential impact of the initiative. It is important to note that because Innovation Center models are new and evolving, early estimates of the potential impact of an initiative are subject to change as models are developed, implemented, and thoroughly evaluated.

While the Innovation Center typically works closely with the Office of the Actuary during the development of models, the statutorily mandated certification of savings by the Chief Actuary does not occur in the design phase, but rather in the testing phase to determine whether modification or termination of the testing of a model is needed or prior to any expansion or wide-scale adoption of the initiative. To date, none of the Innovation Center models have been in the testing phase long enough to generate sufficient data for the Actuary to make such a determination.

Initiatives that are undertaken by the Innovation Center under the authority of section 1115A(f) of the Social Security Act as of March 31, 2012 are summarized in Tables 4 and 5 below. The shaded initiatives have savings estimates from the Office of the Actuary, while the other initiatives have savings opportunities analyses prepared by the Innovation Center.

Table 4
CENTER FOR MEDICARE AND MEDICAID INNOVATION
ESTIMATED MEDICARE SAVINGS

Model Name[1,2]	Testing Period	Estimated Medicare Savings
Office of the Actuary Estimates		
Pioneer ACO Model	2012-2017	Up to $1.1 billion over 5 years (with a median savings estimate of $610 million over 5 years)
Advance Payment ACO Model	2012-2014	The savings estimates are built into the estimate that the Medicare Shared Savings Program would save up to $940 million over 4 years (with a median savings estimate of $470 million over 4 years of which savings of $60 million are attributed to the Advance Payment ACO model).
Innovation Center Savings Opportunities Analysis		
Comprehensive Primary Care Initiative	2012-2016	$141 million over 5 years
FQHC Advanced Primary Care Practice Demonstration	2011-2014	$42 million over 4 years
Bundled Payment for Care Improvement	2012-2016	$2.4 billion over 5 years
The Partnership for Patients	2011-2014	$10 billion over 3 years if the goals of the initiative are met
Reducing Avoidable Hospitalizations Among Nursing Facility Residents	2012-2016	$45 million over 4 years

1/The State Demonstrations-Integrate Care for Medicare-Medicaid Enrollees and the Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees initiatives are in State design periods, with the majority of States submitting their proposals in late Spring of 2012. Given the designs of these initiatives are specific to each State and that we have not yet received all the proposals, as this time we do not have definitive savings estimates.
2/ The Health Care Innovation Award initiative received a large amount of applications for a broad range of proposals, so quantifiable savings are unable to be estimated at this time.

Table 5
CENTER FOR MEDICARE AND MEDICAID INNOVATION
ESTIMATED FEDERAL/STATE SAVINGS
INNOVATION CENTER SAVINGS OPPORTUNITIES ANALYSIS

Model Name	Testing Period	Estimated Savings
Strong Start for Mothers and Newborns	2012-2015	The first component is estimated to save $75 million over 3 years, with 59% of those savings accruing to the federal government and the remainder accruing to States. (These savings are based on achieving a 10% reduction in the rate of elective deliveries prior to 39 weeks across all Medicaid births.) The second component is estimated to save $14 million over 3 years. (These savings are based on the assumption that clinical interventions would improve maternal and newborn outcomes for all gestational age categories, but with more impacts on pre-term babies born closer to full term. Costs for each gestational age were drawn from a review of the literature and adjusted to account for Medicaid reimbursement policies.)

The Innovation Center generates a range of savings opportunity analyses for all of its models conducted under the authority of section 1115A of the Social Security Act. The data in Tables 4 and 5 are net of any additional payments to providers, such as care management fees. The costs of evaluation, program monitoring or other associated administrative expenses are not included in Tables 4 and 5.

Please see **Attachment 13** for information regarding the assumptions used for the savings estimates listed in Table 4. Please see **Attachment 14** for a memorandum from the Office of the Actuary regarding the savings estimates for the Partnership for Patients initiative.

The Innovation Center also oversees demonstrations or evaluations authorized or funded under authorities other than section 1115A of the Social Security Act. The estimation process used

currently, as well as prior to the formation of the Innovation Center, for these other demonstrations or evaluations typically involves an assessment of the expected costs or savings.

6. **Provide any specific metrics and measures to be used by the Secretary to evaluate the impact of these initiatives and programs on reducing Medicare spending, improving the quality of care, or improving beneficiary access to care, including any internal CMS or HHS guidance.**

Response: An evaluation of the model's performance is planned for each model tested by the Innovation Center. The evaluation is intended to determine the model's impact on spending, quality of care delivered, and patient health outcomes and experiences. The Innovation Center will align its relevant performance measures to those from the U.S. Department of Health and Human Services National Strategy for Quality Improvement in Health Care as well as measures used for other CMS programs, such as those used for the Physician Quality Reporting System and the Medicare Shared Savings Program.

All participating providers will be required to work with an independent evaluator to track and provide agreed-upon data as needed for the evaluation. As applicable, these data will be merged with administrative claims data collected by CMS to allow assessment of performance on topics such as clinical quality performance, patient functional status, and financial outcomes. The Innovation Center anticipates using multiple cycles of data collection due to the changing nature of the approaches used by participants in response to rapid-cycle feedback. Particular care will be taken to identify the effect of each reform in the context of other interventions.

For example, when evaluating participants in the Comprehensive Primary Care initiative, the Innovation Center will review several types of quality and patient experience measures. These measures will include the following domains: patient and caregiver experience; care coordination and care transitions; preventive health; at-risk populations; and practice transformation. The Innovation Center will use well-established quality measures that are currently part of other CMS and HHS initiatives but also recognizes that a variety of other measures exist and may be appropriate to evaluate participants in this initiative. Market-level discussions with participants in the Comprehensive Primary Care initiative will drive harmonization of any additional quality measures and reduce administrative burden to participating practices through a shared approach to quality improvement.

CENTER FOR MEDICARE AND MEDICAID INNOVATION
OPERATIONAL CONTRACT/AGREEMENT DETAIL*

PURPOSE	FY 2011 ACTUAL EXPENDITURES AND OBLIGATIONS	CONTRACTOR/RECIPIENT
Initiatives Conducted Under the Authority of Section 1115A(f) of the Social Security Act		
Models and Evaluations	**$ *36,580,122***	
Federally Qualified Health Care Center (FQHC) Advanced Primary Care Practice Demonstration	**$ 5,801,731**	
Commercial Banking Services	$ 16,397	US Bancorp
Learning System	$ 4,199,624	American Institutes for Research (AIR)
Implementation	$ 117,021	Thomson Reuters Healthcare
Evaluation	$ 1,210,938	Rand Corporation
Implementation	$ 62,016	Noridian Administrative Services
Communications Support	$ 15,735	Intercall, Inc
Payment Processing	$ 180,000	Blue Cross Blue Shield Association
Pioneer Accountable Care Organizations (ACOs)	**$ 16,316,693**	
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	Blue Cross Blue Shield Association
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	La Clinica Del Pueblo, Inc
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	The Urban Institute
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	The Sennett Consulting Group
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	Center for Studying Health Systems Change
Demonstration and Research Proposal Reviewer - Panel Expert	$ 900	American Board of Internal Medicine
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	Center for Studying Health Systems Change
Demonstration and Research Proposal Reviewer - Panel Expert	$ 900	American Board of Internal Medicine
Demonstration and Research Proposal Reviewer - Panel Expert	$ 500	Ann S. O'Mally
Demonstration and Research Proposal Reviewer - Panel Expert	$ 900	Katrina Armstrong
Monitoring	$ 1,011,025	Logistics Management Institute
Implementation	$ 11,990,000	Research Triangle Institute (RTI)
Design	$ 1,159,468	Research Triangle Institute (RTI)
Implementation	$ 2,150,000	Rand Corporation
State Demonstrations to Fully Integrate Care for Medicare-Medicaid Enrollees	**$ 1,495,660**	
Evaluation	$ 1,495,660	Research Triangle Institute (RTI)
Partnership for Patients	**$ 11,541,637**	
Acquisition Support	$ 1,000,000	MITRE Corporation
National Social Marketing & Engagement Contractor	$ 2,258,792	CMGRP Inc DBA Weber Shandwick
Evaluation	$ 2,535,721	Health Services Advisory Group
National Content Developer	$ 5,445,146	Econometrica
Enhanced Survey & Certification	$ 301,978	Acumen LLC
Bundled Payments for Care Improvement	**$ 1,424,401**	
Data Dissemination Products	$ 500,000	Agreement with Assistant Secretary for Planning & Evaluation/HHS
Data Dissemination Support	$ 384,401	Buccaneer Computer Systems
Project Management Support	$ 500,000	MITRE Corporation
Research Data Assistance	$ 40,000	University of Minnesota
Innovation Supports/Operational Contracts (not specific to one model)	**$ 22,603,922**	
Learning Networks	**$ 3,946,083**	
Infrastructure to support the rapid adoption of successful care and payment models	$ 3,946,083	Mathematica Policy Research American Institutes for Research BL Seamon Corporation
Building the Innovation Pipeline	**$ 5,000,000**	
Design and development work on a variety of potential models	$ 5,000,000	The Mitre Corporation
Information Technology	**$ 9,764,258**	
Develop technical business requirements, develop the initial pilot for an enterprise data sharing and data management system, develop business intelligence programming in the Integrated Data Repository, purchase licenses for data management software, and perform overall program management	$ 9,764,258	Northrop Grumman Carahsoft Technology Corporation DEDE Inc. DBA Genova Technology Quality Software Services Inc. HP Enterprise Services LLC Lockheed Martin Services Inc. Maricom System Inc. Jeskell Incorporated
Project Management	**$ 3,393,581**	
Project planning, management, and reporting for the entire portfolio of the Innovation Center	$ 3,393,581	Multiple contractors: Lockheed Martin Services Mitre Corporation Buan Consulting Inc

PURPOSE	FY 2011 ACTUAL EXPENDITURES AND OBLIGATIONS	CONTRACTOR/RECIPIENT
Report to Congress	**$ 500,000**	
ACA mandated report due September 2012	$ 500,000	The Mitre Corporation
Administrative Contracts (not specific to one model)	**$ 5,900,000**	
Innovation Advisors	**$ 5,900,000**	
Initiative Administration	$ 5,900,000	Department of Energy
Innovation Center Activities Under Other Authorities		
Other Affordable Care Act	***$ 17,598,435***	
ACA Section 2707 - Medicaid Emergency Psychiatric Demonstration	**$ 749,982**	
Design, Analysis and Monitoring	$ 749,982	IMPAQ
ACA Section 3024 - Independence at Home Demonstration	**$ 3,895,381**	
Technical Assistance Contractor	$ 3,895,381	Research Triangle Institute (RTI)
ACA Section 3026 - Community-Based Care Transitions Demonstration	**$ 3,854,983**	
Design and Implementation	$ 1,574,547	Lewin
Implementation - Regional Technical Assistance Contracts	$ 2,280,436	Mathmatica Policy Research
ACA Section 3113 - Treatment of Certain Complex Diagnostic Laboratory Tests	**$ 2,934,788**	
Design and Implementation	$ 948,480	Research Triangle Institute (RTI)
Evaluation	$ 1,986,308	Research Triangle Institute (RTI)
ACA Section 4108 - Medicaid Incentives for Prevention of Chronic Disease Demonstration	**$ 3,898,364**	
Implementation and Monitoring	$ 3,898,364	Econometrica
ACA Section 4202 - Community-Based Wellness and Prevention Programs for Medicare Beneficiaries	**$ 1,233,783**	
Phase 1 Evaluation	$ 1,233,783	Altarum
ACA Section 10323 - Medicare Coverage for Individuals Exposed to Environmental Health Hazards Demonstrations	**$ 631,158**	
Design, Analysis, Claim Processing Care Coordinator and MAC Contractor	$ 631,158	Noridian Administrative Services
ACA Sections 3022and 10308-Physician Group Practice Transition Demonstration	**$ 399,996**	
Implementation	$ 399,996	Research Triangle Institute (RTI)
Other Demonstrations and Research Activities	**$ 18,035,486**	
Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration		
Design and Implementation	$ 1,675,257	Actuarial Research Corporation
Evaluation	$ 3,158,854	Research Triangle Institute (RTI)
Other Research and Development Demonstrations and Research Activities		
Care Management for High Cost Beneficiaries Demonstration Evaluation	$ 395,333	Research Triangle Institute (RTI)
Evaluation National Competitive Bidding (MIPPA section 154)	$ 636,363	Abt Associates
Medicare Grouper Evaluation (MIPPA section 188)	$ 329,474	Acumen
Implementation Support for Health Systems Payment Report Demonstration Proposals and Related Demonstrations	$ 622,594	Mathematica Policy Research
Evaluation of Senior Risk Reduction Demonstration	$ 399,970	IMPAQ
Electronic Health Records (EHR) Demonstration Implementation and Evaluation	$ 813,046	Research Triangle Institute (RTI); Actuarial Research Corporation;Mathematica
Acute Care Episode (ACE) Demonstration Implementation, Evaluation, System Changes, Payment Contractor	$ 1,262,636	Research Triangle Institute (RTI); Trailblazers; Technical Financial Services; Impac
Evaluation of Medicare Coordinated Care Demonstration	$ 520,119	Mathematica Policy Research
Senior Risk Reduction Demonstration/Cancer Prevention and Treatment Demonstration/Outpatient Vision Rehabilitation Demonstration Support	$ 81,966	Thomson Reuters Healthcare Inc
Evaluation of Frontier Extended Stay Clinic Project (Medicare Modernization Act of 2003 section 434)	$ 348,357	Mathematica Policy Research
Design, Implementation, Evaluation (Medicare Modernization Act of 2003 section 646) Medicare Health Care Quality Demonstration	$ 940,656	Research Triangle Institute (RTI)
Implementation of Medicare Care Management Performance (MCMP) Demonstration (Medicare Modernization Act of 2003 section 649)	$ 229,771	Research Triangle Institute (RTI)
Fiscal Intermediary Costs for Rural Community Hospital Demonstration (section 410A of the Medicare Modernization Act of 2003)	$ 10,000	WPS-Medicare Administrative Contractor-Jurisdiction 5
Evaluation of For-Profit Demo of PACE	$ 480,406	Mathematica Policy Research
Evaluation of ESRD Bundled Payment	$ 659,918	Acumen
Evaluation Part D Medication Therapy Management Programs	$ 438,955	Acumen
Data Purchases	$ 116,662	Multiple Contractors
HBCU/Hispanic Research Grants Program	$ 800,000	Multiple Contractors
Aging Forum	$ 20,000	Interagency Agreement with National Cancer Instititute
Surveillance, Epidemiology and End Results (SEER)	$ 20,000	Interagency Agreement with Center for Disease Control and Prevention
Hospital Acquired Condition-Present on Admission Program Evaluation	$ 285,792	Research Triangle Institute (RTI)

PURPOSE	FY 2011 ACTUAL EXPENDITURES AND OBLIGATIONS	CONTRACTOR/RECIPIENT
Small Business Research and Demonstration Task Orders	$ 10,000	Actuarial Research Corporation; Acumen, LLC; Berkley Policy Associates; Dobson DaVanzo & Associates, LLC; Econometrica, Inc.; Insight Policy Research, Inc.; JEN Associates; Kennell and Associates, Inc.; L&M Policy Research, LLC; Optimal Solutions Group, LLC
Home Health Third Party Liability Demonstration Arbitration Expense	$ 928,000	American Arbitration Association
Care Management for High Cost Beneficiaries	$ 1,857,216	Actuarial Research Corporation
Medicare Advantage Quality Bonus Payment Evaluation	$ 994,141	L&M Policy Research

*** Attachment 2 includes a list of outside operational contactors, but does not include contracts, awards, or grants to organizations participating in the initiative.**

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
IBERIA COMPREHENSIVE COMMUNITY	LA	ABBEVILLE	70510
CROSS TRAILS MEDICAL CENTER	MO	ADVANCE	63730
BEN ARCHER HEALTH CENTER	NM	ALAMOGORDO	88310
CUMBERLAND FAMILY MEDICAL CENTE	KY	ALBANY	42602
FIRST CHOICE COMMUNITY HEALTHCA	NM	ALBUQUERQUE	87102
FIRST CHOICE COMMUNITY HEALTHCA	NM	ALBUQUERQUE	87107
FIRST CHOICE COMMUNITY HEALTHCA	NM	ALBUQUERQUE	87107
DOWNRIVER COMMUNITY SERVICES IN	MI	ALGONAC	48001
HUDSON RIVER HEALTHCARE INC.	NY	AMENIA	12501
CHAMBERS COUNTY PUBLIC HOSPITAL	TX	ANAHUAC	77514
FIRST CHOICE COMMUNITY HEALTH C	NC	ANGIER	27501
APEX FAMILY MEDICINE	NC	APEX	27502
COMMUNITY HEALTH CENTERS INC	FL	APOPKA	32703
OPEN DOOR COMMUNITY HEALTH CENT	CA	ARCATA	95521
PRESBYTERIAN MEDICAL SERVICES	NM	ARTESIA	88210
CLINICA SIERRA VISTA	CA	ARVIN	93203
WEST END MEDICAL CENTERS INC	GA	ATLANTA	30310
SOUTHERN JERSEY FAMILY MEDICAL	NJ	ATLANTIC CITY	08401
CHAPA-DE INDIAN HEALTH PROGRAM	CA	AUBURN	95603
ARCARE	AR	AUGUSTA	72006
ARCARE	AR	AUGUSTA	72006
CENTRAL TEXAS COMMUNITY HEALTH	TX	AUSTIN	78723
CENTRAL TEXAS COMMUNITY HEALTH	TX	AUSTIN	78702
CENTRAL TEXAS COMMUNITY HEALTH	TX	AUSTIN	78751
CLINICA SIERRA VISTA	CA	BAKERSFIELD	93302
CLINICA SIERRA VISTA	CA	BAKERSFIELD	93304
NATIONAL HEALTH SERVICES INC	CA	BAKERSFIELD	93308
ARCARE	AR	BALD KNOB	72010
PARK WEST MEDICAL CENTER INC	MD	BALTIMORE	21215
TOTAL HEALTH CARE INC.	MD	BALTIMORE	21217
INTERCARE COMMUNITY HEALTH NETW	MI	BANGOR	49013
FAMILY HEALTH CENTER OF BATTLE	MI	BATTLE CREEK	49017
HIDALGO MEDICAL SERVICES	NM	BAYARD	88023
HUDSON RIVER HEALTHCARE INC.	NY	BEACON	12508
CHEROKEE HEALTH SYSTEMS	TN	BEAN STATION	37708
JUNIPER HEALTH INC	KY	BEATTYVILLE	41311
VIRGINIA GARCIA MEMORIAL HEALTH	OR	BEAVERTON	97005
FIRST CHOICE COMMUNITY HEALTHCA	NM	BELEN	87002
EAST JORDAN FAMILY HEALTH CENTE	MI	BELLAIRE	49615
HEALTHPOINT FAMILY CARE INC	KY	BELLEVUE	41073
COOS COUNTY FAMILY HEALTH SERVI	NH	BERLIN	35702
COOS COUNTY FAMILY HEALTH SERVI	NH	BERLIN	35703
GASTON FAMILY HEALTH SERVICES	NC	BESSEMER CITY	28016
COAL COUNTRY COMMUNITY HEALTH CI	ND	BEULAH	58523
HEALTHREACH COMMUNITY HEALTH CE	ME	BINGHAM	49200
MOUNTAIN FAMILY HEALTH CENTERS	CO	BLACK HAWK	80422
PRIMARY CARE OF SOUTHWEST GEORG	GA	BLAKELY	39823
ACCESS COMMUNITY HEALTH NETWORI	IL	BLOOMINGDALE	60108
ACCESS COMMUNITY HEALTH NETWORI	IL	BLUE ISLAND	60406
CLINICAS DE SALUD DEL PUEBLO I	CA	BLYTHE	92225
THE FAMILY MEDICINE RESIDENCY O	ID	BOISE	83704

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

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Practice Name	State	City	Zip
BOUNDARY REGIONAL COMMUNITY HEA	ID	BONNERS FERRY	83805
DAVID RAINES COMMUNITY HEALTH C	LA	BOSSIER	71111
CLINICA CAMPESINA FAMILY HEALTH	CO	BOULDER	80304
COMMUNITY HEALTH PARTNERS	MT	BOZEMAN	59715
GREATER BADEN MEDICAL SERVICE I	MD	BRANDYWINE	20613
OPTIMUS HEALTH CARE	CT	BRIDGEPORT	66082
ARCARE	AR	BRINKLEY	72021
MID-STATE HEALTH CENTER	NH	BRISTOL	3222
URBAN HEALTH PLAN INC.	NY	BRONX	10459
SOUTHEAST MISSISSIPPI RURAL HEA	MS	BROOKLYN	39425
ODA PRIMARY HEALTH CARE CENTER IN	NY	BROOKLYN	11211
SU CLINICA FAMILIAR	TX	BROWNSVILLE	78526
CUMBERLAND FAMILY MEDICAL CENTE	KY	BURKESVILLE	42717
PIEDMONT HEALTH SERVICES INC	NC	BURLINGTON	27217
BALDWIN FAMILY HEALTH CARE INC	MI	CADILLAC	49601
COMMUNITY HEALTH & EMERGENCY SE	IL	CAIRO	62914
COMMUNITY HEALTH CENTERS OF THE	CA	CAMBRIA	93428
CHOPTANK COMMUNITY HEALTH SYSTE	MD	CAMBRIDGE	21613
CAMCARE HEALTH CORPORATION	NJ	CAMDEN	81031
FIRST CHOICE COMMUNITY HEALTH C	NC	CAMERON	28326
SEBASTICOOK FAMILY DOCTORS	ME	CANAAN	4924
RICHARD D WATKINS CANTON COMMUN	OH	CANTON	44707
CROSS TRAILS MEDICAL CENTER	MO	CAPE GIRARDEAU	63703
PRESBYTERIAN MEDICAL SERVICES	NM	CARLSBAD	88220
CENTERVILLE CLINICS INC.	PA	CARMICHAELS	15320
SANTA BARBARA COUNTY COUNTY AUD	CA	CARPINTERIA	93013
SHAWNEE HEALTH CARE AND DEVELOP	IL	CARTERVILLE	62918
SUN LIFE FAMILY HEALTH	AZ	CASA GRANDE	85222
SUN LIFE FAMILY HEALTH CENTER, INC.	AZ	CASA GRANDE	85230
SUN LIFE FAMILY HEALTH CENTER, INC.	AZ	CASA GRANDE	85230
SUN LIFE FAMILY HEALTH CENTER, INC.	AZ	CASA GRANDE	85230
COMMUNITY HEALTH CENTER OF CENTF	WY	CASPER	82602
LAKELAND IMMEDIATE CARE CENTER	MI	CASSOPOLIS	49031
BORREGO COMMUNITY HEALTH FOUND/	CA	CATHEDRAL CITY	92234
VALLEY HEALTH SYSTEMS INC	WV	CEDAR GROVE	25039
CHATTANOOGA HAMILTON COUNTY HOS	TN	CHATTANOOGA	37406
GREAT SALT PLAINS HEALTH CENTER	OK	CHEROKEE	73728
IRONTON & LAWRENCE COUNTY AREA	OH	CHESAPEAKE	45619
ACCESS COMMUNITY HEALTH NETWORI	IL	CHICAGO	60614
ACCESS COMMUNITY HEALTH NETWORI	IL	CHICAGO	60609
ACCESS COMMUNITY HEALTH NETWORI	IL	CHICAGO	60624
ALIVIO MEDICAL CENTER INC.	IL	CHICAGO	60608
CHICAGO FAMILY HEALTH CENTER I	IL	CHICAGO	60628
CHICAGO FAMILY HEALTH CENTER I	IL	CHICAGO	60617
CIRCLE FAMILY CARE INC	IL	CHICAGO	60651
CIRCLE FAMILY HEALTHCARE NETWOR	IL	CHICAGO	60644
ERIE FAMILY HEALTH CENTER INC	IL	CHICAGO	60647
HEARTLAND HEALTH OUTREACH INC.	IL	CHICAGO	60640
PCC COMMUNITY WELLNESS CENTER	IL	CHICAGO	60644
FAMILY HEALTHCARE INC.	OH	CHILLICOTHE	45601
DARIN M. CAMARENA HEALTH CENTER	CA	CHOWCHILLA	93610

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
CENTRO DE SALUD DE LA COMUNIDAD	CA	CHULA VISTA	91911
THE HEALTHCARE CONNECTION INC.	OH	CINCINNATI	45215
THE HEALTHCARE CONNECTION INC	OH	CINCINNATI	45231
DAYSPRING FAMILY HEALTH CENTER	TN	CLAIRFIELD	37715
MID-DELTA HEALTH SYSTEMS INC	AR	CLARENDON	72029
SOUTHEAST ALABAMA RURAL HEALTH	AL	CLAYTON	36016
PUSHMATAHA FAMILY MEDICAL CNTR	OK	CLAYTON	74536
NEIGHBORHOOD HEALTH CARE INCORP	OH	CLEVELAND	44102
NORTHEAST OHIO NEIGHBORHOOD HEA	OH	CLEVELAND	44105
FLORIDA COMMUNITY HEALTH CENTER	FL	CLEWISTON	33440
VERMILLION-PARKE COMMUNITY HEAL	IN	CLINTON	47842
PRIMARY CARE PROVIDERS FOR A HE	LA	CLINTON	70722
PRESBYTERIAN MEDICAL SERVICES	NM	CLOUDCROFT	88317
LA CASA DE BUENA SALUD INC	NM	CLOVIS	88101
ROANOKE CHOWAN COMMUNITY HEALT	NC	COLERAIN	27924
PEAK VISTA COMMUNITY HEALTH CEN	CO	COLORADO SPRINGS	80910
CUMBERLAND FAMILY MEDICAL CENTE	KY	COLUMBIA	42728
FAMILY HEALTH CENTER OF BOONE C	MO	COLUMBIA	65203
LOWER LIGHTS CHRISTIAN HEALTH C	OH	COLUMBUS	43222
SOUTHWEST GEORGIA HEALTH CARE	GA	CORDELE	31015
ADAMS COUNTY HEALTH CENTER INC	ID	COUNCIL	83612
COUNCIL BLUFFS COMMUNITY HEALTH	IA	COUNCIL BLUFFS	51503
NORTH FLORIDA MEDICAL CENTERS I	FL	CROSS CITY	32628
PRESBYTERIAN MEDICAL SERVICES	NM	CUBA	87013
ST CHARLES HEALTH COUNCIL INC	VA	DAMASCUS	24236
BEN ARCHER HEALTH CENTER	NM	DEMING	88030
DENVER HEALTH & HOSPITAL AUTHORIT	CO	DENVER	80204
DENVER HEALTH & HOSPITAL AUTHORIT	CO	DENVER	80204
DENVER HEALTH & HOSPITAL AUTHORIT	CO	DENVER	80204
PRIMARY HEALTH CARE	IA	DES MOINES	50320
PRIMARY HEALTH CARE INC.	IA	DES MOINES	50317
SEBASTICOOK FAMILY DOCTORS	ME	DEXTER	49301
HARBOR HEALTH SERVICES INC	MA	DORCHESTER	21253
HUDSON RIVER HEALTHCARE INC.	NY	DOVER PLAINS	12522
WESTERN SIERRA MEDICAL CLINIC	CA	DOWNIEVILLE	95936
CLINCH RIVER HEALTH SERVICES	VA	DUNGANNON	24245
FISH RIVER RURAL HEALTH	ME	EAGLE LAKE	47390
SOUTHERN ILLINOIS HEALTHCARE FO	IL	EAST ALTON	62024
EAST JORDAN FAMILY HEALTH CENTE	MI	EAST JORDAN	49727
SOUTHERN ILLINOIS HEALTHCARE FO	IL	EAST ST LOUIS	62205
FIRST CHOICE COMMUNITY HEALTHCA	NM	EDGEWOOD	87015
PRESTON TAYLOR COMMUNITY HEALTH	WV	EGLON	26716
BORREGO COMMUNITY HEALTH FOUND	CA	EL CAJON	92020
HEART CITY HEALTH CENTER INC.	IN	ELKHART	46516
BIG SPRINGS MEDICAL ASSOCIATION	MO	ELLINGTON	63638
NEIGHBORHOOD HEALTHCARE	CA	ESCONDIDO	92025
EL CENTRO FAMILY HEALTH	NM	ESPANOLA	87532
COMMUNITY HEALTH CENTER OF SNOH	WA	EVERETT	98204
COMMUNITY HEALTH CENTER OF SNOH	WA	EVERETT	98201
ST CHARLES HEALTH COUNCIL INC	VA	EWING	24248
COMMUNITY HEALTH SYSTEMS INC	CA	FALLBROOK	92028

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
FALL RIVER VALLEY HEALTH CENTER	CA	FALL RIVER MILLS	96009
FAMILY PRACTICE CENTER	ND	FARGO	58102
NEW RIVER HEALTH ASSOCIATION IN	WV	FAYETTEVILLE	25840
CHOPTANK COMMUNITY HEALTH SYSTE	MD	FEDERALSBURG	21632
TRI AREA COMMUNITY HEALTH	VA	FERRUM	24088
COMMUNITY HEALTH CONNECTIONS I	MA	FITCHBURG	14201
NORTH COUNTRY HEALTHCARE:FLAGST	AZ	FLAGSTAFF	86004
FORDLAND CLINIC INC.	MO	FORDLAND	65652
VALLEY HEALTH SYSTEMS INC	WV	FORT GAY	25514
FAMILY HEALTH CENTERS OF SOUTHW	FL	FORT MYERS	33916
FLORIDA COMMUNITY HEALTH CENTER	FL	FORT PIERCE	34950
AMMONOOSUC COMMUNITY HEALTH SE	NH	FRANCONIA	35804
RURAL HEALTH CORPORATION OF NOR	PA	FREELAND	18224
CLINICA SIERRA VISTA	CA	FRESNO	93702
CLINICA SIERRA VISTA	CA	FRESNO	93721
PRESBYTERIAN MEDICAL SERVICES	NM	GALLUP	87301
COMMUNITY HEALTH CONNECTIONS I	MA	GARDNER	14402
COMMUNITY ACTION PARTNERSHIP OF	NE	GERING	69341
FRANKLIN PRIMARY HEALTH CENTER	AL	GILBERTOWN	36908
COMMUNITY HEALTH SYSTEMS INC.	WV	GLEN DANIEL	25844
MOUNTAIN FAMILY HEALTH CENTERS	CO	GLENWOOD SPRINGS	81601
CHOPTANK COMMUNITY HEALTH SYSTE	MD	GOLDSBORO	21636
COOS COUNTY FAMILY HEALTH SERVI	NH	GORHAM	35811
PRESTON TAYLOR COMMUNITY HEALTH	WV	GRAFTON	26354
BALDWIN FAMILY HEALTH CARE INC	MI	GRANT	49327
PRESBYTERIAN MEDICAL SERVICES	NM	GRANTS	87020
COMMUNITY HEALTH CARE CENTER	MT	GREAT FALLS	59401
WHATLEY HEALTH SERVICES INC	AL	GREENSBORO	36744
TENDERCARE CLINIC INC.	GA	GREENSBORO	30642
CORNERSTONE CARE INC	PA	GREENSBORO	15338
ST HELENA COMMUNITY HEALTH CENT	LA	GREENSBURG	70441
NORTH FLORIDA MEDICAL CENTERS I	FL	GREENVILLE	32331
GREENE COUNTY HEALTH CARE INCOR	NC	GREENVILLE	27834
COMMUNITY HEALTH CENTERS INC	FL	GROVELAND	34736
WEST COUNTY HEALTH CENTERS INC	CA	GUERNEVILLE	95446
VALLEY HEALTH SYSTEMS INC	WV	GUYANDOTTE	25702
NORTHWEST HEALTH SERVICES INC.	MO	HAMILTON	64644
BUTLER COUNTY COMMUNITY HEALTH	OH	HAMILTON	45011
SOUTHERN JERSEY FAMILY MEDICAL	NJ	HAMMONTON	80372
FAMILY FIRST HEALTH CORPORATION	PA	HANOVER	17331
VALLEY HEALTH SYSTEMS INC	WV	HARTS	25524
BEN ARCHER HEALTH CENTER	NM	HATCH	87937
SOUTHEAST MISSISSIPPI RURAL HEA	MS	HATTIESBURG	39401
ARCARE	AR	HAZEN	72064
COOPERATIVE HEALTH CENTER	MT	HELENA	59601
REGENCE HEALTH NETWORK INC	TX	HEREFORD	79045
VIRGINIA GARCIA MEMORIAL HEALTH	OR	HILLSBORO	97123
BAY CLINIC INC.	HI	HILO	96720
INTERCARE COMMUNITY HEALTH NETW	MI	HOLLAND	49424
RURAL HEALTH GROUP INC.	NC	HOLLISTER	27844
HOLYOKE HEALTH CENTER INC	MA	HOLYOKE	10405

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration **ATTACHMENT 3**

Practice Name	State	City	Zip
WAYNE MEMORIAL COMMUNITY HEALTH	PA	HONESDALE	18431
WAYNE MEMORIAL COMMUNITY HEALTH	PA	HONESDALE	18431
SOUTHERN TIER COMMUNITY HEALTH	NY	HOUGHTON	14744
MANET COMMUNITY HEALTH CENTER	MA	HULL	20453
VALLEY HEALTH SYSTEMS INC	WV	HUNTINGTON	25701
VALLEY HEALTH SYSTEMS INC	WV	HUNTINGTON	25704
CHOPTANK COMMUNITY HEALTH SYSTE	MD	HURLOCK	21643
HARBOR HEALTH SERVICES INC	MA	HYANNIS	26015
HYNDMAN AREA HEALTH CENTER INC	PA	HYNDMAN	15545
COLLIER HEALTH SERVICES INC	FL	IMMOKALEE	34142
IMPERIAL BEACH COMMUNITY CLINIC	CA	IMPERIAL BEACH	91932
IRONTON & LAWRENCE COUNTY AREA	OH	IRONTON	45638
KATAHDIN VALLEY HEALTH CENTER	ME	ISLAND FALLS	47474
JUNIPER HEALTH INC	KY	JACKSON	41339
CENTRAL MISSISSIPPI HEALTH SERV	MS	JACKSON	39204
PRIMARY HEALTH NETWORK	PA	JAMESTOWN	16134
SANDHILLS MEDICAL FOUNDATION I	SC	JEFFERSON	29718
DAYSPRING FAMILY HEALTH CENTER	TN	JELLICO	37762
WILL CO COMM HEALTH CTR	IL	JOLIET	60433
ARCARE	AR	JONESBORO	72403
OZARK TRI-COUNTY HEALTH CARE CO	MO	JOPLIN	64801
KONZA PRAIRIE COMMUNITY HEALTH	KS	JUNCTION CITY	66441
WEST HAWAII COMMUNITY HEALTH CE	HI	KAILUA KONA	96740
FAMILY HEALTH CENTER INC.	MI	KALAMAZOO	49001
BAY CLINIC INC.	HI	KEAAU	96749
ARCARE	AR	KENSETT	72082
UNITED HEALTH CENTERS OF THE SA	CA	KERMAN	93630
VALLEY HEALTH TEAM INC	CA	KERMAN	93630
VALLEY HEALTH SYSTEMS INC	WV	KERMIT	25674
HEALTHREACH COMMUNITY HEALTH CE	ME	KINGFIELD	49474
NORTH COUNTRY HEALTHCARE	AZ	KINGMAN	86401
INDIANA HEALTH CENTERS INC.	IN	KOKOMO	46902
COMMUNITY HEALTH OF EAST TENNES	TN	LAFOLLETTE	37766
WAYNE MEMORIAL COMMUNITY HEALTH	PA	LAKE COMO	18437
NORTH COUNTRY HEALTHCARE	AZ	LAKE HAVASU CIT	86403
CLINICA SIERRA VISTA	CA	LAKE ISABELLA	93240
HIGH PLAINS COMMUNITY HEALTH CE	CO	LAMAR	81052
COMMUNITY HEALTH CENTERS OF SOU	IA	LAMONI	50140
CLINICA SIERRA VISTA	CA	LAMONT	93241
COUNTY OF INGHAM	MI	LANSING	48912
COUNTY OF INGHAM	MI	LANSING	48915
EL CENTRO FAMILY HEALTH	NM	LAS VEGAS	87701
HEALTHPOINT FAMILY CARE INC	KY	LATONIA	41011
COMANCHE COUNTY HOSPITAL AUTHOF	OK	LAWTON	73505
CLINICA SIERRA VISTA	CA	LEBEC	93243
CHEROKEE HEALTH SYSTEMS	TN	LENOIR CITY	37771
SOUTH PLAINS RURAL HEALTH SERVI	TX	LEVELLAND	79336
LINCOLN COUNTY CHC: LIBBY	MT	LIBBY	59923
PRIMARY HEALTH NETWORK	PA	LINESVILLE	16424
AMMONOOSUC COMMUNITY HEALTH SE	NH	LITTLLETON	35613
HEALTHREACH COMMUNITY HEALTH CE	ME	LIVERMORE FALLS	42541

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration **ATTACHMENT 3**

Practice Name	State	City	Zip
COMMUNITY HEALTH PARTNERS	MT	LIVINGSTON	59047
FAMILY HEALTHCARE INC.	OH	LOGAN	43138
INDIANA HEALTH CENTERS INC.	IN	LOGANSPORT	46947
COMMUNITY HEALTH CENTERS OF THE	CA	LOMPOC	93436
HIDALGO MEDICAL SERVICES	NM	LORDSBURG	88045
ASIAN PACIFIC HEALTH CARE VENTU	CA	LOS ANGELES	90027
QUEENSCARE FAMILY CLINICS	CA	LOS ANGELES	90026
QUEENSCARE FAMILY CLINICS	CA	LOS ANGELES	90029
SOUTH CENTRAL FAMILY HEALTH CEN	CA	LOS ANGELES	90011
GOLDEN VALLEY HEALTH CENTER	CA	LOS BANOS	93635
FIRST CHOICE COMMUNITY HEALTHCA	NM	LOS LUNAS	87031
SUNRISE COMMUNITY HEALTH INC	CO	LOVELAND	80537
HEALTHSOURCE OF OHIO	OH	LOVELAND	45140
LOWELL COMMUNITY HEALTH CENTER	MA	LOWELL	18522
LOWELL COMMUNITY HEALTH CENTER	MA	LOWELL	18522
SANDHILLS MEDICAL FOUNDATION I	SC	LUGOFF	29078
SOUTHEAST MISSISSIPPI RURAL HEA	MS	LUMBERTON	39544
COMMUNITY HEALTH CENTER OF SNOH	WA	LYNNWOOD	98036
FIRST CHOICE PRIMARY CARE INC.	GA	MACON	31203
HEALTHREACH COMMUNITY HEALTH CE	ME	MADISON	49504
MANCHESTER COMMUNITY HEALTH CEN	NH	MANCHESTER	31011
PRIMARY HEALTH CARE INC.	IA	MARSHALLTOWN	50128
SEA-MAR COMMUNITY HEALTH CENTER	WA	MARYSVILLE	98270
ROBESON HEALTH CARE CORPORATION	NC	MAXTON	28364
CHEROKEE HEALTH SYSTEMS	TN	MAYNARDVILLE	37807
FAMILY HEALTHCARE INC.	OH	MCARTHUR	45651
BALDWIN FAMILY HEALTH CARE INC	MI	MCBAIN	49657
ARCARE	AR	MCCRORY	72101
VIRGINIA GARCIA MEMORIAL HEALTH	OR	MCMINNVILLE	97128
SOUTHWEST VIRGINIA COMMUNITY HE	VA	MEADOWVIEW	24361
COMMUNITY HEALTH CENTER INC.	OR	MEDFORD	97504
LA CLINICA DEL VALLE FAMILY HEA	OR	MEDFORD	97501
HEALTH ACCESS NETWORK INC	ME	MEDWAY	44603
PRIMARY HEALTH NETWORK	PA	MERCER	16137
JESSIE TRICE COMMUNITY HEALTH C	FL	MIAMI	33142
MIAMI BEACH COMMUNITY HEALTH CE	FL	MIAMI BEACH	33139
BUTLER COUNTY COMMUNITY HEALTH	OH	MIDDLETOWN	45044
VALLEY HEALTH CARE INC	WV	MILL CREEK	26280
VALLEY HEALTH SYSTEMS INC	WV	MILTON	25541
16TH STREET COMMUNITY HEALTH CE	WI	MILWAUKEE	53215
PARTNERSHIP HEALTH CENTER	MT	MISSOULA	59802
FRANKLIN PRIMARY HEALTH CENTER	AL	MOBILE	36606
FRANKLIN PRIMARY HEALTH CENTER	AL	MOBILE	36652
GOLDEN VALLEY HEALTH CENTERS	CA	MODESTO	95354
GOLDEN VALLEY HEALTH CENTERS	CA	MODESTO	95354
COMMUNITY HEALTH CARE INC.	IL	MOLINE	61265
EZRAS CHOILIM HEALTH CENTER	NY	MONROE	10950
GEORGIA MOUNTAINS HEALTH SERVIC	GA	MORGANTON	30560
MT. ENTERPRISE COMMUNITY HEALTH	TX	MT ENTERPRISE	75681
SEA-MAR COMMUNITY HEALTH CENTER	WA	MT VERNON	98273
HACKLEY COMMUNITY CARE CENTER I	MI	MUSKEGON	49444

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
COMMUNITY HEALTH CLINICS INC	ID	NAMPA	83687
LAMPREY HEALTH CARE INC	NH	NASHUA	30603
UNITED NEIGHBORHOOD HEALTH SERV	TN	NASHVILLE	37206
CENTRO DE SALUD DE LA COMUNIDAD	CA	NATIONAL CITY	91950
OPERATION SAMAHAN INC.	CA	NATIONAL CITY	91950
UNIVESITY OF MEDICINE & DENTIST	NJ	NEW BRUNSWICK	89011
PRIMARY HEALTH NETWORK	PA	NEW CASTLE	16101
DOWNRIVER COMMUNITY SERVICES IN	MI	NEW HAVEN	48048
FAMILY HEALTHCARE INC	OH	NEW LEXINGTON	43764
SOUTHERN JERSEY FAMILY MEDICAL	NJ	NEW LISBON	08064
LAMPREY HEALTH CARE INC	NH	NEWMARKET	38571
HEALTHSOURCE OF OHIO	OH	NEW RICHMOND	45157
CHEROKEE HEALTH SYSTEMS	TN	NEW TAZEWELL	37825
ALBANY AREA PRIMARY HEALTH CARE	GA	NEWTON	39870
CHARLES B. WANG COMMUNITY HEALT	NY	NEW YORK	10013
WILLIAM F. RYAN COMMUNITY HEALT	NY	NEW YORK	10009
CLINICAS DE SALUD DEL PUEBLO I	CA	NILAND	92257
COMMUNITY HEALTH CENTERS OF THE	CA	NIPOMO	93444
RURAL HEALTH GROUP INC	NC	NORLINA	27563
WATERFALL CLINIC INC	OR	NORTH BEND	97459
NORTHWEST COMMUNITY HEALTH CARI	RI	NORTH KINGTOWN	28527
MANET COMMUNITY HEALTH CENTER	MA	NORTH QUINCY	21712
SOUTHWEST VIRGINIA COMMUNITY HE	VA	NORTH TAZEWELL	24630
MARIN COMMUNITY CLINIC	CA	NOVATO	94945
RURAL HEALTH CORPORATION OF NOR	PA	NOXEN	18636
RURAL HEALTH CORPORATION OF NOR	PA	NUREMBERG	18241
LIFELONG MEDICAL CARE	CA	OAKLAND	94612
WEST OAKLAND HEALTH COUNCIL IN	CA	OAKLAND	94607
PCC COMMUNITY WELLNESS CENTER	IL	OAK PARK	60302
COWLITZ FAMILY HEALTH CENTER	WA	OCEAN PARK	98640
SEA-MAR COMMUNITY HEALTH CENTER	WA	OCEAN SHORES	98569
VISTA COMMUNITY CLINIC	CA	OCEANSIDE	92054
BEAUFORT JASPER HAMPTON COMPREI	SC	OKATIE	29909
FLORIDA COMMUNITY HEALTH CENTER	FL	OKEECHOBEE	34972
OKLAHOMA COMMUNITY HEALTH SERVI	OK	OKLAHOMA CITY	73139
SOUTHERN TIER COMMUNITY HEALTH	NY	OLEAN	14760
UNITED HEALTH CENTERS OF THE SA	CA	ORANGE COVE	93646
NORTHWEST HEALTH SERVICES INC.	MO	OREGON	64473
COUNTY OF CLACKAMAS OFFICE OF C	OR	OREGON CITY	97045
COMMUNITY HEALTH CENTERS INC	FL	ORLANDO	32808
OPEN DOOR FAMILY MEDICAL CENTER	NY	OSSINING	10562
COLUMBIA BASIN HEALTH ASSOCIATI	WA	OTHELLO	99344
CLINICAS DEL CAMINO REAL INC	CA	OXNARD	93030
BAY CLINIC INC.	HI	PAHOA	96778
NORTH FLORIDA MEDICAL CENTERS I	FL	PANACEA	32346
KATAHDIN VALLEY HEALTH CENTER	ME	PATTEN	47650
ROBESON HEALTH CARE CORPORATION	NC	PEMBROKE	28372
HEARTLAND COMMUNITY HEALTH CLIN	IL	PEORIA	61605
HEARTLAND COMMUNITY HEALTH CLIN	IL	PEORIA	61603
ESPERANZA HEALTH CENTER INC.	PA	PHILADELPHIA	19134
COMMUNITY ACTION COMMITTEE OF P	OH	PIKETON	45661

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration **ATTACHMENT 3**

Practice Name	State	City	Zip
BIG SPRINGS MEDICAL ASSOCIATION	MO	PILOT KNOB	63663
JEFFERSON COMPREHENSIVE CARE SY	AR	PINE BLUFF	71601
HUDSON RIVER HEALTHCARE INC.	NY	PINE PLAINS	12567
EAST LIBERTY FAMILY HEALTH CARE	PA	PITTSBURGH	15206
SEBASTICOOK FAMILY DOCTORS	ME	PITTSFIELD	49671
GOLDEN VALLEY HEALTH CENTER	CA	PLANADA	95365
SOUTHERN JERSEY FAMILY MEDICAL	NJ	PLEASANTVILLE	8232
MID-STATE HEALTH CENTER	NH	PLYMOUTH	3264
CORNING AREA HEALTHCARE INC	AR	POCAHONTAS	72455
HEALTH WEST INC	ID	POCATELLO	83204
BIG SPRINGS MEDICAL ASSOCIATION	MO	POPLAR BLUFF	63901
FAMILY HEALTH CENTERS OF SOUTHW	FL	PORT CHARLOTTE	33952
OPEN DOOR FAMILY MEDICAL CENTER	NY	PORT CHESTER	10573
CENTRAL CITY CONCERN INC	OR	PORTLAND	97209
FAMILIES FIRST OF THE GREATER S	NH	PORTSMOUTH	38015
COMMUNITY ACTION COMMITTEE OF P	OH	PORTSMOUTH	45663
FRANKLIN PRIMARY HEALTH CENTER	AL	PRICHARD	36610
THREE LOWER COUNTIES COMMUNITY	MD	PRINCESS ANNE	21853
ST CROIX REGIONAL FAMILY HEALTH	ME	PRINCETON	46683
PIEDMONT HEALTH SERVICES INC	NC	PROSPECT HILL	27314
INTERCARE COMMUNITY HEALTH NETW	MI	PULLMAN	49450
PRESBYTERIAN MEDICAL SERVICES	NM	QUESTA	87556
NORTH FLORIDA MEDICAL CENTERS I	FL	QUINCY	32351
MANET COMMUNITY HEALTH CENTER	MA	QUINCY	21691
MANET COMMUNITY HEALTH CENTER	MA	QUINCY	21693
ROCK QUARRY RD FAMILY MEDICINE	NC	RALEIGH	27610
HEALTHREACH COMMUNITY HEALTH CE	ME	RANGELEY	49700
SU CLINICA FAMILIAR	TX	RAYMONDVILLE	78580
SHASTA COMMUNITY HEALTH CENTER	CA	REDDING	96099
REDWOODS RURAL HEALTH CENTER	CA	REDWAY	95560
VERNON J HARRIS EAST END COMMUN	VA	RICHMOND	23223
PRESBYTERIAN MEDICAL SERVICES	NM	RIO RANCHO	87124
HEALTHSOURCE OF OHIO	OH	RIPLEY	45167
EAST BAY COMMUNITY ACTION PROGR	RI	RIVERSIDE	29155
TRICOUNTY HEALTH CLINIC INC.	WV	ROCK CAVE	26234
WHITESIDE COUNTY COMMUNITY HEAL	IL	ROCK FALLS	61071
COMMUNITY HEALTH CARE INC.	IL	ROCK ISLAND	61201
OPPORTUNITIES INDUSTRIALIZATION	NC	ROCKY MOUNT	27801
CORNERSTONE CARE INC	PA	ROGERSVILLE	15339
MIDMICHIGAN HEALTH SERVICES	MI	ROSCOMMON	48653
LA CASA DE BUENA SALUD INC	NM	ROSWELL	88203
HILL COUNTRY COMMUNITY CLINIC	CA	ROUND MOUNTAIN	96084
MYRTLE HILLIARD DAVIS COMPREHEN	MO	SAINT LOUIS	63112
MYRTLE HILLIARD DAVIS COMPREHEN	MO	SAINT LOUIS	63120
MYRTLE HILLIARD DAVIS COMPREHEN	MO	SAINT LOUIS	63113
PEOPLE'S HEALTH CENTERS INCORP	MO	SAINT LOUIS	63112
SOUTHERN JERSEY FAMILY MEDICAL	NJ	SALEM	8079
COUNTY OF MONTEREY	CA	SALINAS	93906
EL CENTRO DEL BARRIO INC.	TX	SAN ANTONIO	78211
EL CENTRO DEL BARRIO INC.	TX	SAN ANTONIO	78221
CENTRO DE SALUD DE LA COMUNINDA	CA	SAN DIEGO	92113

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
OPERATION SAMAHAN INC.	CA	SAN DIEGO	92126
NORTH EAST MEDICAL SERVICES	CA	SAN FRANCISCO	94134
NORTH EAST MEDICAL SERVICES	CA	SAN FRANCISCO	94122
NORTH EAST MEDICAL SERVICES	CA	SAN FRANCISCO	94133
UNITED HEALTH CENTERS OF THE SA	CA	SANGER	93657
NORTH EAST MEDICAL SERVICES - L	CA	SAN JOSE	95131
MARIN COMMUNITY CLINIC	CA	SAN RAFAEL	94901
AMERICAN INDIAN HEALTH & SERVIC	CA	SANTA BARBARA	93110
SANTA BARBARA COUNTY COUNTY AUD	CA	SANTA BARBARA	93103
SCHENECTADY FAMILY HEALTH SERVI	NY	SCHENECTADY	12307
INTERNATIONAL COMMUNITY HEALTH	WA	SEATTLE	98118
NEIGHBORCARE HEALTH	WA	SEATTLE	98103
NEIGHBORCARE HEALTH	WA	SEATTLE	98103
NEIGHBORCARE HEALTH	WA	SEATTLE	98126
NEIGHBORCARE HEALTH	WA	SEATTLE	98101
NEIGHBORCARE HEALTH	WA	SEATTLE	98118
NEIGHBORCARE HEALTH	WA	SEATTLE	98118
WEST COUNTY HEALTH CENTERS INC	CA	SEBASTOPOL	95472
REGIONAL HEALTH CARE CLINIC INC	MO	SEDALIA	65301
SOUTHEAST MISSISSIPPI RURAL HEA	MS	SEMINARY	39479
INDIANA HEALTH CENTERS INC.	IN	SEYMOUR	47274
CHEROKEE HEALTH SYSTEMS	TN	SEYMOUR	37865
PRIMARY HEALTH NETWORK	PA	SHARON	16146
SHASTA COMMUNITY HEALTH CENTER	CA	SHASTA LAKE	96019
RURAL HEALTH CORPORATION OF NOR	PA	SHICKSHINNY	18655
DAVID RANIES COMMUNITY HEALTH C	LA	SHREVEPORT	71107
CATAHOULA PARISH HOSPITAL DIST.	LA	SICILY ISLAND	71368
HIDALGO MEDICAL SERVICES	NM	SILVER CITY	88061
FALLS COMMUNITY HEALTH	SD	SIOUX FALLS	57104
NEW HORIZON FAMILY HEALTH SERVI	SC	SLATER	29683
SOUTHEAST ALABAMA RURAL HEALTH	AL	SLOCOMB	36375
GREENE COUNTY HEALTH CARE INC	NC	SNOW HILL	28580
PRESBYTERIAN MEDICAL SERVICES	NM	SOCORRO	87801
NEW RIVER HEALTH ASSOCIATION IN	WV	SOPHIA	25921
INDIANA HEALTH CENTERS INC.	IN	SOUTH BEND	46619
CARING HEALTH CENTER INC.	MA	SPRINGFIELD	11082
LANE COUNTY OREGON	OR	SPRINGFIELD	97477
FIRST CHOICE COMMUNITY HEALTH C	NC	SPRING LAKE	28390
FAMILY HEALTH CENTERS OF SOUTHW	FL	ST JAMES CITY	33956
FAMILY CARE HEALTH CENTERS	MO	ST LOUIS	63110
PEOPLE'S HEALTH CENTERS INC.	MO	ST. LOUIS	63033
CHOPTANK COMMUNITY HEALTH SYSTE	MD	ST MICHAEL'S	21663
ST CHARLES HEALTH COUNCIL INC	VA	ST PAUL	24283
PLAINS MEDICAL CENTER INC.	CO	STRASBURGC	80136
HEALTHREACH COMMUNITY HEALTH CE	ME	STRONG	49833
SOUTHEAST MISSISSIPPI RURAL HEA	MS	SUMRALL	39482
SEA-MAR COMMUNITY HEALTH CENTER	WA	TACOMA	98405
TAMPA FAMILY HEALTH CENTERS IN	FL	TAMPA	33612
TAMPA FAMILY HEALTH CENTERS INC	FL	TAMPA	33612
CHOTA COMMUNITY HEALTH SERVICES	TN	TELLICO PLAINS	37385
FAMILY MEDICAL CENTER OF MICHIG	MI	TEMPERANCE	48182

Participants in the Federally Qualified Health Center Advanced Primary Care Practice Demonstration

ATTACHMENT 3

Practice Name	State	City	Zip
COMMUNITY HEALTH CARE SYSTEMS	GA	TENNILLE	31089
CLINICA CAMPESINA FAMILY HEALTH	CO	THORNTON	80229
NEIGHBORHOOD HEALTH ASSOCIATION	OH	TOLEDO	43604
COMMUNITY HEALTH & WELLNESS CTR	CT	TORRINGTON	67904
PRIMARY HEALTH NETWORK	PA	TRANSFER	16154
EL RIO SANTA CRUZ\TUCSON	AZ	TUCSON	85745
CENTERVILLE CLINICS INC.	PA	UNIONTOWN	15401
HEALTHLINC INC.	IN	VALPARAISO	46383
BIG SPRINGS MEDICAL ASSOCIATION	MO	VAN BUREN	63965
ST. CHARLES HEALTH COUNCIL INC	VA	VANSANT	24656
CLINICAS DEL CAMINO REAL INC	CA	VENTURA	93004
BIG SPRINGS MEDICAL ASSOCIATION	MO	VIBURNUM	65566
VISTA COMMUNITY CLINIC	CA	VISTA	92084
VISTA COMMUNITY CLINIC	CA	VISTA	92084
CHOTA COMMUNITY HEALTH SERVICES	TN	VONORE	37885
CORNING AREA HEALTHCARE INC	AR	WALNUT RIDGE	72476
NATIONAL HEALTH SERVICES INC	CA	WASCO	93280
UNITY HEALTH CARE INC	DC	WASHINGTON	20020
UNITY HEALTH CARE INC	DC	WASHINGTON	20019
UNITY HEALTH CARE INC	DC	WASHINGTON	20001
UNITY HEALTH CARE INC	DC	WASHINGTON	20019
UNITY HEALTH CARE INC	DC	WASHINGTON	20024
UNITY HEALTH CARE INC	DC	WASHINGTON	20001
METROPOLITAN COMMUNITY HEALTH S	NC	WASHINGTON	27889
SOUTHERN ILLINOIS REGIONAL WELL	IL	WASHINGTON PARK	62204
SALUD PARA LA GENTE	CA	WATSONVILLE	95076
VALLEY HEALTH SYSTEMS INC	WV	WAYNE	25570
SUNSET COMMUNITY HEALTH CENTER:\	AZ	WELLTON	85356
RURAL ALLIANCE FOR BETTER FAMIL	MO	WEST PLAINS	65775
SALUD CLINIC	CA	WEST SACRAMENTO	95605
THUNDERMIST HEALTH CENTER	RI	WEST WARWICK	28934
NORTH FLORIDA MEDICAL CENTERS I	FL	WEWAHITCHKA	32465
RURAL HEALTH GROUP INC.	NC	WHITAKERS	27891
AMMONOOSUC COMMUNITY HEALTH SE	NH	WHITEFIELD	35983
GRACEMED HEALTH CLINIC INC	KS	WICHITA	67214
MENDOCINO COMMUNITY HEALTH CLIN	CA	WILLITS	95490
CLINICAS DE SALUD DEL PUEBLO I	CA	WINTERHAVEN	92283
CLINICA SIERRA VISTA	CA	WOFFORD HEIGHTS	93285
HILLTOWN COMMUNITY HEALTH CENTE	MA	WORTHINGTON	10989
SUNSET COMMUNITY HEALTH CENTER	AZ	YUMA	85364
SUNSET COMMUNITY HEALTH CENTER	AZ	YUMA	85364

DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 352-G
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Washington, DC 20201
Office of Communications

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FACT SHEET

FOR IMMEDIATE RELEASE
December 19, 2011

Contact: CMS Media Relations Group
(202) 690-6145

Pioneer Accountable Care Organization Model:
General Fact Sheet

The Pioneer ACO Model is a CMS Innovation Center initiative designed to support organizations with experience operating as Accountable Care Organizations (ACOs) or in similar arrangements in providing more coordinated care to beneficiaries at a lower cost to Medicare. The Pioneer ACO Model will test the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients, and reducing Medicare costs.

Accountable Care Organizations
Accountable Care Organizations (ACOs) are one way CMS is working to ensure better health care, better health, and lower growth in expenditures through continuous improvement.

The Medicare Shared Savings Program provides incentives for ACOs that meet standards for quality performance and reduce cost while putting patients first. Established by the Affordable Care Act, CMS published final rules for the Shared Savings Program on November 2, 2011. More information is available at www.cms.gov/sharedsavingsprogram.

Working in concert with the Shared Savings Program, the Innovation Center is testing an alternative ACO model, the Pioneer ACO Model. The Innovation Center is also testing the Advance Payment ACO Model, which will provide additional support to physician-owned and rural providers participating in the Shared Savings Program who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.

More information on all of these initiatives is available on the Innovation Center website at www.innovations.cms.gov.

The Pioneer ACO Model and Selected Organizations

The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. The selected organizations were chosen for their significant experience offering this type of quality care to their patients, along with other criteria listed in the Request for Applications (RFA) document available at www.innovations.cms.gov. These organizations were selected through an open and competitive process from a large applicant pool that included many qualified organizations.

The 32 organizations participating in the Pioneer ACO Model:

Organization	Service Area
1. Allina Hospitals & Clinics	Minnesota and Western Wisconsin
2. Atrius Health	Eastern and Central Massachusetts
3. Banner Health Network	Phoenix, Arizona Metropolitan Area (Maricopa and Pinal Counties)
4. Bellin-Thedacare Healthcare Partners	Northeast Wisconsin
5. Beth Israel Deaconess Physician Organization	Eastern Massachusetts
6. Bronx Accountable Healthcare Network (BAHN)	New York City (the Bronx) and lower Westchester County, NY
7. Brown & Toland Physicians	San Francisco Bay Area, CA
8. Dartmouth-Hitchcock ACO	New Hampshire and Eastern Vermont
9. Eastern Maine Healthcare System	Central, Eastern, and Northern Maine
10. Fairview Health Systems	Minneapolis, MN Metropolitan Area

11. Franciscan Alliance	Indianapolis and Central Indiana
12. Genesys PHO	Southeastern Michigan
13. Healthcare Partners Medical Group	Los Angeles and Orange Counties, CA
14. Healthcare Partners of Nevada	Clark and Nye Counties, NV
15. Heritage California ACO	Southern, Central, and Costal California
16. JSA Medical Group, a division of HealthCare Partners	Orlando, Tampa Bay, and surrounding South Florida
17. Michigan Pioneer ACO	Southeastern Michigan
18. Monarch Healthcare	Orange County, CA
19. Mount Auburn Cambridge Independent Practice Association (MACIPA)	Eastern Massachusetts
20. North Texas ACO	Tarrant, Johnson and Parker counties in North Texas
21. OSF Healthcare System	Central Illinois
22. Park Nicollet Health Services	Minneapolis, MN Metropolitan Area
23. Partners Healthcare	Eastern Massachusetts
24. Physician Health Partners	Denver, CO Metropolitan Area
25. Presbyterian Healthcare Services – Central New Mexico Pioneer Accountable Care Organization	Central New Mexico

26. Primecare Medical Network	Southern California (San Bernardino and Riverside Counties)
27. Renaissance Medical Management Company	Southeastern Pennsylvania
28. Seton Health Alliance	Central Texas (11 county area including Austin)
29. Sharp Healthcare System	San Diego County
30. Steward Health Care System	Eastern Massachusetts
31. TriHealth, Inc.	Northwest Central Iowa
32. University of Michigan	Southeastern Michigan

The Innovation Center

The Innovation Center was created by the Affordable Care Act to test new models of health care delivery and payment. The Center also offers technical support to providers to improve the coordination of care and share lessons learned and best practices throughout the health care system. It is committed to refining the Medicare, Medicaid and CHIP programs to deliver better care for individuals, better health for populations, and lower growth in expenditures.

Payment Arrangement and Beneficiary Alignment

The first performance period begins in January 1st, 2012. In the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program. These shared savings would be determined through comparisons against an ACO's benchmark, which is based on previous CMS expenditures for the group of patients aligned to the Pioneer ACO

In year three of the program, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model. Population-based payment is a per-beneficiary per month payment amount intended to replace some or all of the ACO's fee-for-service (FFS) payments with a prospective monthly payment.

Additionally, during the application process, organizations were invited to propose alternative payment arrangements. CMS established two alternatives to the core payment arrangement discussed above based on this input. Both of these alternatives follow a shared savings model in years one and two, and provide an option for a partial population based payment that removes limits on rewards and risks in year three. These arrangements will allow Pioneer ACOs more flexibility in the speed at which they assume financial risk.

Under the Pioneer ACO Model, CMS will prospectively align beneficiaries to ACOs, allowing care providers to know at the beginning of a performance period for which patients' cost and quality they will be held accountable.

Beneficiary Protections and Quality Measures

Providing the beneficiary with a better care experience is one of the central focuses of the Pioneer ACO Model. Under the Pioneer ACO Model, beneficiaries will maintain the full benefits available under traditional Medicare (fee-for-service), as well as the right to receive services from any healthcare provider accepting Medicare patients.

To ensure beneficiaries receive high quality care and enjoy a positive experience, CMS has established robust quality measures that will be used to monitor the quality of care provided and beneficiary satisfaction. These measures mirror those in the Shared Savings Program. For more information, visit www.cms.gov/sharedsavingsprogram and view the fact sheet entitled "Improving Quality of Care for Medicare Patients: Accountable Care Organizations."

More information about beneficiary protections and quality measures is available in the fact sheet entitled "The Pioneer ACO Model: A Better Care Experience Through a New Model of Care."

Eligibility Criteria/Program Requirements

To be eligible to participate in the Pioneer ACO Model, organizations are required to be providers or suppliers of services structured as:

1) ACO professionals in group practice arrangements;
2) Networks of individual practices of ACO professionals;
3) Partnerships or joint venture arrangements between hospitals and ACO professionals;
4) Hospitals employing ACO professionals; or
5) Federally Qualified Health Centers (FQHC).

Health Information Technology

By the end of 2012, Pioneer ACOs must attest and CMS will confirm that at least 50% of the ACO's primary care providers have met requirements for meaningful use of certified electronic health records (EHR) for receipt of payments through the Medicare and Medicaid EHR Incentive Programs.

Minimum Number of Aligned Beneficiaries

Beneficiaries are aligned to ACOs through the healthcare providers that choose to participate. CMS will review where a beneficiary has been receiving the plurality of his/her primary care services, and use that information to establish which beneficiaries are aligned to a participating provider. If a primary care provider chooses to participate in an ACO, the beneficiaries aligned to him or her through this process would be aligned to the ACO. If a beneficiary receives less than 10 percent of their care from a primary care provider, CMS will review where a beneficiary has been receiving the majority of his/her specialty services to determine alignment.

Participants generally must have a minimum of 15,000 aligned beneficiaries unless located in a rural area, in which case are to have a minimum of 5,000 beneficiaries. In order to be aligned, beneficiaries must be enrolled in original, fee for service Part A and B Medicare. They cannot be participating in Medicare Advantage plans.

Participation of Other Payers

The Innovation Center believes that Pioneer ACOs will be more effective in producing improvements in three part aim of better care for individuals, better health for populations, and slower growth in expenditures if they fully commit to a business model based on financial and performance accountability. The Innovation Center therefore requires Pioneer ACOs to enter similar contracts with other payers (such as insurers, employer health plans, and Medicaid) such that more than 50 percent of the ACO's revenues will be derived from such arrangements by the end of the second Performance Period.

Selection Process

CMS conducted a lengthy, open and competitive application process to select the final participants in the Pioneer ACO Model. CMS released a Request for Applications (RFA) in May 2011 that detailed the selection criteria. Applicants were required to submit both a Letter of Intent and Application. Applications were reviewed by a panel of experts from the Department of Health and Human Services as well as from external organizations, with expertise in the areas of provider payment policy, care improvement and coordination, primary care, and care of vulnerable populations. These panels assessed the applications based on the criteria detailed in the RFA. Applicants with the highest scores were invited to participate in interviews with Innovation Center leadership at the CMS facility in Baltimore. Based on these interviews, CMS chose a pool of finalists. The Pioneer ACOs announced in December 2011 were those finalists choosing to sign a final agreement with CMS.

Pioneer ACO Model and the Shared Savings Program

The Pioneer ACO Model is distinct from the Shared Savings Program. The Shared Savings Program fulfills a statutory obligation set forth by the Affordable Care Act to establish a permanent program that develops a pathway forward for groups of health care providers to become ACO's, while the Pioneer ACO Model is an initiative designed to test the effectiveness of a particular model of payment. Final rules for the Shared Savings Program were published in November 2011. More information is available at www.cms.gov/sharedsavingsprogram.

The Pioneer ACO Model differs from the Medicare Shared Savings Program in the following ways, among others:

- The first two years of the Pioneer ACO Model are a shared savings payment arrangement with higher levels of savings and risk than in the Shared Savings Program.
- Starting in year three of the initiative, those organizations that have earned savings over the first two years will be eligible to move to a population-based payment arrangement and full risk arrangements that can continue through optional years four and five.
- Pioneer ACOs are required to develop similar outcomes-based payment arrangements with other payers by the end of the second year, and fully commit their business and care models to offering seamless, high quality care.

Additional Information

Additional information about the Pioneer ACO Model is available on the Pioneer ACO Model website - http://www.innovations.cms.gov/initiatives/aco/pioneer

ATTACHMENT 5

Partnership for Patients: Hospital Engagement Networks

American Hospital Association
Ascension Health
Carolinas HealthCare System
Catholic Healthcare West
Dallas-Fort Worth Hospital Council Foundation
Georgia Hospital Association Research and Education Foundation
Healthcare Association of New York State
Hospital & Health System Association of Pennsylvania
Intermountain Healthcare
Iowa Healthcare Collaborative
Joint Commission Resources, Inc.
Lifepoint Hospitals, Inc
Michigan Health & Hospital Association
Minnesota Hospital Association
National Public Health and Hospital Institute
New Jersey Hospital Association
Nevada Hospital Association
North Carolina Hospital Association
Ohio Children's Hospital Solutions for Patient Safety
Ohio Hospital Association
Premier
Tennessee Hospital Association
Texas Center for Quality & Patient Safety
UHC
VHA
Washington State Hospital Association

INNOVATION ADVISORS

First Name	Last Name	Credentials	Organization	City	State
Clay	Ackerly	MD, MS	Massachusetts General Hospital	Boston	MA
Parag	Agnihotri	MD	Medical Clinic of Sacramento Inc.	Sacramento	CA
Rod	Baird	MS	Geriatric Practice Management, Inc.	Asheville	NC
Christine	Baker	RN, PhD, MBA, FACHE	St. Mary's Hospital	Madison	WI
David	Baker	DrPH, MBA, ME	LifeBridge Health System	Baltimore	MD
Randi	Berkowitz	MD	Hebrew SeniorLife	Roslindale	MA
Barbara	Blakeney	BSN, MSN	Massachusetts General Hospital	Boston	MA
Rosemary	Botchway	MS HCA	Primary Care Coalition of Montgomery County, MD, Inc.	Silver Spring	MD
Laura Beth	Brown	RN, BSN, MSN	Vanderbilt University Medical Center	Nashville	TN
Stephanie	Bruce	MD	Washington Hospital Center, Medical House Call Program	Washington	DC
Anna Marie	Butrie	MS	Catholic Health East	Newtown	PA
Gary	Christensen	MS	Rhode Island Quality Institute	Providence	RI
Beverly	Christie	DNP, RN, PHN	Fairview Health Services	St. Paul	MN
Erin	Conklin	MPA	Genesys Health System	Grand Blanc	MI
Laura	Conley	MHSA	Children's Memorial Hospital	Chicago	IL
Yeates	Conwell	MD	University of Rochester Medical Center	Rochester	NY
Diane	Curley	MSN, RN, CNOR, CBN	Catholic Health Services of Long Island	Smithtown	NY
Jennifer	DeCubellis	LPC, LPA	Hennepin County	Minneapolis	MN
Erin	Denholm	MSN, RN	Centura Health	Denver	CO
Pamela	Duncan	PhD, PT, FAPTA, FAHA	Wake Forest Baptist Health	Winston Salem	NC
Erin	DuPree	MD	The Mount Sinai Medical Center	New York	NY
Zahra	Esmail	DO	White Memorial Medical Center	Los Angeles	CA
Anna	Flattau	MD, MSc, MS	Montefiore Medical Center	Bronx	NY
Christian	Furman	MD, MSPH	University of Louisville Research Foundation, Inc.	Louisville	KY
Corita	Grudzen	MD, MSHS	Mount Sinai Medical Center Dept. of Emergency Medicine	New York	NY

Kellie	Hamblin	RN, BSN, MBA, CPHQ, SSGB	Providence Health & Services	Renton	WA
Grace	Hines	MBA	Sentara Healthcare	Norfolk	VA
Srikant	Iyer	MD, MPH	Cincinnati Children's Hospital Medical Center	Cincinnati	OH
Jonathan	Jaffrey	MD, MS	The University of Wisconsin School of Medicine and Public Health	Middleton	WI
Daniel	Johnson	MD, FAAHPM	Kaiser Permanente (Colorado)	Aurora	CO
Colleen	Kraft	MD	Carilion Medical Center	Roanoke	VA
Candice	Lagasse	PharmD	USAF; 460th Medical Group	Buckley AFB	CO
Suzanne	Landis	MD, MPH	Mountain Area Health Education Center (MAHEC)	Asheville	NC
Larry	Lawhorne	MD	Wright State Physicians, Inc.	Dayton	OH
Barbara	Levin	MPH, MD	Chota Community Health Services, Inc	Madisonville	TN
Julie	Lewis	MBA	Amedisys Holding, L.L.C.	Baton Rouge	LA
Stephen	Liu	MD, MPH, FACPM	Dartmouth-Hitchcock Medical Center	Lebanon	NH
Jeanne	McAllister	RN, BSN, MS, MHA	Crotched Mountain Foundation (CMF)	Concord	NH
Tonya	Moody		AmeriHealth Mercy Health Plan	Philadelphia	PA
Maureen	Murphy	MD, FAAFP, ABMA	SSM Healthcare of Wisconsin, Inc.	Lake Delton	WI
Nancy	Murphy	MD	University of Utah	Salt Lake City	UT
Margaret	Namie	RN, BSN, MPH, CPHQ	Mercy Health Partners of Southwest Ohio	Cincinnati	OH
Zeev	Neuwirth	MD, MHCM	Carolinas Healthcare System	Charlotte	NC
Len	Nichols	PhD	George Mason University	Fairfax	VA
Deborah	Peartree	RN, MS	Monroe Plan for Medical Care, Inc.	Pittsford	NY
Janice	Pringle	PhD	University of Pittsburgh School of Pharmacy	Pittsburgh	PA
Judith	Rabig	RN, PhD	Masonic Health System of Massachusetts	Leeds	MA

Jack	Resnick	MD	Empire State Medical Associates, P.C.	Roosevelt Island	NY
Neil	Resnick	MD	University of Pittsburgh Medical Center	Pittsburgh	PA
Stevi	Riel		Muskegon Community Health Project	Muskegon	MI
Nancy	Roberts	RN, MSN	Kent County Visiting Nurse Association	Warwick	RI
Jean	Sanders	BSN	Aquidneck Medical Associates, Inc	Newport	RI
Michelle	Schoepflin Sanders	MD	Providence Health & Services	Portland	OR
Christina	Schwien	MPH, MN, BS, BA	Qualis Health	Seattle	WA
Kathy	Scott	PhD, MPA, RN, FACHE	ProHealth Care, Inc.	Waukesha	WI
Cordelia	Sharma	MBBS	Westchester County Health Care Corp.	Valhalla	NY
Phyllis	Sherard	MPA	Cheyenne Regional Medical Center	Cheyenne	WY
Jason	Stein	MD, SFHM	Emory Healthcare	Atlanta	GA
Winnie	Suen	MD, MSc, LMT	Boston Medical Center	Boston	MA
Cristin	Sullivan	BSN, MBA	St. Vincent Hospital	Green Bay	WI
Paula	Suter	BSN, MA, RN	Sutter Health	Fairfield	CA
Sharon	Tapper	MD	Palo Alto Medical Foundation	Santa Cruz	CA
Kelly	Taylor	RN, MSN,CCM	Mercy Clinics, Inc.	Des Moines	IA
Maureen	Thompson	BSN, RN, CWOCN	St. Francis Healthcare Services	Wilmington	DE
Thomas	Tsang	MD, MPH, FACPM	Office of the Governor, State of Hawaii	Honolulu	HI
Maxine	Vance	BSN, MSN, PhD	Baltimore Healthy Start, Inc.	Baltimore	MD
Betty	Vohr	MD	Women & Infants Hospital	Providence	RI
Alen	Voskanian	MD	VITAS Innovative Hospice Care	Torrance	CA
Jay	Want	MD	Center for Improving Value in Health Care	Denver	CO
Victoria	Wilkins	MPH, MD	University of Utah	Salt Lake City	UT
Janet	Will	BSN, MSN	Joseph Richey Hospice	Baltimore	MD
Sarah	Woolsey	MD	HealthInsight	Salt Lake City	UT
Richard	Young	MD	JPS Physician's Group	Fort Worth	TX

Center for Medicare and Medicaid Innovation Center Portfolio
Initiatives Announced Prior To March 31, 2012*

Initiative	Testing	Authority	Target	Key Dates
Initiatives Conducted Under Section 1115A(f) of the Social Security Act				
Comprehensive Primary Care Initiative	Public-private partnership to enhance primary care services, including 24-hour access, care plans, and care coordination	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	7 markets: • Arkansas: Statewide • Colorado: Statewide • New Jersey: Statewide • New York: Capital District-Hudson Valley Region • Ohio: Cincinnati-Dayton Region • Oklahoma: Greater Tulsa Region • Oregon: Statewide	RFA Announced: 9/28/2011 Payer Application Date: 1/17/2012 Select Markets: 4/2012
FQHC Advanced Primary Care Practice Demonstration	Care coordination payments to FQHCs in support of team-led care, improved access, and enhanced primary care services	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	500 FQHCs with at least 200 Medicare FFS beneficiaries	RFA Announced: 6/6/2011 Application Date: 9/9/2011 Began: 11/1/2011
Pioneer ACO Model	Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	32 provider organizations with at least 15,000 Medicare FFS beneficiaries (5000 in rural areas)	RFA Announced: 5/17/2011 Application Date: 8/19/2011 Began: 1/1/2012
Advance Payment ACO Model	Prepayment of expected shared savings to support ACO infrastructure and care coordination	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Small physician-led or rural organizations participating in the Medicare Shared Savings Program	RFA Announced: 11/2/2011 Application Dates: 2/1/2012 and 3/30/2012
Bundled Payment for Care Improvement	Evaluate 4 different models of episodic payments around inpatient hospitalization to incentivize care redesign Model 1: Retrospective Acute Care Model 2: Retrospective Acute Care Episode & Post Acute Model 3: Retrospective Post Acute Care Model 4: Prospective Acute Care	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Medicare FFS beneficiaries with a recent acute care hospitalization	RFA Announced: 8/23/2011 Application Due: 11/18/11 (model 1) and 6/28/12 (models 2, 3, and 4)

Initiative	Testing	Authority	Target	Key Dates
The Partnership for Patients	Efficacy of hospital engagement networks (other interventions) in reducing HACs/Readmissions by 20 and 40 percent, respectively. (Community Based Care Transition is covered in another row.)	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Efficacy of hospital engagement networks (other interventions) in reducing HACs/readmissions by 20 and 40 percent, respectively.	RFA Announced for Hospital Engagement Networks (HEN): 7/5/11 HEN Applications Date: 8/5/11 HENs Began: 12/9/2011
Health Care Innovation Awards	A broad appeal for innovations with a focus on developing the workforce for new care models	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Diverse set of models and applicants with an emphasis on those that will train and deploy the health care workforce of the future and can be deployed within 6 months	RFA Announced: 11/14/2011 Application Date: 1/27/2012
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Support States in designing integrated care programs for Medicare-Medicaid enrollees.	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	15 State Medicaid programs (CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI)	RFA Announced: 12/ 2010 Application Date: 2/2011 Began: 4/14/2011
Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees	Opportunity for States to implement new integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	State Medicaid programs	RFA Announced: 7/8/2011 Letters of Intent: 10/1/2011
Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents	Initiative to improve quality of care and reduce avoidable hospitalizations among long-stay nursing facility residents by partnering with independent organizations with nursing facilities to test enhanced on-site services and supports to reduce inpatient hospitalizations	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	States, nursing facilities, and other organizations to provide enhanced care coordination	RFA Announced: 3/15/2012 Application Date: 6/14/2012

Initiative	Testing	Authority	Target	Key Dates
Strong Start for Mothers and Newborns	Strategy I: Testing the effectiveness of shared learning and diffusion activities to reduce the rate of early elective deliveries among pregnant women. 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.	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Strategy I: Providers of obstetric care, hospitals participating in the Partnership for Patients, and industry stakeholders Strategy II: Providers of obstetric care, State Medicaid Agencies, Medicaid managed care organizations, and conveners in partnership with other applicants	Strategy I: Initiative announced 2/08/2012 Strategy II: RFA Announced: 2/08/2012 Application Date: 6/13/2012
Million Hearts Campaign	Integrating the Million Hearts goals and strategies into each of the Innovation Center models, as appropriate.	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	High-risk Medicare, Medicaid and commercial beneficiaries	RFA Announced: N/A Application Date: N/A Began: 9/2011
Innovation Advisors	Engage individuals to test and support models of payment and care delivery to improve quality and reduce cost through continuous improvement processes	Section 1115A(f) of the Social Security Act (section 3021 of the Affordable Care Act)	Advisors seeking to improve knowledge and skills in system improvement who are willing and able to utilize this training in their home organizations	RFA Announced: 10/17/2011 Application Date: 11/15/2011 Began: 1/2/2012

Initiative	Testing	Authority	Target	Key Dates
Initiatives Conducted Under Affordable Care Act Provisions Other Than Section 3021 (Section 1115A of the Social Security Act)				
Graduate Nurse Education (GNE) Demonstration	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	Hospitals, schools of nursing, and non-hospital based community-based care settings	RFA Announced: 3/21/2012 Application Date: 5/21/2012
Independence at Home Demonstration	Home-based care for patients with multiple chronic conditions	Section 1866E(h) of the Social Security Act (section 3024 of the Affordable Care Act)	Practices with at least 200 high-need beneficiaries	RFA Announced: 12/21/2011 Application Date: 2/6/2012
Physician Group Practice (PGP) Transition Demonstration	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 (sections 3022 and 10307 of the Affordable Care Act)	Sites from previous PGP demo were asked to participate. Billings Clinic, Billings, MT Dartmouth-Hitchcock Clinic, Bedford, NH; The Everett Clinic, Everett, WA; Forsyth Medical Group, Winston-Salem, NC; Geisinger Health System, Danville, PA; Marshfield Clinic, Marshfield, WI; Middlesex Health System, Middletown, CT; Park Nicollet Health Services, St. Louis Park, MN; St. John's Health System, Springfield, MO; University of Michigan Faculty Group Practice, Ann Arbor, MI Note: Everett terminated their participation on 12/31/11. Dartmouth-Hitchcock, Park Nicollet, and University of Michigan transitioned to the Pioneer ACO model effective 1/1/12.	RFA Announced: N/A (an extension of the original PGP) Application Date: N/A Began: 1/1/2011

Initiative	Testing	Authority	Target	Key Dates
Medicaid Emergency Psychiatric Demonstration	Provide 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	State Medicaid programs -- Alabama, Illinois, North Carolina , California, Maine Rhode Island, Connecticut, Maryland, Washington, District of Columbia, Missouri, West Virginia	RFA Announced: 8/9/2011 Application Date: 10/14/2011 Participating states announced 3/13/12
Community-Based Care Transitions (a part of the Partnership for Patients)	Reduce readmissions by improving transitions of beneficiaries from the inpatient hospital setting to home or other care settings	Section 3026 of the Affordable Care Act	Hospitals with high readmission rates that partner with community-based organizations (CBOs) or CBOs that provide care transition services. 30 have been selected to date.	RFA Announced: 4/12/2011 Application Date: Rolling Began: 11/18/2011
Treatment of Certain Complex Diagnostic Laboratory Tests	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	Laboratories performing certain complex tests can request payment under the Demonstration using a claim level Project Identifier.	RFA Announced: 7/5/2011 Request for submission of supporting information (Demonstration G code) due 8/1/2011. A second Federal Register Notice published on 8/10/2011 announced an extension of the due date to 9/6/2011. The Demonstration period began 01/2012.
Pilot Program for Care of Certain Individuals Residing in Emergency Declaration Areas	Furnishing comprehensive, coordinated, and cost-effective care to individuals exposed to environmental health hazards	Section 1881 of the Social Security Act (section 10323 of the Affordable Care Act)	Individuals residing near Libby, MT, affected by environmental exposure	RFA Announced: N/A Application Date: N/A Began: 07/01/2011
Incentives for Prevention of Chronic Diseases in Medicaid	Test the impact of incentives for prevention for a Medicaid population	Section 4108(f) of the Affordable Care Act	10 States (WI, MN, NY, NV, NH, MT, HI, TX, CA, CT)	RFA Announced: 2/23/2011 Application Date: 5/2/2011 Began: 9/13/2011
Rural Community Hospital Demonstration Program	The demonstration tests the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals	Sections 3123 and 10313 of the Affordable Care Act, amending section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	20 States with the lowest population density (AK, AZ, AR, CO, ID, IA, KS, ME, MN, MS, MT, NE, NV, NM, ND, OK, OR, SD, UT, WY) -- 23 hospitals are participating across 11 states	RFA Announced: 8/30/2010 Application Date: 10//14/2010 Extension effective 10/1/2010; Expansion to additional hospitals effective 4/1/11

Initiative	Testing	Authority	Target	Key Dates
Demonstration Project on Community Health Integration Models in Certain Rural Counties	Explore ways to increase access to and improve the adequacy of payments for Medicare and Medicaid health care services in eligible counties	Section 3126 of the Affordable Care Act, amending section 123 of the Medicare Improvements for Patients and Providers Act of 2008	Health care providers in certain rural counties	Under development
Initiatives Conducted Under Other Authorities				
Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)	Evaluate effectiveness of advanced primary care supported by common payment method from Medicare, Medicaid, and private health plans	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Existing or developing State multi-payer health reform initiatives that included Medicaid and private health plans. 8 states are participating: ME, VT, RI, NY, PA, NC, MI, and MN	RFA Announced: 6/2/2010 Application Date: 8/17/2010 Began: 7/2011
Care Management for High Cost Beneficiaries Demonstration	Test the ability of direct care provider models to coordinate care for high-cost/high-risk beneficiaries by providing such beneficiaries with clinical support	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Six organizations were selected: Health Hero/Health Buddy, Care Level Management, Massachusetts General Hospital and Massachusetts General Physicians Organization, Montefiore Medical Center, RMS DM (subsequently renamed Village Health), LLC, and Texas Senior Trails. Three organizations that demonstrated success received a demonstration extension for three more years: Village Health, Massachusetts General Care Management Program; and Health Hero Network, Health Buddy Project	RFA Announced: 10/6/2004 Application Date: 1/4/2005 Began: 10/1/2005-8/1/2006 Three organizations (Mass General, Health Hero/Health Buddy, & Village Health) extended 2008-09; phase-down of last demo site ending 7/1/2012

Initiative	Testing	Authority	Target	Key Dates
Medicare Hospital Gainsharing Demonstration	Test and evaluate methodologies and arrangements between hospitals and physicians designed to govern the utilization of inpatient hospital resources and physician work and to develop improved operational hospital performance with the sharing of remuneration	Deficit Reduction Act of 2005 and Section 3027 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Arrangements between hospitals and physicians. Two sites were a part of the initial demonstration, Beth Israel Medical Center, New York City and Charleston Area Medical Center, West Virginia	Initial RFA Announced: 9/18/2006 Application Date: 11/17/2006 Rural site RFA: 7/5/2007 Application Date: 9/4/2007 Began: 10/1/2008 Ended 9/30/2011
Home Health Third Party Liability Demonstration Arbitration	CMS entered into individual agreements with the state Medicaid agencies of Connecticut, Massachusetts, and New York to operate a demonstration program to determine the Medicare payment of certain home health services provided to certain individuals. If any one of the states or its agents was dissatisfied with CMS's determination of Medicare coverage for these claims, the parties agreed to utilize arbitration services of the American Arbitration Association	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Connecticut, Massachusetts, and New York	RFA Announced: N/A Application Date: N/A Began: 11/ 2005 to reprocess FY2001 claims; continuing through reprocessing of FY 2007 claims (CT & MA), FY 2010 claims (NY)
Senior Risk Reduction Demonstration	Test the ability of risk reduction programs to achieve improvements in a population's health risk profile	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Started with 5 vendors. Two organizations stayed on providing risk reduction services under this demonstration: Pfizer Health Solutions (withdrew 4/30/2011) and StayWell Health Management. Approximately 40,000 Medicare beneficiaries were invited to participate in the demonstration	RFA Announced: 8/23/2006 Application Date: 11/21/2006 Began Pilot 1: 4/1/2008 - 3/31/2009; Pilot 2: 5/1/2009 Concludes: 4/30/2012

Initiative	Testing	Authority	Target	Key Dates
Medicare Coordinated Care Demonstration Project	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	Health Quality Partners (HQP) in Doylestown, PA is the one remaining site	RFA Announced: 7/28/2000 Application Date: 10/11/2000 Selection of 15 Organizations: 1/2001 Began: 4/01/2002; one organization extended through 6/30/2013
Private, For-Profit Demonstration Project for the Program of All-Inclusive Care for the Elderly (PACE)	Study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs	Section 4804 of the Balanced Budget Act of 1997	Five Pennsylvania providers are participating in the demonstration: Pennsylvania PACE, Inc., Life at Home, LLC, SeniorLIFE York, Inc., SeniorLIFE Washington, Inc., and SeniorLIFE Altoona, Inc.	Original RFA Announced: 8/10/2001 Application Date: 12/2001 Began for the first 2 providers in 2007. 2nd RFA Announced: 7/24/2009 Application Date: 7/26/2010 Three providers began operations in 5/2011. Two providers are not yet operational.
Demonstration Project to Assess the Appropriate Use of Imaging Services	Collect data regarding physician use of advanced diagnostic imaging services to determine the appropriateness of services in relation to medical specialty guidelines	Section 135 of the Medicare Improvements for Patients and Providers Act of 2008	Thirty-five practices in five sites are testing the impact of decision support on the appropriateness of advanced imaging orders relative to medical specialty guidelines	RFA Announced: 7/23/2010 Application Date: 9/21/2010 Sites selected and announced 1/2011. Baseline data collection 10/2011-3/2012. Intervention phase 4/2012 - 10/2013
Frontier Extended Stay Clinic Demonstration Project	Allows remote clinics to treat patients for more extended periods, including overnight stays, than are entailed in routine physician visits	Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Five clinics are participating in the demonstration: Alicia Roberts Medical Center, Haines Health Center, Cross Road Medical Center, Iliuliuk Family & Health Services, and Inter Island Medical Center	RFA Announced: 8/2006 Application Date: 11/2006 Began: 4/15/2010

Initiative	Testing	Authority	Target	Key Dates
Physician Hospital Collaboration Demonstration	This demonstration 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	The demonstration is comprised of a consortium of twelve hospitals state-wide New Jersey, the New Jersey Care Consortium, that is administered by the New Jersey Hospital Association	RFA Announced: 9/11/2006 Application Date: 1/9/2007 Began: 7/2009
Medicare Health Care Quality Demonstration	Test major changes to improve quality of care while increasing efficiency across an entire health care system	Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	The Indiana Health Information Exchange (IHIE); the North Carolina Community Care Networks, Gundersen Lutheran Health System, and Meridian are participating in the demonstration	RFA Announced: 9/16/2005 First Round Application Date: 01/30/2006 Second Round Application Date: 09/29/2006 Began: IHIE - 7/1/2009; North Carolina - 1/1/2010; Gundersen - 2/1/2010; Meridian anticipated to start 7/1/2012
Acute Care Episode (ACE) Demonstration	Test the effect of bundling Part A and B payments for episodes of care to improve the coordination, quality, and efficiency of care	Section 646 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	Hospitals performing minimum numbers of orthopedic and/or cardiovascular procedures in states covered by the J4 MAC (OK, TX, NM, CO) 5 Hospitals selected	RFA Announced: 5/15/2008 Application Date: 8/15/2008 Earliest hospital began 5/1/2009; Last hospital began 11/1/2010
Nursing Home Value-Based Purchasing Demonstration	Provide financial incentives to nursing homes that demonstrate delivery of high quality care or improvement in care	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Nursing homes in Arizona, New York, and Wisconsin	RFA Announced: 1/2009 Application Date : 3/2009 Began: 07/01/2009
Electronic Health Records Demonstration	The goal of this demonstration was to foster the implementation and adoption of EHRs and health information technology more broadly as effective vehicles not only to improve the quality of care provided, but also to transform the way medicine is practiced and delivered	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	The four communities selected for implementation were Louisiana; Maryland/Washington, D.C.; Pittsburgh, PA (and surrounding counties); and South Dakota (and surrounding counties in Iowa, Minnesota, and North Dakota)	RFA Announced: 2/2008 Application Date for communities: 4/2008 Application Date for practices: 11/2008 Began: 6/1/2009 Terminated: 08/01/2011

Initiative	Testing	Authority	Target	Key Dates
Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities	The Medicare Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities used a randomized control design to study the impact of various evidence based, culturally competent models of patient navigator programs designed to help minority beneficiaries navigate the healthcare system in a more timely and informative manner and facilitate cancer screening, diagnosis and treatment to improve healthcare access and outcomes, as well as lower total costs to Medicare	Section 122 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000	Approximately 12,700 Medicare fee-for-service beneficiaries were eligible to be enrolled in the study during this four-year project. Six organizations were selected as the awardees: Huntsman Cancer Institute, Molokai General Hospital, M.D. Anderson Cancer Center, New Jersey Medical School, Johns Hopkins University, Josephine Ford Cancer Center	RFA Announced: 12/23/2004 Application Date: 3/23/2005 Began: 04/03/2006 Ended: 12/31/2010
Medicare Low Vision Rehabilitation Demonstration	The Low Vision Rehabilitation Demonstration examines the impact of coverage for vision rehabilitation services provided to Medicare beneficiaries with moderate to severe visual impairments, which cannot be corrected through surgery or glasses. Services may be provided in the office of physician or in the home and home environment by qualified physicians or occupational therapists, or by certified low vision rehabilitation professionals under the general supervision of the physician.	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)	Low Vision Rehabilitation Demonstration locales include New Hampshire, New York City (all 5 boroughs), Atlanta, GA., North Carolina, Kansas, and Washington State. Eligible beneficiaries who live in these areas and receive their medical eye care from an ophthalmologist or optometrist who practices in these areas could be covered for up to 9 hours of rehabilitation services provided in an appropriate setting, including in the home	RFA Announced: N/A Application Date: N/A Began: 04/03/2006 Ended: 3/31/2011

Initiative	Testing	Authority	Target	Key Dates
ESRD Disease Management	Provides the opportunity for Medicare beneficiaries with ESRD to join integrated care management systems. The demonstration is designed to test the effectiveness of disease management models to increase quality of care for ESRD patients.	Section 402 of PL 90-248 as amended (42 USC 1395b-1), specifically sections 402(a)(1) and 402(b)	Targeted at dialysis organizations partnering with MA plans to provide MA programs for ESRD beneficiaries -- 2 organizations (DaVita and Fresenius) are participating in 11 States. Evercare withdrew on 12/31/2008.	RFA Announced: 6/4/2003 Application Date: 10/2/2003 Began: 1/1/2006 Ended: 12/31/2010
Medicare Care Management Performance Demonstration	This 3 year demonstration was designed to promote the use of health information technology and improve the quality of care for beneficiaries. Doctors in small to medium sized practices who meet clinical performance measure standards received a bonus payment for managing the care of eligible Medicare beneficiaries and reporting quality measure data to CMS from a CCHIT-certified electronic health record.	Section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	The demonstration was implemented in California, Arkansas, Massachusetts and Utah	RFA Announced: 10/2006 Application Date: 3/2007 Began: 7/2007 Ended: 6/30/2010

*This attachment includes demonstrations that are being conducted under authorities other than 1115A(f) of the Social Security Act, but does not include individual research activities unrelated to demonstrations administered by the Innovation Center.

ATTACHMENT 8

Mission

The Innovation Center fosters healthcare transformation by finding new ways to pay for and delivery care that can lower costs and improve care. The Innovation Center identifies, tests and spreads new ways to pay for and delivery care that can deliver better care and better health at reduced costs through improvement for all Americans.

The Innovation Center has the resources and flexibility to identify, develop, rapidly test and encourage widespread adoption of innovative care and payment models, laying the groundwork for a broader transformation of our healthcare system to one that delivers better health care at lower costs.

Better healthcare: Improve individual patient experiences of care along the Institute of Medicine's six domains of quality: Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity.

Better health: Encourage better health for entire populations by addressing underlying causes of poor health, such as physical inactivity, behavioral risk factors, lack of preventive care and poor nutrition.

Lower costs through improvement: Lower the total cost of care resulting in reduced monthly expenditures for each Medicare, Medicaid or CHIP beneficiary by improving care.

ATTACHMENT 9

Process Statement

Solicit ideas for new models

There is a great richness of innovation occurring in local communities, states, and the private sector. Clinicians, health systems, community leaders, and other innovators throughout the country are developing new models of care that may be fostered by changes in payment to provide better health and better healthcare at lower costs. We want to hear about and learn from your great work and partner with you to transform the healthcare system.

Select the most promising models

The Innovation Center will review payment and service delivery models submitted through the web form and will evaluate them against the Innovation Center Portfolio Criteria. The review process will include input from across CMS, HHS, other Federal partners and an array of external stakeholders.

Once the Center identifies payment changes or service delivery models that show promise and are ready for testing, the Center will determine the appropriate payment methodology, identify the appropriate performance measures and the means to collect them, consider how to engage beneficiaries, and identify technical assistance or learning opportunities that sites might need to implement the model. We may use additional "Requests for Innovation and Input" and listening sessions to allow the public and stakeholders to help us hone ideas into testable models.

Test and evaluate the models

After selecting a promising model and refining it, the Innovation Center will solicit partners to test the model through mechanisms such as issuing a competitive "Innovation Partnership Opportunity" (IPO). IPOs may include competitive processes such as Requests for Applications, Requests for Proposals or tools to solicit ways for clinicians or others to partner with the Innovation Center. IPOs will be posted on the Innovation Center's website. The specific selection process of partners to test each model will vary, but in all cases the competitive process will:

- Be open and transparent, providing opportunities and mechanisms for potential partners to ask questions
- Provide ways for the Innovation Center to share information regarding our expectations
- Rely on multi-stakeholder expertise and community engagement to select the most qualified partners

The Innovation Center will work closely with our partners as they implement new models. States and other payers will be invited to collaborate with us in testing models. The Innovation Center will engage in rigorous evaluation of models to assess the overall impact of a model and identify for which beneficiaries and under what conditions the model performs best. Models will be carefully monitored during the testing phase and participants will be required to share data that can inform the Innovation Center's understanding of how best to implement similar models and what modifications might be needed. In addition, all partners in Innovation Center efforts will be expected to participate in learning activities to share lessons learned from their care or payment model to improve their programs and in order to contribute to continuous system improvement.

The Innovation Center evaluation strategy focuses relentlessly on results requiring all models to meet the three-part aims – better healthcare, better health and reduced cost through improvement. Models may be modified or adjusted as they proceed based on lessons learned and statutory criteria. In addition, the Innovation Center will identify clear, objective benchmarks that, if not met, will lead to the termination of the testing and evaluation of a model.

Spread successful models

The Innovation Center will spread successful models through a variety of mechanisms. Under the legal authority that established the Innovation Center, the Secretary of Health and Human Services may, through formal rule-making processes, expand the duration and scope of a successful payment or delivery model that meets cost and quality tests to the entire Medicare, Medicaid, or CHIP programs. This process will allow CMS to speed the expansion of successful payment and delivery system changes more broadly through the Medicare, Medicaid, and CHIP programs.

In addition, the Innovation Center will employ a number of other methods for taking best practices to scale, including:

- Sponsoring structured learning activities (e.g., learning collaboratives, campaigns)
- Partnering with states, the private sector, and local communities
- Publicly reporting our results
- Publishing results in peer-reviewed and other journals
- Hosting an electronic community of innovators through the Center's website

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Innovation Center Portfolio Criteria
March 2011

To meet its aims, the Innovation Center seeks to have a portfolio of models that address a range of populations, issues, problems and potential solutions. While it is unlikely that any one model will meet all elements of the Portfolio Criteria, taken as a whole the Center's portfolio will reflect these priorities. The Innovation Center will test models of care that deliver better healthcare, better health at reduced costs through improvement.

> **Better healthcare:** improve individual patient experiences of care along the IOM 6 domains of quality: Safety, Effectiveness, Patient-centeredness, Timeliness, Efficiency, and Equity.
> **Better health:** encourage better health for entire populations by addressing underlying causes of poor health, such as physical inactivity, behavioral risk factors, lack of preventive care and poor nutrition.
> **Reduced costs:** lower the total cost of care resulting in reduced monthly expenditures for each Medicare, Medicaid or CHIP beneficiaries by improving care.

The Innovation Center seeks models that deliver better healthcare and better health at reduced costs AND:

- ***Have the greatest potential impact on Medicare, Medicaid, and CHIP beneficiaries, and the ability to improve how care is delivered nationally.*** The Innovation Center will sponsor a mix of models with particular attention to models that simultaneously address beneficiaries across multiple settings and programs. The goal of transforming health care means the Innovation Center will be mindful of how models align with and impact States, private payers and others as they are implemented.
- ***Focus on health conditions that offer the greatest opportunity to improve care and reduce costs.*** Many aspects of our health care system have room for improvement; the Innovation Center will focus on those health conditions which offer the greatest opportunity to improve the lives of patients, improve the quality of care and generate cost reductions.
- ***Address the priority areas in the National Quality Strategy.*** The Innovation Center seeks payment and delivery system change models that will address the six priority areas identified in the National Quality Strategy:
    - Making care safer by reducing harm caused in the delivery of care.
    - Assuring care that engages each person and family as partners.

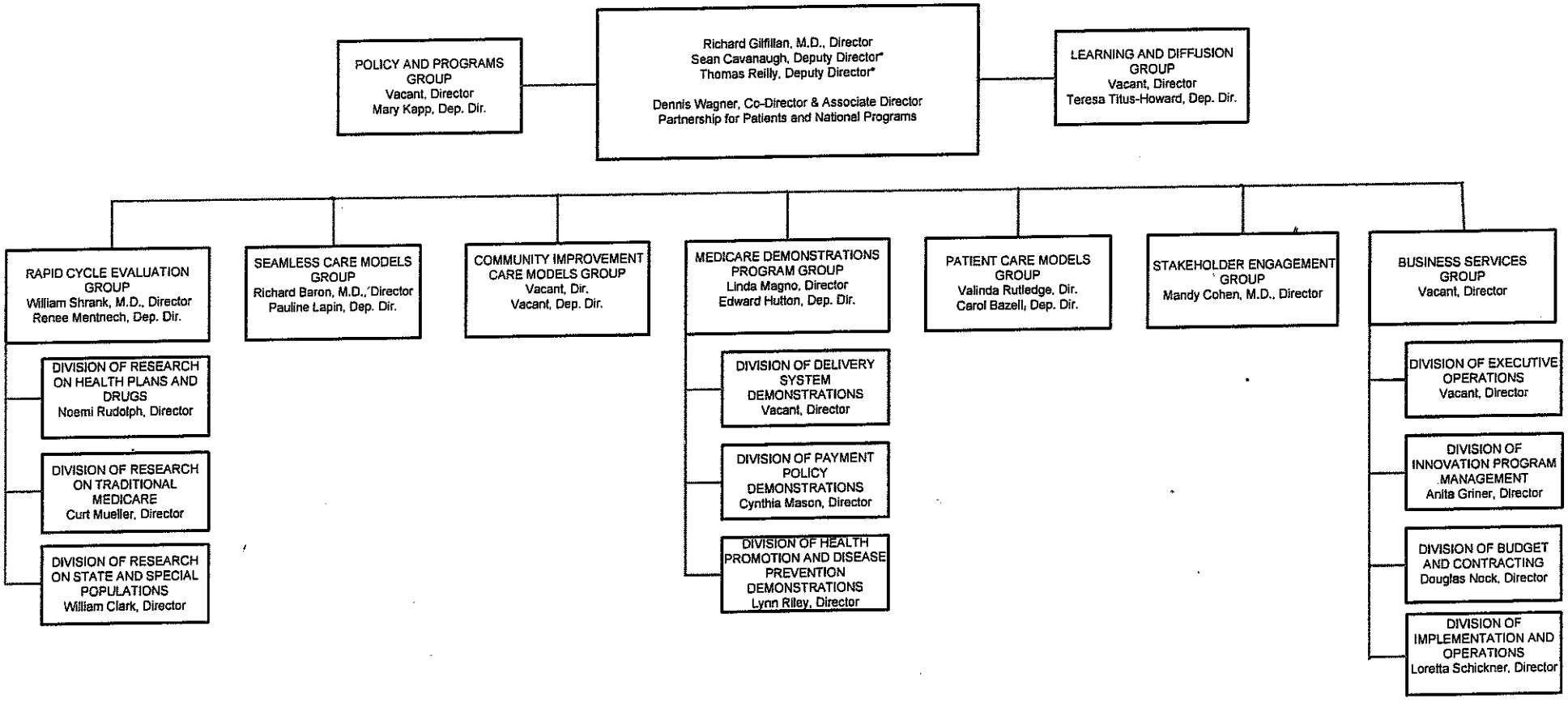
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote better health by enabling healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and disseminating new health care delivery models.

- ***Meet the needs of the most vulnerable and address disparities in care.*** The Innovation Center will sponsor models that specifically address the health and health care needs of the most vulnerable Americans. In addition, all models will be judged by their potential to reduce disparities of care – reflected in differences in how care is delivered and outcomes based on characteristics such as race, gender, income, education, sexual orientation, or cultural background.
- ***Improve existing Medicare, Medicaid and CHIP payments to promote better outcomes and patient-centeredness***. The Innovation Center will support payment and delivery system models that foster new ways to provide incentives to meet the three-part aim of better health, better care and reduced costs through improvement. In addition, the Innovation Center will actively seek ways to test and spread changes in existing payment methodologies that have the potential for near-term and immediate impacts on improving care and reducing costs through changes in health care payment.
- ***Are relevant across diverse geographic areas and states***. The Innovation Center recognizes that all health care is local. There are substantial differences that may impact payment and delivery system models depending on a variety of geographic factors including: the state they are located in, whether the service area is urban, suburban or rural, and others. Recognizing this diversity, the Innovation Center will sponsor models that span geographic areas or that may be specific to particular areas.
- ***Involve major provider types.*** The Innovation Center will test payment and delivery system models that involve all of the major providers of services to Medicare, Medicaid, and CHIP beneficiaries including the full range of clinicians and health care workers and the settings in which care is provided.
- ***Engage broad segments of the delivery system***. The Innovation Center will give particular consideration to payment and delivery system models that engage broad segments of the health care delivery system simultaneously, including multiple delivery settings, providers, purchasers, consumers and others who together are committed to making positive changes to transform health and health care delivery.
- ***Balance short-term and long-term investments***. The Innovation Center recognizes that some payment and delivery system models may take many years to demonstrate their success or to be shown ineffective, while other models have the potential to be proven in a relatively short timeframe (e.g., one year). The Innovation Center intends to have a portfolio that have a variety of likely time-periods for which fully developed evidence to either terminate or propose a model for expansion can be proven.

- ***Structured at a scale and scope consistent with the evidence.*** The Innovation Center will test promising models in a manner consistent with the evidence of their effectiveness. For concepts that need further development, the Innovation Center will support work to clarify models and articulate how they can be effectively tested. For those models that show high promise and have a clear path to begin testing – but for which there is limited evidence – the Innovation Center may conduct "proof of concept" tests. These tests will be sufficient to identify implementation issues and potential benefits, but may not provide evidence that would warrant the implementation of the model throughout the Medicare, Medicaid or CHIP program. For models that have significant evidence of their benefits and how they would be implemented, the Innovation Center will consider larger "tests to scale," which would involve sufficient numbers of participants, across multiple settings, to support an evaluation robust enough to determine whether they warrant national implementation.
- ***Consistent with Innovation Center and CMS capacity***. The Affordable Care Act provides CMS with dedicated resources and authority to support innovation, but these resources and the staff to support testing and assessment of models are finite. The Innovation Center will continually assess its capacity and that of CMS to effectively support, monitor, evaluate and spread lessons learned from models it considers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE AND MEDICAID INNOVATION

APPROVED LEADERSHIP
As of April 1, 2012
*** Acting**



CENTER FOR MEDICARE AND MEDICAID INNOVATION
January 2012

The Innovation Center oversees initiatives that are authorized and funded under various authorities. Staffing costs are paid out of the appropriate funding source. For example, staff funded through Affordable Care Act section 3021 (Social Security Act section 1115A) support only section 3021 models. Table 1 shows the number of FTEs by funding source. Table 2 shows the number of FTEs in each group, regardless of funding source.

TABLE 1: FTE BY FUNDING SOURCE

FUNDING SOURCE	FTEs
CMS Federal Administration Account	36
Affordable Care Act Section 3021	106
Affordable Care Act Section 10323	2
Affordable Care Act Section 3024	3
Affordable Care Act Section 3026	2
Affordable Care Act Section 3113	2
Affordable Care Act Section 4108	1
Affordable Care Act Section 4202	1
Affordable Care Act Section 5509	1
TOTAL FTEs	**154**

TABLE 2: FTE BY GROUP

JOB TITLE	SCHEDULE	GS	NUMBER OF FTEs
OFFICE OF THE DIRECTOR			
Director	SES	SES	1
Deputy Center Director	GS	15	1
Co-Director & Associate Director	SES	SES	1
Health Insurance Specialist	GS	15	1
Special Assistant	GS	14	1
Supervisory Medical Officer	GS	15	1
Office Support Assistant	GS	8	1
Total Number of FTEs			**7**
STAKEHOLDER ENGAGEMENT GROUP			
Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	13	2
Health Insurance Specialist	GS	12	1
Health Insurance Specialist	GS	9	2
IT Specialist	GS	12	1
Management Analyst	GS	13	1
Management Analyst	GS	11	1
Total Number of FTEs			**9**

JOB TITLE	SCHEDULE	GS	NUMBER OF FTEs
SEAMLESS CARE MODEL GROUP			
Supervisory Medical Officer	GS	15	1
Supervisory Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	15	3
Health Insurance Specialist	GS	14	1
Health Insurance Specialist	GS	13	3
Health Insurance Specialist	GS	11	3
Health Insurance Specialist	GS	9	2
Management Analyst	GS	9	1
Total Number of FTEs			**15**
RAPID CYCLE EVALUATION GROUP			
Supervisory Social Science Research Analyst	GS	15	4
Supervisory Medical Officer	GS	15	1
Social Science Research Analyst	GS	15	2
Social Science Research Analyst	GS	14	3
Social Science Research Analyst	GS	13	7
Social Science Research Analyst	GS	12	1
Supervisory Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	13	2
Health Insurance Specialist	GS	11	3
Senior Social Science Research Analyst	CC	4	1
IT Specialist	GS	13	1
Economist	GS	15	3
Economist	GS	14	1
Economist	GS	13	2
Social Science Trainee	GS	11	1
Management Analyst	GS	9	1
Total Number of FTEs			**34**
POLICY AND PROGRAMS GROUP			
Supervisory Social Science Research Analyst	GS	15	1
Health Insurance Specialist	GS	15	3
Health Insurance Specialist	GS	14	2
Health Insurance Specialist	GS	13	1
Total Number of FTEs			**7**
PATIENT CARE MODEL GROUP			
Health Insurance Specialist	GS	15	4
Health Insurance Specialist	GS	13	3
Health Insurance Specialist	GS	12	2
Health Insurance Specialist	GS	11	1
Total Number of FTEs			**10**

ATTACHMENT 12

JOB TITLE	SCHEDULE	GS	NUMBER OF FTEs
MEDICARE DEMONSTRATIONS GROUP			
Auditor	GS	14	1
Health Insurance Specialist	GS	15	2
Health Insurance Specialist	GS	14	1
Health Insurance Specialist	GS	13	9
Health Insurance Specialist	GS	11	1
Social Science Research Analyst	GS	15	2
Social Science Research Analyst	GS	14	4
Social Science Research Analyst	GS	13	4
Social Science Research Analyst	GS	12	1
Supervisory Health Insurance Specialist	GS	15	1
Supervisory Social Science Research Analyst	GS	15	2
Total Number of FTEs			**28**
LEARNING AND DIFFUSION GROUP			
Chief Medical Officer	CC	5	1
Senior Technical Advisor	CC	5	1
Supervisory Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	13	5
Health Insurance Specialist	GS	12	1
Health Insurance Specialist	GS	11	1
Health Insurance Specialist	GS	9	2
Management Analyst	GS	9	1
Total Number of FTEs			**14**
COMMUNITY IMPROVEMENT CARE GROUP			
Supervisory Health Insurance Specialist	GS	15	1
Health Insurance Specialist	GS	13	2
Total Number of FTEs			**3**
BUSINESS SERVICES GROUP			
Executive Officer	GS	14	1
Supervisory Health Insurance Specialist	GS	15	2
Supervisory IT Specialist	GS	15	1
Health Insurance Specialist	GS	14	2
Health Insurance Specialist	GS	13	7
Health Insurance Specialist	GS	11	3
Health Insurance Specialist	GS	9	3
IT Specialist	GS	14	2
Management Analyst	GS	14	1
Management Analyst	GS	13	2
Management Analyst	GS	12	1
Operations Specialist	GS	9	1
Office Support Assistant	GS	7	1
Total Number of FTEs			**27**
Total - FTEs			**154**

CENTER FOR MEDICARE AND MEDICAID INNOVATION
SAVINGS ESTIMATE ADDITIONAL DETAIL

Pioneer ACO Model: To develop an estimate for the ACO Pioneer Initiative, the Office of the Actuary leveraged research and modeling that was originally developed to assess the impacts of the proposed and final rule versions of the Medicare Shared Saving Program. The two initiatives are closely related in their reliance on voluntary provider agreements to accept financial incentives based on assessment of the efficiency and quality of care delivered to aligned beneficiaries within traditional fee-for-service Medicare. Because of significant uncertainties regarding the new and innovative program designs and uncertain provider responses, a stochastic model was chosen to incorporate the assumed probability distributions for each of a number of key variables. Using a Monte Carlo simulation approach, the model randomly draws a set of specific values for each variable, reflecting the expected covariance among variables, and calculates the program's financial impact based on the specific set of assumptions. The process is repeated for a total of 5,000 random trials, and the resulting individual cost or savings estimates are tabulated to produce a distribution of potential outcomes that reflects the assumed probability distributions of the incorporated variables.

In each trial, the estimated program net savings are a function of three financial outcomes from the model, which are detailed below:

(1) Gross savings assumed to be generated by participating ACOs relative to their underlying expenditure trends assumed in the absence of the program.

(2) Less the anticipated shared savings bonuses paid to ACOs (which could result from either real savings assumed in #1 or from random variation and/or bias affecting the ACOs' underlying expenditure growth patterns relative to the program's savings measurement formula).

(3) Plus any penalties paid by ACOs that experience measured losses (if applicable).

In addition to reviewing literature and examining empirical evidence where possible, much of the Actuary's assumption base was derived from expert opinion, including the experience of private payers and expert actuaries consulted through the American Academy of Actuaries. Because the Pioneer ACO Model and Shared Savings Program are so closely related in design and timing, the Actuary attempted to construct assumption ranges that appropriately reflected the interplay between the two initiatives. Assumptions included:

- Number and size mix of participating ACOs.
- Type of ACO that would consider accepting downside risk.
- Current preparedness for improving the quality and efficiency of care delivery.
- Baseline per-capita costs for prospective ACOs, relative to national average.
- Range of savings for participating ACOs over the course of the agreement period.
- Local variation in expected claims cost growth relative to the national average.

•Quality reporting scores and resulting attained sharing (or loss) percentages.

Relative to the Medicare Shared Savings Program, the Actuary anticipated that the Pioneer ACO Model would draw a more capable mix of providers in terms of near-term savings potential, in part due to the accelerated risk/reward offered by the Pioneer ACO Model.

A particularly important assumption that drives a shared-savings model is the degree of variability expected for local per-capita cost growth rates relative to the national average growth that is generally used to trend an ACO's expenditure target. Factors such as preexisting favorable expenditure trends can trigger shared savings payments even in the absence of any efficiency gains. Similarly, some ACOs could find that their hard-fought efficiency gains are overshadowed by extraneous factors that are not factored in to the program's savings formula. The Actuary's modeling was based on observing empirical expenditure patterns for beneficiaries grouped at a local level over six or more successive years. This data provided an empirical basis from which each stochastic trial could assume an underlying ACO expenditure growth pattern in the absence of participation in the program.

Advance Payment ACO Model: The Innovation Center asked the Office of the Actuary to model the savings that would be generated by the Advance Payment ACO Model that is in excess of what the Medicare Shared Savings Program would be expected to generate in the absence of the Advance Payment ACO Model. We expect that increased savings could be generated in three ways: by generating greater participation in the Medicare Shared Savings Program; by accelerating the rate of savings among ACOs receiving advance payments; and by increasing the magnitude of the savings generated by ACOs receiving advance payments.

The Actuary's estimates indicate that without the Advance Payment ACO Model the Medicare Shared Savings Program would generate $60 million less in Medicare savings over the first three performance periods (with a potential range of $0 to $80 million). These savings then have the potential to be compounded in future performance periods of Medicare Shared Savings Program because the Advance Payment ACO Model will have successfully introduced more participants into the ACO business model and the Medicare Shared Savings Program. The Actuary has not conducted modeling of long term impacts.

These savings will be weighed against the cost of operating the model. Assuming an average ACO size of 13,000 aligned beneficiaries, and that of the 50 ACO recipients, 30 will begin April ($84,240,000), and 20 will begin in July 2012 ($49,920,000), the Innovation Center tentatively estimates gross costs at $170 million over 27 months. Of that amount, the Actuary estimates a recoupment percentage of 59 percent, for a net cost just over $70 million. Another $5 million is needed for an evaluation of the model.

Thus, the most likely scenario is that the Advance Payment Initiative comes very close to budget neutral during the initial term of the Medicare Shared Savings Program ($60 million in additional savings generated leaving $10 million in costs not offset by recoupment or added savings to Medicare Shared Savings Program, plus $5 million in operating costs). More important, the ACOs brought into the Medicare Shared Savings Program by the Advance Payment Model could continue generating savings to the Medicare program after the initial term of the program and after they have stopped receiving advance payments.

Comprehensive Primary Care Initiative: The savings opportunity identified in Table 4 is based on an estimated gross savings of approximately $401 million, less costs of $261 million of care management payments to providers over five years. The care management fees are based on a per beneficiary per month payment for Medicare beneficiaries of $20 in the first two years and $15 in the last two years. Payments on behalf of Medicaid beneficiaries are estimated to average $5 per beneficiary per month in all years (actual payments are dependent on applications from States and will vary by State). Total enrollment is estimated to range from 330,750 in 2013 to 311,000 in 2016 for an average of 320,959 Medicare and Medicaid beneficiaries each year (enrollment is assumed to decline because of attrition). The savings percentage estimates increase over time and average about 4% over the duration of the model.

FQHC Advanced Primary Care Practice Demonstration: The $42 million in savings in Table 4 are based on an estimated gross savings of $84 million and payments to providers of $42 million (from 2011 to 2014). To calculate expenses, the Innovation Center assumed that 500 FQHCs and 195,000 beneficiaries would participate for three full years at a cost of $6 per beneficiary per month. The savings estimates were derived from modest reductions in average Part A and B costs ranging from 1% to 2% for Medicare beneficiaries in this demonstration. The demonstration will span four calendar years but will be operational for only 36 months.

Bundled Payment for Care Improvement: The Bundled Payments for Care Improvement initiative includes four different bundled payment models related to an acute care inpatient admission. Under each model, applicants propose a discounted price for the bundle of services. Anticipated Medicare savings are estimated by multiplying the expected number of episodes in each model by the difference between the expected episode payment and the discounted episode payment. Awardees will enter into a 3-year agreement, with the potential to extend the agreement for 2 additional years. All estimates assume that awardees will participate for 5 years.

The Innovation Center calculated savings opportunity analyses for each of the four models. Model 1 savings were estimated using a base assumption of 200 awardees and 9,000 annual episodes per awardee, with a discount increasing to 2.5% at year 3 ($2.1 billion). Model 2 savings were calculated using a base assumption of 30 awardees and 700 annual episodes per awardee, with a discount of 5% during all years ($117 million). Model 3 savings were calculated using a base assumption of 30 awardees and 700 annual episodes per awardee, with a discount of 7% during all years ($33 million). Model 4 savings were calculated using a base assumption of 50 awardees and 700 annual episodes per awardee, with a discount of 5% during all years ($156 million). The Innovation Center will update these estimates after it has had an opportunity to review applications to each of the four models.

Reducing Avoidable Hospitalizations Among Nursing Facility Residents: Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as "enhanced care & coordination providers") to implement evidence-based interventions that reduce avoidable hospitalizations. To implement a clinical intervention, CMS will pay operating entities a per facility fee, based on the number of target residents in each facility. Applicants will bid on the per facility fee and price will be among the competitive factors used to select operating entities. The Innovation Center anticipates making awards to approximately seven organizations and expects that the initiative would support implementation in approximately 150 nursing facilities with an average census of 150 residents.

Over four years, the total cost of the intervention will be capped at $128 million. An additional 5% is estimated for supplemental funds based on meeting operational, quality, and savings criteria totaling $6 million over four years. The total four year costs for implementing the intervention and supplemental funds will not exceed $134 million. The Innovation Center has worked with a contracted actuary on financial modeling. Implementation at 150 nursing facilities would reduce Medicare expenditures by $187 million, driven by reduction in costs for hospitalization, emergency department visits, and post-acute skilled nursing facility payments. Total Federal savings may be partly offset by modest increases in Medicaid spending (estimated at 0.4% per member per month). In summary, over four years, under the most likely case analysis, the clinical intervention is estimated to generate $45 million in net savings.

Strong Start for Mothers and Newborns: The Strong Start initiative consists of two different but related strategies to improve birth outcomes: a test of a nationwide public-private partnership and awareness campaign to reduce the rate of early elective deliveries for all populations; and a test of enhanced prenatal care approaches to reduce pre-term births in women covered by Medicaid.

The $75 million in estimated savings for the first component are based on achieving a 10% reduction in the rate of elective deliveries prior to 39 weeks (assuming a baseline rate of 9%) across all Medicaid births. Approximately 59% of these savings would accrue to the federal government and the remainder would accrue to states.

The $14 million estimate of savings for the second component of the Strong Start initiative are based on an estimated gross savings of $50 million and intervention-related payments to providers of $36 million. The payments are based on an assumption that 90,000 mothers would benefit from one of the enhanced prenatal care models at an average intervention cost of $400 per mother. To estimate savings, CMS assumed that clinical interventions would improve maternal and newborn outcomes for all baseline gestational age categories, but with varying levels of improvement for each group – i.e. pre-term babies born closer to full term would be easier to affect through these delivery models. Costs for each gestational age were drawn from a review of the literature with adjustments to account for Medicaid reimbursement policies.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of the Actuary

DATE: September 2, 2011

FROM: John D. Shatto
Thomas P. Nolan

SUBJECT: Analysis of the Partnership for Patients Initiative

Studies generally agree that significant unnecessary costs result from overuse, underuse, or misuse of health care (in both reduced quality and added expenditure). The Partnership for Patients initiative is focused on two such costly breakdowns in care delivery: (1) preventable harm inflicted on patients during hospitalization (termed *hospital-acquired conditions*, or HACs) and (2) poorly managed transitions between care settings, leading to an otherwise-preventable patient rehospitalization within 30 days of discharge.

These instances of inefficiency in health care delivery represent important opportunities for improving quality while potentially reducing the total cost of care. However, the improvements necessary to realize these opportunities are numerous, heterogeneous, and complex and often require dedication of significant organizational leadership and provider resources—virtually all of which are uncompensated by fee-for-service payment arrangements, which are the most common form of provider reimbursement. Payers (public and private) and proactive providers are beginning to engage in a wide range of efforts that are aimed, at least in part, at reducing preventable patient injury and/or rehospitalization. The Partnership for Patients program is defined as an effort to align private and public sector efforts to identify, test, incentivize, fund, or otherwise propagate such initiatives in an accelerated manner. This goal would be pursued in a number of ways, from direct Medicare and Medicaid interventions and demonstrations, to the funding of the development and dissemination of tools for care delivery improvement across a multitude of provider settings and patient populations.

Because the initiative depends on behavioral changes from providers that would be either voluntary, supported by private payers or public-private partnerships, or driven by private payer or Federal payment reforms or interventions (many of which are in the process of being designed), a comprehensive cost estimate is currently not feasible. In addition, certain preexisting efforts would be expected to account for a portion of any future reductions in costs, but these effects would be very difficult to differentiate from results specifically achieved by the Partnership for Patients initiative. For example, the Partnership for Patients program assumes the that multiple incentives for hospitals to improve care enacted in law, such as the Hospital Value-Purchasing Initiative and reductions in payments to hospitals based on their rate of HACs or avoidable readmissions, will be important contributors to changing hospital's behavior. As a result, our analysis is limited to three areas: (1) available evidence on the costs pertaining to avoidable hospital errors and preventable readmissions, (2) the reasonableness of the stated goals

for reductions and the illustrations of savings that would result from accomplishing those goals, and (3) examples of associated interventions currently announced or under development. We are not able to comment on any of the objectives related to saving lives.

Hospital-Acquired Conditions

Researchers have found the measurement of incidence of HACs to be challenging. A Society of Actuaries-sponsored claim study found that 7 percent of inpatient admissions resulted in medical injury, with an estimated 24 percent of such injuries due to medical error—but with the important caveat that many adverse events go unreported in claims data and that therefore the true injury rate may be as high as triple the measurable 7 percent.[1] An ensuing study found that expenditures associated with such measurable errors totaled over $17 billion in 2008.[2]

The risk is significant for Medicare beneficiaries, who are more likely to receive inpatient care than the population overall. The HHS Office of the Inspector General (OIG) estimated that 13.5 percent of fee-for-service beneficiaries receiving hospital care experience an adverse event (the rate is doubled if temporary harm is also included) and that 44 percent of such adverse and temporary harm events are preventable.[3] OIG also estimated that 3.5 percent ($4.4 billion) of Medicare inpatient expenditures for fiscal year 2009 were incurred because of adverse events. Further, $1.8 billion of such expenditures could have been avoided because the adverse events were preventable.

Therefore, evidence supports the initiative's assertion that the ultimate goal of a 40-percent reduction in preventable HACs would represent approximately $700 million in annual Medicare program savings. The stated goals are one-quarter, one-half, and full attainment of the 40-percent reduction in years 2011, 2012, and 2013, respectively. If these aims were achieved, Medicare would save an estimated total of at least $1.2 billion in program expenditures through 2013. Assuming that the ultimate goal (40 percent reduction) was sustained for each of the following 7 years, at least $6 billion in program expenditures would be saved over the full 10 years. We believe that these are reasonable illustrations of the potential gross Medicare savings from achieving the specified reductions in hospital-acquired conditions. The actual gross impact of meeting these goals could be even larger, as (1) the reduced cost of follow-up care was not included alongside the inpatient cost identified in the analysis, and (2) the illustrations make no adjustment for known or expected growth in program population, utilization, or price from the evidence baseline period, fiscal year 2009, to the intervention years. Conversely, the net Medicare savings from the Partnership for Patients initiative would be somewhat smaller than the gross savings, should Medicare provide administrative financial support for implementing improvement efforts. The cost of such support will depend on the specific interventions that are developed.

We believe that the goal of reducing preventable HACs by 40 percent is aggressive. There is an increasing array of CMS initiatives that provide substantial financial incentives to hospitals to

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[1] *The Economic Measurement of Medical Errors* (June 2010)
http://www.soa.org/Research/Research-Projects/Health/research-econ-measurement.aspx

[2] *The $17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors* (April 2011)
http://content.healthaffairs.org/content/30/4/596.full.pdf

[3] *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010)
http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

improve their performance, such that by 2015 an individual hospital may have a portion of their Medicare payments directly affected by their performance on quality metrics such as reducing HACs. However, while dramatic improvement in HAC rates has been demonstrated in specific hospitals and regions, the widespread improvement sought from this initiative would be unprecedented. Many of the initiatives designed to spread the knowledge of what works among America's hospitals to achieve this outcome have not yet been developed. As a result, reaching that goal by 2013 will be quite challenging.

Rehospitalizations

Avoidable rehospitalizations are found across the health care system, signaling deficiencies in quality of care for individuals and unnecessary expense for payers. We limited our review to Medicare fee-for-service beneficiaries, a population that is uniquely vulnerable because of a greater need for inpatient care, limited care-coordination across provider settings, and a reimbursement system that can, in some circumstances, lead to an inpatient stay of fewer days than might have been optimal.

The rehospitalization rate for Medicare fee-for-service beneficiaries is consistently found to be between 18 and 20 percent. The initiative's assumption for 2008—that roughly 2.6 million fee-for-service rehospitalizations were responsible for $26 billion in program expenditures—is reasonable in our view. Identifying *avoidable* readmissions, however, is more difficult. Various studies have estimated that between 12 and 90 percent of readmissions are avoidable, and MedPAC has estimated 75 percent. An observational study found that certain managed care plans had reduced the likelihood of readmission by 27 percent relative to Medicare fee-for-service.[4]

The Partnership for Patients initiative includes a $500-million investment called for under the Affordable Care Act (section 3026) to support improving transitions between care settings (for example, from a hospital discharge to the patient's home, with outpatient therapy services). By better monitoring and coordinating care across settings, providers may be able to prevent situations in which the patient would have to be readmitted as a result of inadequate discharge instructions, his or her failure to follow the prescribed drug, therapy, or other regimens, or other difficulties in treatment. In addition, the Partnership for Patients program hopes to achieve their goals by coordinating efforts across payers and through multiple initiatives, including the Medicare Shared Savings Program, medical home initiatives, and efforts of the Quality Improvement Organizations.

The initiative's goals are aggressive: to ultimately reduce all inpatient hospital readmissions by 20 percent. For fee-for-service Medicare beneficiaries, this goal equates to 500,000 fewer readmissions per year. Such a reduction would represent at least $9.2 billion in gross total Medicare fee-for-service savings over the first 3 years (2011-2013, with the goal phased in at $1.3, $2.6, and $5.3 billion for 2011, 2012, and 2013, respectively). If the objective can be met for 2014 through 2020, it would yield 10-year gross total Medicare savings in excess of $46 billion. The potential gross savings from successful implementation would be slightly greater than the illustrations above, as the designers of the initiative chose not to inflate baseline

[4] *The Benefits of Care Coordination: A Comparison of Medicare Fee-for-Service and Medicare Advantage* http://www.achp.org/files.php?force&file=front/JohnsHopkinsStudy-FinalReport.pdf

expenditures for expected growth in fee-for-service enrollment and per-readmission cost. Conversely, the net Medicare savings would be somewhat lower, reflecting the $500-million start-up funding and any other administrative expenditures in support of the initiative.

Context for Assessing Initiative Goals and Results

Together, the two facets of the Partnership for Patients initiative set a gross total goal for avoiding preventable Medicare expenditures of at least $10 billion, $22 billion, and $52 billion over 3, 5, and 10 years, respectively. Considerable evidence suggests that these goals are indeed possible, but we reiterate that achieving consistent improvement across all providers and patient populations will be very challenging, particularly if it must be done primarily through voluntary efforts. New initiatives are expected to change the financial incentives to providers, however it is not known to what extent these changes will cause providers to change their customary practices or adopt new methods of care. We are currently unable to estimate what the initiative will save relative to these goals primarily due to the uncertainty regarding the program's scope and because these interventions are still being developed.

Numerous existing initiatives across the health care system have aimed at reducing readmissions and HACs. In addition to traditional health maintenance organizations, patient-centered medical homes, accountable care organizations, and similar efforts that invest in care coordination virtually all cite the opportunity to reduce rehospitalizations and thereby generate significant savings for payers. Other interventions and demonstrations involving nursing facilities, care management for complex populations, and hospital and physician pay-for-performance (among many others) have been implemented or are planned under future Medicare, Medicaid, or other endeavors. Nearly all such interventions point to reducing readmissions and/or HACs as sources of savings that can offset investments. Attribution of savings to the Partnership initiative would depend heavily on the extent to which it could improve the efficacy of such interventions and/or hasten their adoption. Such parsing would be exceedingly difficult, if not impossible, given the influence that the program is likely to have on a wide spectrum of providers, patients, and existing efforts.

The Affordable Care Act contains two specific Medicare provisions that are directly related to the goals outlined in the Partnership for Patients program. OACT previously estimated over $3.2 billion in Medicare savings for fiscal years 2015-2019 stemming from reduced payments for HACs (section 3008, *Payment Adjustment for Conditions Acquired in Hospitals)*. In addition, a provision that reduces payment for excess readmissions (section 3025, *Hospital Readmissions Reduction Program*) initially will apply to three types (heart attack, heart failure, and pneumonia) where there is confidence that high rates of such rehospitalizations were caused by poor quality of care. For this provision, we previously estimated savings of $0.5 billion in 2013 and a total of $8.2 billion over 2013-2019. The savings estimated for these two provisions are largely due to reductions in payment rates, rather than reductions in harmful or unnecessary services, and are therefore not directly comparable to Partnership goals. However, the payment reductions represent incentives for providers to reduce HACs and readmissions and could enhance provider participation and effort in Partnership initiatives. Because these provisions rely on *relative* scoring of provider performance, payment reductions would likely still represent significant Medicare savings even if the Partnership program were to achieve its goals. Yet in

such cases it would be quite challenging to estimate the portions of cost reductions attributable to the Affordable Care Act payment incentives versus the Partnership endeavors.

As noted earlier, additional Medicare initiatives that may generate savings for reductions in readmissions and/or HACs include the following:

- Medicare Shared Savings Program (Affordable Care Act section 3022): The proposed rule was estimated to result in over $500 million in net Federal savings (2012-2015) after bonuses are paid to providers, although the portion of gross savings resulting from readmissions and/or HACs was not explicitly projected. (The specific design parameters for this program will be established in the final regulation, and the estimated savings may differ accordingly.)
- Multi-Payer Advanced Primary Care Practice Demonstration: This demonstration is in development and will partner with providers in up to eight States to improve primary care coordination with possible savings from reduced readmissions.
- The CMS Center for Medicare and Medicaid Innovation (CMMI) has released a proposal for agreements with accountable care organizations in a similar relationship to the Medicare Shared Savings Program, but with more aggressive risk/reward arrangements. These arrangements are expected to generate material savings, although the portion attributable to HACs and/or readmissions was not separately estimated.
- CMMI is currently designing numerous additional demonstrations.
- Other relevant programs include Medicaid Health Homes and those promoting electronic health records, efforts of Quality Improvement Organizations, and reduced payments for "never events."

In conclusion, we believe that the illustrative gross Medicare savings that could be realized by achieving the goals for reductions in preventable HACs and rehospitalizations, as identified by the Partnership for Patients initiative, are reasonable. However, we are unable to estimate the actual savings that should be expected since the specific initiatives to accomplish these goals have not yet been fully developed. Also, it will be very difficult to distinguish among the various contributing programs and initiatives in determining the reasons for an ultimate decrease in HAC and readmission rates.

Because of the many challenges in generating consistent, sustained improvement across virtually all providers, reaching the stated goals, especially by 2013, is unlikely. That said, we fully support the Partnership program's goals and applaud all efforts to promote higher quality of care that reduces the incidence of harm to hospitalized patients and prevents the need for rehospitalization. Both areas represent important opportunities to improve outcomes for beneficiaries and to simultaneously enhance program value and efficiency.

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