Centers for Medicare & Medicaid Services

Center for Medicare and Medicaid Innovation

REPORT TO CONGRESS

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The Center for Medicare and Medicaid Innovation

1. Executive summary

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

The statute requires that the Secretary of Health and Human Services submit to Congress a report on the Innovation Center's activities at least once every other year, beginning in 2012. This report covers activities between January 1, 2011 and October 31, 2012. During that time, the Innovation Center announced 14 initiatives under the authority of section 1115A of the Social Security Act (Appendix 1). Interest in these initiatives has been significant and the level of public and provider engagement has been high. Hundreds of ideas for improvement in care delivery and payment have been shared with the Innovation Center through its web site. One initiative – the Health Care Innovation Awards – received almost 3,000 applications.

The Innovation Center's portfolio of initiatives has attracted participation from a broad array of health care providers, states, payers and other stakeholders and affects Medicare, Medicaid and CHIP beneficiaries in all fifty states and the District of Columbia. We currently estimate that over 1 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care furnished by the more than 50,000 providers participating in these Innovation Center initiatives (Table 1). As required by the statute, each of these initiatives are expected to reduce program expenditures in Medicare, Medicaid, and CHIP, over the life of the model while maintaining or improving the quality of care received by beneficiaries.

All of the Innovation Center initiatives addressed in this report are in the early stages of implementation and testing and, as a result, have not yet generated sufficient data to make a determination of impact on care improvement and cost. Consequently, this report does not include any recommendations for legislative action to facilitate the development or expansion of successful models.

2. Introduction

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits. Congress provided the Secretary of Health and Human Services with the authority to expand the scope and duration of a model being tested through rulemaking, including the option of testing on a nationwide basis. In order for the Secretary to exercise this authority, a model must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits. These determinations are made based on evaluations performed by the Centers for Medicare & Medicaid Services (CMS) and the certification of CMS's Chief Actuary with respect to spending.

The law also requires that models tested by the Innovation Center shall be modified or terminated, unless the Secretary determines (and the CMS Chief Actuary certifies, with respect to spending) after testing has begun that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending.

The Innovation Center is organized to support the development and testing of new payment and service delivery models, as well as support CMS's additional demonstration and research requirements. To better coordinate initiatives, demonstrations, and research projects at CMS and to prevent duplication of effort and expense, the former Office of Research, Development and Information was merged with the Innovation Center in early 2011. As a result, the Innovation Center oversees not only initiatives that are authorized under section 3021 of the Affordable Care Act, but also activities under several other authorities, including other provisions of the Affordable Care Act or other laws, and certain projects authorized under section 402 of the Social Security Amendments of 1967 as amended. Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination and more efficient operations.

The Innovation Center works closely with the Center for Medicare, the Center for Medicaid and CHIP Services, the Federal Coordinated Health Care Office (known as the Medicare-Medicaid Coordination Office), and other CMS components and colleagues throughout the federal government. This collaboration helps the Innovation Center effectively develop and test new models as well as execute mandated demonstrations.

Innovation Center priorities and accomplishments: 2011— 2012

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

- developing and testing new payment and service delivery models,
- effectively developing and managing congressionally mandated and authorized demonstrations and related initiatives,
- rapidly evaluating results and advancing best practices, and
- engaging a broad range of stakeholders to develop additional models for testing.

Test new payment and service delivery models

New payment and service delivery models are developed by the Innovation Center in accordance with the requirements of section 1115A of the Social Security Act and in consideration of the suggestions outlined in the legislation. During the development of models, the Innovation Center builds on the ideas received from stakeholders and consults with clinical and analytical experts, as well as with representatives of relevant Federal agencies as required by the statute. For example, during the development of the Strong Start for Mothers and Newborns initiative, the Innovation Center consulted extensively with the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC) and the Administration for Children and Families (ACF), as well as with various stakeholders, including the March of Dimes and the American Congress of Obstetricians and Gynecologists, to develop strategies to reduce early elective deliveries and identify enhanced prenatal care models to test.

The Innovation Center solicits and selects organizations to participate in model tests through open processes. The process follows established protocols to ensure that it is fair and transparent, provides opportunities for potential partners to ask questions regarding the Innovation Center's expectations, and relies on multi-stakeholder input to inform selection of the most qualified partners. The Innovation Center does not fund unsolicited proposals, but does use such ideas to inform model development.

Conduct congressionally mandated or authorized demonstrations and related activities

Congress has assigned – both through the Affordable Care Act and previous legislation – a number of specific demonstrations to be implemented by CMS. For example, the Independence at Home Demonstration was authorized by section 3024 of the Affordable Care Act and the Medicaid Emergency Psychiatric Demonstration was authorized by Section 2707 of the Affordable Care Act.

Some of these demonstrations are designed to test improvements in care delivery and payment. Others are designed to confirm findings from previous demonstrations or to help monitor the effectiveness of Medicare, Medicaid, and CHIP. These activities are funded by specific statutory authorities and are conducted by the Innovation Center. The findings from these demonstrations will inform possible changes in health care payment and policy, as well as the development and testing of new models when necessary or appropriate.

The Innovation Center staff has managed 23 statutorily prescribed active demonstrations during the period between January 1, 2011 and October 31, 2012. A full listing of all demonstrations active during the relevant time period is included in Appendix 1.

Evaluate results and advance best practices

The statute requires the Innovation Center to conduct an evaluation of each new payment and service delivery model tested. The statute also specifies that measures in each evaluation must include an analysis of the quality of care furnished under the model (including the measurement of patient-level outcomes and patient-centeredness criteria) as well as changes in spending. In order to expand the scope or scale of a model tested by the Innovation Center, the Secretary must determine that such expansion is expected to reduce spending under Medicare, Medicaid or CHIP without reducing the quality of care, or improve the quality of patient care without increasing spending. In expanding the scope or scale of any model, the coverage or provision of benefits cannot be denied or limited. Before any expansion can take place, the CMS Office of the Actuary must certify that expansion of the model would reduce – or not result in an increase in – net program expenditures.

The Innovation Center's Rapid Cycle Evaluation Group assesses each model's impact regularly and frequently – without compromising the rigor of the model testing and evaluation process – to identify successful programs as quickly as possible. To evaluate models, the evaluation group employs advanced statistical methods, carefully defines and selects comparison groups and applies conservative evidence thresholds to assure that programs deemed to be successful represent high-value investments of taxpayer dollars.

Central to this evaluation approach is the recognition that evaluators must not only assess results, they must also understand the context that allows for those results. For each model, the Innovation Center collects qualitative information about provider practices, organizational characteristics and their systems of practice. This information also includes participants' perceptions regarding the opportunities they faced, the enablers of and barriers to change they encountered, and how well their experience went. These data are merged with performance metrics to allow evaluators to assess what features of interventions are associated with successful outcomes.

In addition to the rigorous evaluation of the impact of each model on outcomes of interest, the Innovation Center provides frequent feedback to providers who participate in each model in order to support continuous quality improvement, with the understanding that learning and adaptation are essential to enable providers and health systems to achieve the greatest efficiencies and improvements possible in each new payment model. The Innovation Center leverages claims data to deliver actionable feedback to providers about their performance, and encourages participating providers to use their own performance data to drive continuous improvement in their outcomes.

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

Engage stakeholders

The Innovation Center has actively sought input from a broad array of stakeholders from across the country. Since its formation, the Innovation Center has held numerous regional meetings and "listening sessions," engaging thousands of innovators from around the country. In addition, hundreds of ideas for improving health care have been shared with the Innovation Center through the Innovation Center web site. The result is a growing portfolio of innovative service delivery model tests, with the support and participation of over 50,000 health care providers, over 3,700 hospitals, and Medicare, Medicaid and CHIP beneficiaries nationwide.

The Innovation Center has also sought input from experts and stakeholders in the design of individual models. For example, the Innovation Center held open door sessions for obstetrical providers to provide input on the Strong Start initiative. Every Innovation Center model has similarly benefitted from broad stakeholder input and information sharing derived from webinars, open door conference calls, and other venues for communication.

The Innovation Center has also worked to widen opportunities for health care system transformation by creating a network of Innovation Advisors. In December 2011, 73 Innovation Advisors were selected from a nationwide pool of applicants to work with the Innovation Center in testing and refining new models to drive delivery system reform. These advisors utilize their own knowledge and skills in addition to lessons learned from each other and from learning sessions sponsored by the Innovation Center to benefit their home organizations and communities by improving health, improving care, and lowering costs

through continuous improvement. They work with other local organizations or groups to improve care delivery and serve as a field task force for developing and testing new service delivery and payment models, and effectively diffusing knowledge.

In addition to these activities, the Innovation Center actively engages all willing innovators through its website, social media outreach, and an email listserv that reaches an audience of over 30,000 people across the country who are interested in innovations in health care delivery and payment.

3. Review of Innovation Center activities

To date, the Innovation Center has introduced a range of initiatives – involving a broad array of health care providers, states, payers and others stakeholders – that will touch the lives of Medicare, Medicaid and CHIP beneficiaries in all fifty states and the District of Columbia. In all initiatives, beneficiaries retain access to all of their regular Medicare benefits and remain free to select the providers and services of their choice.

The initiatives highlighted in this section include only models authorized by section 3021 of the Affordable Care Act. A full listing of all activities being managed under the Innovation Center, and the specific statutory authority for each is included in Appendix 1. Each of these models will be comprehensively evaluated for their effects on quality and costs as described above.

Innovation Center initiatives fall into a number of categories:

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

Primary care transformation

Primary care providers are a key point of contact for patients' health care needs. Strengthening primary care is critical to promoting health and reducing overall health care costs. In recent years, new ways have emerged to expand primary care to create the capacity for population-based care and care coordination. Advanced primary care practices – also known as "medical homes" – utilize a team-based approach, while emphasizing prevention,

health information technology, care coordination and shared decision making among patients and their providers.

The Innovation Center has developed a broad portfolio of initiatives to test the ability of these new models to improve quality and reduce the cost of care. These include the following:

The Comprehensive Primary Care initiative

The Comprehensive Primary Care Initiative is a multi-stakeholder collaboration between public and private payers and primary care practices to test an expanded model of patient-centered primary care in communities across the country. Primary care practices will receive new public and private funding for primary care functions not currently supported by visit-based fee-for-service (FFS) payments.

Initially, the Innovation Center pays participating practices a monthly care management fee on behalf of Medicare FFS beneficiaries and, in participating markets, Medicaid FFS beneficiaries. Beginning in the third year of the initiative (2014), the model will offer each participating practice the opportunity to share net savings generated from improved care for Medicare beneficiaries attributed to the practice. Participating practices provide patients 24-hour access to care, create care management plans for high risk patients attributed to their practice, and build systems to coordinate with other providers.

In developing the Comprehensive Primary Care initiative, the Innovation Center drew upon research from the Medicare Patient Centered Medical Home demonstration (http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1199247.html) that started in 2006 and on previous CMS experience with other primary care improvement initiatives. The Innovation Center then invited other public and private payers individually to propose their own support models for comprehensive primary care.

Once applications were received from payers, local markets were selected in which a preponderance of the payers, including Medicare, were willing to align their approaches to increase support to primary care practices offering the advanced primary care model as defined by CMS. The Innovation Center ultimately selected seven markets with a total of 43 participating payers. Participating payers receive no payment under the Comprehensive Primary Care initiative, only the assurance that they will be investing alongside CMS and other payers within the community to obtain the comprehensive model of care described in the solicitation.

The seven selected markets, which all have multiple payers including private health plans, state Medicaid agencies (in select markets), and employers willing to participate, are as follows:

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

After selecting these markets, the Innovation Center then released a solicitation for primary care practices located in these geographic areas participating in the initiative. The solicitation deadline was July 20, 2012. On August 22, 2012, the Innovation Center announced that 500 practices will participate in the initiative. On October 1, 2012, participating practices in Arkansas and Oklahoma began implementing their care improvements. CMS began making payments to participating practices in Arkansas and Oklahoma under this initiative in late October 2012.

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

Under the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, the Innovation Center is testing whether implementing a medical home model within FQHCs can improve the quality of care and reduce costs for the Medicare beneficiaries they serve. Participating FQHCs are expected to achieve "level three" patient-centered medical home recognition, as defined by the National Committee for Quality Assurance (NCQA). More information about NCQA's criteria can be found at http://www.ncqa.org/tabid/631/Default.aspx. To help participating FQHCs make these investments in patient care and infrastructure, they are paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. CMS is partnering with HRSA to provide technical assistance to help the FQHCs achieve these goals. In October 2011, 500 FQHCs in 44 states were selected to receive approximately $42 million over three years to achieve NCQA level three Patient Centered Medical Home recognition.

Accountable Care Organizations (ACOs)

The Innovation Center is currently testing two Accountable Care Organization (ACO) models, the Pioneer ACO Model and the Advance Payment ACO Model. These ACO models are designed to incentivize heath care providers to become accountable for a patient population and to invest in infrastructure and redesigned care processes for high quality and efficient service delivery.

Pioneer ACO model

The Pioneer ACO Model tests the ability of hospital and physician organizations experienced

in care and risk management to achieve savings for Medicare while sustaining or improving the quality of care for beneficiaries. The model tests payment arrangements that hold providers accountable for the cost, quality, and patient experience outcomes for a defined population of beneficiaries. Participating organizations have agreed to enter into similar outcomes-based arrangements with other private sector payers as well as Medicare, thus fully committing to improving care for all the patients that they serve.

The Pioneer ACO Model also includes strong patient protections to ensure that patients have access to and receive high quality care. In addition, the performance of Pioneer ACOs on quality metrics, including patient experience ratings, will be publicly reported. In this model, CMS will evaluate the extent to which Pioneer ACOs improve the health and experience of care for individuals, improve the health of populations, and reduce the rate of growth in health care spending.

Beginning January 1, 2012, thirty-two organizations are participating in the Pioneer ACO Model, serving more than 750,000 Medicare beneficiaries.

Advance Payment ACO models

The Advance Payment ACO model is testing whether pre-paying a portion of future shared savings will allow more entities such as physician-based and rural ACOs to create savings for the Medicare program through successful participation in the Medicare Shared Savings Program. In the Shared Savings Program, groups of Medicare enrolled providers, including those that provide primary care services, may come together as ACOs to improve care coordination for Medicare beneficiaries. These ACOs are eligible to share in any savings that result, as long as they also meet quality performance standards. The Advance Payment ACO model provides support to smaller organizations whose ability to improve care and lower costs would be enhanced with access to capital made available in the form of an advance on the shared savings they are expected to earn after investments in infrastructure and staff are in place. This model will test the extent to which providing an advance on future shared savings (in the form of up-front and monthly payments to be repaid in the future) will increase participation in the Shared Savings Program, generate Medicare savings more quickly, and increase the amount of Medicare savings.

Twenty ACOs are participating in the testing of the Advance Payment ACO Model in 2012. In addition, ACOs applying to start in the Shared Savings Program in January 2013 are also eligible to apply to participate in the testing of the model.

Bundled Payments for Care Improvement

Medicare currently makes separate payments to various providers for the services they furnish to the same beneficiary for a single illness or course of treatment (an episode of care),

a practice which can lead to fragmented care with minimal coordination across heath care settings. Offering these providers a single, bundled payment for an episode of care makes them jointly accountable for the patient's care. It also allows providers to achieve savings based on effectively managing resources as they provide treatment to the beneficiary throughout the episode.

The Bundled Payments for Care Improvement initiative is preparing to test four models for bundling acute and post-acute care payment by episode of care. The model options would allow participating organizations considerable choice among clinical conditions and services to be included and financial risk to be assumed. The four models are:

- **Retrospective Acute Care Hospital Stay Only (Model 1):** Under Model 1, hospitals will be allowed to "gainshare" savings obtained by working with participating physicians and other practitioners to improve care during an acute care hospital inpatient stay. The episode of care for this model is the inpatient stay for all Medicare fee-for-service beneficiaries admitted to a participating acute care hospital regardless of the assigned Medicare Severity Diagnosis Related Group (MS-DRG). Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System. Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule. Hospitals will be allowed to share the gains with physicians and other practitioners if there are savings in the cost of inpatient care and key quality targets are also met.
- **Retrospective Acute Care Hospital Stay plus Post-Acute Care (Model 2):** This model extends the episode of care beyond the acute care inpatient hospitalization to include post-acute care following and associated with the hospitalization. The episode of care is based on the reason for hospitalization and only includes selected MS-DRGs. The episode includes services provided by the hospital, participating physicians, certain post-acute care providers, as well as other Medicare-covered items and services provided during the inpatient hospital stay and following discharge. Awardees must offer Medicare a discount based on the episode's historical cost, which will be used to determine a target price for the episode. The model is administered retrospectively in that Medicare will continue to pay each provider participating in the episode under the applicable fee-for-service payment system. After the episode of care concludes, the aggregate Medicare expenditures for the episode will be reconciled against the predetermined target price for the episode. If aggregate Medicare expenditures are less than the target price, Medicare will pay the difference to the awardee to share among participating providers, assuming certain quality targets are met. If aggregate Medicare expenditures exceed the target price, the awardee must repay Medicare.

- **Retrospective Post-Acute Care (Model 3):** This model will test bundled payment for an episode of care consisting of post-acute care following an acute care hospital inpatient stay. In this model, the initial inpatient hospital stay is not included in the episode. The episode of care begins with the initiation of post-acute care services following discharge from an acute care hospital for selected MS-DRGs. The episode of care includes physician services, hospital readmissions, services furnished by certain post-acute care providers, as well as other Medicare-covered items and services during the episode. The payment methodology for this model includes the reconciliation of aggregate Medicare fee-for-service expenditures for the episode with a predetermined discounted target price.
- **Prospective Acute Care Inpatient Hospital Stay Only (Model 4):** In this model, the episode of care includes all services, including physician services, furnished during the inpatient hospital stay only. CMS will make a single, prospectively determined bundled payment to the hospital that will encompass all of these services, including physicians' services, for selected MS-DRGs and that will incorporate a discount rate proposed by the awardee. Physicians and other practitioners will submit "no-pay" claims to Medicare for covered services furnished as part of the episode and will be paid by the hospital directly from the bundled payment. Participants will be permitted to share gains arising from better coordination of care if specified quality targets are met.

In each of these models, specific measures will be used to evaluate the impact of the bundled payment on the clinical outcomes and total cost associated with the episode of care. Applications for the Bundled Payments for Care Improvement initiative were due by June 28, 2012. The Innovation Center is reviewing the applications and working with applicants to finalize the specific episodes to be tested.

Initiatives focused on the Medicaid and CHIP populations

Strong Start for Mothers and Newborns

Nationwide, approximately 12 percent of infants are born prematurely, a 36 percent increase over the last 20 years. This is a growing public health problem with significant health and financial consequences for families. At the same time, up to 15 percent of all babies are electively delivered prior to 39 weeks without medical indication, despite long established evidence that elective deliveries prior to 39 weeks significantly increase the risk of complications.

Strong Start for Mothers and Newborns is a national initiative to improve birth outcomes, using two complementary strategies:

- **Strategy 1**: Tests a learning collaborative model to encourage the adoption of best practices to reduce early electives deliveries prior to 39 weeks; and
- **Strategy 2:** Tests enhanced prenatal care interventions to reduce preterm births in women covered by Medicaid or CHIP who are at high risk for pre-term birth.

Strategy 1 consists of three distinct activities: spreading best practices, promoting awareness and promoting transparency. To help speed and spread the adoption of best practices that reduce early elective deliveries, this initiative is building on the efforts and infrastructure of the Partnership for Patients, and the commitment of the nearly 4,000 participating institutions. A more detailed description of the Partnership for Patients in included later in this report. CMS has worked with the Partnership for Patients' 26 Hospital Engagement Networks to establish measurable goals for participating hospitals and is providing all participating hospitals with technical assistance in adopting proven strategies and practices for reducing early elective deliveries.

CMS is supporting broad-based awareness efforts through visible partnerships with leading organizations, including the March of Dimes and the American Congress of Obstetricians and Gynecologists, as well as other professional and advocacy organizations. In addition to supporting industry wide efforts to develop and publish data on early elective deliveries, the Hospital Engagement Networks are supporting participating hospitals efforts to collect data, measure success and promote quality improvement and transparency.

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

- **Enhanced Prenatal Care through Centering/Group Visits** – Group prenatal care that incorporates peer-to-peer interaction in a facilitated setting for health assessment, education, and additional psycho-social support.

- **Enhanced Prenatal Care at Birth Centers** – Comprehensive prenatal care facilitated by teams of health professionals including peer counselors and doulas. Services include collaborative practice, intensive case management, counseling and psycho-social support.

- **Enhanced Prenatal Care at Maternity Care Homes** – Enhanced prenatal care including psychosocial support, education, and health promotion in addition to traditional prenatal care. Services provided will expand access to care, improve care coordination and provide a broader array of health services.

The Innovation Center is also partnering with HRSA and ACF to evaluate the impact of a fourth intervention: enhanced prenatal care through home visiting. This intervention is

currently being tested by ACF as part of the existing Maternal, Infant, and Early Childhood Home Visiting program.

CMS will evaluate the impact of these models on both the rate of pre-term birth, birth weight and other specific indicators of improved birth outcomes.

Applications for the Strong Start funding opportunity were due on August 9, 2012, with award decisions anticipated in early 2013.

Initiatives focused On Medicare-Medicaid enrollees

The Medicare and Medicaid programs were designed with distinct purposes. As a result, there are often barriers that prevent beneficiaries enrolled in both programs (Medicare-Medicaid enrollees) from receiving coordinated, high-quality, and cost-efficient care. Today, there are over nine million low-income seniors and people with disabilities who are Medicare-Medicaid enrollees. These individuals must deal with multiple rules, benefits, insurance cards and providers to access care across multiple programs (Medicare Part A and B or Medicare Part C, Medicare Part D, and Medicaid). Many have complicated and complex health care needs and, as a result, account for a disproportionate share of the programs' expenditures. There are opportunities to strengthen the Medicare and Medicaid programs for Medicare-Medicaid enrollees by addressing inefficiencies and misaligned incentives. A fully integrated, person-centered system of care that ensures that all their needs – primary, acute, long-term care, prescription drug, behavioral and social — are met could better serve this population in a high quality, cost effective manner.

Section 2602 of the Affordable Care Act established the Federal Coordinated Health Care Office (also known as the Medicare-Medicaid Coordination Office) to more effectively integrate program services and improve the coordination between the Federal government and states for Medicare-Medicaid enrollees. Working together, the Innovation Center and the Medicare-Medicaid Coordination Office have created new opportunities to develop, test, and rapidly deploy innovative and effective care models for Medicare-Medicaid enrollees. These new opportunities and supports to better coordinate care for Medicare-Medicaid enrollees include the following:

- State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees;
- Financial Alignment Initiatives;
- Initiative to Reduce Preventable Hospitalization among Nursing Facility Residents

These initiatives are designed to improve the overall beneficiary care experience and coordination of services while addressing inefficiencies in care delivery. More information about the Medicare-Medicaid Coordination Office and supporting initiatives is available at

http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html.

State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees

In April 2011, CMS awarded 15 states up to $1 million each to design person-centered approaches to coordinate care across primary, acute, behavioral health, prescription drugs, and long-term support services for Medicare and Medicaid enrollees. CMS awarded these design contracts to the following states:

- California
- Colorado
- Connecticut
- Massachusetts
- Michigan
- Minnesota
- New York
- North Carolina
- Oklahoma
- Oregon
- South Carolina
- Tennessee
- Vermont
- Washington
- Wisconsin.

These states were selected to develop new ways to meet the often complex and costly needs of Medicare-Medicaid enrollees. Subsequent to their awards, all 15 states submitted a demonstration proposal to CMS, the majority of which are consistent with one of the two models offered in the Financial Alignment Initiative described below. CMS will work with the states to evaluate the potential for each individual model to succeed in improving the care received by Medicare-Medicaid recipients and reducing the total cost of care to both CMS and states.

Financial Alignment Initiative

In July 2011, CMS announced the Financial Alignment Initiative, a federal-state partnership to test alignment of the service delivery and financing between the Medicare and Medicaid programs to provide better care for Medicare-Medicaid enrollees. The initiative seeks to address barriers to better care coordination for this population that result from financial misalignment between the two programs. For example, the current system provides little incentive for state Medicaid programs to invest in care coordination for services, particularly acute medical care for which Medicare is the primary payer. State-led care improvement efforts can decrease hospitalization, emergency department utilization, and skilled nursing care but the resulting savings are believed to primarily accrue to the Medicare program and not to the states.

CMS provided states with two possible models – capitated and managed fee-for-service – to partner with the federal government to better integrate care for Medicare-Medicaid enrollees and address this misalignment. Both models are designed to achieve both state and federal

health care savings by improving health care delivery and encouraging high-quality, efficient care. CMS is fully committed to an open and transparent process for these Demonstrations. As a result, a robust public engagement process was required as part of the Demonstration proposal process, including the posting of proposals on both state and CMS sites for a public comment periods. In addition, states held public forums, workgroups, focus groups, and other meetings to obtain public input on the development of their demonstration proposal. As required by law, CMS will conduct an evaluation of the model to analyze changes in spending as well as the impact on quality of care.

On August 23, 2012 CMS announced a memorandum of understanding with the State of Massachusetts to test a capitated model and on October 25, 2012, CMS announced a memorandum of understanding with the state of Washington to test a managed fee-for-service model. On December 12, 2012 CMS announced a memorandum of understanding with the state of OH.[1]

Initiative to Reduce Preventable Hospitalization among Nursing Facility Residents

Nursing facility residents are subject to frequent preventable inpatient hospitalizations. These hospitalizations are expensive, disruptive, disorienting, and often dangerous for frail elders and people with disabilities. A 2005 study of hospitalizations that were associated with beneficiaries receiving either Medicare skilled nursing facility services or Medicaid nursing facility services found that approximately 45 percent of the hospitalizations were potentially avoidable.[2] Combined Medicare and Medicaid costs for these approximately 314,000 potentially avoidable hospital admissions totaled $2.7 billion per year, and Medicare costs accounted for $2.6 billion of that total, demonstrating opportunities for improvements in quality and costs.[3]

Under this model, CMS has competitively selected and partnered with independent organizations that will provide enhanced clinical services to beneficiaries in approximately 150 nursing facilities. Interventions will be targeted to long-stay, Medicare-Medicaid enrollees in nursing facilities with a preference for implementation in locations with high Medicare costs and high rates of potentially avoidable hospitalizations. In this test, CMS will evaluate the effectiveness of these evidence-based interventions in reducing the number of avoidable hospitalizations for nursing home residents, while also lowering the total cost of care. Applications for this initiative were due June 14, 2012. CMS received applications from organizations in 29 states, including health plans, hospitals, Area Agencies on Aging,

[1] This announcement occurred after the close of the reporting period (10/31/2012) for this report, but prior to publication and was subsequently included.

[2] Walsh, E., Freiman, M., Haber, S., Bragg, A., Ouslander, J., & Wiener, J. (2010). *Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community Based Services Waiver Programs.* Washington, DC: CMS.

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Insight-Briefs/downloads/pahinsightbrief.pdf

hospice groups, and other types of care management organizations. On September 27, CMS announced seven organizations selected to participate in this initiative.

Initiatives to speed the adoption of best practices

The Partnership for Patients

The Partnership for Patients is a public-private partnership that is improving the quality, safety, and affordability of health care for Medicare, Medicaid, and CHIP beneficiaries as well as patients of private payers. Through the Partnership's three-year national campaign, the Innovation Center is partnering with hospitals, patients, physicians, nurses, front-line staff, home and community based service providers, consumer and patient advocacy groups, employers, health plans, professional and medical societies, hospital associations, state health departments, and numerous federal agencies to test new models for disseminating evidence-based best practices. Two aims of the partnership are to:

- keep patients from getting injured or sicker – reducing preventable hospital-acquired conditions by 40 percent, and
- help patients heal without complication -- reducing 30-day hospital readmissions by 20 percent.

The Partnership has contracted with 26 Hospital Engagement Networks who are providing technical support to participating hospitals in the sharing and use of strategies proven to reduce preventable hospital-acquired conditions and readmissions. The Hospital Engagement Networks are primarily national and state hospital associations, and large health systems. More information about the Hospital Engagement Networks is available on the Innovation Center website at http://innovation.cms.gov/initiatives/Partnership-for-Patients/index.html.

As of the date of this report, over 7,500 organizations have voluntarily pledged to participate, including over 3,700 hospitals. Members of the Partnership are dedicated to reducing the number of patients getting injured or sicker while in the hospital, as well as improving care transitions and reducing 30-day hospital readmissions.

The Community-based Care Transitions Program created by section 3026 of the Affordable Care Act, is also part of the Partnership for Patients. More information about the CCTP and participating communities can be found at http://innovation.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html.

These two components of the Partnership for Patients have the potential to save 60,000 lives, reduce millions of preventable injuries and complications in patient care, and produce significant cost savings both for Medicare and across the health care system.

Million Hearts

Heart disease and stroke are the first and fourth leading causes of death in the United States, respectively. Million Hearts™ is a national initiative that has set an ambitious goal to prevent 1 million heart attacks and strokes by 2017.

Million Hearts™ brings together existing efforts and new programs to improve health across communities and help Americans live longer, healthier, more productive lives. CDC and CMS are the co-leaders of Million Hearts™ within HHS, working alongside other Federal agencies including the Administration for Community Living, National Institutes of Health, the Agency for Healthcare Research and Quality, the Food and Drug Administration, HRSA, the Substance Abuse and Mental Health Services Administration, the Office of the National Coordinator, and the Veterans Administration. Key private-sector partners include the American Heart Association and the YMCA among many others.

The Million Hearts™ initiative focuses, coordinates, and enhances cardiovascular disease prevention activities across the public and private sectors in an unprecedented effort to prevent 1 million heart attacks and strokes over 5 years and demonstrate to the American people that improving the health system can save lives. Million Hearts™ will scale-up proven clinical and community strategies to prevent heart disease and stroke across the nation.

Through the Million Hearts™ initiative, the Innovation Center is supporting the widespread adoption of best practices and improvements in cardiovascular health, while gaining valuable data and insights to support the development of new payment and service delivery models consistent with the goals of the initiative.

Initiatives to accelerate the development and testing of new payment and service delivery models

Health Care Innovation Awards

The Innovation Center recognizes that many of the best ideas will come from external partners and innovative thinkers in communities across the country. The Health Care Innovation Awards are providing nearly $900 million in grants to test innovative new payment and service delivery models that originate in the field and that have the potential to produce better care, better health, and reduced cost through improvement for CMS's programs and beneficiaries.

The Health Care Innovation Awards were designed to support innovators who can rapidly deploy care improvement models (within 6 months of award) through new ventures or expansion of existing efforts to new populations of patients, in conjunction (where possible) with other public and private sector partners.

This initiative encouraged applicants to include new models of workforce development and deployment that efficiently support their service delivery model proposal. Enhanced infrastructure to support more cost-effective system-wide function is also a critical component of health care system transformation, and applicants were encouraged to include this as an element of their proposals.

The Innovation Center announced the first batch of awardees for the Health Care Innovation Awards on May 8, 2012 and the second and final batch on June 15, 2012. The 107 total awarded organizations will implement projects in communities across all 50 states, with the potential to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid, and the CHIP, particularly those with the highest health care needs. Funding for these projects is for three years.

Collectively, these awardees are testing models designed to address a broad range of health care challenges. These range from a sepsis early recognition and response initiative (sepsis is the sixth most common reason for hospitalization and typically requires double the average time in the hospital) to a multi-provider collaboration to create community-wide health intervention teams that help people get fast and appropriate care, reduce unnecessary hospitalizations, and lower costs. Each model will be evaluated on its ability to improve the quality of care and lower the cost for the target population it is designed to serve.

More information about the Health Care Innovation awardees is available on the Innovation Center website at http://innovation.cms.gov/initiatives/Innovation-Awards/index.html.

State Innovation Models

States play a critical role in determining the effectiveness of the health care system and the health of their population. In addition to being health care payers for the Medicaid, CHIP and state employee populations, states impact the delivery of care through their licensing and public health activities. States therefore are uniquely positioned to partner with CMS in testing new care and payment models to deliver better health, better care and lower costs through improvement.

This initiative will provide financial and technical support to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP. States cannot use State Innovation Model funding to supplant funding levels for activities that are already provided by states or other payers, but they can use State Innovation Model funding to supplement existing efforts to enhance the broader transformation of the delivery system.

The State Innovation Models will support two broad areas of activity:

- **Model Design Awards** will support states as they engage stakeholders and complete a Comprehensive Health Care Innovation Plan. The Comprehensive Plan must provide a vision of health system transformation and payment reform, including the state's strategy for multi-payer delivery system and payment reform and community-integrated health care. States receiving these awards must complete their Plan and Model Design and submit a Model Testing proposal in the second round of Model Testing awards, anticipated in the spring of 2013.

- **Model Testing Awards** will support states that are ready to implement their Comprehensive Health Care Innovation Plan. We expect these states to: 1) bring a broad range of stakeholders into the implementation process; 2) create multi-payer payment and service delivery models that include Medicare, Medicaid, CHIP, and other payers; 3) utilize their executive and legislative authority to facilitate and support new health care delivery models; and 4) ensure that models complement and coordinate with other initiatives sponsored by CMS and HHS, including the Administration for Community Living.

  The testing award provides funds for the state to carry out a three year test and evaluation of their transformative payment and service delivery model.

The first funding opportunity announcement was released on July 19, 2012, targeting those states ready to submit a Comprehensive Health Care Transformation Plan and begin model testing within 6 months of receiving an award.

4. Beneficiaries receiving services from providers participating in Innovation Center initiatives

The following table identifies the estimated number of beneficiaries expected to receive services furnished by providers and practitioners participating in models authorized under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). A comprehensive listing of all initiatives currently being administered by the Innovation Center is contained in Appendix 1.

Table 1: Individuals receiving services furnished By providers and practitioners participating in Innovation Center initiatives

Initiative	# Beneficiaries Receiving Services (estimate as of October 31, 2012)
Primary Care Transformation	
• Comprehensive Primary Care initiative[4]	90,000 Medicare 4,000 Medicaid
• Federally Qualified Health Center Advanced Primary Care Practice Demonstration	214,000 Medicare
Accountable Care Organizations (ACOs)	
• Pioneer Accountable Care Organization Model	750,000 Medicare
• Advance Payment Accountable Care Organization Model	145,000 Medicare
Bundled Payments for Care Improvement	
• Bundled Payments for Care Improvement	Not Yet Available
Initiatives Focused on the Medicaid Population	
• Strong Start for Mothers and Newborns (Strategy 2)	Not Yet Available
Initiatives Focused on Medicare-Medicaid Enrollees	
• State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Not Yet Available
• Financial Alignment Initiative	Not Yet Available
• Initiative to Reduce Preventable Hospitalization Among Nursing Facility Residents	Not Yet Available
Initiatives to Speed the Adoption of Best Practices	
• Partnership for Patients	Not Applicable
• Million Hearts	Not Applicable
• Innovation Advisors	Not Applicable
Initiatives to Accelerate New Service Delivery and Payment Model Testing	
• Health Care Innovation Awards	Not Yet Available
• State Innovation Models	Not Yet Available

[4] Initiative launched in first 2 markets on October 1, 2012; these numbers reflect the estimate as of October 31st.

5. Payments made to providers for services on behalf of beneficiaries and potential savings

Table 2 below outlines the estimated additional payments made to providers of services and suppliers on behalf of beneficiaries assigned to models and initiatives authorized under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act), as well as Innovation Center obligations to date to support each initiative. A comprehensive listing of all demonstrations and other initiatives administered by the Innovation Center is included in Appendix 1. In general, payments made under the applicable titles for services on behalf of beneficiaries assigned to Innovation Center models continue to be made in accordance with the existing payment provisions. This table does not include Medicare, Medicaid, and CHIP payments that providers and suppliers receive for covered services provided to beneficiaries.

As required by the statute, each of these initiatives is expected to reduce program expenditures in Medicare, Medicaid, and CHIP, over the life of the model while maintaining or improving the quality of care received by beneficiaries. During the review of each model, the Innovation Center will evaluate the models' evidence base by reviewing the potential cost and quality impact of the initiative. The Innovation Center will also prepare estimates, typically with the participation of the CMS Office of the Actuary, of the financial impact of the proposed initiatives as well as an analysis of their potential impact on the quality of health care among beneficiaries. The strength of this evidence will be used to support decisions to advance a particular initiative. For example the Pioneer ACO program was projected to generate Medicare savings of up to $1.1 billion over 5 years, with a median savings estimate of about $600 million over five years.

The data included in this table are defined as follows:

- The column titled "***Payments made to providers of services and suppliers***" reflects payments for additional services in support of the models and initiatives being tested (e.g. care management fees) that are paid through Innovation Center funds as provided under section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). These payments were made by October 31, 2012.

- Certain models (such as the Pioneer ACO Model) include opportunities to share in the savings that providers generate for Medicare. These shared savings payments as well as certain other payments will be made from the Medicare Trust Funds and are listed in Table 2 in the column titled "***Shared savings or similar Medicare Trust Funds payments made to providers of services and suppliers***." No payments were made as of October 31, 2012.

- The column titled "***Innovation Center funds obligated to support model development and testing, excluding shared savings or similar Medicare trust funds payments made to providers of services and suppliers***" reflects the total funds obligated as of the end of Fiscal Year 2012, September 30, 2012, including contract awards, services rendered and, as applicable, payments to providers on behalf of beneficiaries. Shared savings or similar payments from the Medicare Trust Funds are not included in this estimate.

Table 2*: Additional payments made to providers of services and suppliers, shared savings or similar Medicare Trust Funds payments, and Innovation Center obligations*

Initiative	Estimated Payments Made to Providers of Services and Suppliers (as of October 31, 2012)	Estimated Shared Savings or Similar Medicare Trust Funds Payments Made to Providers of Services and Suppliers (as of October 31, 2012)	Innovation Center Funds Obligated to Support Model Development and Testing, Excluding Shared Savings or Similar Medicare Trust Funds Payments Made to Providers of Services and Suppliers (estimate as of September 30, 2012)[5]
Primary Care Transformation			
• Comprehensive Primary Care initiative	Data Not Yet Available[6]	Payments Not Yet Made	$10,005,982
• Federally Qualified Health Center Advanced Primary Care Practice Demonstration	$15,274,548	Not Applicable	$26,659,768
Accountable Care Organizations (ACOs)			
• Pioneer Accountable Care Organization Model	Not Applicable	Payments Not Yet Made	$40,179,309
• Advance Payment Accountable Care Organization Model	$14,636,516	Payments Not Yet Made	$15,975,265
Bundled Payments for Care Improvement			
• Bundled Payments for Care Improvement	Payments Not Yet Made	Payments Not Yet Made	$12,173,890
Initiatives Focused in the Medicaid Populations			
• Strong Start	Payments Not Yet Made	Not Applicable	$37,491,087
Initiatives Focused on Medicare-Medicaid Enrollees			
• State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Payments Not Yet Made	Not Applicable	$17,024,450
• Financial Alignment Initiative	Payments Not Yet Made	Not Applicable[7]	$36,340,585
• Initiative to Reduce Preventable Hospitalization Among Nursing Facility Residents	$26,262,112	Not Applicable	$30,697,197
Initiatives to Speed the Adoption of Best Practices			
• Partnership for Patients	Not Applicable	Not Applicable	$242,976,571
• Million Hearts	Not Applicable	Not Applicable	$0
• Innovation Advisors	Not Applicable	Not Applicable	$5,900,000
Initiatives to Accelerate New Service Delivery and Payment Model Testing			
• Health Care Innovation Awards	$280,109,691 [8]	Payments Not Yet Made	$289,786,697
• State Innovation Models	Payments Not Yet Made	Not Applicable	$5,143,566

[5] Represents Innovation Center funds obligated through the end of Fiscal Year 2012.

[6] Initiative launched in first 2 markets on October 1, 2012; payment data not yet available as of the writing of this report.

[7] Note that shared savings payments to States will be made under the fee-for-service model.

[8] This total reflects the full amount of the grant funding provided to the HCIA awardees for the first year of model testing. These funds are to be used by awardees to implement the models as defined, including some payments to providers of services and suppliers.

To date, models announced by the Innovation Center are expected to cost about $3 billion over the life of the model tests. Those commitments may ultimately vary based on the numbers of providers and beneficiaries participating, as well as changes in expected operational and evaluation costs.

6. Results and recommendations

Results from evaluations

The payment and service delivery models announced by the Innovation Center under the authority of section 1115A of the Social Security Act, as well as the initiatives to speed the adoption of best practices, are all in the early stages of implementation. As a result, evaluation results are not yet available.

Models chosen for expansion

None of the Innovation Center models tested under section 1115A of the Social Security Act have been in the testing phase long enough to generate sufficient data to determine whether the model should be modified, terminated, or expanded.

Recommendations for legislative action

None of the Innovation Center models tested under section 1115A of the Social Security Act have been in the testing phase long enough to generate sufficient data to determine whether legislative action is needed.

7. Conclusion

As demonstrated in this report, the Innovation Center has been actively fulfilling the legislative requirement that it test new models of payment and service delivery models that show promise of reducing program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and CHIP beneficiaries.

Furthermore, the Innovation Center has performed its work in the manner specified in its statutory charge. It is working with the health care community, clinicians, and researchers to elicit ideas and discover best practices. It is expanding its efficiency and reach through cooperative efforts with private payers, states, and other federal agencies. It is evaluating models in a timely, rigorous, and proactive manner. It is fostering improvements in models as they are tested. It is disseminating lessons learned among program participants and throughout the health care system.

These activities – and the models being tested – have the potential to reduce health care costs while improving care, and they take critical steps toward important and needed reforms in our nation's health care delivery system.

Appendix 1:
The Innovation Center portfolio (all initiatives and activities)

The Innovation Center is organized to support the development and testing of new payment and service delivery models, as well as support CMS's additional demonstration and research requirements. To better coordinate initiatives, demonstrations, and research projects at CMS and to prevent duplication of effort and expense, the former Office of Research, Development and Information was merged with the Innovation Center in early 2011. As a result, the Innovation Center oversees not only initiatives that are authorized and funded under 1115A (Section 3021 of the Affordable Care Act) (as described in the main body of this report), but also activities authorized under several other authorities, including other provisions of the Affordable Care Act and Section 402 of the Social Security Amendments of 1967 as amended. Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination and more efficient operations.

The following table identifies and describes all model tests, initiatives and demonstrations that were active as of October 31, 2012. This includes all model tests that were announced and in any stage of implementation or operations, as well as any mandated or authorized demonstrations that were active and in their performance period during that time. This table does not include demonstrations for which the performance period had expired prior to January 1, 2011. The statutory authority listed in the following table permits CMS to test payment and service delivery models with respect to the underlying programs described in titles XVIII, XIX, and XXI of the Social Security Act or otherwise make changes to the programs under such titles.

Appendix 1*: Innovation Center Initiatives and Activities*

Initiative Name	Description	Statutory Authority
New Payment and Service Delivery Model Tests and Related Initiatives Authorized under Section 1115Aof the Social Security Act (section 3021 of the Affordable Care Act)		
Advance Payment ACO Model	Prepayment of expected shared savings to support ACO infrastructure and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Bundled Payment for Care Improvement	Evaluate 4 different models of bundled payments for a defined episode of care to incentivize care redesign Model 1: Retrospective Acute Care Hospital Inpatient Stay Model 2: Retrospective Acute Care Hospital Inpatient Stay & Post-Acute Care Model 3: Retrospective Post-Acute Care Model 4: Prospective Acute Care Hospital Inpatient Stay	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

Initiative Name	Description	Statutory Authority
Comprehensive Primary Care Initiative	Public-private partnership to enhance primary care services, including 24-hour access, creation of care management plans, and care coordination	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Federally Qualified Health Center 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 of the Social Security Act (section 3021 of the Affordable Care Act)
Financial Alignment Initiative	Opportunity for states to implement new integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Innovation Advisors	This initiative is not a payment and service delivery model for purposes of section 1115A, but rather is an initiative that is part of the infrastructure of the Innovation Center to engage individuals to test and support models of payment and care delivery to improve quality and reduce cost through continuous improvement processes	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Health Care Innovation Awards	A broad appeal for innovations with a focus on developing the health care workforce for new care models	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Initiative to Reduce Preventable Hospitalization 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 of the Social Security Act (section 3021 of the Affordable Care Act)
Million Hearts	This initiative is not a payment and service delivery model for purposes of section 1115A, but rather is an initiative that is part of the infrastructure of the Innovation Center. Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over five years; brings together communities, health systems, nonprofit organizations, federal agencies, and private-sector partners from across the country to fight heart disease and stroke.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Partnership for Patients	Hospital engagement networks (and other interventions) in reducing HACs/Readmissions by 20 and 40 percent, respectively. (Community Based Care Transition is covered in another row.)	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Pioneer ACO Model	Experienced provider organizations taking on financial risk for improving quality and lowering costs for all of their Medicare patients	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
State Demonstrations to Integrate Care for Medicare-Medicaid Enrollees	Support States in designing integrated care programs for Medicare-Medicaid enrollees.	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
State Innovation Models	Provides financial, technical, and other support to states that are either prepared to test, or are committed to designing and testing new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)

Initiative Name	Description	Statutory Authority
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 of the Social Security Act (section 3021 of the Affordable Care Act)
Accelerated Learning Development Sessions	A series of collaborative learning sessions with stakeholders across the country to inform the design of the Accountable Care Organization (ACO) initiatives	Section 1115A of the Social Security Act (section 3021 of the Affordable Care Act)
Mandated Demonstrations and other Initiatives Authorized Under Various Statutes		
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 as amended by section 3021 of the Affordable Care Act
Community-Based Care Transitions Program (a part of the Partnership for Patients)	Reduce readmissions by improving transitions of high-risk Medicare beneficiaries from the inpatient hospital setting to home or other care settings	Section 3026 of the Affordable Care Act
Care Management for High Cost Beneficiaries Demonstration	Tests a pay-for-performance contracting model and new intervention strategies for Medicare fee-for-service (FFS) beneficiaries, who are high cost and who have complex chronic conditions, with the goals of reducing future costs, improving quality of care and quality of life, and improving beneficiary and provider satisfaction	Section 402 of the Social Security Amendments of 1967 as amended
Pilot Program for Care of Certain Individuals Residing in Emergency Declaration Areas	Pilot program provides cost effective and medically necessary benefits not normally covered by Medicare for patients with asbestos related disease.	Section 10323 of the Affordable Care Act
Frontier Extended Stay Clinic Demonstration	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
Graduate Nurse Education 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 added as a result of the demonstration	Section 5509 of the Affordable Care Act
Health Quality Partners Demonstration	Assess impact of care coordination models on hospitalization, ER use, cost for rural community hospitals	Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as extended by Section 3123 of the Affordable Care Act
Incentives for Prevention of Chronic Disease in Medicaid	Test the impact of incentives for prevention for a Medicaid population	Section 4108 of the Affordable Care Act
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)

Initiative Name	Description	Statutory Authority
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 of the Affordable Care Act
Medicare Coordinated Care Demonstration	This project tests whether providing coordinated care services to Medicare fee-for-service beneficiaries with chronic conditions can yield better patient outcomes without increasing program costs.	Section 4016 of the Balanced Budget Act of 1997
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
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 Affordable Care Act
Medicare Imaging Demonstration	Collect data regarding physician use of advanced diagnostic imaging services in relation to appropriateness criteria which for purposes of the demonstration are medical specialty guidelines meeting specific conditions	Section 135(b) of the Medicare Improvements for Patients and Providers Act of 2008
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 the Social Security Amendments of 1967 as amended
Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)	State-led, multi-payer collaborations to help primary care practices transform into medical homes	Section 402 of the Social Security Amendments of 1967 as amended
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 the Social Security Amendments of 1967 as amended
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)
Physician Hospital Collaboration 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 3021of the Affordable Care Act
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

Initiative Name	Description	Statutory Authority
Rural Community Hospital Demonstration	The demonstration tests the feasibility and advisability of providing reasonable cost reimbursement for small rural hospitals	Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as amended by sections 3123 and 10313 of the Affordable Care Act
Senior Risk Reduction Demonstration	Test the ability of risk reduction programs to achieve improvements in a population's health risk profile	Section 402 of Social Security Amendments of 1967 as amended
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