Multi-payer Advanced Primary Care Practice Demonstration Solicitation

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I. Background/General Information

A. Scope

The Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration is open to States that are developing and have implemented or will be ready to implement in 2010, or within 6 months of being notified of being selected, whichever is later, multi-payer initiatives that promote the principles of advanced primary care practice (APCP), which is often referred to as the patient-centered medical home. States initiatives may be implemented either State-wide or on a pilot basis.

B. Authority

The demonstration is being conducted under the authority of §402 of the Social Security Amendments of 1967 (as amended). Section 402 authorizes the Secretary to conduct demonstration projects to evaluate changes in methods of payment for covered services and payment for services not otherwise covered and which are incidental to services for which payment may be made.

C. Purpose

The MAPCP Demonstration is an opportunity to assess the effect of APCP, when supported by Medicare, Medicaid, and private health plans, on:

1. The safety, effectiveness, timeliness, and efficiency of health care;
2. Variation in utilization and expenditure not related to differences in health status;
3. The ability of beneficiaries to participate effectively in decisions concerning their care;
4. The delivery of care consistent with evidence-based guidelines in historically underserved areas; and
5. Utilization of, and expenditures for, services covered by Medicare and Medicaid.

The Centers for Medicare & Medicaid Services (CMS) will conduct an independent evaluation of the demonstration projects conducted under this initiative.

D. Application Deadline

Applications must be received by CMS no later than August 17, 2010 Data that may be useful in preparing an application will be made available to States that submit a notice of intent no later than June 30, 2010.

E. Support Available from CMS

CMS will make available to States data on historical utilization and expenditure patterns by fee-for-service Medicare beneficiaries that will help to inform development of assumptions to support the projection of budget neutrality.

F. Limitation on Amount of Federal Financial Support

CMS expects to enter into cooperative agreements with up to six States. If more than six applications meeting the eligibility requirements are received, qualified applications will be

rank-ordered using the criteria outlined in section V.B., and CMS will enter into cooperative agreements with the six highest ranked applications unless a compelling case can be made for entering into cooperative agreements more than six States. A compelling case may be that the additional States offer an opportunity to evaluate distinctly different approaches to defining and paying APCPs, or the effect of APCP practice initiatives in States or communities with distinctive utilization patterns or community characteristics. An additional factor that will be considered in deciding to enter into cooperative agreements with more than six States is the availability of resources to support CMS participation in the additional State initiatives.

CMS generally expects that up to 150,000 eligible beneficiaries will be assigned to participating APCPs. However, if a compelling case is made for allowing participation by more than 150,000 eligible beneficiaries, this limit may be waived.

II. Eligibility Requirements

To be considered for a cooperative agreement under the MAPCP Demonstration, an applicant must demonstrate that it meets all of the requirements in this section.

A. State Sponsorship

The applicant must be a State agency with responsibility for developing and implementing multi-payer reform initiatives. The State agency may be a State health department, a Medicaid agency, or other agency operating under State legislative authority including the general executive authority of the Governor.

B. Implementation Status

The State reform initiative must begin paying participating primary care practices at the same time or prior to the date on which Medicare begins to pay participating practices. In general, this means that applicants must have: enlisted the active participation of private payers; specified an overall design for the State initiative; identified participating practices and/or pilot communities; and be ready to begin payment of participating practices by the end of 2010. States that are implementing APCP reforms on a pilot basis may participate and may expand the scope and scale of their pilot programs over the course of the MAPCP Demonstration.

C. Multi-payer Participation

The State initiative must include participation by Medicaid, private health plans offering coverage in both the group and individual health insurance market, and self-insured employer-sponsored group health plans at the same time that Medicare joins the multi-payer initiative.

Participating private health insurers and/or employers must together enroll more than half of all State residents covered under group or individual health plans. The purpose of this requirement is to assure the availability of the resources that participating practices need to support implementation of the advanced primary care model. Investment in practice transformation is feasible only if a substantial majority of the participating practices' patients are covered by participating payers.

Substantial participation does not require that a majority of the State's residents covered by group and individual health plans actually participate in the State initiative. If the State initiative is being conducted on a pilot basis in selected communities or with selected practices, substantial participation would require participation only by a majority of the privately covered residents of the selected pilot communities or a majority of the privately covered patients of the selected practices.

D. Evidence of Primary Care Physician Support and Participation

The State initiative must demonstrate commitment to the APCP reforms by a majority of primary care physicians practicing in the State. The purpose of this requirement is to make sure that the types of reforms being tested by the State initiative are intended to be implemented more broadly.

If the State's APCP program is being conducted on a pilot basis in selected practices or communities, the application must provide evidence that a majority of primary care practices in the State would endorse the reforms were they implemented on a State-wide basis by all participating payers. Endorsement by a majority of primary care physicians may be demonstrated by active participation in and endorsement of the State reform initiative by organizations representing a substantial majority of primary care physicians practicing in the State. Endorsement may be demonstrated by attaching to the application letters of support from State medical societies or organizations representing a majority of primary care physicians practicing in the State.

E. Advanced Primary Care Practice

The State initiative has as a principal objective the implementation of reforms consistent with the concepts of APCP (also referred to as the patient-centered medical home). The basic elements of an APCP include:

1. Establishment of an ongoing relationship between each beneficiary and an identified primary care provider;
2. Acceptance by the primary care provider of responsibility for providing timely access to care and consultation with patients outside of normal office hours;
3. Establishment of a multi-disciplinary team that includes the primary care provider to coordinate care obtained from physicians, hospitals, home care agencies, nursing homes and other community resources;
4. Integration and coordination of medical services with community resources, including community-based health promotion and disease prevention initiatives;
5. Adoption of health information technology to support effective primary care/patient management;
6. Changes in primary care payment methods (which may include payment for community-based resources that support primary care practice) to provide resources needed to implement APCP; and
7. On-going measurement of quality/performance to support payment reforms and quality improvement initiatives.

No one definition, model, or set of criteria for identifying APCP will be required. However, all applications must include a rigorous definition of, and method of implementing, APCP. The application must identify the practices and the estimated number of Medicare beneficiaries that would participate in the multi-payer initiative in the first year. It must

also describe the anticipated impact of any planned expansion of the State multi-payer initiative on the number of participating practices and number of participating beneficiaries.

F. Community-based Support for Participating Practices

The State initiative must include specific mechanisms to support the participating practices' implementation of the APCP model and to link participating practices to community-based resources. Mechanisms must be identified to:

1. Connect patients with community-based resources (such as transportation for patients with restricted mobility or programs for nutritional counseling and support);
2. Coordinate transitions across care settings with appropriate involvement of the patient's primary care provider;
3. Support self-management by patients; and
4. Support practice improvement and transformation (particularly by smaller primary care practices).

No one method of linking advanced primary care practices with community resources will be required. Different methods may include the establishment of networks of community resources, requiring each participating practice to establish appropriate methods of referring patients to community resources, the sharing of staff providing these services by small independent practices, or linking APCP with existing sources of community support (e.g., area agencies on aging).

G. Integration with Health Promotion/Disease Prevention

The State initiative must be coordinated with state-wide health promotion and disease prevention initiatives that address significant causes of chronic disease and avoidable morbidity and mortality in the State's population. Whereas community-based practice support might make use of existing resources in the community to support effective primary care and patient adherence to a medical regimen, primary care providers can also support efforts to prevent disease and promote health by making appropriate referrals to health promotion and disease prevention initiatives sponsored by the State.

H. Expectation of Budget Neutrality

The application must include credible evidence to support an expectation that CMS participation in the State initiative will reduce Medicare expenditures under parts A and B by an amount that exceeds the payment that Medicare will make under the demonstration for otherwise non-covered services.

These demonstration-related payments may include payments to participating APCPs, payments for community-based care coordination, and payments that represent Medicare's share of operating expenses related to the State initiative (to the extent that these expenses are apportioned among participating payers). To the extent permitted by applicable statutes, CMS will make payments related to community-based APCP support and to cover operating expenses only to the extent that all participating payers make such payments. CMS also will make such payments only for those services and to those entities to which CMS may make payment under the authority of applicable statutes. CMS expects that the total CMS payment to participating practices, community support organizations, and for shared administrative expenses will not exceed $10 per participating beneficiary per

month. Consideration may be given to a marginally higher expenditure only if a compelling case can be made that shows why the higher payment is necessary and to the extent that all participating payers make a comparable expenditure.

Applications must describe specific opportunities for improvements in the way the needs of patients are met under existing (or historical) arrangements, the changes in care delivery that the implementation of the APCP initiatives are expected to bring about, and the anticipated impact of these changes on Medicare expenditures.

I. Implementation Requirements and Administrative Arrangements

Because CMS will assume responsibility for administering payment for participating Medicare beneficiaries, the application must include a specific description of the data and methods that payers participating in the State initiative will use to:

- Identify participating primary care practices and providers;
- Identify eligible beneficiaries and, if required, solicit their participation;
- Associate participating beneficiaries with participating practices;
- Calculate and make payments to participating practices for participating beneficiaries;
- Calculate and make payments related to community-based APCP support to the extent payment for these services are also made by other participating payers; and
- Calculate and make payments related to administration of the multi-payer initiative (e.g., costs related to collection of data on quality, qualification, and monitoring of participating APCPs, etc.) to the extent payment for these administrative expenses are also made by other participating payers.

Only those Medicare beneficiaries residing in the State that submits the application will be eligible to participate in the demonstration. Applicants are not required to use any specific payment method, but the application must describe the specific methods that would be used. Possible payment methods include payment of a monthly fee for otherwise non-covered services provided by participating practices, an add-on to otherwise payable fees, or fee-for-service payments for otherwise non-covered services.

CMS generally expects that an application will identify only one payment arrangement to be used across all participating practices and by all participating payers. This payment arrangement may combine monthly care management fees, fee-for-service payments, and pay-for-performance incentives. Consideration may be given to applications that will test different payment methods in different communities or pilot projects, but only if a compelling case is made that the different payment methods are necessary, provide an important test of distinctive methods that would not otherwise be demonstrated, and can be meaningfully evaluated.

CMS reserves the right to modify and adapt the State initiative's methods of payment to accommodate the limitations of its administrative systems. In addition, section 402 of the Social Security amendments permits CMS to pay only for certain services and to pay only certain entities. For example, a direct payment cannot be made to a community-based support organization that is not capable of providing Medicare-covered ambulatory health care services. These restrictions may require CMS to make further modifications to the State initiative's methods of payment.

J. Initiative Monitoring and Evaluation

The State initiative must include a well-designed evaluation plan to monitor performance and provide feedback to participating payers, providers, and communities. The evaluation will address how the intervention has affected access to care (particularly primary care), quality of care (using structure, process, and outcome measures), and patterns of utilization and expenditure. The application must describe the specific questions the evaluation will address, how the effect of the State initiative will be determined, and how the results of the evaluation will be used by the State and other stakeholders.

K. Commitment to Cooperate in Evaluation

The application must include a statement that the State, participating providers, and participating payers, including the State Medicaid agency, will cooperate in an independent formal evaluation of Medicare's participation in the demonstration, including submission of cost and other program data and site visits, conducted by CMS and/or its contractor. Under a cooperative agreement, States will be required to secure written agreement by participating practices and payers to provide data needed to conduct the independent evaluation of the effect of Medicare participation in the State initiative on the Medicare and Medicaid programs and on Medicare and Medicaid beneficiaries.

L. Participation in Other Medicare Demonstrations

The application must include a statement that the State and participating providers understand that participation in the MAPCP Demonstration will preclude participation of the practices in other demonstrations conducted by Medicare. A primary care practice and a beneficiary may participate in one and only one Medicare demonstration at any point in time. Under a cooperative agreement, States will be required to submit to CMS a written statement that each participating practice agrees not to apply to participate in any Medicare demonstration that covers the period between the start and end dates of the MAPCP Demonstration.

III. Application Content/Outline

The application must contain the information needed both to determine that the State multi-payer initiative meets the requirements outlined in section II and to apply the ranking criteria outlined in section V. To facilitate review, applications must be organized as outlined in this section and must not exceed 40 pages. Supplemental materials may be included with the application, particularly to document operational requirements (e.g., the State initiative's definition of "APCP," documentation of methods used to associate beneficiaries with participating practices, methods of calculating payments to participating practices, etc.) and budget neutrality projections but must not exceed an additional 30 pages.

A. Background on the State Reform Initiative

This section of the application must demonstrate that the application meets the requirements related to implementation status, multi-payer participation, primary care provider support, and integration with health promotion/disease prevention efforts.

1. Authority and Historical Background on the State Initiative

The application must identify the legal authority under which the State initiative is conducted. For example, a State initiative may be conducted under the general executive authority of the Governor, under general statutory authority of the health department or other executive agency, or under specific statutory authority. The application must contain evidence that the request for Medicare participation in the State initiative has been approved by the Governor of the State.

The application must indicate whether participation by private health insurers and providers is voluntary or mandated by State authority. Finally, the application must describe the current status of the State initiative and identify key dates in its history, including any preliminary work by reform commissions, passage of specific enabling statutes, formal action by the Governor, recruitment of participating private health insurers and providers, and initiation of provider payment under the initiative.

2. Participation of Private Insurers

The application must identify the specific private health insurers that participate in the State initiative and describe their role in the initiation, development and ongoing operation of the initiative. It must include information on the percentage of State residents with individual or group (whether self-funded and insured plans) health insurance coverage that is provided by participating insurers. It must also include an estimate of the percentage of the total revenues of participating primary care practices that is derived from participating private health insurers.

3. Participation by Medicaid

The application must describe the State Medicaid program's participation in the State reform initiative. It must describe the role of Medicaid in the initiation, development, and ongoing operation of the State initiative. It must also include an estimate of the number of Medicaid beneficiaries (separately identifying dual-eligible and Medicaid-only beneficiaries) that are expected to participate in the demonstration and the percentage of the revenues of participating practices that is derived from Medicaid. If the State agency submitting the application is not responsible for administering the State's Medicaid program, evidence of Medicaid participation in the State initiative must be referenced in the application such as a Memorandum of Understanding between the State Medicaid agency and the agency submitting the application

4. Support by Primary Care Physicians

The application must describe the role of primary care physicians in the initiation, development, and ongoing operation of the State initiative. It must describe how practicing primary care physicians are represented (e.g., representation by State medical societies or by practicing physicians affiliated with large primary care practices) and provide evidence of support for the reforms that are being implemented under the State initiative. Letters of support by organizations representing practicing primary care physicians must be included as attachments to the application.

B. Problem Statement

The application must provide a clear and comprehensive description of:

1. The nature of the problem(s) it addresses;
2. The extent (prevalence) and magnitude of the problem(s);
3. The causes of these problem(s);
4. How the State initiative addresses these problem(s); and
5. The specific goals for the State initiative.

Examples of problems might include lack of access to primary care, inappropriate use of hospital emergency rooms for primary care, fragmentation of care, lack of coordination of care between primary care providers and specialists and/or during transitions between hospitals and other providers, unnecessary or avoidable duplication of testing, patient non-adherence to recommended treatment or regimen, provider non-adherence to evidence-based guidelines for treatment of acute episodes and chronic disease. The application must document the estimated prevalence of these (or other) problems in the Medicare population that is expected to participate in the demonstration. Applications must describe the basis for these estimates.

Examples of causes might include the inability of patients to contact and consult with primary care physicians outside of normal office hours, the inability of patients to obtain a timely appointment for office visits, limitations on the data that are available in the patient records that are available to primary care physicians, deficiencies in the discharge planning process, impediments to follow-up by/with primary care after referral to specialists, lack of referral to community-based resources that would facilitate adherence to recommended regimens for patients with chronic conditions, limits on the amount of time physicians and other providers can spend with patients, etc. The application must provide a concise but specific description of the factors that have given rise to the problems that the State multi-payer initiative is designed to address. It must identify and describe how the specific elements of the State initiative will address each of these factors.

The purpose of the “Problem Statement” section of the application is to establish a foundation for the determination of budget neutrality. The application must identify specific, material opportunities to improve the delivery of care, and link the implementation of the “APCP” model, as defined by the State multi-payer initiative, to these opportunities.

C. Description of the State Reform Initiative

1. Structure and Overall Design of the State Initiative

The application must describe the overall design of the State initiative: (1) whether the initiative is State-wide (2) is being conducted in pilot communities; or (3) is being conducted in selected primary care practices. If the State initiative is being conducted in pilot communities, the application must identify the communities and describe how and why these communities were selected. It should also describe any planned expansion in the number of participating communities and practices.

2. Participating Primary Care Practices

The application must provide the specific definition of "APCP" adopted by the State initiative, and discuss how it differs from other common definitions (e.g., the National Committee for Quality Assurance criteria for a patient-centered medical home, or the statement of Joint Principals of the Patient-Centered Medical Home). This description will be used to determine that the State initiative has a rigorous definition of "APCP."

The application must describe the methods used to recruit participating practices and describe how the definition of "APCP" was used to select or qualify these practices. The application must identify and describe the participating practices in terms of size, location, general organizational structure, and extent to which the practices meet the definition of "APCP" if the definition of APCP recognizes differing levels of "advanced practice."

The application must also describe the methods that will be used to monitor continued adherence by participating practices to the definition of "APCP."

3. Identification and Recruitment of Participating Beneficiaries

The application must describe the specific criteria that are to be used to identify the Medicare beneficiaries who will be eligible to participate in the State multi-payer initiative and whether participation in the initiative will be transparent to the beneficiary or offer the beneficiary the opportunity to opt-in or opt-out of the initiative. It must describe the procedures that will be followed to inform beneficiaries about the initiative and, if relevant, solicit their participation in the initiative. Participating Medicare beneficiaries may not be required to obtain care from the practice with which they are affiliated, nor will affiliation with a participating practice limit the ability of a beneficiary to obtain services covered by Medicare from any Medicare provider.

The application must specifically describe CMS' role in identifying and recruiting beneficiaries to participating practices. Any information that will be provided to beneficiaries concerning their participation in the State multi-payer initiative must be included as an attachment to the application.

4. Attribution of Participating Beneficiaries to Participating Practices

If Medicare beneficiaries will be asked to designate a participating practice as their "medical home," the application must describe the specific procedures that will be used and the role of participating payers in this process. If Medicare beneficiaries will be transparently "attributed" to participating practices, the specific attribution methods and algorithms must be provided as an attachment to the application. The application must include information on how other participating payers, including Medicaid, will handle attribution.

The application must specifically describe CMS' role in attributing beneficiaries to participating practices. It must describe the methods or procedures by which a beneficiary's affiliation with a participating practice may be changed or by which disputed attributions will be reconciled.

The application must also clearly and unambiguously indicate that a participating beneficiary will not be required to obtain a referral from his or her primary care provider in order to receive any otherwise covered Medicare service.

5. Community-based Practice Support

The application must describe the specific mechanisms on which participating practices will rely to perform or receive support for performing the functions described in section II.F: connecting patients with community-based resources; care coordination and support for care transitions; support for beneficiary self-care; and support for practice improvement and transformation.

If these mechanisms rely on resources acquired by participating practices, the application must describe these resources (e.g., the number and qualifications of specific staff that have been retained) and the services that will be provided to beneficiaries and primary care providers. The application must also specifically describe the support that will be provided to small participating practices.

To the extent that community-based support is provided by organizations distinct from the participating practices, the application must clearly identify the corporate, governmental, or other organizational entity that will provide services to the participating practices. An attachment to the application must be included in the supplemental information that provides information on the governing and operating structure of these organizations, including any organization by which they are owned, identifying tax information, and the annual operating budget (either actual or projected) for these organizations.

6. Integration with Health Promotion/Disease Prevention

The application must briefly describe the State's health promotion and disease prevention initiatives and describe how the participating practices will both support and make use of these initiatives.

7. Payment Provisions and Methods

The application must describe the specific methods that will be used to pay participating providers for services that are not otherwise covered. These payment methods may include, but are not limited to, a monthly fee for each participating beneficiary attributed to a participating practice, an add-on to otherwise payable fees for covered services, and pay-for-performance incentives.

If payments for community-based practice support is made separately from payments to participating practices (or as a distinct component of the payment to participating practices), the application must provide a total annual expenditure for these services, indicate how the contribution of each participating payer is determined, indicate the anticipated amount of the anticipated CMS payment for these services, and describe the logistics of how the organizations are paid. The application must demonstrate that the CMS payment related to such support services is commensurate with the amount of effort expended on behalf of Medicare patients when compared with payments for and effort required to provide community-based practice support for patients covered by other participating payers.

If payments related to operating expenses of the multi-payer initiative (e.g., to support collection and reporting of data on practice performance) are made by participating payers, the application must describe the operating costs that are apportioned among participating payers, the method used to apportion these expenses, and the anticipated amount of CMS'

share of these expenses. To the extent permitted by applicable statutes, CMS will contribute toward such administrative expenses only to the extent that they are directly related to and necessary to carry out the demonstration. The application must demonstrate that the CMS payment for administrative expenses is commensurate with the administrative expense related to the participation of Medicare patients in the demonstration when compared with the payments made by other participating payers that are related to the administrative expense related to their participation in the State initiative.

The application must provide a sufficiently detailed and specific description of payment methods to allow CMS to determine: (1) how it will pay participating providers and other entities and that proposed payments are permitted by applicable Federal law; (2) to determine that the amount of total CMS payments to participating practices and related organizations will be less than $10 per beneficiary per month; and (3) should the total payment to participating providers and other entities exceed $10 per beneficiary per month, that the excess is justified by compelling evidence of a commensurate improvement in performance. The application must demonstrate that the payment methods for Medicare beneficiaries are the same as the payment methods used by other participating payers, including both Medicaid and participating private health plans.

D. Operating Structure

The application must describe the resources that the State and its partners (including both the participating payers and participating providers) are relying on to implement the demonstration. The purpose of this section is to provide assurance that the State and its partners have the capacity to implement the proposed reforms.

1. Key Personnel and Organizational/Governing Structure

The application must provide a listing of key personnel for the project, including an overall point of contact for the demonstration and a description of the responsibilities of all persons working on the project. The application must describe the organizational and reporting structure of personnel involved in the project. To the extent that personnel involved in the project are employees or members of governing bodies of participating payers or providers, their employment or governance relationship must be indicated.

The application must describe the governance structure of the State initiative, including any policymaking body (such as a commission or advisory board) and any committees that advise the policymaking body. The responsibilities of any advisory committees must be specified. The membership of the policymaking body and advisory committees must be listed, and the organizational affiliations of any members of the policymaking body or advisory committees given.

2. Medicare Participation in Multi-payer Data Systems

To the extent that the State asks CMS to contribute data to a multi-payer health information exchange or other data system that supports the State initiative, the application must describe:

1. The population of Medicare beneficiaries whose data that State is requesting;
2. The type of data that the State is requesting (e.g., claims data, descriptive demographic and related data);

3. The period for which data are requested (e.g., claims data for the years 2008 through 2009);
4. The type of data that would be provided and requested frequency of updates;
5. How the Medicare data would be used;
6. The individuals and organizations that would have access to data on individual Medicare beneficiaries; and
7. How and where the data would be housed.

If CMS participation in a multi-payer health information exchange is requested, the application must also clearly indicate that the State agrees to comply with all applicable Federal regulations governing the security of data and protection of individual privacy and confidentiality. To the extent permitted by law, CMS will make data available only to the extent that other participating payers contribute data to the State initiative. Release of data to the State will be contingent upon the State's executing a CMS Data Use Agreement.

3. Use of Consultants and Vendors

The application must identify all consultants and vendors of services (including academic institutions) that are involved in the State multi-payer initiative, identify their responsibilities and the services they provide, describe the nature of the relationship between the State initiative and these organizations, describe the relationship between participating payers and these organizations, and describe how the State initiative oversees and manages the work they perform.

E. Evidence Supporting Expectation of Budget Neutrality

The application must provide a basis for CMS to make a prospective determination that Medicare participation in the State's advanced primary care initiative will not increase Medicare expenditures for already covered services. Over the course of the demonstration, we will closely monitor total expenditures and utilization patterns of the beneficiaries who receive care from the participating primary care practices. We expect to provide monitoring reports, not less than quarterly, to both participating practices as well as to the State. Should these reports suggest that expenditures for otherwise covered services are increasing, we will require the State to examine and provide an explanation of the factors responsible. If the causes of increased expenditures that are attributable to the demonstration cannot be mitigated, we will consider modifying either the amount of payment or the terms of Medicare participation in the State initiative. The demonstration agreement will make provision for termination of Medicare participation in the demonstration should our analysis indicate that continued participation will not meet the requirement of budget neutrality.

We are not requiring the State to establish a mechanism to recover fees paid by CMS to participating practices (or related entities) should analysis indicate that expenditures for otherwise covered services have increased. However, the application should include credible evidence that the State initiative has identified opportunities to achieve savings through improvements in the safety, timeliness, effectiveness, and efficiency of care that are clearly linked to the implementation of the State's advanced primary care practice initiative. We believe the strongest prospective assurance of budget neutrality will be the identification of specific goals for changes in the organization of care and patterns of care delivery that are supported by strong, locally-developed evidence.

1. Projected APCP Payments

The application must include a year-by-year projection of anticipated CMS demonstration payments to participating APCPs for participating Medicare beneficiaries, payments for supportive services (e.g., community-based care coordination services, data collection, and reporting, etc.), and payments related to State multi-payer initiative operations. To the extent that CMS is asked to contribute to operational expenses of the State multi-payer initiative, the application must include a *pro forma* operating budget covering the 3 years of the demonstration and identifying the contribution of each participating payer toward the operating expenses of the initiative.

The application must include a projection of anticipated payments by CMS for participating Medicare beneficiaries, by the State for Medicaid beneficiaries and by other participating payers for their enrollees, related to the demonstration including:

- The projected number of participating practices in each of the 3 years of the demonstration;
- The projected number of participating Medicare, Medicaid (non-dual), and privately insured patients in each of the 3 years of the demonstration;
- The projected Medicare payments to participating practices for community-based APCP support and for shared administrative expenses in each year of the demonstration;
- The projected Medicaid payments to participating practices for community-based APCP support and for shared administrative expenses in each year of the demonstration; and
- The projected payments by participating private payers to participating practices for community-based APCP support and for shared administrative expenses in each year of the demonstration.

All projections must be accompanied by a description of and basis for the underlying assumptions.

2. Projected Impact of State Initiative on Medicare Expenditures

The application must describe the anticipated effect of the State initiative on aggregate or global expenditures under the Medicare program for all covered services combined. It must demonstrate, specifically, an understanding of historical utilization patterns and opportunities for improvement in the efficiency and effectiveness of care for Medicare beneficiaries, including both Medicare beneficiaries also eligible for Medicaid (dual-eligible beneficiaries) and beneficiaries eligible only for Medicare (Medicare-only beneficiaries) who may also be covered by supplemental or MediGap policies.

The application must describe the specific changes in utilization patterns of Medicare patients that are expected to result from the State initiatives. These changes must be related to and support the projection of the State initiative's impact on Medicare expenditures. The application must also describe the evidence that supports the State's expectation that the projected or targeted changes in utilization patterns are achievable.

To facilitate development and submission of this supporting documentation, CMS will provide the State with historical data on the utilization patterns of Medicare beneficiaries covered under the traditional fee-for-service program. CMS has also developed a tool populated with national data that will be made available on the CMS website. States that submit a notice of intent to apply for this demonstration will be sent a version of the tool pre-populated with data specific to the State. The tool provides a moderately detailed

profile of historical expenditures in the State, derived from the Chronic Condition Warehouse. The tool shows total expenditures for each type of service as the product of four factors:

- The percentage of Medicare fee-for-service beneficiaries who use that service;
- The average number of services used by beneficiaries who use that service;
- The average payment per service made by Medicare; and
- The number of fee-for-service beneficiaries in the State.

For example, approximately 20 percent of beneficiaries use inpatient hospital services during a year. If the average Medicare beneficiary is admitted for inpatient care 1.7 times each year (i.e., a use rate of 170 admissions per 1,000 beneficiaries) and the average payment per admission is $8,000, the average annual expenditure per beneficiary for inpatient hospital care is $2,720 (=0.2 × 1.7 × $8,000). If the number of fee-for-service beneficiaries residing in the State is 50,000, the total Medicare fee-for-service expenditure for inpatient hospital services in the State is $136 million (=$2,720 × 50,000).

For each category of covered service, e.g., inpatient acute-care hospital services, evaluation and management services, surgical procedures, imaging and diagnostic tests, skilled nursing facility services, home health visits, and durable medical equipment, the application must specify assumptions on:

- The anticipated impact of the State's initiative on the percentage of beneficiaries who use the service;
- The rate at which those beneficiaries use that service; and
- The average payment per unit of service.

The third of these assumptions, payment per unit of service, will be affected by changes in Medicare policy, which are independent of the State's initiative. However, it will also be affected by changes in the mix of services within the category that are used by participating beneficiaries. It is the effect of the State initiative on the mix of services that is of interest to CMS.

The application must provide a brief commentary giving the basis for each assumption and linking the State's intervention to the projected change. For example, if the applicant assumes that the use rate (percent of beneficiaries admitted to hospitals or number of admissions per user of inpatient hospital services) will decline by 5 percent, the application should describe the evidence on which the assumption that 5 percent of admissions can be eliminated is based, and why/how "APCP" will prevent these hospitalizations. The evidence on which assumptions are based may range from national studies of the relationship between primary care practices and hospital utilization, to analyses of utilization patterns conducted by the State as part of its reform initiative, to small-scale pilot studies conducted by participating providers. Citations to publications presenting the results of national studies used to develop these assumptions should be cited. Summaries of the results of unpublished studies should be included as a supplementary attachment to the application. A description of the methods, results, and findings of small-scale pilot studies should also be included as a supplementary attachment to the application.

3. Related Medicaid Waiver Requests

To the extent that participation in the State's multi-payer initiative by Medicaid requires the approval by CMS of waivers and State Plan Amendments under Title XIX of the Social

Security Act, the application must identify all waivers and State Plan Amendments that have been requested, including those that have been approved and those for which the State is awaiting approval, and indicate the status of these requests. For example, if a State has a primary care case manager (PCCM) program, the application should indicate the year in which the PCCM program was approved.

F. Evaluation Plan

The application must include a description of how the State will evaluate and monitor the effect of the initiative on access to care (particularly primary care), quality of care (using structure, process, and outcome measures), and patterns of utilization and expenditure.

The application must include information on:

1. Study design and methods (e.g., how comparison groups will be identified);
2. Identify the types of data and data sources that will be used in the evaluation;
3. The specific questions the evaluation will address;
4. How the results of the evaluation will be used by the State and other stakeholders (e.g., specific changes in State policy that may be made based on findings from the State's evaluation);
5. The organization and/or individuals who will conduct the evaluation; and
6. The expected timeline for completion, including the timing of interim reports;

Applicants must note that the State evaluation is separate and independent of the evaluation that CMS will conduct of Medicare's participation in the demonstration. The application must, however, indicate the State's willingness to share data and findings from the State's evaluation with the CMS evaluator.

G. Commitment to Cooperate in Evaluation

The application must include a statement by the State that it and the participating providers and payers, agree to cooperate in an independent formal evaluation of the demonstration, including submission of cost and other program data and making relevant staff of participating organizations available for site visits conducted by CMS and/or its contractor.

H. Limitation on Participation in Other Medicare Demonstrations

The application must include a statement by the State that it and the participating providers agree not to participate in more than one Medicare demonstration at any point in time, and will not apply to participate in any Medicare demonstration (other than the MAPCP Demonstration) that covers the period between the start and end dates of the MAPCP Demonstration.

IV. Application Process

A. Application Timetable/Milestones

The deadline for submission of applications is 60 calendar days following the publication of the solicitation. Applications must be received by CMS at the location indicated below no later than 5:00 pm Eastern time on August 17, 2010.

A notice of intent to apply to the demonstration must be submitted within 2 weeks (10 working days) of the date of publication, or no later than 5:00 pm Eastern Time June 30, 2010. The notice of intent must specify the State entity that will be applying for the demonstration, a contact person, and the proposed location for the demonstration if it is not going to be state-wide.

B. Length of Application

Applications must be not more than 40 pages in length and must include not more than 30 pages of supporting material (e.g., documentation related to financial projections, profiles of participating communities and/or practices, letters of endorsement from professional associations).

C. Submission Requirements

Applicants must submit six paper copies of the complete original application plus one unbound copy suitable for copying. Applicants must also submit an electronic copy of the complete application. All applications should be sent by the due date specified above to:

MAPCP Demonstration
c/o Jody Blatt, Project Officer
Medicare Demonstrations Program Group
CMS
Mail Stop C4-17-27
7500 Security Boulevard
Baltimore, MD 21244

D. Availability of Data/Releases of Data to State Programs

CMS will make selected aggregate data derived from the Chronic Condition Warehouse available to a State that notifies CMS of its intent to submit an application as described in section I.D. The information will be sent to the contact person identified in the letter of intent as described in section IV.A. The purpose of these data is to facilitate the State's development of projections of budget neutrality. These data will describe historical patterns of Medicare utilization and expenditure by Medicare beneficiaries covered under the fee-for-service program.

V. Review Process and Criteria

A. Review Process

CMS expects to enter into cooperative agreements with up to six qualifying States. Applications will be reviewed by a panel of experts drawn from within CMS and Health and Human Services to determine whether they meet the basic eligibility requirements outlined in section II. If the number of qualified applications exceeds six, the qualified applications will be rank-ordered by the review panel according to the criteria outlined in section V.B.2. CMS will enter into cooperative agreements with the six most highly ranked qualified applications unless a compelling case can be made to increase the number of cooperative agreements and CMS resources will permit participation in more than six State initiatives. CMS reserves the right to enter into fewer than six cooperative agreements.

B. Review Criteria

1. Mandatory Eligibility Criteria

Applications will be reviewed by a panel of technical experts to determine whether the goals of the State's initiative are clearly defined, whether the components of the State's initiative are well defined, and whether the projection of success is supported by adequate evidence. The specific criteria that will be used to evaluate applications correspond to the principal sections of the application and will include:

- *Eligibility*--Does the State initiative meet the eligibility requirements? Has the State initiative identified mechanisms to support advanced primary care, particularly in small practices? Does the State initiative provide an effective means of using community resources to support APCP? Does the State have established programs of health promotion/disease prevention that the APCP initiative will support?

- *Problem Statement*--Has the State identified a problem or problems in the organization and delivery of care to Medicare beneficiaries that (a) are prevalent in the Medicare population; (b) have a substantial effect on both quality of care and expenditures; (c) can be reasonably attributed to and addressed by implementation of the State initiative? Another way of formulating this criterion is--will the State's initiative result in changes in the organization and delivery of care that it is reasonable to believe will lead to substantial improvements in the safety, timeliness, effectiveness, equity, and efficiency, and to more effective participation by patients in decision making concerning their care?

- *Description of the State Initiative*--Has the State initiative adopted a rigorous definition of "APCP" that will, when implemented, result in the transformation of primary care practices? Have specific changes in the organization and delivery of primary care been identified that will increase coordination of care, reduce fragmentation, and increase the ability of beneficiaries to navigate the health care system, and more effectively manage their condition?

- *Organizational Structure and Capacity*--Does the State initiative have the organizational structure and resources that are needed to achieve its goals?

- *Projection of Budget Neutrality*--Has the State initiative developed a reasonable, credible projection of anticipated Medicare expenditures for services not otherwise covered by parts A and B of the Medicare program? Does the application demonstrate an understanding of utilization and expenditure patterns in the Medicare population? Has the application identified realistic and reasonable goals for changes in utilization and expenditure patterns in the Medicare population that are supported by reasonable evidence? How strong is the evidence on which the projection of the effect of the State initiative on Medicare expenditures is based?

2. Ranking Criteria for Qualified Applications

If more than six applications are received that meet the required eligibility criteria, the qualifying applications will be ranked to identify those State initiatives that provide the most useful information on: (1) the potential of the advanced medical home concept to improve health care delivery; (2) the effect of different APCP definitions and payment methods and

effect on patterns of health care delivery; and (3) the extent to which changes in payment policy encourages transformation of primary care practice and health care delivery.

To rank individual applications, each will be measured against the following criteria:

- What is the magnitude of the opportunities for material improvements in health care delivery within the State that will be effectively addressed by the proposed reforms? Priority will be given to State initiatives that identify with the greatest credibility and greater opportunities for improvement. That is, an application that credibly identifies greater opportunities for improvement will be rated more highly than an application that identifies more limited opportunities.

- How prevalent in other States are the opportunities for improved performance represented by a specific application? Are the opportunities addressed by the State initiative unique to the State or are they generally found elsewhere? Recognizing the great variation across states in both the organization and delivery of care, it is important to select a set of applications that will provide information on the effects of the advanced medical home model in different States. Priority would be given to applications that offer the opportunity to test the advanced medical home model in different kinds of communities (e.g., urban, rural, low-income, high-utilization, etc.).

- How broadly could the payment methods being used in a State program be adopted? Priority would be given to those applications from programs that make use of payment methods that could be adopted in a larger number of communities or States.

- What is the strength of the evidence that the proposal will not result in an increase in Federal expenditures? Priority will be given to those applications that include stronger evidence, e.g., based on rigorous analysis of practice patterns in the State or a design that focuses on reducing unjustified variation in use of and expenditures for medical services.

C. Budget Neutrality Certification

The State's projections of impact on Medicare expenditures will be reviewed by both the Office of Research, Development, and Information and the Office of the Actuary (OACT). The purpose of this review is to determine whether the projection of budget neutrality is credible. OACT must certify that the State initiative as described in the application is likely to result in expenditures that are not greater and are likely to be less than would be incurred in the absence of Medicare's participation in the State multi-payer initiative.

D. Award and Clearance

After completion of the review, awards will be made by the Acting Administrator based on a review by and the recommendations of the panel of technical experts. All awards must also be cleared by both Health and Human Services and the Office of Management and Budget.