Overview

The following document provides a high level overview of major federal Centers for Medicare and Medicaid Services (CMS) initiatives impacting long term care populations and long term care services. All information was pulled directly from www.cms.gov or www.medicaid.gov.

Bundled Payments for Care Improvement

Subscribe to receive emails about the Bundled Payments initiative.

Recent Updates:

04/05 - The online application will be available the week of April 23, 2012. The applications for Models 2-4 are now due by 5 PM EDT, June 28, 2012. Additional information on Models 2-4 update page.

Overview

The Bundled Payments for Care Improvement initiative is seeking applications for four broadly defined models of care, three of which would involve a retrospective bundled payment arrangement, with a target price (target payment amount) for a defined episode of care and one of which would be paid prospectively. Read the Fact Sheet (PDF).

Under the Bundled Payments initiative, CMS would link payments for multiple services patients receive during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together.

Background

Medicare currently makes separate payments to providers for the services they furnish to beneficiaries for a single illness or course of treatment, leading to fragmented care with minimal coordination across providers and health care settings. Payment is based on how much a provider does, not how well the provider does in treating the patient.

Research has shown that bundled payments can align incentives for providers – hospitals, post acute care providers, doctors, and other practitioners– to partner closely across all specialties and settings that a patient may encounter to improve the patient’s experience of care during a hospital stay in an acute care hospital, and during post-discharge recovery.
Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Medicare offers several ACO programs, including:

- **Medicare Shared Savings Program (cms.gov)** - For fee-for-service beneficiaries
- **Advance Payment Model** - For certain eligible providers already in or interested in the Medicare Shared Savings Program
- **Pioneer ACO Model** - Health care organizations and providers already experienced in coordinating care for patients across care settings

General information on ACOs can also be found at [cms.gov/aco](https://www.cms.gov/aco) and this [HealthCare.gov ACO Fact Sheet](https://www.healthcare.gov/aco).

Community-based Care Transitions Program

Subscribe to receive automatic updates on this initiative.

**Recent Updates:**
03/22 - CCTP webinar announced
03/14 - 23 new partners added

**Overview**

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

[View the site selections for the CCTP.](https://www.cms.gov/aco)

**Background**

Hospitalizations account for approximately 33 percent of total Medicare expenditures and represent the largest program outlay. The Medicare Payment Advisory Commission estimated Medicare costs of approximately $15 billion due to readmissions, $12 billion of which is for cases considered preventable. Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible, including the quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions, and identifying the key drivers of readmissions for a
hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.

CMS is particularly concerned that increasing rates of avoidable hospital readmissions will also result in negative health outcomes for Medicare beneficiaries impacting their levels of safety and quality of care. The CCTP seeks to correct these deficiencies by encouraging a community to come together and work together to improve quality, reduce cost, and improve patient experience.

How to Apply

CMS is accepting applicants and enrolling participants on a rolling basis as funding permits. The program will run for 5 years. Participants will be awarded two-year agreements that may be extended annually through the duration of the program based on performance.

Download the Solicitation for Applications (PDF)
Download the Application (PDF)
More information on how to apply is on the CMS.gov CCTP program page

State Demonstrations to Integrate Care for Dual Eligible Individuals

The Medicare/Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation (Innovation Center) are partnering to bring this opportunity to states. The Medicare/Medicaid Coordination Office and the Innovation Center will work closely with the Center for Medicare (CM), the Center for Medicaid, CHIP and Survey & Certification (CMCS) and other partners across the Centers for Medicare and Medicaid Services and the Department of Health and Human Services (HHS) on this initiative.

Overview

Under the State Demonstrations to Integrate Care for Dual Eligible Individuals, fifteen states across the country have been selected to develop new ways to meet the often complex and costly medical needs of the approximately nine million Americans who are eligible for both the Medicare and Medicaid programs, known as “dual eligibles.”

States received funding to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral and long-term supports and services for dual eligible individuals. States will work with beneficiaries, their families and other stakeholders to develop their demonstration proposals. The goal of the program is to eliminate duplication of services for these patients, expand access to needed care, and improve the lives of dual eligibles, while lowering costs.

15 States were selected to receive up to $1 million to support the design of programs to better coordinate care for dual eligible individuals.
Background
There are around 9 million individuals who are dual eligibles; that is, eligible for both Medicare and Medicaid. While this 9 million represents a small percentage of the approximately 100 million people enrolled between the two programs, they account for a disproportionate amount of spending (about $300 billion a year) across both programs. For example, dual eligible beneficiaries account for 16 percent of Medicare enrollees but 27 percent of Medicare spending; in the Medicaid program, individuals dually enrolled make up 15 percent of the program but account for 39 percent of costs.

For more information on State Demonstrations to Integrate Care for Dual Eligible Individuals, please visit cms.gov/medicare-medicaid-coordination.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

This initiative is possible through the collaboration of the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office.

Recent Updates:
04/02 - Slides for April 3 webinar posted on ‘Overview and How To Apply’ webinar page
03/26 - New webinar announced for April 3, 2012 to provide initiative overview and how to apply information.

Overview
This new effort aims to improve the quality of care for people residing in nursing facilities. The Centers for Medicare & Medicaid Services (CMS) is currently accepting applications to participate in this initiative.

CMS will support organizations that will partner with nursing facilities to implement evidence-based interventions that both improve care and lower costs. The initiative is focused on long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs, with the goal of reducing avoidable inpatient hospitalizations. This initiative supports the Partnership for Patients’ goal of reducing hospital readmission rates by 20% by the end of 2013.

See the details of these state efforts.
Background

Nursing facility residents often experience potentially avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, and disorienting for frail elders and people with disabilities. Nursing facility residents are especially vulnerable to the risks that accompany hospital stays and transitions between nursing facilities and hospitals, including medication errors and hospital-acquired infections.

Many nursing facility residents are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). CMS research on Medicare-Medicaid enrollees in nursing facilities found that approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005.

Initiative Details

Through this initiative, CMS will partner with eligible, independent, non-nursing facility organizations (referred to as “enhanced care & coordination providers”) to implement evidence-based interventions that reduce avoidable hospitalizations. Eligible organizations can include physician practices, care management organizations, and other entities. Both for-profit and not-for-profit organizations are eligible to apply.

The enhanced care & coordination providers will collaborate with States and nursing facilities, with each enhanced care & coordination provider implementing its intervention in at least 15 partnering nursing facilities.

Applicants will propose an intervention that meets the objectives of the initiative, which those selected will then implement. Interventions will be evaluated for their effectiveness in improving health outcomes and providing residents with a better care experience.

Addition Information

- Fact Sheet
- Solicitation (PDF)
- Webinar: Overview and How to Apply
  - Notice of Intent to Apply - completing this NOIA by April 30, 2012 at 3:00pm ET is required to apply to this initiative

For more information on this initiative, including archived information, visit cms.gov/medicare-medicaid-coordination.
Nursing Home Value-Based Purchasing Demonstration

Background

The Nursing Home Value-Based Purchasing (NHVBP) Demonstration is part of the Centers for Medicare & Medicaid Services (CMS) initiative to improve the quality and efficiency of care furnished to Medicare beneficiaries. Under this demonstration, CMS will offer financial incentives to nursing homes that meet certain conditions for providing high quality care. The demonstration will be open to free-standing and hospital-based facilities and will include beneficiaries who are on a Part A stay as well as those with Part B coverage only. The demonstration will be conducted in 3 states: Arizona, New York and Wisconsin.

Basic Approach

Each year of the demonstration, CMS will assess each participating nursing home’s quality performance based on four domains: staffing, appropriate hospitalizations, minimum data set (MDS) outcomes, and survey deficiencies. CMS will award points to each nursing home based on how they perform on the measures within each of the domains. These points will be summed to produce an overall quality score. For each State, nursing homes with scores in the top 20 percent and homes that are in the top 20 percent in terms of improvement in their scores will be eligible for a share of that State’s savings pool.

Financing

The demonstration will be budget neutral to Medicare. We anticipate that potentially avoidable hospitalizations may be reduced as a result of improvements in quality of care. The reduction in hospitalizations and subsequent skilled nursing facility stays is expected to result in savings to Medicare. These savings would be used to fund a savings pool for each state from which payment awards would be made.

Within each state, CMS selected demonstration participants from among applicant nursing homes. Then CMS selected a control group of nursing homes that matched the characteristics of the demonstration group. After each year, CMS will compare total risk-adjusted Medicare expenditures between the demonstration and control groups in each state. The actual savings pool for each state will be determined based on the difference in the growth of risk-adjusted Medicare expenditures between the two groups.

Status

The demonstration began July 1, 2009 with the following number of participants: Arizona: 41 New York: 79 Wisconsin: 62

Additional Information
Balancing Long-Term Services and Supports

Despite increasing use of home and community-based services, the organization, financing, and delivery of Medicaid-funded long-term care services remains biased towards institutional care. Recognizing the challenges, the Affordable Care Act contains a number of provisions to help States balance their Medicaid long-term service delivery systems by expanding access to an array of home and community-based services and reducing dependence on institutional care, including:

- A new State Balancing Incentive Payments Program to encourage States to increase Medicaid long-term services and supports (LTSS) in the home and community
- New Medicaid State Plan options for home and community-based services
- Increased funding for rebalancing initiatives like Money Follows the Person (MFP)

In addition to the Affordable Care Act provisions, there are several grant and program initiatives designed to assist States in balancing and promoting systems change, including:

- Real Choice Systems Change Grant program (RCSC)
- Homelessness Initiatives
- Employment Initiatives

Goals of a Balanced Medicaid Funded Delivery System

The goal of the Medicaid balancing initiatives is to create a person-driven, long-term support system that offers people with disabilities and chronic conditions choice, control and access to services that help them achieve independence, good health and quality of life.

A balanced system is:

**Person-driven**: The system gives people choice over where and with whom they live, control over the services they get and who they get services from, the chance to work and earn money, the option to include friends, and supports to help them participate in community life.

**Inclusive**: The system encourages people to live where they want to live, with access to a full array of community services and supports.

**Effective & Accountable**: The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners, and includes personal accountability and planning for long-term care needs, including greater use of private funding sources.

**Sustainable & Efficient**: The system efficiently coordinates and manages a package of paid services appropriate for the beneficiary, paid for by the right entity.
Coordinated & Transparent: The system coordinates services from various funding streams to provide a seamless package of supports, and uses health information technology to effectively provide transparent information to consumers, providers and payers.

Culturally Competent: The system provides user-friendly, culturally-appropriate, accessible information and services.

National Balancing Indicator Project

The Centers for Medicare & Medicaid Services (CMS) commissioned the National Balancing Indicator Project (NBIP) to develop and test the feasibility of implementing national indicators to assess States’ efforts toward attaining and maintaining a balanced, person-driven long-term supports and services (LTSS) system. The mission of the NBIP is to assist CMS and States in developing indicators that will help gauge a State’s success in “balancing” its long-term support program, which will in turn inform Federal and State policy making.

The NBIP began in FFY 2007 and continues into 2014. Get more information on NBIP.

Health Homes

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 2703 of the Social Security Act. CMS expects states health home providers to operate under a “whole-person” philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

Who Is Eligible for a Health Home?

Health Homes are for people with Medicaid who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.

States can target health home services geographically but states may not exclude people with both Medicaid and Medicare from health home services.

Health Home Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
• Patient & family support
• Referral to community & social support services

Health Home Providers

States have flexibility to determine eligible health home providers. Health home providers can be:

• A designated provider: May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.
• A team of health professionals: May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.
• A health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractics, licensed complementary and alternative practitioners.

Reporting Requirements

Health Home service providers must report quality measures to the state. States are also required to report utilization, expenditure and quality data for an interim survey and an independent evaluation.

Health Home Financing

States have the flexibility in designing their payment methodologies and may propose alternatives. States receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the specific health home services in Section 2703. The enhanced match doesn’t apply to the underlying Medicaid services also provided to people enrolled in a health home.

The 90% enhanced FMAP is good for the first eight quarters the program is effective. A state can get more than one period of enhanced FMAP, but can only claim the enhanced FMAP for a total of eight quarters for one enrollee.

The Integrated Care Resource Center (ICRC) is available to provide technical assistance to States considering the health home Medicaid State Plan option. The ICRC website provides useful information on health homes, such as approved state plan amendments and frequently asked questions. To view the website, click here.

For more information, contact: healthhomes@cms.hhs.gov.