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(202) 690-6343

Affordable Care Act to help improve care for Medicare beneficiaries
500 Federally Qualified Health Centers to receive funding, participate in a program to improve care

Thanks to the Affordable Care Act, 500 community health centers in 44 States across the country will receive approximately $42 million over three years to improve the coordination and quality of care they deliver to people with Medicare and other patients, the Department of Health and Human Services announced today.

"Health centers are integral parts of our communities," said Centers for Medicare & Medicaid Services (CMS) Administrator Donald M. Berwick, M.D. "This initiative will give participating health centers the help they need to improve care for many people with Medicare who rely on them as their main source of care."

Under this Advanced Primary Care Practice demonstration, created by the Affordable Care Act, Medicare will pay community health centers based on the quality of care they deliver. This improved payment system will reward clinics for such things as helping patients manage chronic conditions like diabetes or high blood pressure.

In addition, health centers will use this funding to expand their hours, make same day appointments and accommodate patients with urgent care needs.

"The goal of this demonstration is to help patients get the care they need in a primary care setting rather than in an emergency department," said Dr. Berwick. "When patients are able to use a health center as their primary source of care, it helps primary care doctors, nurses and specialists coordinate their care. Health centers will also use health care dollars more wisely as patients receive the right tests, right medications and right treatments in the right setting."

The demonstration will be conducted from November 1, 2011 through October 31, 2014. Participating health centers will be paid a monthly fee for each eligible person with Medicare that receives primary care services. The CMS Center for Medicare and Medicaid Innovation (Innovation Center) and the Health Resources Services Administration (HRSA) will provide technical assistance to help participating community health centers throughout the demonstration.

“The lessons learned from this demonstration project will help all community health centers improve on their long–standing commitment to providing high quality, patient-centered primary care,” said Health Resources and Services Administration (HRSA) Administrator Mary K. Wakefield, PhD., R.N. “This program will help strengthen the relationship between the more than 8,100 health center sites HRSA helps fund and the communities they serve.”

To study the process and challenges involved in transforming community health centers into advanced primary care practices, the Innovation Center will conduct an independent evaluation of the demonstration. The evaluation will assess the project’s impact on hospital admission rates, emergency department visits rates, access, quality and cost of care provided to Medicare beneficiaries. The evaluation will also assess whether the demonstration was cost effective.

This Advanced Primary Care Practice demonstration is operated by the Innovation Center in partnership with HRSA. It is one of a number of initiatives made possible by the Affordable Care Act to help bring better health and better health care not just to Medicare beneficiaries, but to all Americans, while helping use healthcare dollars more wisely.

For example, the HRSA Health Center Quality Improvement and Patient Centered Medical Home Supplemental Funding initiative is providing 904 community health centers nationwide new support to provide care coordination services to patients including care planning and efforts to help doctors work together to deliver better care for patients.

Health centers improve the health of the nation and assure access to quality primary health care services at more than 8,100 service delivery sites around the country. They are also an integral source of local employment and economic growth in many underserved and low-income communities. Since the beginning of 2009, health centers across the country have added more than 18,600 new full-time positions in many of the nation’s most economically distressed communities. In 2010, they employed more than 131,000 staff and new funds, made available by the Affordable Care Act in September, will help create thousands more jobs nationwide.

For more information on how the Affordable Care Act is finding better ways to improve healthcare, visit www.HealthCare.gov.

More information on the Advanced Primary Care Practice demonstration project, including a fact sheet, and a list of participating health centers can be found at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/fqhc/.

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FACT SHEET

FOR IMMEDIATE RELEASE Contact: CMS Media Relations Group

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Medicare Federally Qualified Health Center
Advanced Primary Care Practice Demonstration

OVERVIEW

On October 24, 2011, the Centers for Medicare and Medicaid Services announced that 500 Federally Qualified Health Centers (FQHC) have been selected for the FQHC Advanced Primary Care Practice (APCP) demonstration project from over 800 applicants. The initiative is designed to evaluate the impact of the advanced primary care practice model, also known as the patient-centered medical home, on improving health, improving quality of care, and lowering the cost of care provided to Medicare beneficiaries served by FQHCs.

The demonstration was developed by the Center for Medicare and Medicaid Innovation (Innovation Center) in cooperation with the Health Resources Services Administration (HRSA). This initiative will provide health care opportunities for nearly 200,000 Medicare beneficiaries aimed at improving their quality and coordination of care while lowering costs.

This fact sheet provides a general description of the Federally Qualified Health Center Advanced Primary Care Practice demonstration.

BACKGROUND

The Innovation Center was created by the Affordable Care Act to test new models of health care delivery and payment, offer technical support to providers to improve the coordination of care, and diffuse lessons learned and best practices widely throughout the healthcare system. It is committed to transforming the Medicare, Medicaid and CHIP programs to deliver better care for individuals, better health for populations, and slower growth in expenditures through improvement for Medicare and Medicaid beneficiaries.

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower costs for all Americans. The Advanced Primary Care Practice is a physician-based or nurse practitioner-led medical practice that provides continuous, comprehensive, coordinated, and patient-centered medical care. An APCP links multiple points of health delivery by utilizing a team approach with the patient at the center. It is designed to encourage doctors, hospitals, and other healthcare providers to work together to better coordinate care for Medicare patients.

FEDERALLY QUALIFIED HEALTH CENTER ADVANCED PRIMARY CARE PRACTICE DEMONSTRATION

On December 9, 2009, President Barack Obama directed the Secretary of Health and Human Services (HHS) to implement a Medicare Federally Qualified Health Center Advanced Primary Care Practice demonstration designed to improve quality and coordination of care, and to reduce preventable hospitalizations. The 3 year demonstration will test the effectiveness of doctors and

other health professionals working in teams to improve the care coordination for Medicare patients at FQHCs. CMS will conduct an independent evaluation of the demonstration that will determine whether FQHCs that deliver advanced primary care improve access and quality, promote appropriate use of services, and reduce health care costs.

The FQHC APCP demonstration will assess the impact of Medicare paying a care coordination fee to participating FQHC practices, in addition to the established "all inclusive per visit payment amount," for the FQHC to provide care coordination and management services as would typically be provided in an advanced primary care practice. The care management fee would apply to all Medicare beneficiaries who receive medical care from participating FQHCs as long as the beneficiaries remain eligible to participate. CMS will monitor practice changes over time to determine how well participating FQHCs are progressing in providing and expanding the delivery of continuous, comprehensive, and coordinated primary health care.

Becoming an APCP requires that a medical practice change the way it delivers medical care to its patients. This transformation requires considerable thought and planning by a medical practice and may require various levels of investments in both time and money. Practices must shift from an acute care complaint-driven primary care paradigm that fragments health care delivery to one that is geared to maintain the patient's overall health and anticipates when additional services or coordination needs to occur.

For example, an APCP practice must be able to offer enhanced access to care through expanded hours, same day appointments, or priority appointments so the patient does not need to seek urgent care through more expensive means, such as the emergency department. In addition, APCP practices are likely to employ a team approach, sometimes consisting of nurse coordinators, physician assistants, pharmacists, and social workers, to coordinate health care and other services, all of which are overseen by a physician or nurse practitioner. In the end, the APCP is based on the relationship between the physician-led or nurse practitioner-led medical team and the patient. Through this relationship the team is aware of all the medical services the patient needs and uses, even if the APCP does not provide those services directly (i.e., specialty care, hospitalizations, emergency care).

The patient participates in all decision making and communicates with the team about his or her individual health needs, experiences and treatments. The patient shares information with the team on symptoms or health concerns, as well as visits to other health care providers so that all parties can decide how best to proceed. The APCP team is responsible for coordinating the overall care of the patient across providers and settings to facilitate compliance with the agreed-upon treatment plan.

CMS expects that FQHC practices participating in the demonstration not only will have an interest in serving as medical homes to their Medicare patients but also are willing to make the necessary practice transformations to become fully functioning advanced primary care practices.

A description of the functions of a medical home can be found in the Joint Principles of the Patient Centered Medical Home which were adopted in February of 2007, by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA, and the American Academy of Pediatrics (AAP). http://www.acponline.org

Eligibility Requirements:
To participate in the FQHC APCP demonstration, FQHCs must have met certain eligibility requirements. Specifically, an FQHC:

- Must be in an individual (brick and mortar) physical location.
- Must be a current FQHC with a valid Provider Transaction Account (PTAN) number from CMS.
- Must not currently be under a corrective action plan for serious financial or safety issues according to HRSA.
- Must be a physician-based or nurse practitioner-led practice. (Clinical decisions and oversight are provided by one of these clinicians.)
- Must be providing primary care services (as opposed to only providing specialty service, such as dental or vision care).
- Must provide primary care services to a general population and not exclusively to migrant workers or to the homeless.
- Must have provided medical services to at least 200 unique, qualified fee-for-service Medicare beneficiaries (with both Part A and Part B coverage, not Medicare Advantage) in the most recent 12 months for which CMS has data, including those with both Medicare and Medicaid (dual eligible) coverage.
- Must not be participating in another Medicare medical home of advanced primary care practice demonstration.
- Must agree to participate in the evaluation of the demonstration.

Medicare Beneficiaries:
- Beneficiaries, including dually eligible Medicare/Medicaid beneficiaries, must be enrolled in the Medicare Part A and Part B fee-for-service program, during the initial 12 month look-back period, and must not be currently in hospice care or under treatment for end-stage renal disease.
- Beneficiaries enrolled in Medicare Advantage are not eligible to participate in this Demonstration.
- Attribution of beneficiaries to an FQHC will be based on Medicare administrative data for beneficiaries for whom CMS has a claim in the look-back period.
- Beneficiary eligibility is verified each quarter prior to payments being made. Participating FQHCs will receive an updated roster of attributed beneficiaries along with the quarterly fee payment.

Payment:
- Participating FQHCs will receive a monthly care management fee of $6.00 for each eligible Medicare beneficiary attributed to their practice to help defray the cost of transformation into a person-centered, coordinated, seamless primary care practice. This payment, which will be made quarterly, is in addition to the usual all-inclusive payment FQHCs receive for providing Medicare covered services.
- The fee will be paid automatically without the need to submit a claim.
- Payment can only be made via Electronic Funds Transfer (EFT).

Terms and Conditions:
As a condition of participation in the FQHC APCP demonstration, FQHCs must have agreed to:

- Pursue Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) by the end of the Demonstration;
- Remain in the Demonstration for the 3-year duration beginning November 1, 2011.
- Submit a completed Application to participate by 11:59 pm (ET) on Friday, September 9, 2011, and to submit an initial Patient Centered Medical Home (PCMH) Readiness Assessment as part of the application process by 11:59 pm (ET) on Friday, September 16, 2011.
- Submit a revised Readiness Assessment every 6 months for the duration of the Demonstration.
- Cooperate with the organization CMS engages to evaluate the Demonstration. This may include providing additional information or data.
- Comply with all monitoring requirements. This includes repeating the Readiness Assessment every 6 months throughout the Demonstration.

Additionally, FQHCs must:
- Attest that it is not currently under a corrective action plan from HRSA for serious safety or financial issues.
- Acknowledge that CMS can terminate participation in the Demonstration for failure to progress toward PCMH recognition based on periodic Readiness Assessment scores.
- Acknowledge that CMS can terminate participation in the Demonstration by any FQHC that has committed Medicare fraud.
- Agree to participate in learning cooperatives and other technical assistance that is offered by CMS and HRSA.
- Acknowledge that failure to comply with all terms and conditions may result in disqualification from the Demonstration.

The terms and conditions are subject to change in the interest of improving results under the demonstration. Such changes would require the consent/approval of both parties and at least 30 days' advance notice to facilitate their implementation.

Demonstration Implementation:
The three-year demonstration will begin on November 1, 2011.

Beneficiary Verification and Attribution Process:
CMS will review Medicare administrative claims data of participating FQHCs to identify beneficiaries who have received services from those FQHCs in the most recent 12-month period (look-back period). These beneficiaries will then be attributed to the appropriate FQHC. In order to be eligible for attribution to an FQHC, Medicare beneficiaries must meet the following criteria:

- Must be enrolled in Medicare Part A and Part B fee-for-service, or be covered as a dually eligible beneficiary during the most current look-back period.
- Must not be covered under a Medicare Advantage plan or Medicaid Managed Care (for dually eligible beneficiaries) during the most current look back period.
- Must receive the majority of their primary care from the FQHC site with which they are attributed over the past 12 consecutive months.

- Must receive advanced primary care services from only one participating FQHC practice

In the event that a beneficiary has received services from more than one participating FQHC in the past 12-month period, the beneficiary will be assigned to the FQHC where the majority of their care was received. If a beneficiary has the same number of visits for more than one participating FQHC in the past 12-month period the beneficiary will be assigned to the most recently visited FQHC. Each participating FQHC will be provided with a roster of their assigned beneficiaries using this attribution methodology.

Each participating FQHC will receive a roster of eligible Medicare beneficiaries who are assigned to their practice and for whom they will receive a care management fee. CMS assumes responsibility for the assignment of beneficiaries to participating FQHCs. Participating FQHCs will not be permitted to contest these assignments.

On a quarterly basis, CMS will repeat the administrative claims data review process to add new beneficiaries seen by the FQHC and remove beneficiaries that have become ineligible since the last look-back period from assignment rosters.

<u>Management Fee Payments</u>:
Each participating FQHC will receive a quarterly prospective care management fee of $18 for each beneficiary identified by CMS and attributed to the FQHC. The quarterly fee payment does not require a claim to be submitted and is in addition to, and exclusive of the usual all inclusive per visit payment amount for Medicare covered services. The fee will be paid regardless of whether a beneficiary utilizes any FQHC services during any given month. It will automatically be paid for each enrolled beneficiary as long as the beneficiaries remain eligible to participate in the demonstration. Fees will be electronically transferred to the practice account each quarter after each beneficiary's eligibility has been verified. Quarterly prospective care management fee payments will begin November 15, 2011.

<u>Technical Assistance</u>:
CMS and HRSA will provide technical assistance to all participating FQHCs to help with developing PCMH capabilities for the recognition process and to help with practice transformation. All participating FQHCs are expected to actively participate in available trainings and transformational learning systems to reach the goal of Level 3 NCQA recognition by the end of the Demonstration.

CMS and HRSA will make technical assistance available to participating FQHCs to support their transformation and achieve NCQA recognition as a PCMH.

HRSA, through a contract with NCQA, has developed a series of technical assistance and training resources that highlight successful strategies for obtaining and maintaining PCMH recognition status. The training and educational resources that will be available to participating FQHCs include among others:

- Educational and training sessions
- Webinar(s) on NCQA PCMH recognition standards

Educational and training sessions, and webinars will focus on understanding NCQA standards, and mock surveys to gain experience with the NCQA PCMH recognition process and documentation requirements. In addition, CMS is developing transformational learning systems to assist participating FQHCs to successfully transform their practice into a recognized patient-centered medical home.

Technical assistance will be provided at no cost to participating FQHCs. Core training modules will be provided on specific topics essential to performing as a patient-centered medical or health home. Topics may include patient-centered care, team-based delivery, the use of data/performance feedback for continuous quality improvement, and improving care transitions. Learning communities or collaboratives will also be created where groups of FQHCs, either identified by geographic area, areas of interest for transformation, or some other criteria participate in a series of webinars, conference calls, or face-to-face meetings to receive additional training, share implementation experiences, and provide support to each other in their transformation.

Demonstration Monitoring and Evaluation:

Participating FQHCs will be accountable for implementing practice changes necessary to transform into advanced primary care practices. CMS will monitor each participating FQHC's transformation progress by comparing readiness assessment scores at baseline with readiness assessment scores updated every 6 months. In addition, CMS will conduct random site audits to assure that assessment responses are accurate and true. CMS expects that each FQHC will invest the financial resources generated from the quarterly fees paid to facilitate the transformational areas they have chosen.

CMS will also provide cost and utilization data to participating FQHCs periodically throughout the demonstration so each FQHC can monitor the effect of their transformation on Medicare beneficiary outcomes and Medicare costs.

Demonstration Evaluation:

CMS will evaluate the results of the Demonstration by analyzing practice change over time. A baseline status will be established using a supplemental survey questionnaire which is administered as part of the application process and initial Readiness Assessment responses. Changes in Readiness Re-Assessments every 6 months and changes in practice characteristics from baseline will constitute evaluation measurements over time.

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