The Heartbeat of Texas Community Health Centers | **Weekly Wrap-up - April 13, 2012**

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Patient Exam
Frontera Healthcare Network,
Eden, TX

Upcoming Events

TACHC April CPI Webcast Training: Optimizing Comprehensive Clinical Care (The Really Big Picture)
April 20, 2012, 9:00am to 11:00am CST
During this session, TACHC's Director of Clinical Affairs, Davelyn Eaves Hood, and Associate General Counsel, Cecile Carson, will present what it means to implement an optimized comprehensive clinical care system by leveraging the elements of the OC³ Learning Year and CPI Manual and the Health Center Controlled Network (HCCN) centralized data repository (CDR). This session is a webcast repeat of the live session with the same name given at the April 13th day of the TACHC ACO OC³ Booster Session in Houston; thus registration is **free**.

Information regarding all upcoming events hosted by TACHC can be found **HERE**.

Governance and Finance

1. Texas House of Representatives Committee on County Affairs El Paso and Austin Public Hearings on 1115 Transformation Waiver: The House Committee on County Affairs will hold a public hearing at the University of Texas at **El Paso** in the Union Building on April 26, 2012 at 10:00 AM. The Committee will hear testimony on several interim charges including the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver. The Committee will also hold a public hearing in **Austin** on May 1, 2012 at 10:00 AM where will hear invited testimony on the 1115 Transformation Waiver. Click **HERE** to view the hearing notices and details about the locations.

2. Hogg Foundation RFP - 2012 Integrated Health Care Planning and Implementation Grants: The Hogg Foundation invites nonprofit behavioral health and primary care providers in Texas to submit proposals for integrated health care planning and implementation activities. The foundation is funding this program to support behavioral health and primary care providers as they integrate behavioral and physical health care services, with the ultimate goal of making integrated health care the standard practice in Texas. View proposal details, including eligibility, deadlines and submission information **HERE**. Please read the request for proposals thoroughly before submitting a proposal. Feel free to forward this invitation to others who may be eligible or interested.

3. TMHP Meaningful Use Portal: For eligible professionals (EPs) who are participating in the Texas Medicaid EHR Incentive Program, the state portal is now open for year 2 attestation via the Texas Medicaid & Healthcare Partnership (TMHP) website. As a reminder, the Texas portal has been open for AIU attestation (year 1 participation) since March of 2011. Providers who are ready for meaningful use attestation may now access the MU portal. The attached article provides the announcement and instructions on how to access the portal.

4. TACHC Registration for the Advanced Billing Managed Boot Camp is Open—Only 5 Spots Left! This 2-day training will be held in Austin on **June 11-12, 2012**. Because sessions will examine in more detail the concepts taught in the previous boot camps, focusing more on the individual characteristics and needs of your health center, we are limiting registration to those who attended a Beginner Billing Manager Boot Camp, either in October 2011 or February 2012. *If you did not attend a beginner boot camp but are interested in the advanced

event, please DO NOT register online for the advanced boot camp, as we will have to cancel your registration. Instead, please email Shelby Tracy directly for information on your options. The Advanced Billing Manager Boot Camp will also be limited to 25 participants, so make sure to register soon in order to reserve your spot. This will be the only session of this type to be offered by TACHC, so don't miss out on this opportunity! Click **HERE** to register for this event.

5. The CMS PULSE Provider Newsletter - Dallas Spring 2012 Edition: Attached please find the newsletter from our regional CMS office provided by Melissa Scarborough, MPH, CHES, External Affairs Specialist/Provider Liaison Centers for Medicare & Medicaid Services, Region VI Office of External Affairs, 1301 Young Street, Room 714 Dallas, Texas 75202, PH: 214-767-4407, FX: 214-767-6400, Melissa.Scarborough@cms.hhs.gov.

6. US DHHS Region VI Office of Minority Health RFPs: The Region VI Office of Minority Health announced two funding opportunities last week. The opportunities are intended to support projects, activities, or events in Region VI that address cardiovascular health and local environmental justice and public health issues, targeted to racial/ethnic and underserved populations. Proposals are due on April 30, 2012 at 5:00 PM CST.

7. TACHC Thank You to Accountable Care Leaders: Thank you to accountable care leaders Brazos Valley Community Action Agency, Centro de Salud Familiar La Fe, CentroMed, Community Action Corporation of South Texas, Frontera Healthcare Network, Lone Star Family Health Center, Los Barrios Unidos Community Clinic, North Central Texas Community Healthcare Center, and Su Clinica Familiar. With the leadership of these nine centers, TACHC has spun off a limited liability company, Essential Care Partners, that has built a partnership with a Medicare insurance company, Universal American's Community Health Services, and filed an application with CMS to become an Accountable Care Organization (ACO). This was one of the very few applications by FQHCs to become ACOs and will lead the way into other accountable care projects; we had our second ACO Board meeting in Houston yesterday. We want to thank the executives of these centers for taking the leap into the future with us. We also appreciate the second cohort of centers already working hard to be ready to join the ACO at the end of the year. Exciting times!

Clinical Affairs

1. TACHC Clinical Director Institute: Attention all Chief Medical Officers, Chief Dental Directors, and Behavioral Health Directors, please join your fellow colleagues this year for an interactive 2-day session that will help you prepare for the upcoming challenges at your community health center. The Institute will be July 27-28, 2012 at the Intercontinental Stephen F. Austin Hotel, 701 Congress Avenue, Austin, TX 788701. Presentations include, but not limited to: "Accountable Care, the Sustainability Model", "How to Spread the Knowledge or Proper Coding and Improve the Skills of CHC Providers", "ICD-10 Coding for Clinicians", "Peer Review" and "How to Manage Physicians in Good Times and Bad". Registration will be available on the TACHC Website, Events Page in the near future. For more information, contact Davelyn Eaves Hood, MD, Director of Clinical Affairs at the TACHC office, 512-329-5959, Ext. 2130.

2. National Prescription Drug Take Back Event: The 4th National Prescription Drug Take Back Event will occur on April 28, 2012 from 10 am to 2 pm. The purpose of this event is to provide community members a way to safely dispose of unused or expired drugs. By safely disposing of drugs you can help protect family members from accidental poisoning, our environment from pollution and reduce misuse. To find out more information, click **HERE** or to search by zip code for a collection point in your area, click **HERE**.

3. FTCC U.S./Mexico Border Collaborative Trainings: The TX/OK AIDS Education & Training Center (TX/OK AETC) in collaboration with Federal Training Center Collaborative (FTCC) partners invites you to

participate in a series of webinars/trainings specifically geared towards clinicians working in community health centers on the US-Mexico border and dealing with HIV-related issues. Continuing education will be offered for some of these trainings. For more information, click **HERE** to view details and to register!

Recruitment and Retention

National Health Service Corp Application Cycles Open! Application cycles for the National Health Service Corp Scholarship Program and Loan Repayment Program are open for providers at eligible centers! Applications for the Scholarship Program are due May 8, 2012 and applications for the Loan Repayment Program are due May 15, 2012.

Other News

1. TACHCiversaries: Please join TACHC in celebrating 19 years of working with and for community health centers for Daniel Diaz, TACHC Director of Community Development. Also, we celebrate 4 years for Albert Alvarez, IT Program Assistant, and Marcia Falloure, TACHC Provider Services Specialist, marked her 1 year anniversary with TACHC this month!

2. Community Health Development Inc. Grand Opening of Center for Community Wellness: You are invited to attend CHDI's grand opening of its brand new Center for Community Wellness. The ribbon cutting ceremony will begin at **10:00 AM** this **May 5, 2012** at 908 S. Evans St., Uvalde, TX 78801.

3. TACHC Member News: To learn what your fellow health centers are involved in, click **HERE** for news coverage. We also encourage you to post your news, questions and comments to each other on the TACHC members listserv (members@tachc.org), where only TACHC executives or their designees are recipients.

Meaningful Use Attestation Portal is Now Open for Eligible Professionals (EPs)

If you are participating in the Texas Medicaid Electronic Health Record (EHR) Incentive Program and have already successfully attested to first year requirements (Adopt, Implement, or Upgrade), **you may begin attesting to receive 2012 Stage 1 Meaningful Use incentives.** As a reminder, eligible professionals (EPs) must attest to patient volume, eligibility, and other program requirements for each year of participation. Starting with the second year of participation, EPs must annually attest to meeting meaningful use requirements.

To attest to meeting Stage 1 Meaningful Use requirements and receive a payment for Program Year 2, go to www.tmhp.com, log into your account, scroll to "Manage Provider Account", and click on the "Texas Medicaid EHR Incentive Program" link.

As a reminder, the following resources are available:

- Getting started with the Electronic Health Record Incentive Program: http://www.tmhp.com/Pages/HealthIT/HIT_EHR_GettingStarted.aspx
- Frequently asked questions: http://www.tmhp.com/Pages/HealthIT/HIT_EHR_FAQ.aspx
- Meaningful use and clinical quality measures for eligible professionals: http://www.tmhp.com/TMHP_File_Library/HealthIT/MU-CQMs%20Summary-EPs.pdf
- CMS EHR meaningful use overview: http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage

Please contact HealthIT@tmhp.com or 1-800-925-9126, option 4, if you have questions.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Serving Arkansas, Louisiana, New Mexico, Oklahoma and Texas.

SPECIAL EDITION: 2ND ANNIVERSARY OF THE PASSAGE OF THE AFFORDABLE CARE ACT

It's the 2nd Anniversary of the Passage of the ACA

March 23, 2012 marked the two year anniversary of the Affordable Care Act (ACA). The act was passed by Congress and signed into law by President Obama on March 23, 2010. The law is designed to put into place comprehensive health insurance reforms, which provides the American consumer with more control of their heath and health care coverage. The ACA aims to improve our current health care delivery system by increasing access to health coverage, while at the same time providing protections for people with health insurance, as well as those with pre-existing health conditions.

ACA has introduced safeguards and programs that place consumers at the center of the health care system. This includes a patient's bill of rights, which will help stop insurance companies from limiting needed health care. The law also established the Pre-existing Conditions Insurance Plan (PCIP). This program now provides health insurance coverage to nearly 50,000 people living with high-risk pre-existing medical conditions, acting as a bridge to 2014, when insurance companies will no longer be able to deny coverage to adult individuals with pre-existing conditions. The ACA already afforded this protection to children with pre-existing conditions as of September 2010.

Inside this Issue...

Nearly 50 million seniors and Americans with disabilities depend on Medicare. Now, the health care law makes Medicare even stronger by making several key improvements. First, it makes many key preventive services available to our beneficiaries with no co-pay or deductible. This helps ensure that seniors don't have to skip potentially life-saving screenings because they can't afford it. And, an annual "wellness visit" is now covered with no co-pay or deducible. In addition, Medicare beneficiaries enrolled in Part D who hit the coverage gap known as the "donut-hole," will get a 50 percent discount on name brand prescription drugs, and a 14 percent discount on generic drugs. Before the law, under Medicare Part D, seniors in the donut hole had to pay out of pocket for all prescription drug costs in the coverage gap, which can amount to thousands of dollars.

ACA has also provided additional tools and resources to Medicare in the fight against fraud and abuse. As a result, the Medicare trust fund was able to recover close to $4.1 billion in fraud during 2011. The law reduces health care costs and makes sure health care dollars are spent wisely. For example, it mandates that insurers must now spend at least 80 percent of premiums on health care services or improving care, or provide rebates to their members.

In 2014, the law will introduce a new marketplace for health insurance referred to as the Affordable Insurance Exchange. Exchanges will be introduced in every state for families and small business owners who buy their own health insurance. Consumers will be able to go to online to compare coverage options.

The law has also introduced innovative programs that encourage patient-centered care and lower costs through improved care coordination and transitions, such as the Medicare Shared Savings Program (MSSP), Pioneer Accountable Care Organizations, and Community Based Care Transition Program

Steps Taken to Improve Overpayment Recovery

On Feb 14, 2012, CMS proposed that providers and suppliers must report and return self-identified overpayments either within 60 days of the incorrect payment being identified or on the date when a corresponding cost report is due, whichever is later.

The announcement is one in a series of steps Medicare is taking to protect taxpayer dollars, including efforts to prevent overpayments from occurring. These efforts include letting private auditors working on behalf of Medicare to catch wasteful spending before it happens, by expanding the use of Recovery Audit Contractors; testing changes to outdated hospital billing systems to help prevent over-billing; and changing processes for approving payments for medical equipment with high error rates.

A Medicare overpayment refers to any funds that a person receives or retains under Medicare to which that person is not entitled. Examples of overpayments in Medicare include:

- Duplicate submission of the same service or claim
- Payment to the incorrect payee
- Payment for excluded or medically-unnecessary services
- Payment for non-covered services

Prior to ACA, providers did not face an explicit deadline for returning taxpayers' money. Thanks to the law there will be a specific timeframe by which overpayments must be reported and returned.

The proposed rule that would require providers and suppliers receiving funds under the Medicare program to report and return overpayments can be found on the *Federal Register* at http://www.FederalRegister.gov/a/2012-03642.

Fraud Recovery Efforts Net Close to $4.1 Billion

Attorney General Eric Holder and Department of Health & Human Services Secretary Kathleen Sebelius recently released a new report showing that the government's healthcare fraud prevention and enforcement efforts recovered nearly $4.1 billion in taxpayer dollars in FY2011. This is the highest annual amount ever recovered from individuals and companies who attempted to defraud seniors and taxpayers.

These findings, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of making the elimination of fraud, waste, and abuse a top priority for the administration. The success of this joint Department of Justice and DHHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste, and abuse in the Medicare and Medicaid programs. These efforts to reduce fraud continue to improve with the new tools and resources provided by the ACA

New resources under the ACA include an additional $350 million for HCFAC activities. The new tools authorized by the ACA include enhanced screenings and enrollment requirements, increased data-sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

The departments also continued their successes in civil healthcare fraud enforcement during FY2011. Approximately $2.4 billion was recovered through civil healthcare fraud cases brought under the *False Claims Act (FCA)*. These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the FDA, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks.

Prior to the passage of the ACA, providers and suppliers did not face an explicit deadline for returning taxpayers' money. Thanks to the *Affordable Care Act*, there will be a specific timeframe by which self-identified overpayments must be reported and returned.

The HCFAC annual report can be found at http://oig.HHS.gov/publications/hcfac.asp. More information on the fraud prevention accomplishments under the *Affordable Care Act* can be found at http://www.Healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html.

ACA: Programs that are currently in Effect

Here's a list of the on-going programs created by the ACA:

Partnership for Patients: The Partnership's two goals: to reduce preventable harm in hospitals by 40% and readmissions to hospitals within 30 days of discharge by 20% in the next 3 years. As of January 2012, over 7,100 organizations are participating in the program, including more than 3,200 hospitals.

Accountable Care Organizations (ACO): The **Pioneer ACO Model** tests the rapid transition to a new payment model where experienced organizations are paid according to their ability to improve the health of their patient population, rather than for each specific service they provide. 32 organizations are participating in the Pioneer ACO Model. This model is projected to save Medicare up to $1.1 billion over 5 years. The MSSP allows for providers and suppliers to come together to form ACOs that promote patient-centered care, and share in savings by meeting certain quality improvement metrics.

The **Advanced Payment ACO Model** will test whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the **MSSP.**

Bundled Payments for Care Improvement: Patients experience care in episodes, often visiting multiple doctors' offices, hospitals, and laboratories as they seek treatment and recovery. The **Bundled Payments for Care Improvement initiative** builds on episode-based payment models pioneered in the private sector by redesigning payment to match the patient experience.

Comprehensive Primary Care Initiative & Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: The **Comprehensive Primary Care Initiative** is a collaboration between public and private payers and primary care practices to support patient-centered primary care in communities across the country. Primary care practices will receive new public and private funding for primary care functions not currently supported by fee-for-service (FFS) payments, including an opportunity to share net savings generated through this program.

The **Federally Qualified Health Center Advanced Primary Care Practice Demonstration** tests whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. 500 community health centers in 44 States were selected to receive approximately $42 million over 3 years.

New Models of Care & Payment to Support Medicare-Medicaid Enrollees: Working with the CMS Medicare-Medicaid Coordination Office, the Innovation Center is empowering States to test new payment and service delivery models that will help improve quality of care, and reduce the costs of care, for the nearly 9 million people enrolled in both the Medicare and Medicaid programs.

See **Current ACA Programs** Page 4

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RODALINQUIRY@cms.hhs.gov

Coverage Provided for Nearly 50,000 Americans with Pre-Existing Conditions

The Pre-Existing Condition Insurance Plan (PCIP) program is providing insurance to nearly 50,000 people with high-risk pre-existing conditions nationwide. The Department released a new report demonstrating how PCIP is helping to fill a void in the insurance market for consumers with pre-existing conditions that are denied insurance coverage and are ineligible for Medicare or Medicaid coverage.

Under the ACA, in 2014, insurers will be prohibited from denying coverage to any American with a pre-existing condition. Until then, the PCIP program will continue to provide enrollees with affordable insurance coverage.

As a result of the new law, PCIP enrollees are receiving health services for their conditions on the first day their insurance coverage begins. Their critical need for treatment, combined with their lack of prior health coverage, has led to higher overall per-member claims costs in state-based PCIPs of approximately $29,000 per year, which is more than double the per-member cost that traditional State High-Risk Pools have experienced in recent years.

PCIP provides comprehensive health coverage, including primary and specialty care, hospital care, prescription drugs, home health and hospice care, skilled nursing care, preventive health, and maternity care. The program is available in 50 states and the District of Columbia and open to US citizens and people who reside in the US legally (regardless of income) who have been without insurance coverage for at least six months *and* have a pre-existing condition, or have been denied health insurance coverage because of a health condition.

The PCIP annual report is available in PDF format. Please visit www.pcip.gov for more information regarding eligibility, plan benefits and rates, and the application process.

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ACA Assists with Closing the "Donut Hole"

The ACA includes benefits to make Medicare prescription drug coverage (Part D) more affordable. When the Part D program was created, there was a gap in coverage, where most beneficiaries would pay 100 percent of their drug costs while still paying their premiums. This gap, referred to as the "donut hole," occurs after the prescription drug plan pays a certain amount, but before beneficiaries hit catastrophic coverage where they are responsible for a small percent of his or her drug costs (approximately 5 percent).

The ACA is closing the donut hole over time, and has already saved seniors and people with disabilities over $3.1 billion on prescription drugs since the law was enacted in March 2010. In 2010, those who reached the coverage gap automatically received a one-time $250 rebate check. In 2011, they received a 50 percent discount on covered brand-name drugs and a 7 percent discount on generic drugs, and this year, that discount is 50 percent on brand-name drugs and 14 percent on generics. These discounts will continue to grow over time until the donut hole is closed.

In 2011, about 3.6 million people with Medicare benefited from discounts on prescription drugs while in the coverage gap, receiving more than $2.1 billion in discounts, or an average of $604 per beneficiary. Women who hit the donut hole benefitted from this provision in the Affordable Care Act, with 2.05 million women saving a total of $1.2 billion on their prescription drugs. The 2.8 million beneficiaries who received the 7 percent discount on generic drugs in 2011, realized $32.1 million in savings.

Last year's progress builds on the savings in 2010, when nearly 4 million beneficiaries who hit the donut hole received a $250 rebate under the Affordable Care Act to help them afford prescription drugs in the coverage gap.

Most of these drugs are for chronic conditions, suggesting that the discounts are helping people pay for expensive medications that they must take on an ongoing basis. Making such prescriptions more affordable also helps prevent more costly care that often results from conditions like high blood pressure and cholesterol. About 13 percent of the savings were for drugs to help manage mental illness which also helps keep beneficiaries active and living at home.

April 1st is the Start Date of the Medicare Shared Savings Program (MSSP)

Section 3022 of the ACA requires CMS to establish a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries, and to reduce unnecessary costs.

The program will help doctors, hospitals, and other providers better coordinate care for Medicare patients by forming ACOs. The MSSP creates incentives for health care providers to work together to treat an individual patient across care settings; including doctor's offices, hospitals, and long-term care facilities.

The MSSP will reward ACOs that lower growth in health care costs, while meeting performance standards on quality of care and putting patients first, and at the center of health care.

Patient and provider participation in an ACO is purely voluntary. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating or participating in an ACO.

The Shared Savings Program Application web page has important information and materials on the application process, including the Notice of Intent to Apply (NOI) Memo, the first step in the application process.

See **Start Date** Page 4

Current ACA Programs

Current ACA Programs from Page 2

The **Innovation Advisors Program** : The Innovation Advisors will use their knowledge and skills in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement. They will also work with other local groups to drive delivery system reform, develop new ideas for possible testing by the Innovation Center, and build durable skills in system improvement throughout their area.

A Million Hearts: Million Hearts is a national initiative to prevent 1 million heart attacks and strokes over the next five years.

Value Based Purchasing: Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients. This program marks the beginning of an historic change in how Medicare pays health care providers and facilities--for the first time, hospitals will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide

Million Hearts Program Launched

Million Hearts™ is a national initiative to prevent 1 million heart attacks and strokes in the U.S. over the next 5 years. Launched by the Department of Health and Human Services (HHS) in September 2011, it aligns existing efforts, as well as creates new programs, to improve health across communities and help Americans live longer, more productive lives. The Centers for Disease Control and Prevention (CDC) and CMS, co-leaders of Million Hearts™ within HHS, are working alongside other federal agencies and private-sector organizations to make a long-lasting impact against cardiovascular disease.

Heart disease and stroke are the first and fourth leading causes of death, respectively, in the United States, making cardiovascular disease responsible for 1 of every 3 deaths in the country. Americans suffer more than 2 million heart attacks and strokes each year, and every day, 2,200 people die from cardiovascular disease. Heart disease and stroke are among the leading causes of disability in our country, with more than 3 million people reporting serious illness and decreased quality of life. The goal of preventing 1 million heart attacks and strokes by 2017 can be accomplished by:

1.) **Empowering Americans to make healthy choices** such as preventing tobacco use and reducing sodium and trans fat consumption; and

2.) **Improving care** for people who do need treatment by encouraging a targeted focus on the "**ABCS,**" which include: **A**spirin for people at risk, **B**lood pressure control, **C**holesterol management and **S**moking cessation.

Physicians, other healthcare providers, and health systems are vital to prevent heart attacks and strokes. They can act in preventing heart attacks by focusing in the ABCS. In addition to improving heart disease and stroke prevention with your patients, health systems and health care providers can drive awareness of the initiative. Please visit the million hearts web page for more information regarding the program.

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region III provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

Our newsletter may link to other federal agencies. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. government, HHS, or CMS. HHS or CMS are not responsible for the contents of any "off-site" resource identified.

MSSP Start Date Approaching

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The final rule established participation start dates of April 01, 2012 and July 01, 2012. Participants had the option of selecting either start date for 2012. The initial start date of April 1, 2012 is fast approaching. Potential ACOs desiring to begin during this time period were required to submit their NOIs to CMS between November 01, 2011 and January 06, 2012.

The application submission period for the April 1st start date closed on January 20, 2012. The NOI period for the July 01, 2012 MSSP start date closed on February 17, 2012. However, ACOs who have submitted their NOIs for this start date still have until March 30, 2012 to submit their applications to participate in the program.

Following the April and July 2012 start dates, the next opportunity that ACOs will have to participate in the program is January 01, 2013. NOIs for this time period are due to CMS by June 15, 2012. CMS will issue dates for this application cycle during the Spring of 2012. A list of ACOs participating in the April 1st start date will also be released.