CMMI/CMS's Health Care Innovation Awards and Opportunities for Philanthropy to Advance Population Health

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The CMS Innovation Center

The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP… while preserving or enhancing the quality of care furnished.

- The Affordable Act

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Delivery System Reform

- Our vision for improving health delivery is about **better, smarter, healthier.**
- If we find better ways to **deliver care, pay providers**, and **distribute information**, we can receive better care, spend our dollars more wisely, and have healthier people and communities, and a healthier economy.
- Continue to work across sectors for the goals we share: better care, smarter spending, and healthier people.

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Delivery system and payment transformation

Historical State

Producer-Centered

Volume Driven

Unsustainable

Fragmented Care

FFS Payment Systems

PRIVATE SECTOR

PUBLIC SECTOR

Future State –

People-Centered

Outcomes Driven

Sustainable

Coordinated Care

New Payment Systems and other Policies

- Value-based purchasing
- ACOs, Shared Savings
- Episode-based payments
- Medical Homes and care management
- Data Transparency

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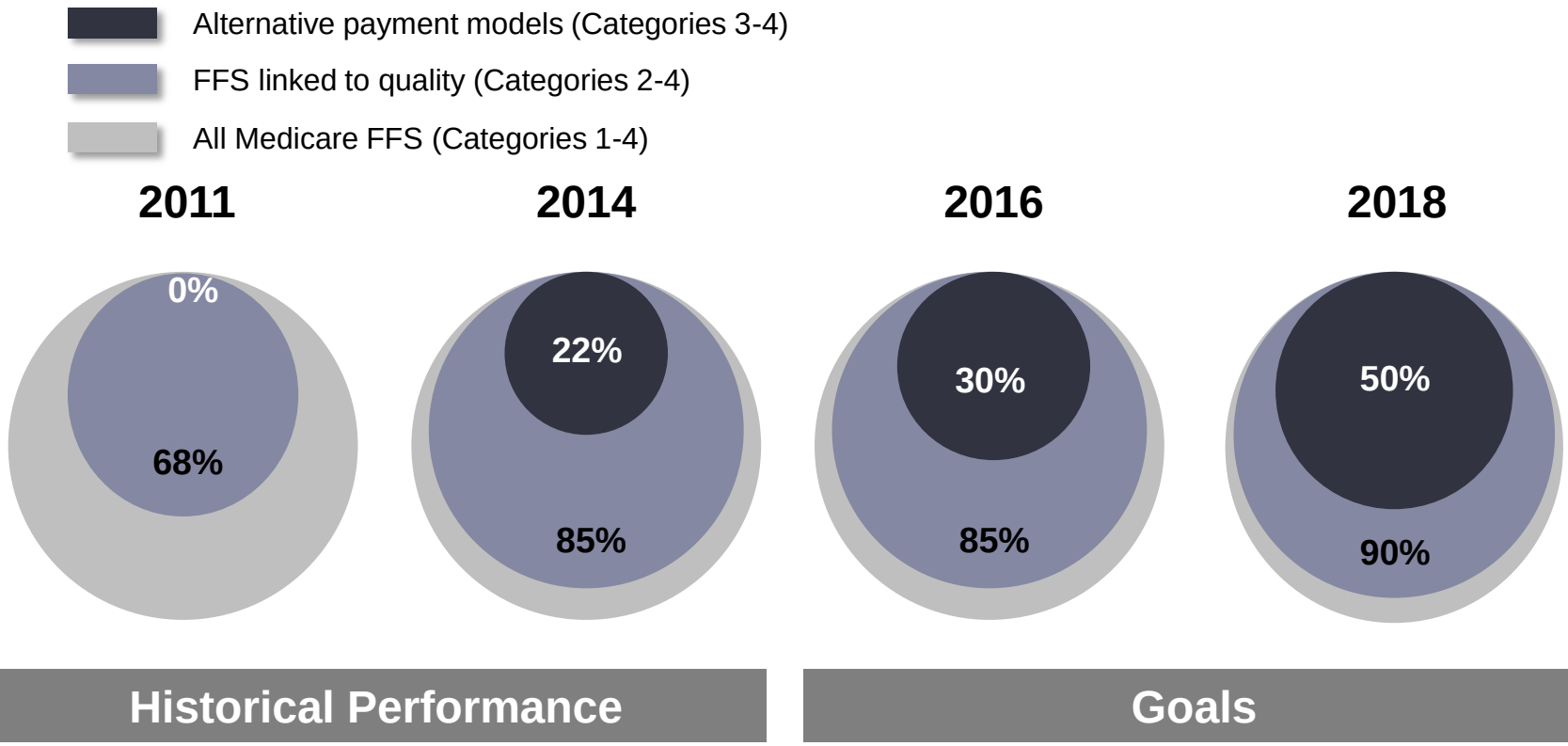
Framework for Progression of Payment to Clinicians and Organizations in Payment Reform

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes • Medicaid shared savings models	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations

Rajkumar R, Conway PH, Tavenner M. The CMS—Engaging Multiple Payers in Risk-Sharing Models. JAMA.

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018



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Innovation Awards Summary

- Open solicitation to identify and test innovative service delivery and payment models that:
  - Improve health and healthcare
  - Improve cost efficiency of CMS programs
  - Rapidly train or deploy a new workforce
- Initial 107 awards, ranging from $1 to $30 million (Round 1), and additional 39 awards ranging from $2 to $24 million (Round 2).
- CMS recognizes that many of the best policy innovations can come from non-government developers

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HCIA Goal

- **GOAL:** To identify and support a broad range of innovative service delivery and payment models that achieve better care, better health and lower costs through improvement in communities across the nation.

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HCIA Implementation

HCIA awardees will:

- Improve care and lower costs for Medicare, Medicaid and CHIP beneficiaries
- Reach diverse populations, including underserved and remote communities
- Rapidly implement the proposed model
- Develop, train, and deploy workforce to support the models

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Innovation Awards Review Process: Round 1

- 2,260 applications were scored by 190 panels. These applications represent $30 billion in requested awards.
- Panels were composed of governmental and non-governmental reviewers.
- Reviewers scored applications along five criteria:
  - Design of project
  - Organizational capacity and management plan
  - Workforce goals
  - Budget and sustainability plan
  - Evaluation and reporting plan

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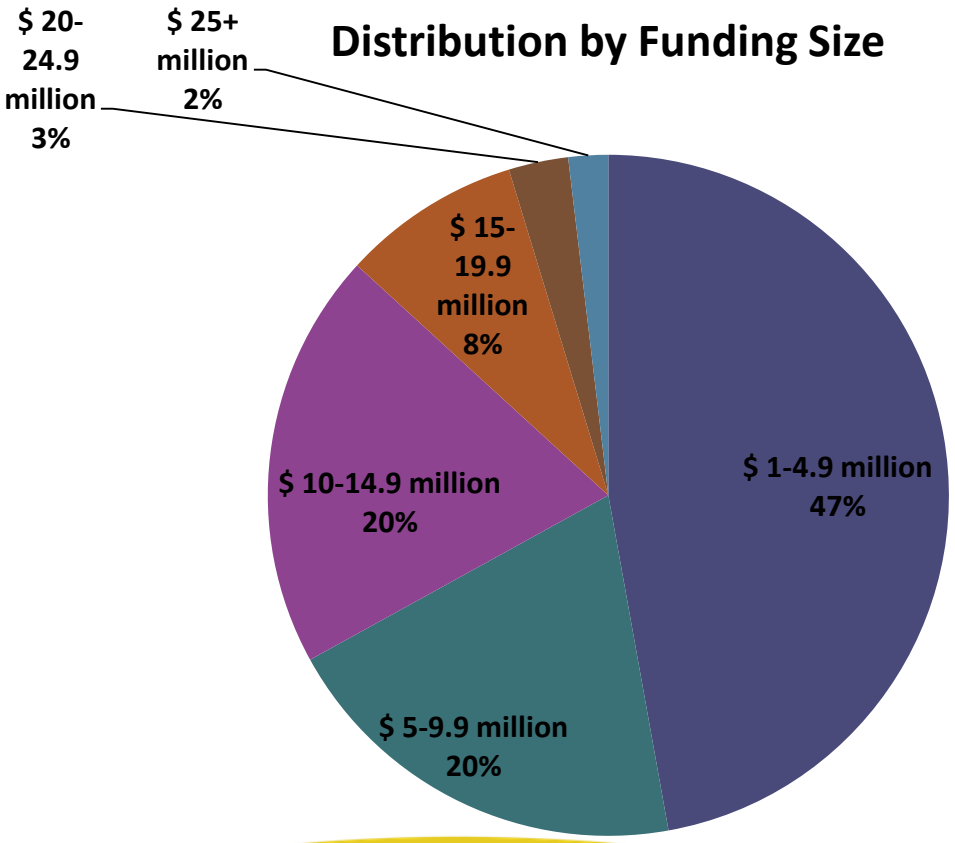
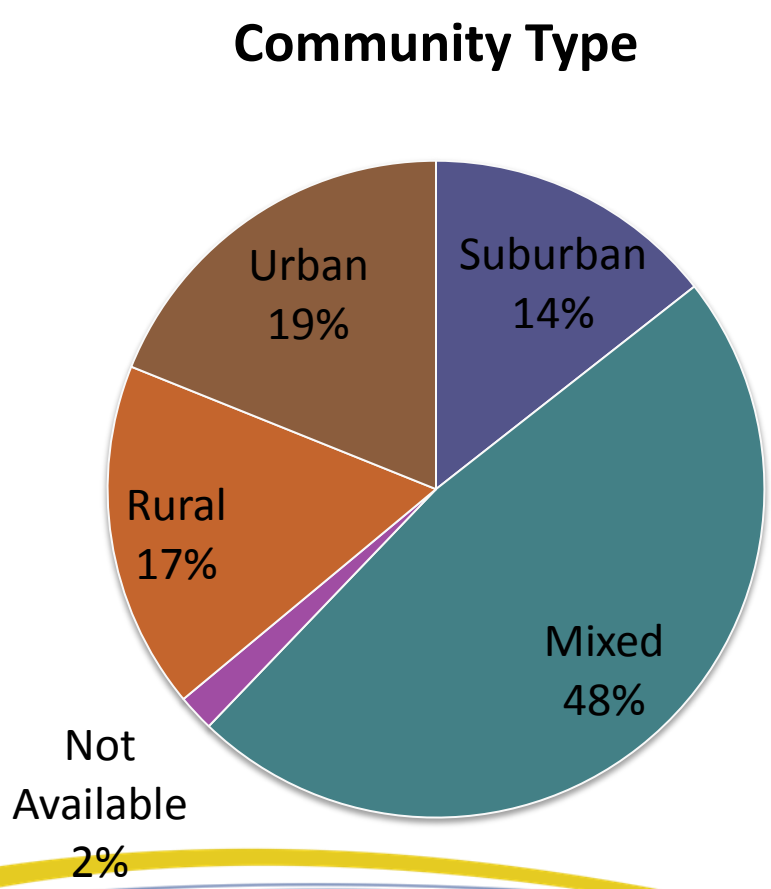
Distribution by Funding Size Awarded



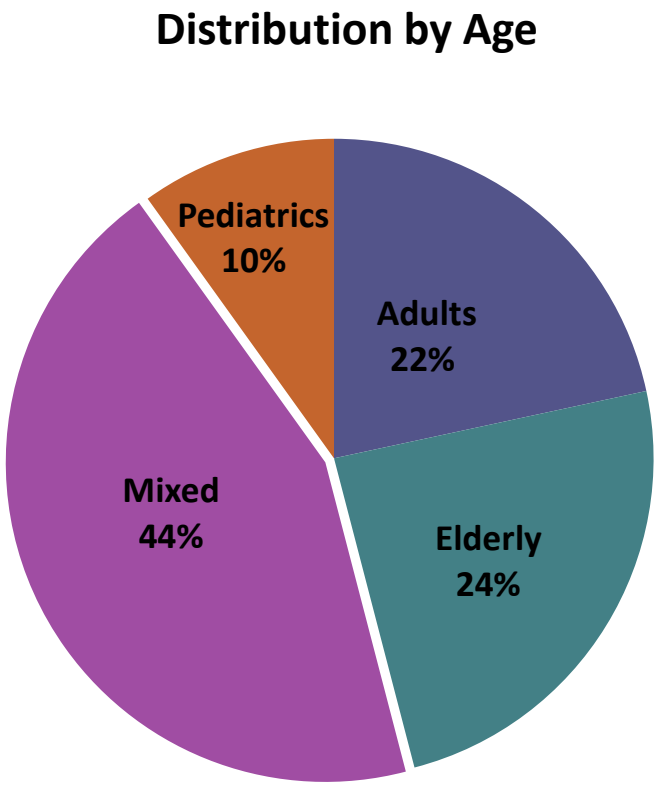
- The HCIA Portfolio has a diversity of initiatives of varying funding size requests.
- 47% of the initiatives funded were <$4.9 million

Distribution by Community Type



- Innovations are happening across all types of communities across our nation.

Distribution by Participant Age



- We are testing innovations to improve the care of all of our beneficiaries across the nation.

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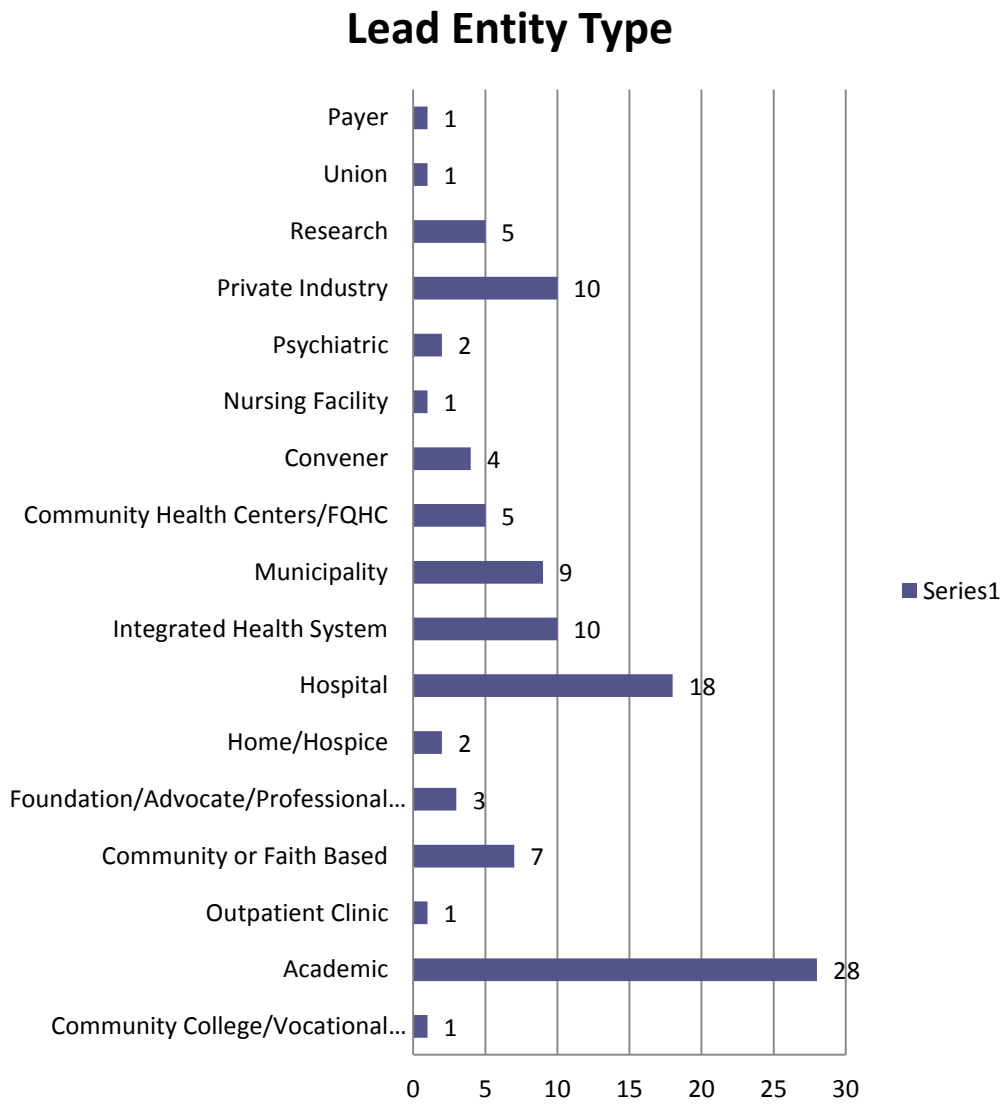
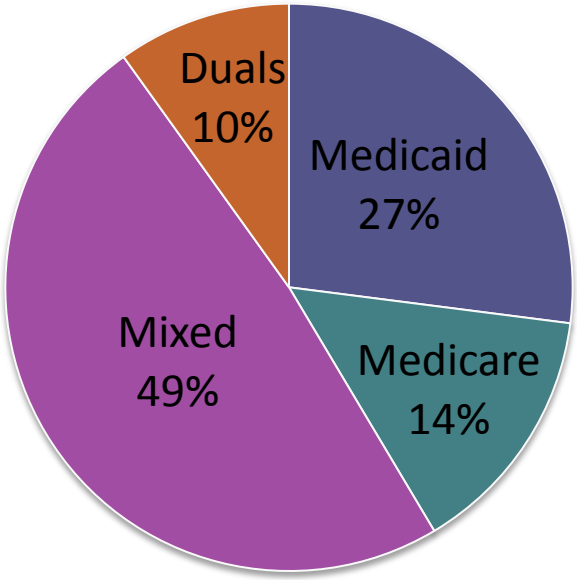
Distribution by Lead Entity Type



- A wide variety of entities are being funded through the HCIA.

Distribution by Insurance Type

Distribution by Primary Insurance Type



- All of our beneficiaries are benefiting from health care innovations across the country.

*"Mixed" describes initiatives with both public and private payers

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Distribution by Category

Type of Intervention	Award Count	Three-Year Total Funding Amount	Percentage of Total Funding
Community interventions	**47**	**$430,355,320**	**48.15%**
Community Resource Planning, Prevention, Monitoring	24	$162,912,663	18.23%
Medication management	6	$42,500,615	4.75%
Primary Care Redesign	15	$208,842,489	23.36%
Shared decision making	2	$16,099,553	1.80%
Hospital Setting Interventions	**10**	**$115,050,185**	**12.87%**
Acute Care Condition Specific	4	$53,923,447	6.03%
Acute Care Management	3	$22,580,365	2.53%
ICU/Remote ICU Care	3	$38,546,373	4.31%
Management of medically fragile patients in the community	**50**	**$348,439,494**	**38.98%**
Behavioral Health/Substance Abuse	9	$66,374,354	7.43%
Complex/High Risk Patient Targeting	23	$162,384,676	18.17%
Disease specific -- Cancer	4	$41,697,462	4.66%
Disease Specific -- Childhood Asthma	3	$10,634,103	1.19%
Disease specific -- Diabetes/Chronic Kidney Disease	3	$18,740,488	2.10%
Disease specific -- Other	8	$48,608,411	5.44%
Grand Total	**107**	**$893,844,999**	**100.00%**

Range of Services Provided

Rank	Service Type	# Awardees	Rank	Service Type	# Awardees
1	Care Coordination	75	23	Integrated Physical, Behavioral/Mental Health, and Social Services	33
2	Care Management / Chronic Disease Management	73	24	Discharge Planning	30
3	Patient/Family Education	65	25	Integrated Health and Social Services	29
4	Self-Management Support	62	26	Medical Home	29
5	Medication Management	59	27	Telehealth	27
6	Referral Services	50	28	Crisis Management	26
7	Patient Care Monitoring	49	29	Benefits and Treatment Options Counseling	25
8	Community Outreach	47	30	Patient Safety	24
9	Decision Making Support (patient)	47	31	E-Prescribing	22
10	HIT	47	32	Home Care or Home Health	18
11	Medication Reconciliation	47	33	Registry	17
12	Needs Assessments	47	34	Home Safety Assessments	16
13	Patient Navigation Support	46	35	Other	14
14	Decision Making Tools (clinicians)	45	36	Substance Abuse Services	13
15	Counseling for Health and Social Supports	44	37	Project does not provide services directly to participant patient populations	12
16	Medical / Physician / Clinical Services	41	38	Palliative care / Comfort care	11
17	Preventive Care	40	39	Critical Care	9
18	Decision Making Joint (patient and provider)	38	40	Home Nurse Hotlines	8
19	Home and Community-Based Services and Supports	38	41	Urgent Care Transports	7
20	Transition Program or Services/Post discharge support	38	42	Dental Services / Oral Preventive Services	5
21	Community Health Resource Provision	35	43	Infant Growth and Development Monitoring	5
22	Behavioral/Mental Health Services	33	44	Radiology / Imaging Services	5

HCIA Implementation

- Project start July 2012
- Most projects scheduled for implementation first quarter, CY 2013.
- Ongoing self monitoring and rapid cycle improvement at each site
- Programs will develop measures of success and use those measures to identify operating issues and make improvements
- Program close June 2015

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Independent Evaluations

- All CMS Innovation Center projects receive independent evaluations
- RAND Corporation is developing an overall evaluation design
- Evaluations of each of the 107 awards are expected using independent contractors
- Those projects that are most promising can be expanded for further analysis of the model

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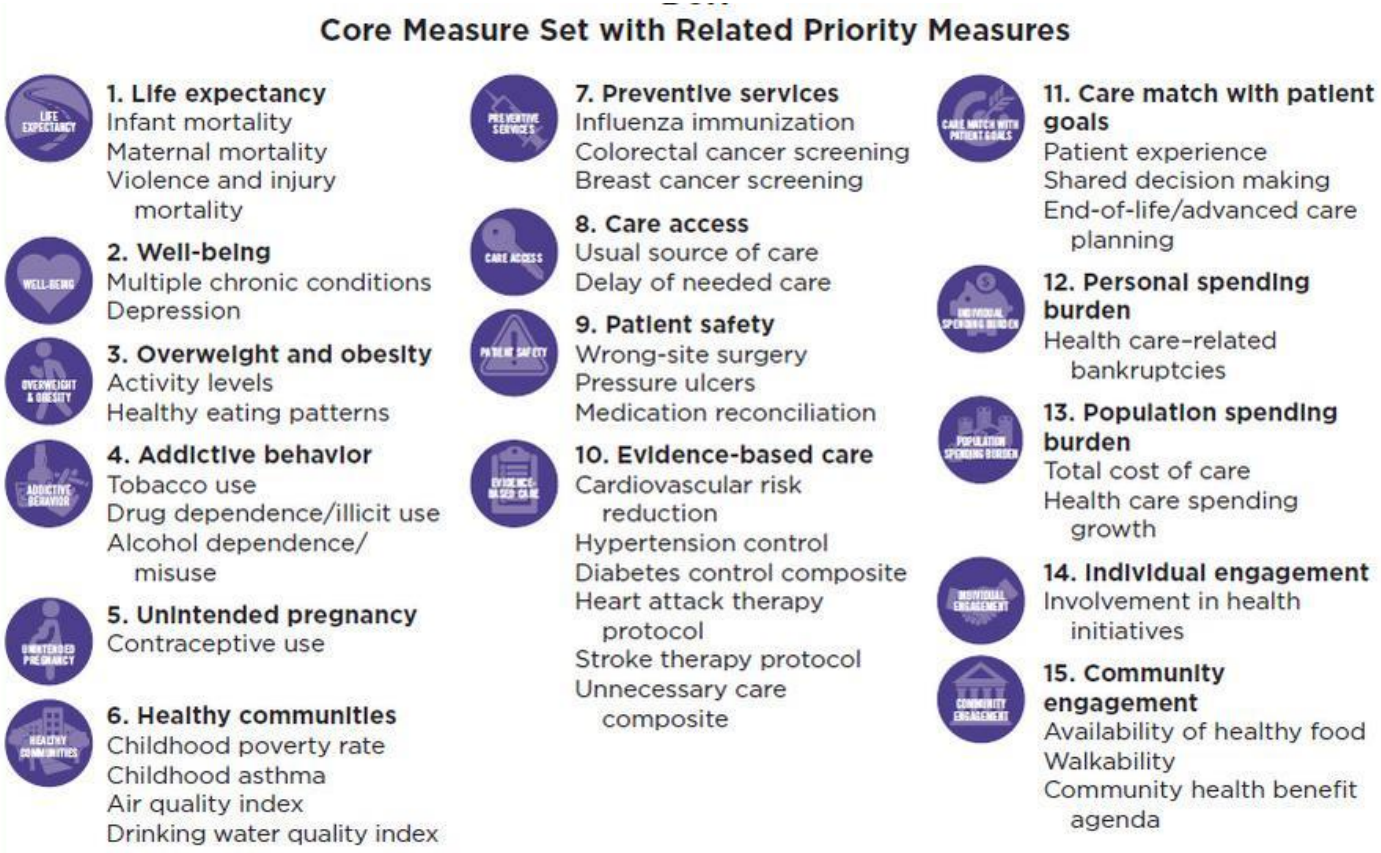
Deep Dive: HCIA Round 2 Award and Example of Accelerating Impact with Philanthropy

IOM Population Health Measures

CDC "Winnable Battles"

"The current Winnable Battles (Tobacco; Nutrition, Physical Activity and Obesity; Food Safety; Healthcare-Associated Infections; Motor Vehicle Injuries; Teen Pregnancy; HIV in the U.S.) have been chosen based on the magnitude of the health problem and our ability to make significant progress in outcomes."



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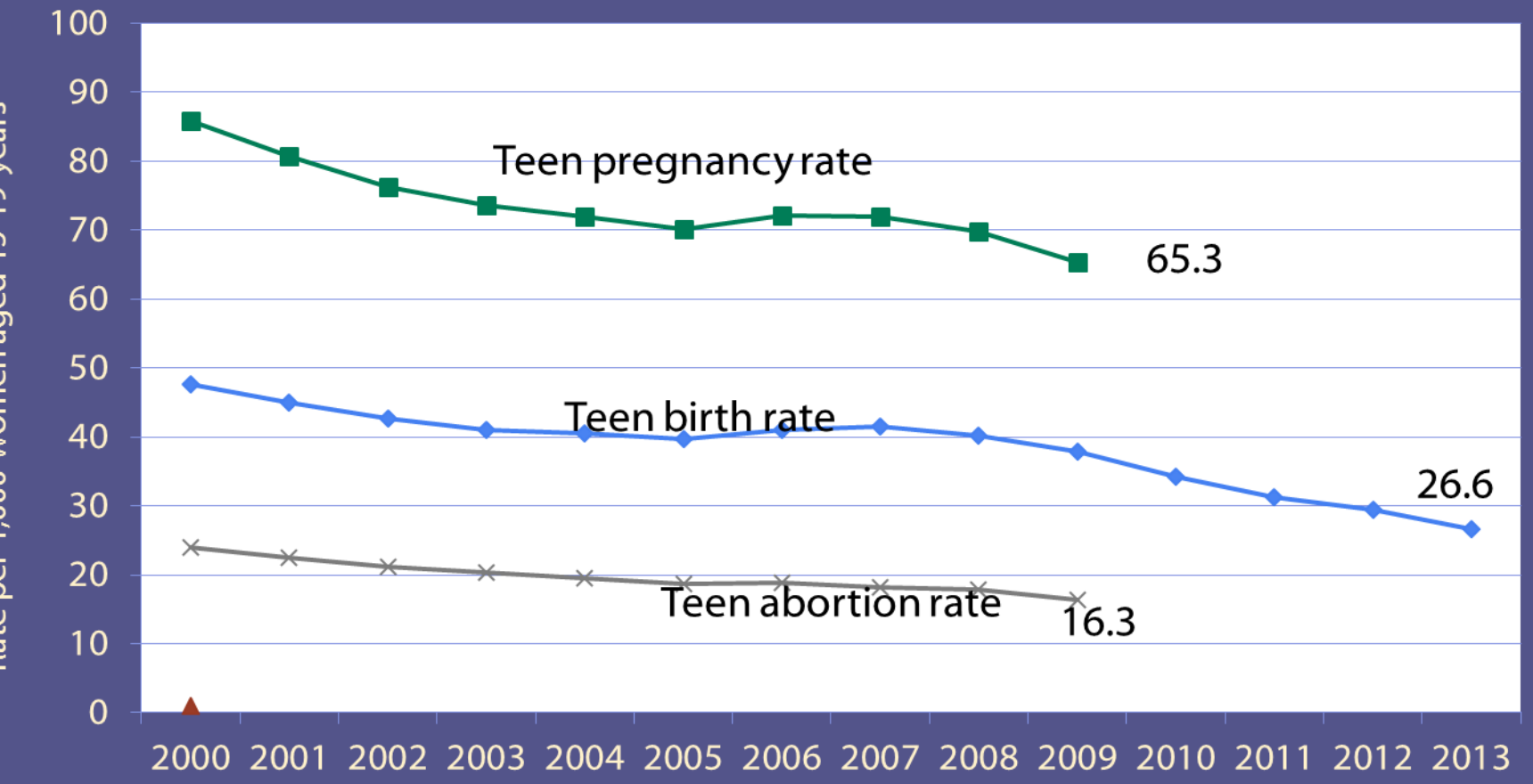
Teen pregnancy and birth rates, United States, 2000–2013



1. Pregnancy, abortion and birth rates 2000-2008: Ventura SJ, Curtin SC, Abma JC. Estimated pregnancy rates and rates of pregnancy outcomes for the United States, 1990–2008. National Vital Statistics Reports, 2012;60(7). Table 2.
2. Pregnancy and abortion rates 2009:Curtin SC, Abma JC, Ventura SJ, Henshaw SK. Pregnancy rates for U.S. women continue to drop. NCHS data brief, no 136. Hya Health Statistics. 2013.
3. Birth rates 2009: Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2010. National Vital Statistics Reports, 2011;60(2). Table S-2.
4. Birth rates 2010–2011: Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2011. National Vital Statistics Reports, 2012;61(5). Table 2.
5. Birth rates 2013: Hamilton, B., Martin, J., Osterman, M., Curtin, S. Births: Preliminary Data for 2013. National Vital Statistics Reports. Vol. 63, No. 2. May 29, 2014.

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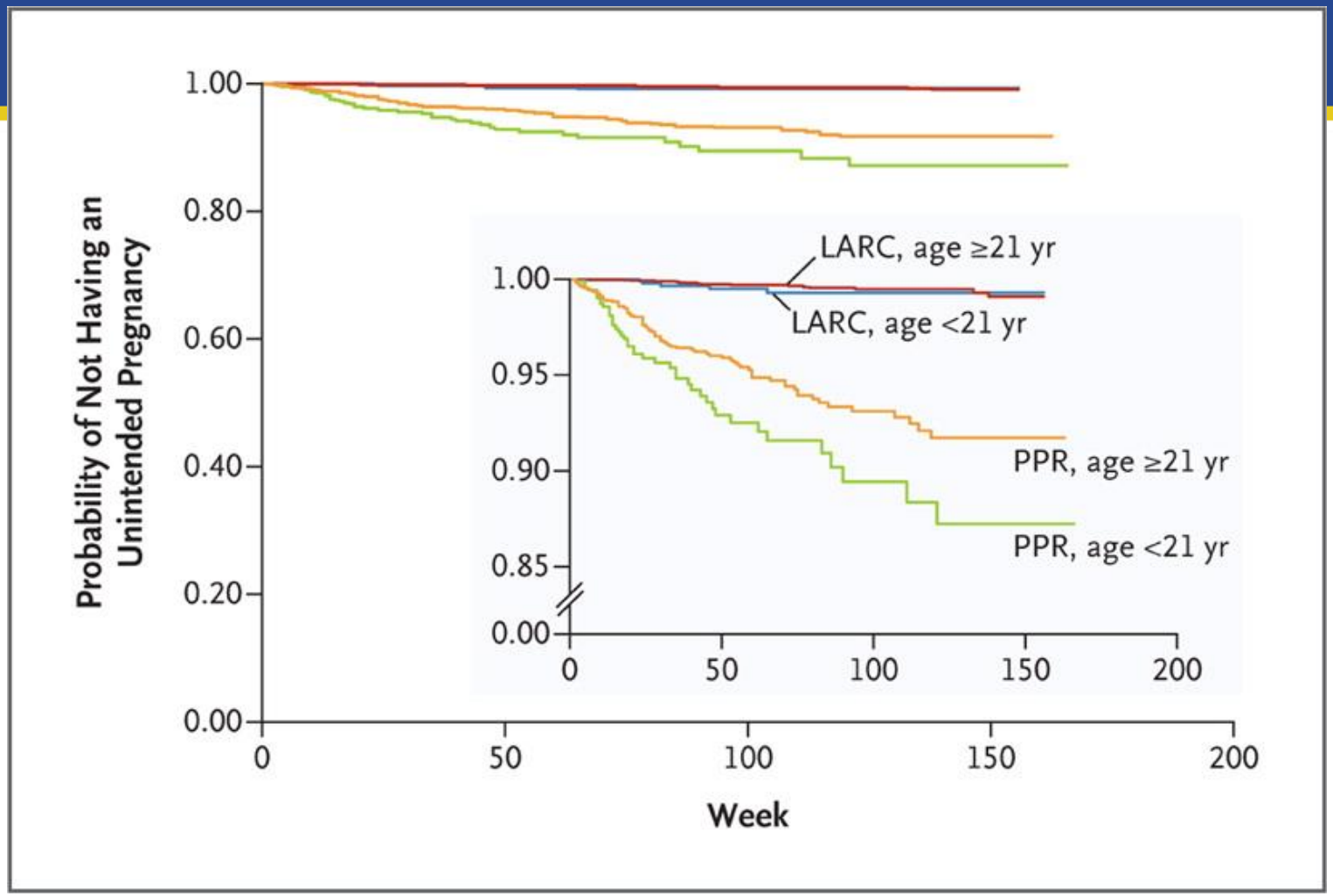
Probability of Not Having an Unintended Pregnancy, According to Contraceptive Method and Age.



And further impact on termination/abortion rates

Year	CHOICE vs. St. Louis Region (City and County)						National Rate‖
	CHOICE Rate*	Region Rate†	*P*	Abortions Prevented‡	Number Treated to Prevent One Abortion		
					NNT§	95% CI	
2008	4.4	17.0	<0.001	3124	79	44–255	19.6
2009	7.5	14.8	<0.001	1810	137	97–224	NA
2010	5.9	13.4	<0.001	1860	133	99–213	NA

NNT, number needed to treat; CI, confidence interval; NA, not applicable.

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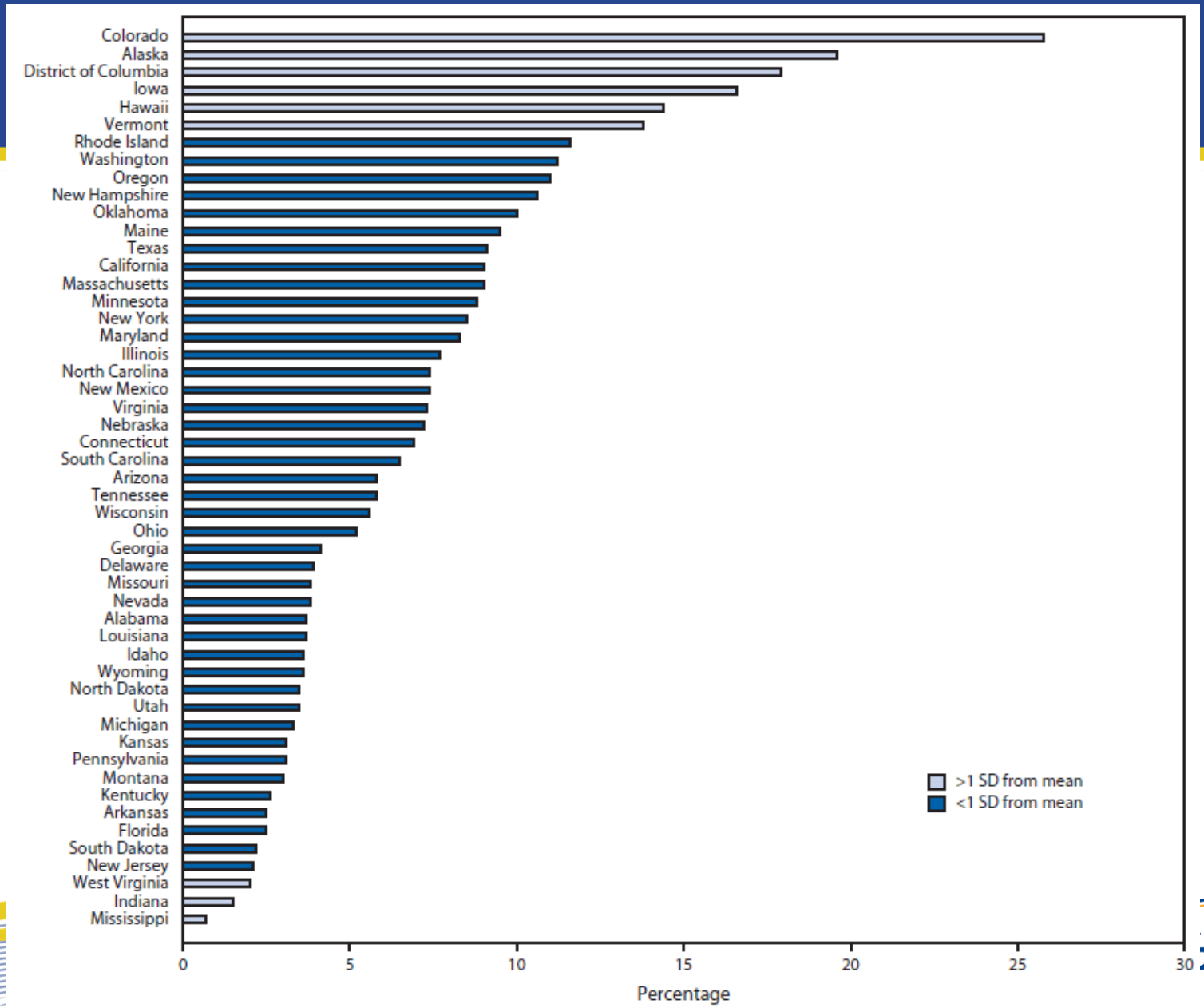

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How Can CMMI/CMS approach this issue?

- Explore payment and delivery system barriers
  - Maternal bundled payments (“Global obstetric package”)
    - Innovation: South Carolina
  - Stocking and high cost of LARC
    - Innovation: Illinois (but unexpected effect…)
  - Inappropriate payment
    - Example: Washington DC – Zero LARC coverage until recently
  - Post-abortion LARC barriers
    - Innovation: New York and Oregon

- But how do we actually advance pop health in this area?
  - Understand the source of variation
    - Helpful role of private philanthropy
  - CMMI/CMS/CMCS could create composite “scorecard”
  - Distinct FQHC Family Planning encounter code
  - CMCS FOA for use of “contraception measure”

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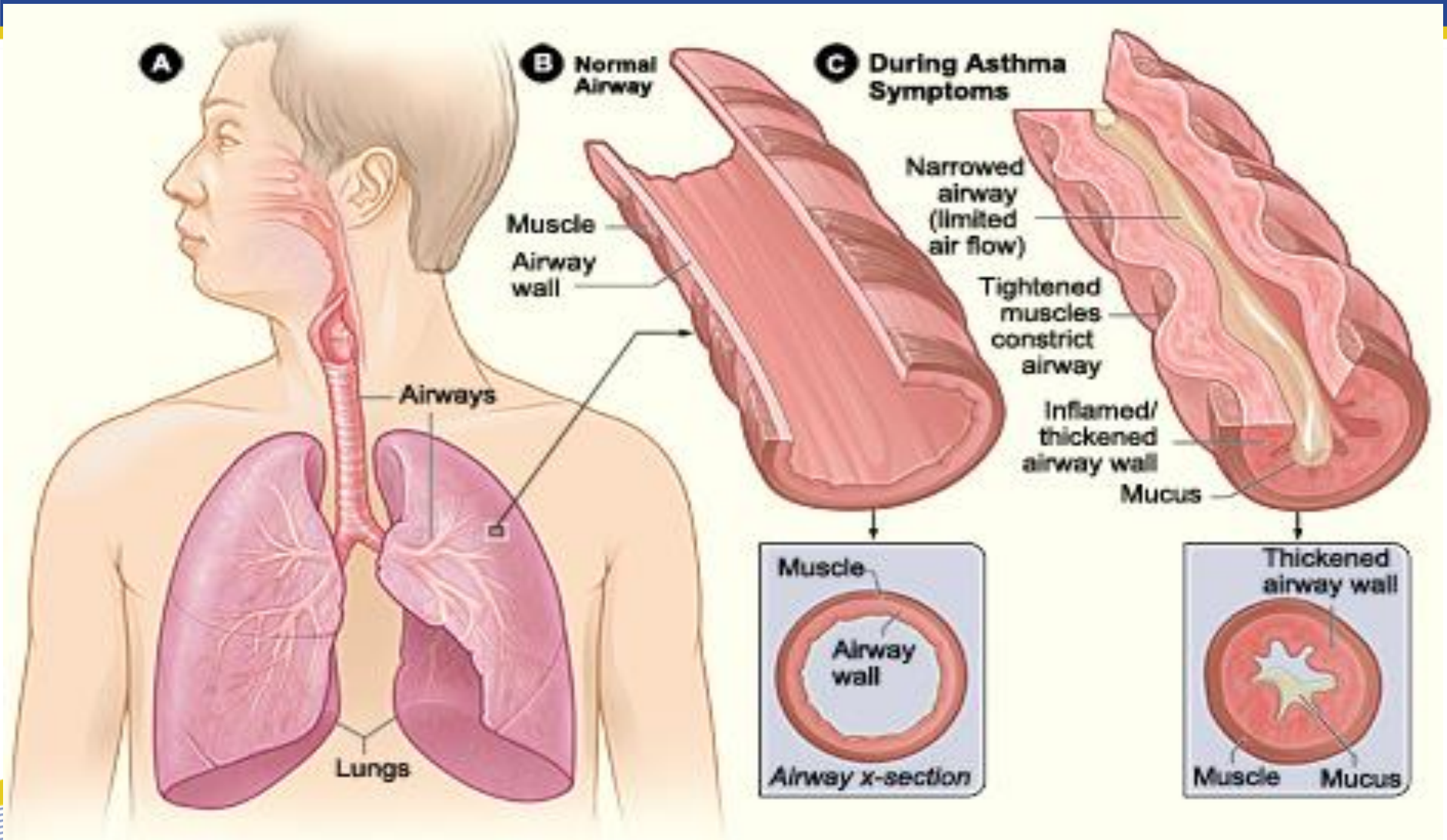
Deep Dive 2: Pediatric Asthma



Treatment is Complex!

	Step 1: Intermittent asthma	Step 2: Persistent Asthma: Daily Medication	Step 3: Persistent Asthma: Daily Medication	Step 4: Persistent Asthma: Daily Medication	Step 5: Persistent Asthma: Daily Medication	Step 6: Persistent Asthma: Daily Medication
Preferred Treatment	inhaled short–acting beta2–agonist (SABA) as needed	low–dose inhaled corticosteroid (ICS)	medium–dose inhaled corticosteroid (ICS)	medium–dose inhaled corticosteroid (ICS) plus either inhaled long–acting beta2–agonist (LABA) or montelukast	high–dose inhaled corticosteroid (ICS) plus either inhaled long–acting beta2–agonist (LABA) or montelukast	high–dose inhaled corticosteroid (ICS) plus either inhaled long–acting beta2–agonist (LABA) or montelukast plus oral corticosteroids
Alternative Treatment (If alternative treatment is used and response is inadequate, discontinue and use preferred treatment before stepping up.)		cromolyn or montelukast				

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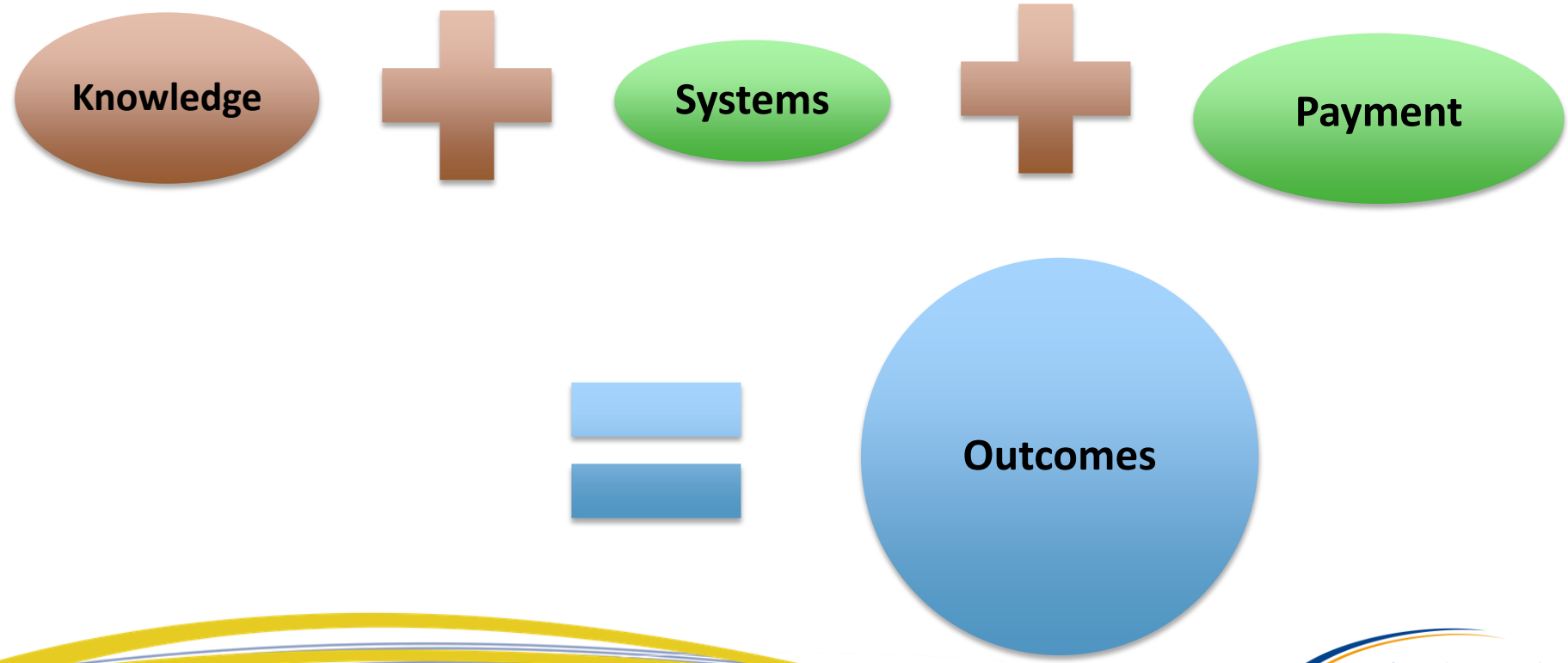
Simple Things…

How do we improve outcomes?



Adapted from Batalden, Qual Saf Health Care, 2007

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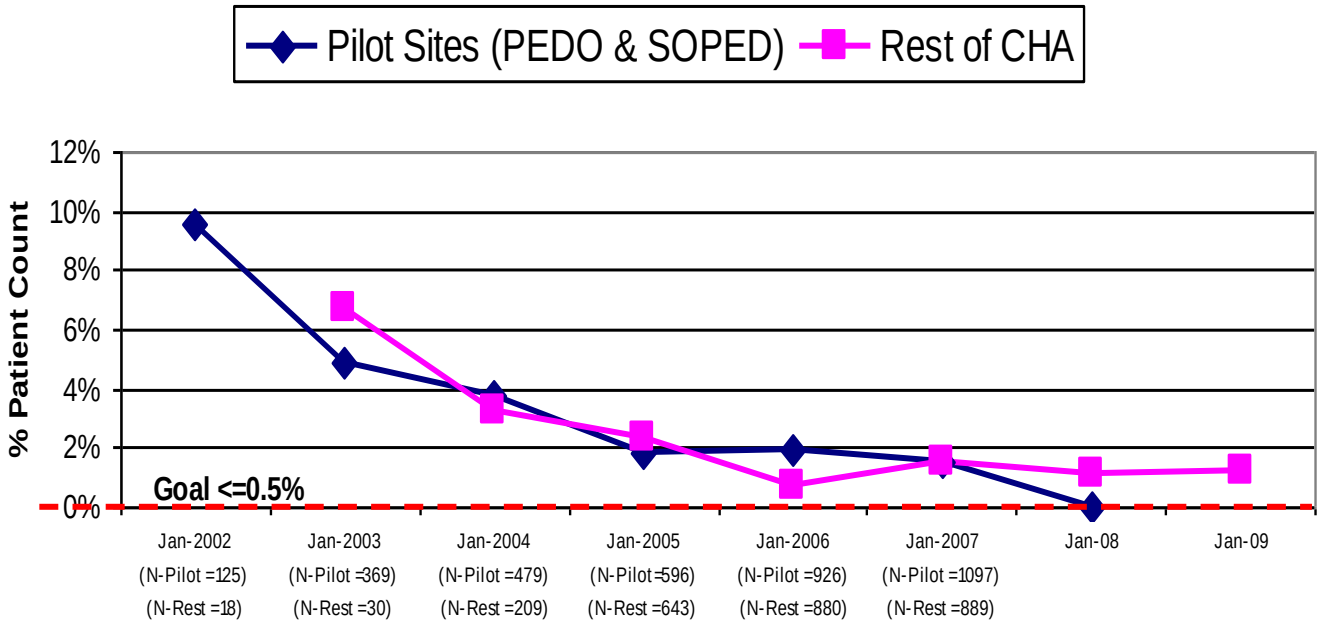
The Potential

Childhood Asthma:
% Patients with Asthma Admissions



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Role for Private Philanthropy (1)

- Currently, CMMI/CMS has funded three programs with focus on pediatric asthma care, yet none have transitioned to clear, sustainable models of reimbursement
- What is the role of philanthropy?
  - Innovative funding structuring (GHHI)
  - Direct funding of services (Community benefit funding from health care organizations)
  - Research and evaluation
  - Sophisticated technical support

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Role for Private Philanthropy (2)

State-led/ statewide

- Strong policy impetus; Medicaid as lead
- Significant multi-payor involvement (multiple MCOs, Commercial)
- Typical: mandatory model, fixed thresholds for performance rewards

Payor-led, voluntary for providers

- Payor-developed program/ framework
- Providers choose whether to participate
- Incentives typically based on shared savings based on performance improvement

Provider-led

- Providers initiate
- May establish rewards with payors or relationships with providers/ ACOs
- Service lines with attractive economics (e.g., orthopedics, cardiac)
- Sometimes prospective payment

Employer-led, consumer-powered

- Employers initiate episode performance framework
- Sometimes involve strong network incentives ("centers of excellence")
- Sometimes prospective payment
- May be linked to reference pricing

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Thank You

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