

Health Care Innovation Awards



*Overview of Innovation
Categories One and Two*

June 12, 2013

Agenda

- **Introduction**
- **Innovation Category 1:** Rapidly reduce Medicare, Medicaid and/or CHIP costs in outpatient and/or post-acute settings
- **Innovation Category 2:** Improve care for populations with specialized needs
- Upcoming Webinar Series and Next Steps

The CMS Innovation Center

Identify, Test, Evaluate, Scale

“ 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. ”

—*The Affordable Care Act*

Innovation Awards Round Two Goals

Engage innovators from the field to:

- Identify new payment and service delivery models that result in better care and lower costs for Medicare, Medicaid and CHIP beneficiaries
- Test models in Four Innovation Categories
- Develop a clear pathway to new Medicare, Medicaid and Children's Health Insurance Program (CHIP) payment models

Measuring Success

- **BETTER HEALTH**

Improved overall health outcomes

- **BETTER HEALTH CARE**

- **LOWER COSTS THROUGH IMPROVED QUALITY**

Reduced total cost of care for Medicare, Medicaid and CHIP beneficiaries

Four Innovation Categories

1. Rapidly reduce Medicare, Medicaid and/or CHIP costs in ***outpatient and/or post-acute settings***
2. Improve care for ***populations with specialized needs***
3. Transform the ***financial and clinical models of specific types of providers and suppliers***
4. Improve the ***health of populations through better prevention efforts***

Today's Webinar

Focus on Innovation Categories 1 and 2:

- Category 1: Rapidly reduce Medicare, Medicaid and/or CHIP costs in *outpatient and/or post-acute settings*
- Category 2: Improve care for *populations with specialized needs*

Please keep in mind:

- Examples described in today's webinar are illustrative only, and not intended to convey a preference or preferred approach
- Applicants will identify a primary innovation category in which to be considered
- Applicants must propose a payment model to support the proposed service delivery model

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Category 1: Rapidly reduce costs in outpatient and/or post-acute settings

Priority Areas

- Diagnostic services
- Outpatient radiology
- High-cost physician-administered drugs
- Home-based services
- Therapeutic services
- Post-acute services

CMS will consider submissions in other outpatient and/or post-acute areas within this Category

Why these areas?

Growth in spending

Outpatient spending is larger than and growing much more rapidly than inpatient spending

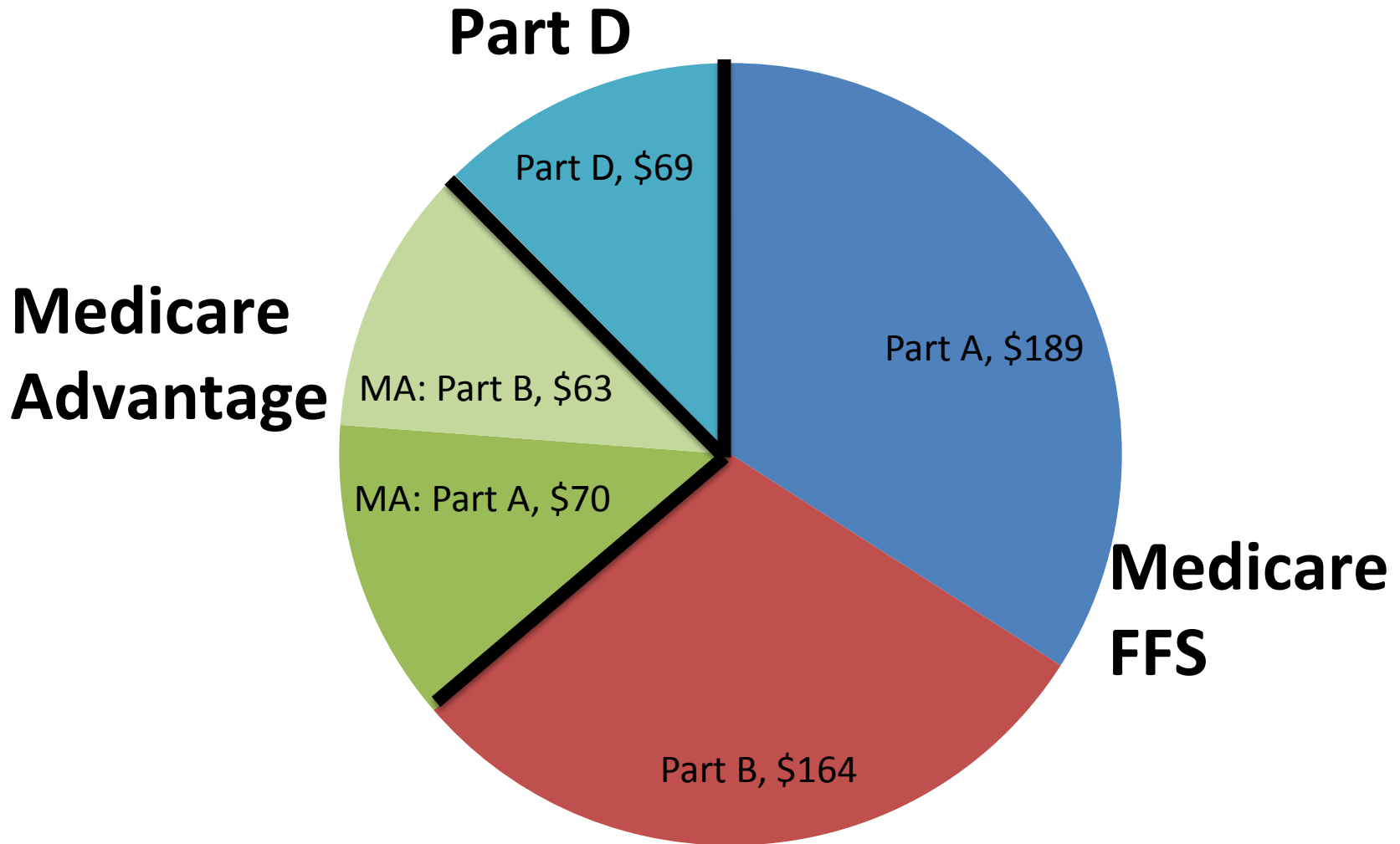
Geographic variation

Post-acute spending is the biggest contributor to geographic spending variation

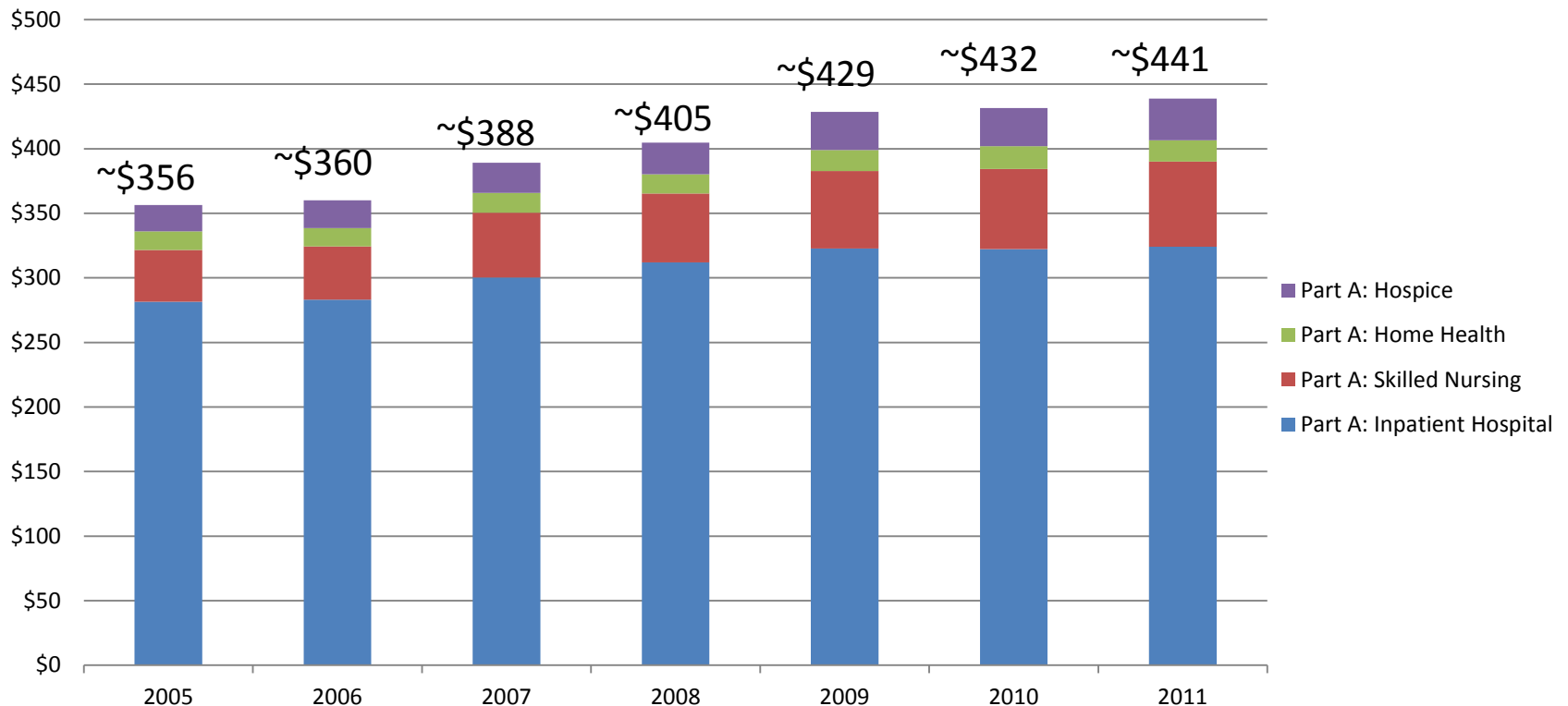
Untapped opportunities

To balance our portfolio, which is well-developed in inpatient settings

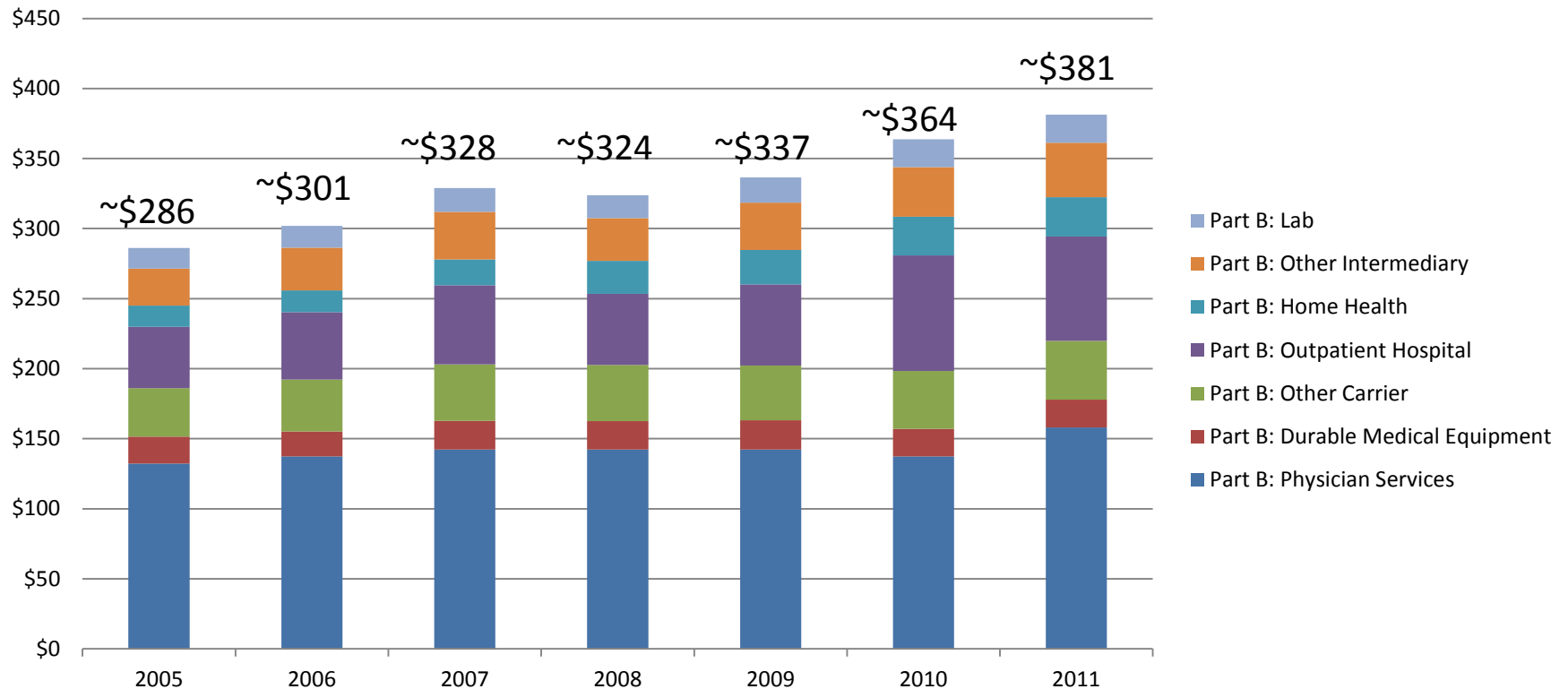
2011 Medicare costs by category (billions)



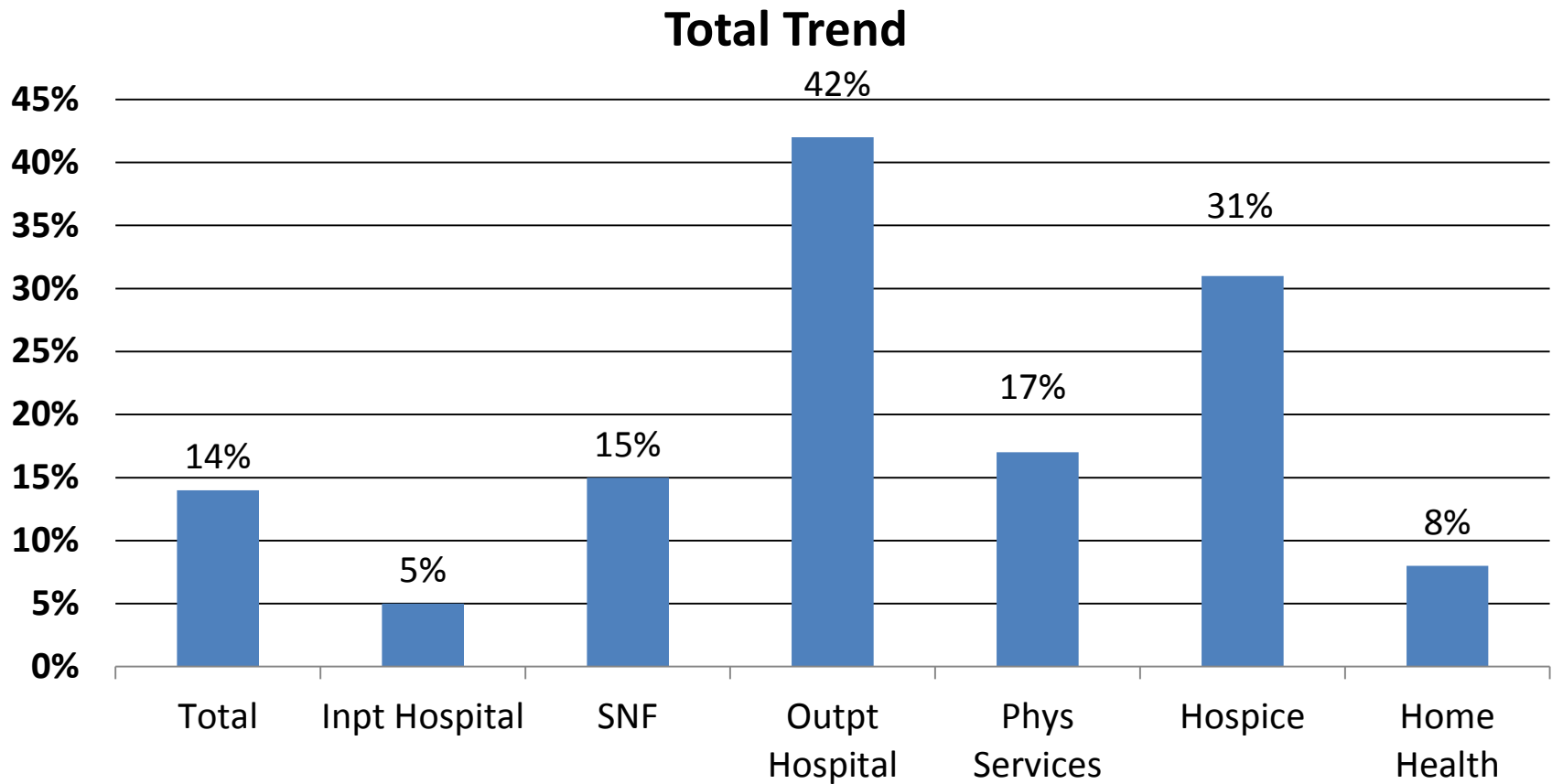
Inpatient hospital PBPM costs growing slower compared to post-acute



Part B PBPM costs continue to grow

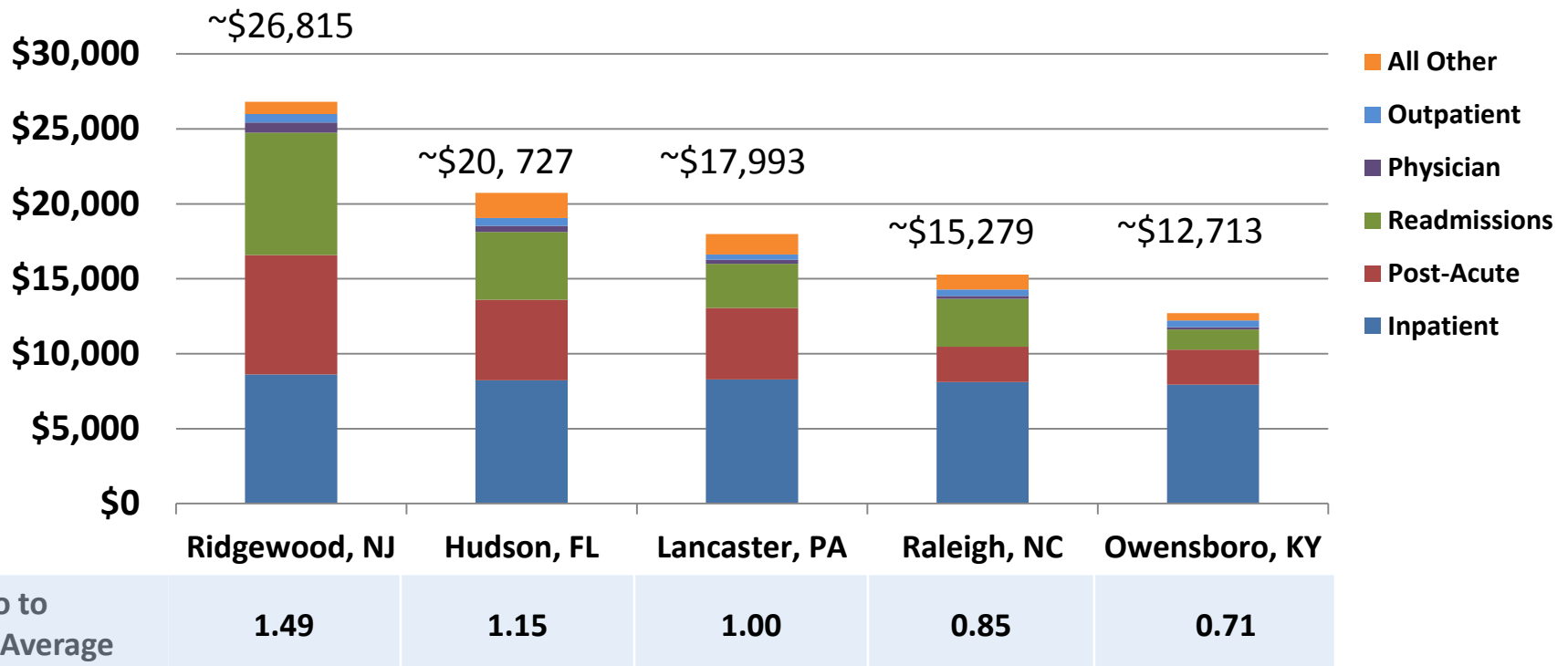


From 2008 to 2012, outpatient and post-acute services increased most rapidly



Medicare spending varies widely across the country

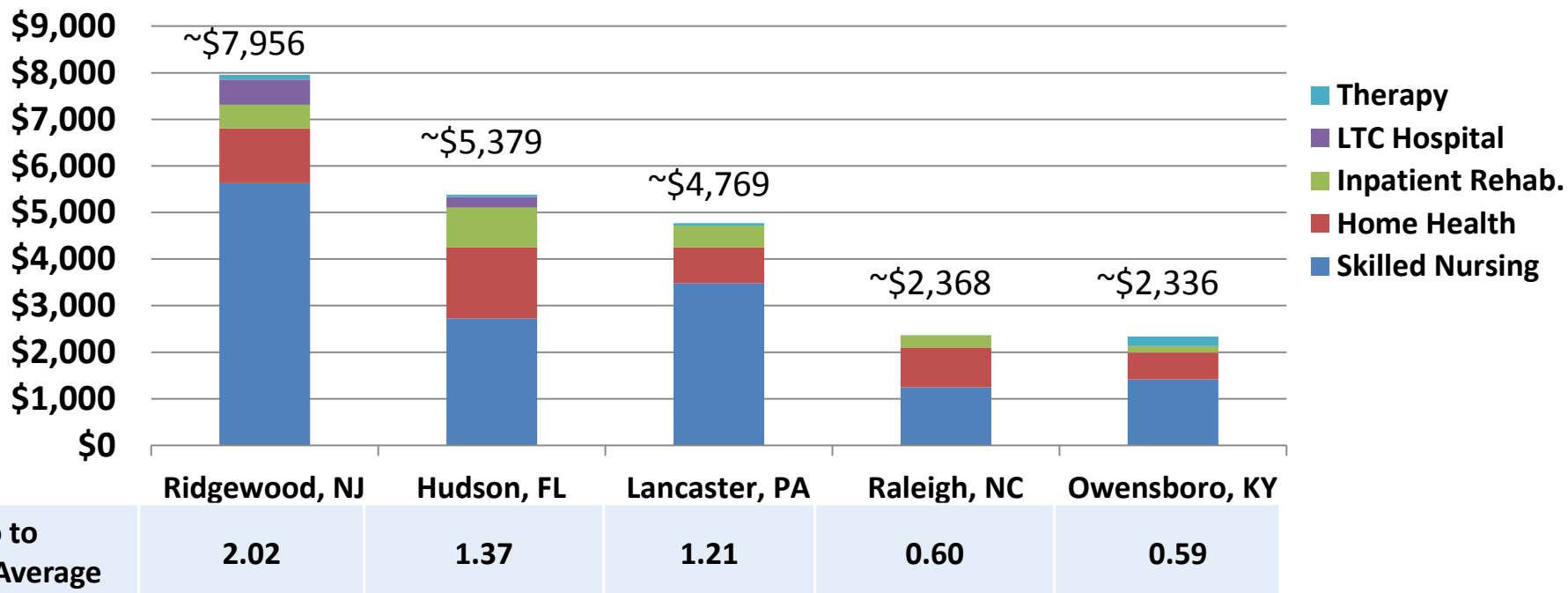
Geographic Variation in Spending, MS-DRG 291 Heart Failure and Shock with Major Complications



Source: CMS Office of Information Products and Data Analytics, Medicare Claims Analysis - 2010

Variation in post-acute spending is even greater

Geographic Variation in Spending on Post-Acute Care, MS-DRG 291 Heart Failure and Shock with Major Complications



Outpatient and post-acute settings

Definitions

Outpatient settings

- Outpatient settings may include hospital outpatient care
- Most of identified priority areas are outpatient

Post-acute settings

- Post-acute services may be outpatient or inpatient
 - Home health agencies
 - Inpatient rehabilitation facilities
 - Skilled nursing facilities
 - Long term care hospitals

Diagnostic Services and Outpatient Radiology

Examples

- Radiology and other imaging
- EKGs, cardiac monitoring, and laboratory

Examples of Settings

- Hospital Outpatient
- Ambulatory Surgical Centers
- Physician Office and SNF Outpatients
- Independent Diagnostic Testing Facilities

Some Payment and Service Delivery Issues

- Appropriate use, duplication, overlap, roles of multiple parties (ordering physician, technical service provider, professional interpretation)
- Shared decision support and Clinical Decision Support for clinicians

Physician Administered Drugs

Examples

- Injectable drugs used in the physician office setting, e.g.: Chemotherapy, Rheumatology, Ophthalmology
- Vaccines: Hepatitis B; Pneumococcal and Influenza Vaccines
- Erythrocyte Stimulating Agents

Examples of Settings (outpatient)

- Physician offices, pharmacies, durable medical equipment suppliers
- Hospital outpatient departments, ambulatory surgical centers
- Outpatient SNF
- Home health agencies: only certain vaccines covered under Medicare

Some Payment and Service Delivery Issues

- Drug pricing; administration fees

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Home-Based Services

Examples

- Home health care
- Home and community-based services

Examples of Settings

- Patient homes

Some Service delivery and payment issues

- Payment tied to therapy utilization
- Home Health Prospective Payment System augments payments for more therapy visits reaching certain thresholds
- Home Health Agencies may focus on therapy payment incentives

Post-Acute Services

Examples

- Rehabilitation services and therapy
- Prolonged ventilator support

Examples of Settings

- Skilled Nursing Facility, Inpatient Rehabilitation Facilities, Home Health Agencies, Long Term Acute Care Hospitals

Some Service Delivery and Payment Issues

- Same patient, different payments
 - By setting
 - By lengths of stay and therapy use
- Avoidable Hospital Readmissions
- Poor care coordination
- Geographic variations in PAC spending drive payment variations nationally
- Shared decision making and clinical decision support

2: Improve care for populations with specialized needs

Priority Areas

- Pediatric populations requiring high-cost services
- Persons with Alzheimer's disease
- Persons living with HIV/AIDS
- Children at high risk for dental disease
- Children in foster care
- Adolescents in crisis
- Persons requiring long-term services and supports
- Persons with serious behavioral health needs

CMS will consider submissions that improve care for other populations with specialized needs

Therapeutic Outpatient Services

Examples

- Surgical and other procedural care
- Physical Therapy, Occupational Therapy, Speech and Language Pathology

Examples of Settings

- Hospital outpatient
- Ambulatory Surgical Centers
- Physician Office

Some Service Delivery and Payment Issues

- Large relative expenditure growth outpatient compared to inpatient care
- Medicare Ambulatory Payment Classifications not diagnosis based in contrast to inpatient DRGs
- Payment for services, not for outcomes and efficiency
- Off-campus provider based services

Why these areas?

High Unmet Need

There are significant opportunities to improve care

Growth in spending

Costs for populations with complex care needs are increasing

Delivery System Change

Significant amount of policy work to integrate care models and payment models

Portfolio Expansion

Create new model tests to cover these patient populations

Pediatric populations requiring high-cost services

Description of Population

- Includes children with multiple medical conditions, behavioral health issues, congenital disease, chronic respiratory disease, and complex social issues
- Medicaid and CHIP pay for half of all pediatric ambulatory care visits and inpatient care for children ¹

Examples of Cost Drivers

- Lack of integration of care across settings, social determinants of health
- Inappropriate use of specialists to provide primary care services
- Fragmentation of services provided by physical and occupational therapists, developmental psychologists

Examples of Opportunities

- Includes improving early screening, assessment and diagnosis; increasing compliance to care plans; coordination of community settings; slowing progression of chronic illness; and reducing avoidable services including hospitalizations and readmissions

¹ <http://hcupnet.ahrq.gov/>

Persons with Alzheimer's disease

Description of Population

- Five million people, onset of the disease normally occurring after age 60
 - 13 percent of men and women aged 65 and over have Alzheimer's disease¹
- Groups unequally challenged by Alzheimer's disease: racial and ethnic minorities, people with intellectual disabilities, and people with young onset of the disease

Examples of Cost Drivers

- Care not always provided in settings best for beneficiaries, including home and community based care vs. institutional care
- Breadth of providers providing duplicative services

Examples of Opportunities

- Implementing new models of dementia-capable service delivery focusing on identifying those with the disease, specialized dementia care, care coordination and/or caregiver support

Persons living with HIV/AIDS

Description of Population

- Nearly half of the people with HIV/AIDS that are estimated to be in regular care are covered under Medicaid
- Many people living with HIV/AIDS historically have inadequate access to care

Examples of Cost Drivers

- Uncoordinated care, behavioral health integration, unmet need for other social supports

Examples of Opportunities

- Improve early screening, diagnosis and treatment
- Improve care coordination service with social support services
- Improve efforts to link and retain patients in care
- Improve medication adherence that addresses drug resistance issues

Children at high risk for dental disease

Description of Population

- Medicaid and CHIP beneficiaries identified as high risk through risk assessment tools

Examples of Cost Drivers

- Emergency department visits, surgery in operating room, over-utilized restorative services

Examples of Opportunities

- Risk-based intensive prevention and chronic disease management approach to childhood caries that leads to less oral disease, fewer surgical interventions, and lower per capita costs

TRAUMA HAS A DISTINCT IMPACT ON THE HEALTH AND DEVELOPMENT OF CHILDREN

Symptoms of Child Trauma that Overlap with Symptoms of Mental Illness

Mental Illness	Overlapping Symptoms	Trauma
Attention Deficit/Hyperactivity Disorder	Restless, hyperactive, disorganized, and/or agitated activity; difficulty sleeping, poor concentration, and hypervigilant motor activity	Child Trauma
Oppositional Defiant Disorder/Conduct Disorder	A predominance of angry outbursts and irritability	Child Trauma
Anxiety Disorder (incl. Social Anxiety, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, or phobia)	Avoidance of feared stimuli, physiologic and psychological hyperarousal upon exposure to feared stimuli, sleep problems, hypervigilance, and increased startle reaction	Child Trauma
Major Depressive Disorder	Self-injurious behaviors as avoidant coping with trauma reminders, social withdrawal, affective numbing, and/or sleeping difficulties	Child Trauma

Children in Foster Care and Adolescents in Crisis

Bryan Samuels, MPP

Commissioner

Administration on Children, Youth and Families

Opportunities to Innovate for Improved Outcomes for Vulnerable Children and Youth



BRYAN SAMUELS, COMMISSIONER
ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES

RATES OF MALTREATMENT AMONG AT-RISK YOUTH ACROSS SYSTEMS

	Any Maltreatment	Multiple Types of Maltreatment
Child Welfare	85%	68%
Substance Abuse Treatment	86%	64%
Mental Health	75%	54%
Juvenile Justice	78%	57%

Miller et al., 2012

CHILDREN KNOWN TO CHILD WELFARE HAVE COMPLEX HEALTH CARE NEEDS

- The behavioral and physical health of children who have been maltreated are inextricably linked.
- **22.7%** of children known to child welfare have at least one chronic health condition (AIDS, asthma, autism, Down syndrome, developmental delay, diabetes, cystic fibrosis, cerebral palsy, or muscular dystrophy).
- Among children who use any mental health service, the prevalence of chronic health conditions is much higher:

Children using mental health services who ALSO have a chronic health condition, by age group

1.5-2 Years	<2-5 Years	6-10 Years	11-15 Years	16+ Years
4.1%	38.9%	53.6%	44.9%	31.6%

PSYCHOTROPIC MEDICATION USE AMONG CHILDREN KNOWN TO CHILD WELFARE AND IN FOSTER CARE

Psychotropic Use and Polypharmacy among Children Known to Child Welfare, by Age Group

AGE GROUP	Any Psychotropic Medication	One Psychotropic Medication as % of Any	Two or More Psychotropic Medications as % of Any
1.5-5 Years Old	1.5%	1.0%	0.5%
6-11 Years Old	19.6%	11.6%	8.0%
12-17 Years Old	16.0%	7.9%	8.1%

Ringeisen, Casanueva, Smith & Dolan, 2011

- Children known to child welfare are three times more likely to use psychotropic medications than Medicaid child enrollees without apparent child welfare involvement (Raghavan et al., 2012).
- There is significant geographic variation in rates of psychotropic medication use among children in foster care, ranging from less than **1% to 22%** in 2008, with a median of **13%** (Rubin et al., 2012).

FOSTER CHILDREN INCUR SIGNIFICANT COSTS TO MEDICAID

- Children in foster care account for **38%** of total Medicaid expenditures (physical health and behavioral health) for children (Allen, 2013).
- On average states spend three times more for this population than for nondisabled children in Medicaid — approximately **\$4,336** for children in child welfare versus **\$1,315** for the general child population without disabilities (Geen, Sommers & Cohen, 2005).
- It is estimated that children known to child welfare incur approximately **\$1,482** in costs for psychotropic medications – **50% to 75% more** than non-foster care Medicaid child enrollees (Raghavan et al, 2012).

IMPROVED OUTCOMES FOR CHILDREN IN FOSTER CARE

- Reduced trauma symptoms and improved functioning across physical, social-emotional, cognitive, and developmental domains
- Reduction in use of acute services, including ER visits and inpatient hospitalization
- Reduction in unnecessary physical exams, immunizations, and routine labs
- Reduction in the use of residential care
- Reduction in use of psychotropic medications and prescribing practices that do not conform to best practice guidelines
- Increased use of evidence-based/evidence-informed, trauma-informed, screening, assessment, and psychosocial interventions as first-line treatments for behavioral health needs

USING DATA TO DRIVE INNOVATION

- Address complex clinical needs by integrating physical and behavioral health
- Leverage EPSDT to provide validated trauma-informed screening and assessment
- Intervene effectively by implementing evidence-based psychosocial interventions
- Improve quality by using standard measures
- Share information across child-serving systems

Long-Term Supports and Services

Mimi Toomey

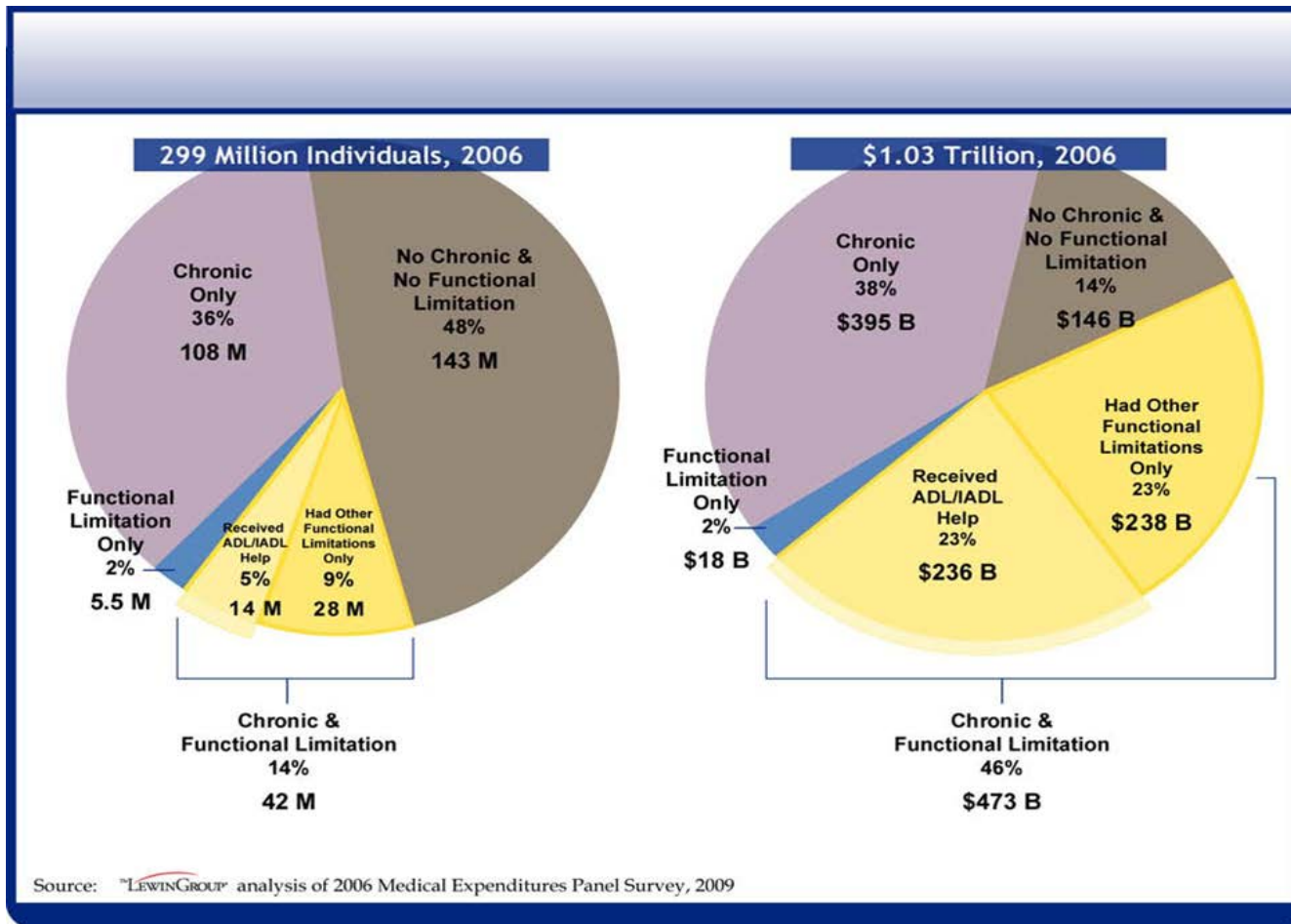
Director, Office of Policy Analysis and
Development

Center for Disability and Aging Policy
Administration for Community Living

What Are Long-Term Services and Supports (LTSS)?

- LTSS help older adults and people with disabilities accomplish everyday tasks
- Persons requiring LTSS:
 - Medicaid is the largest payer of LTSS but not the only payer
 - More states are rethinking their delivery systems under Medicaid LTSS for services including Medicaid Managed Care
- LTSS are directly related to health and health outcomes
 - Greater volume of attendant care, homemaking services and home-delivered meals is associated with lower risk of hospital admissions
 - Increased spending on home-delivered meals was associated with fewer residents in nursing homes with low-care needs

Who are LTSS Users?



Opportunities for LTSS

- Better integration of the health care systems with families and community supports systems through:
 - Support infrastructure and coordination of the LTSS system
 - Building a common language between the health and the LTSS systems
 - Packaging services and supports for the highest impact
 - Health information technology (HIT) opportunities
 - Promoting self direction and person-centered planning
 - Creating a gateway for employment
 - Quality/Evidence Based
 - Paying more attention to individual preference for their settings that are home and community based

LTSS Systems: Networks of Partners and Services

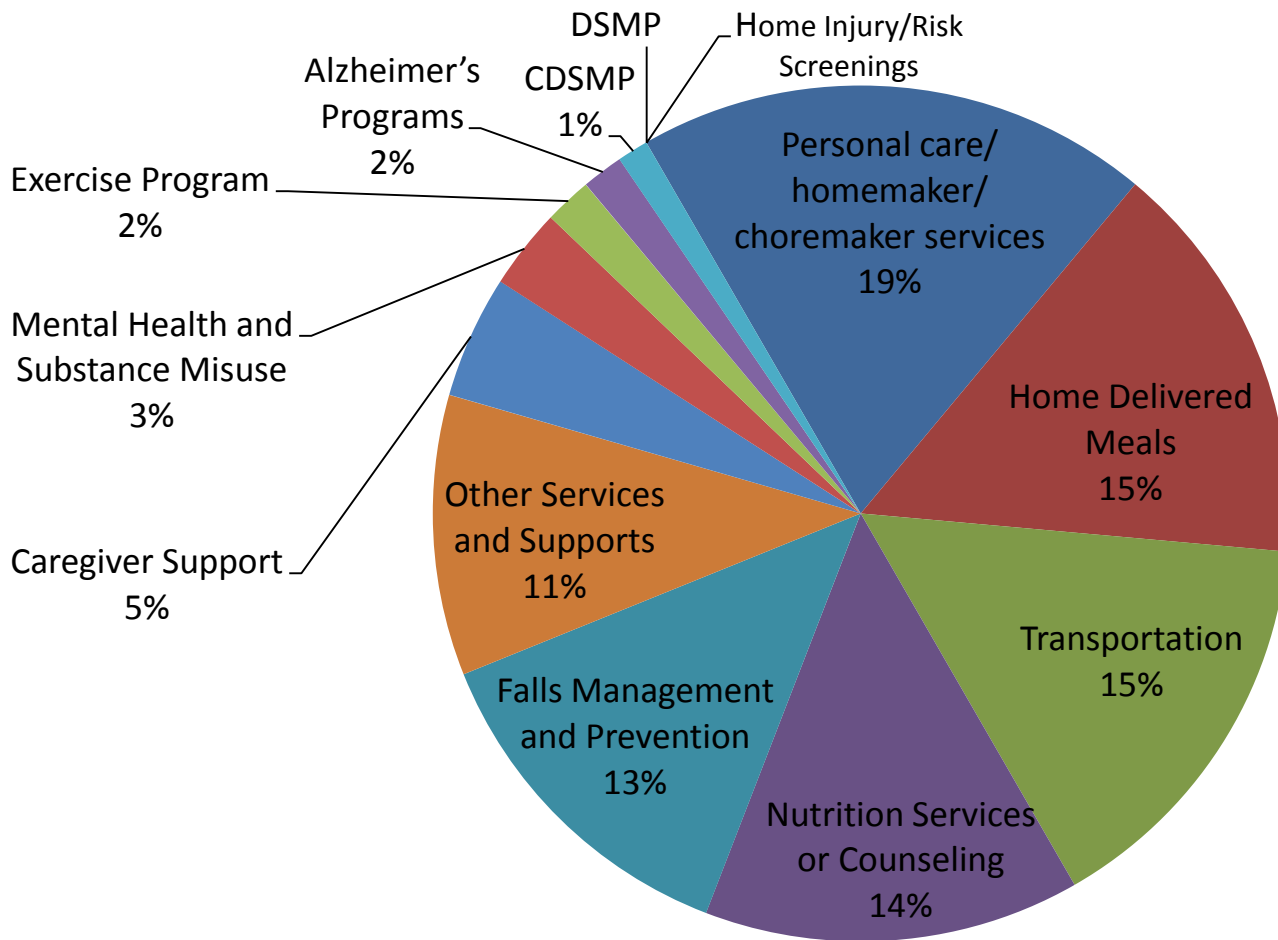
Partnerships

- Hospitals for discharge planning
- Home Care Agencies
- Community Health Centers
- Transportation
- Public Health Departments
- Assisted Living/Nursing Facilities
- Social Security
- Medicaid
- HUD Public Housing
- Alzheimer's Associations
- Senior Centers
- Volunteer Groups
- Home delivered meals providers
- Area Agencies on Aging

Services

- Care Transitions
- Chronic Disease Self-Management
- Information & Referral
- Adult Day Care
- Respite Care
- Home Delivered Meals
- Congregate Meals
- Grocery shopping/meal preparation
- Personal Care/Attendants—Assistance with ADL/IADL
- Socialization/Senior Centers
- Benefits Counseling
- Transportation

Referrals to Long Term Services and Supports During Transitions (n=739 participants and 2,129 referrals)

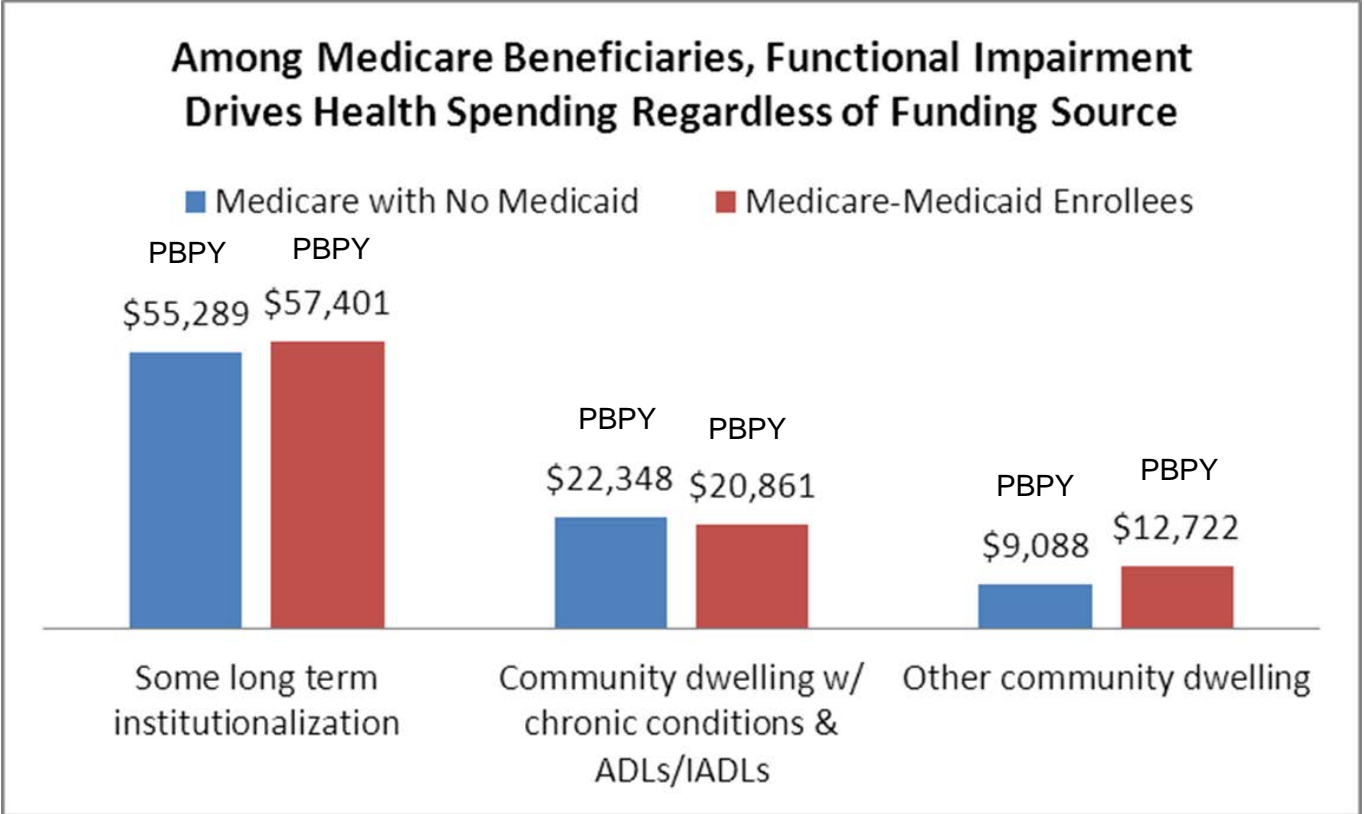


Persons with serious behavioral health needs

Suzanne Fields, MSW, LICSW

Senior Advisor on Health Care Financing
Substance Abuse and Mental Health Services
Administration

High-Risk Medicare Beneficiaries without Medicaid Look Like Those with Medicaid Except Their High Health Costs Put Them on a Slippery Slope to Medicaid Spend Down



Data source: 2006 Medicare Current Beneficiary Survey Cost and Use File

ADULTS

- Over 2/3 of adults with serious mental illness have comorbid physical health conditions such as diabetes, heart disease and chronic obstructive pulmonary disease
- Adults aged 18 or older with any mental illness or major depressive episode in the past year were more likely than to have high blood pressure, asthma, diabetes, heart disease, and stroke
- Those with mental illness were more likely to use an emergency room and to be hospitalized

*SAMHSA NSDUH Report, “Physical Health Conditions among Adults with Mental Illnesses,” 4/5/12

ADULTS

Table 1. Chronic Health Conditions among Persons Aged 18 or Older with and without Mental Illnesses in the Past Year: 2008 and 2009

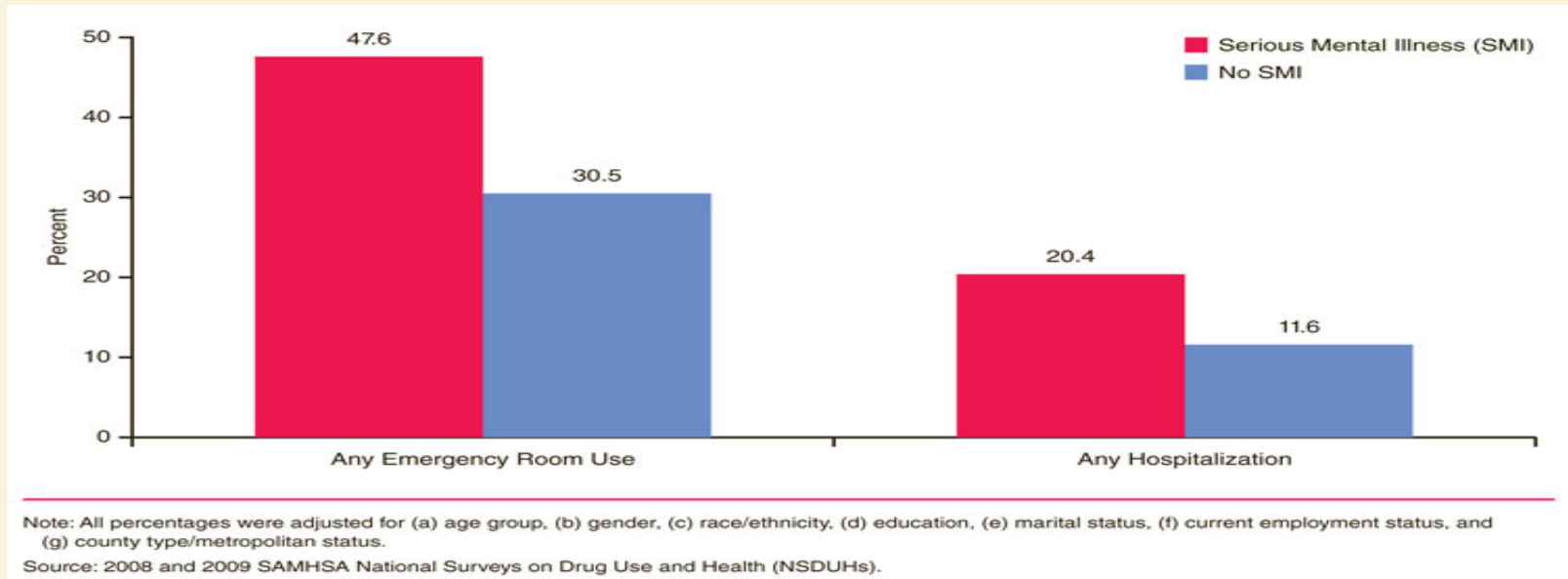
Mental Illness	High Blood Pressure %	Asthma %	Diabetes %	Heart Disease %	Stroke %
Any Mental Illness (AMI)					
Yes	21.9	15.7	7.9	5.9	2.3
No	18.8	10.6	6.6	4.2	0.9
Serious Mental Illness (SMI)					
Yes	21.6	19.1	7.7	5.2	2.6
No	17.7	12.1	6.6	4.2	1.1
Major Depressive Episode (MDE)					
Yes	24.1	17.0	8.9	6.5	2.5
No	19.8	11.4	7.1	4.6	1.1

Note: All percentages were adjusted for (a) age group, (b) gender, (c) race/ethnicity, (d) education, (e) marital status, (f) current employment status, and (g) county type/metropolitan status. All associations between mental illnesses and chronic health conditions are statistically significant at the 0.05 level, except for marginally significant associations for SMI and diabetes (significant at the 0.10 level) and SMI and heart disease (significant at the 0.10 level).

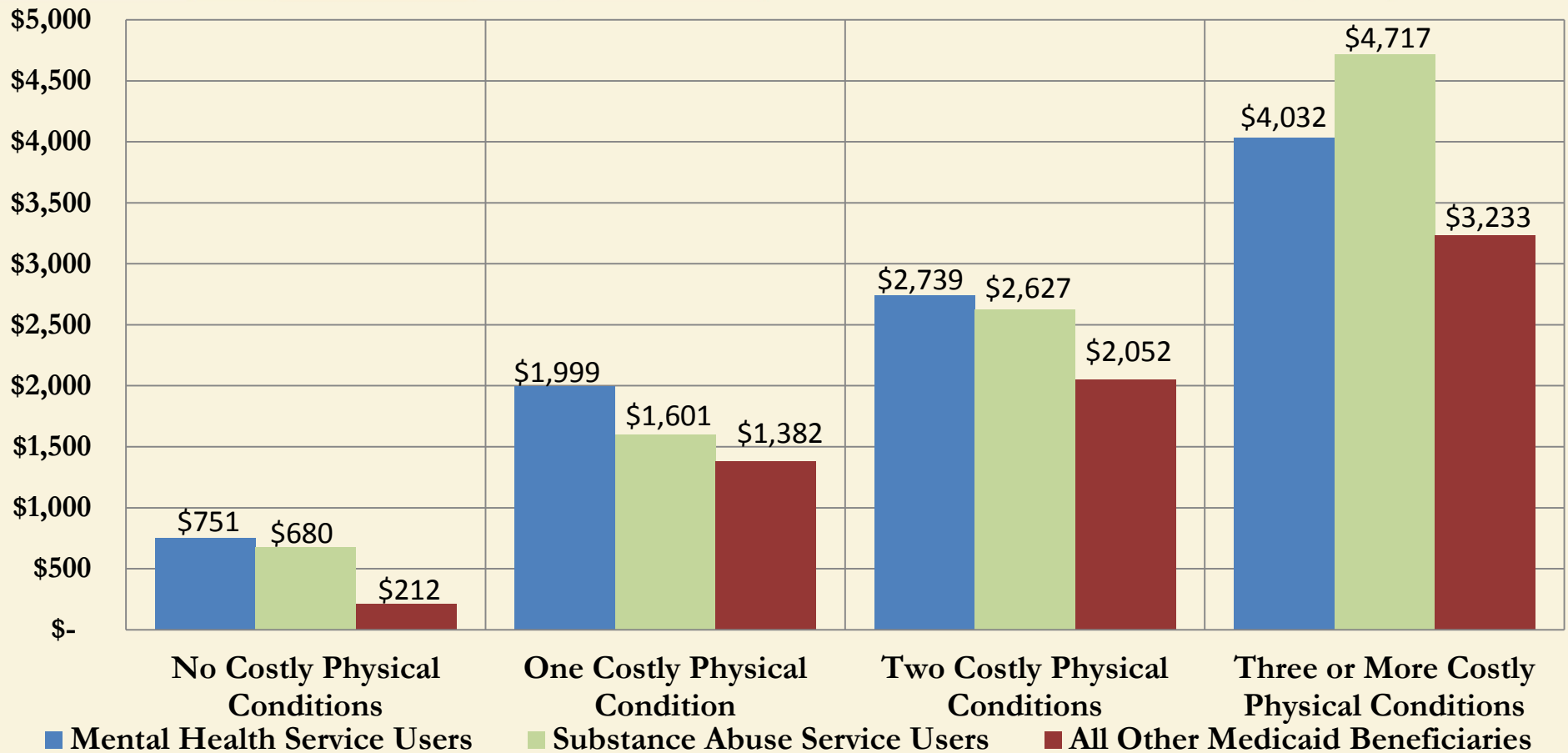
Source: 2008 and 2009 SAMHSA National Surveys on Drug Use and Health (NSDUHs).

ADULTS

Past Year Emergency Room Use and Past Year Hospitalization among Persons Aged 18 or Older with and without Serious Mental Illness in the Past Year: 2008 and 2009



ADULTS



SAMHSA. (2010). Mental health and substance abuse services in Medicaid, 2003: Charts and state tables. HHS Publication No. (SMA) 10-4608.

CHILDREN & YOUTH

- Around 1 in 5 young people have a mental, emotional, or behavioral health disorder, at an estimated annual cost of \$247 billion
- About 1 in 4 pediatric primary care office visits involve behavioral and mental health problems
- About 1 in 3 Medicaid-enrolled children who use behavioral health care have serious medical conditions (primarily asthma)
- In contrast to adults with SPMI and chronic physical conditions (COPD, diabetes, etc.) Medicaid expenditures for children with co-morbid conditions are driven primarily by behavioral health
- Integrated care strategies for children differ from those for adults in a number of important ways, including duration, diagnoses, provisions for consent, involvement of families in peer services, increased staffing ratios for care coordination, etc.

OPPORTUNITIES

- Implement new financing models for integrated care for individuals with serious behavioral health needs
- Support new service delivery models for coordinating and integrating physical and behavioral health treatments and services, with a focus on broader social and educational supports
- Support new service delivery models that address the primary care and behavioral health treatment needs for individuals with substance use disorders
- Create person/family-centered systems of care that improve outcomes, services, and value
- The use of data and the inclusion of functional outcomes

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Upcoming Webinars

June 18, 2013:

- **Webinar 3: Overview of Innovation Category 3–4**

Webinar 4: Achieving Lower Costs Through Improvement; Cost Categories and the Financial Plan; Submitting a Letter of Intent

- Demonstrating how applicants can achieve lower costs through improvement
- Describing the cost categories and completing the Financial Plan
- Technical assistance for LOI submission

Webinar 5: Performance Measures/Developing an Operational Plan

- Driver Diagrams/Theory of Change
- Demonstrating measurable impact on Better Health and Better Care
- Rapid cycle improvement

Webinar 6: Payment Models

- What is a Payment Model?
- What makes a Payment Model “Fully Developed”?
- What is a sustainable Payment Model?

Webinar 7: Application Narrative and Road Map

- Application Narrative
- Awardee Selection Process & Criteria
- Helpful Hints

Webinar 8: Technical Assistance for Submitting an Application

Slides, transcripts and audio will be posted at <http://innovation.cms.gov>

Next Steps

- Letters of Intent (LOI) are due **June 28, 2013**
 - LOI is available online in a web-based form through the Innovation Awards website.
- Additional information regarding the Innovation Awards will be posted on <http://innovation.cms.gov>
- Register for your DUNS number
<http://www.dunandbradstreet.com> ... ASAP
- Register in the System for Award Management (SAM) at:
<https://www.sam.gov/portal/public/SAM/>
- More Questions? Please Email
InnovationAwards@cms.hhs.gov

Thank You!

Please use the webinar chat feature to submit questions