CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Health Care Innovation Awards

Overview of Innovation Categories Three and Four

June 18, 2013

Agenda

- **Introduction**
- **Innovation Category 3:** Transform the financial and clinical models of specific types of providers and suppliers
- **Innovation Category 4:** Improve the health of populations through better prevention efforts
- How to Submit a Letter of Intent
- 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

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***

Measuring Success

- **BETTER CARE**
- **LOWER COSTS**
- **IMPROVED HEALTH STATUS**

Today's Webinar

Focus on Innovation Categories 3 and 4:

- Transform the financial and clinical models of specific types of providers and suppliers
- Improve the health of populations through better prevention efforts

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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3: Transform the financial and clinical models for specific types of providers and suppliers

Priority Areas:

- Models for specific physician specialties and sub-specialties
- Models for pediatric providers who provide services for complex medical issues

Models in these priority areas may include, as appropriate, shared decision-making mechanisms that engage beneficiaries and their families and/or caregivers in treatment choices.

CMS will consider submissions in other areas within this category and from other specific types of non-physician providers

Why these areas?

Transform financial and delivery models

- Specialized areas of care account for a large proportion of health care needs
- Investment needed for broad scale delivery model transformation and proof of concept
- Alignment of financial incentives to support delivery transformation

Geographic variation

- Variation in utilization, outcomes, and delivery models for many specialized areas of care

Portfolio Expansion

- To expand our portfolio, which is well-developed in primary care and inpatient settings

Components of Category 3 models

Transformation of payment and service delivery model for a provider or group of providers

Potential components:

- Promote comprehensive care of patient and coordination with other providers, particularly primary care
- Shared-decision making mechanisms
- Incorporation of evidence-based guidelines, such as appropriate-use criteria, diagnosis and management pathways and clinical decision support tools
- Use of outcome data, such as registry data, to provide feedback and facilitate rapid improvement

Specialty and subspecialty models

Models should address a sufficient proportion of providers' services to promote delivery and financial model transformation

Examples of Providers

- Oncology, cardiology, rheumatology, behavioral health specialists, multi-specialty group practices etc.

Examples of Models

- Models that provide coordinated and evidence-based care for high-volume ambulatory conditions or procedures from initial presentation through treatment
- Models that address most or all services commonly performed in a specialty area

Examples Delivery and Payment Issues and Opportunities

- Improve the degree to which services are evidence based and consistent with patient preferences
- Preventable complications
- Utilization of high-cost sites of care

Pediatric providers of pediatric patients requiring high-cost services

Examples of complex medical issues

- Multiple medical conditions; behavioral health issues; congenital disease; chronic respiratory disease; complex social issues

Examples of Models

- Models targeting high-volume and complex pediatric conditions and populations
- Models that include all or most services commonly performed by a pediatric specialist or hospital
- Pediatric ACOs; medical homes with gain sharing

Examples of payment and service delivery issues

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

Examples of Payment models

- Bundled or episode-based payment
- Capitation
- Contact Capitation
- Pay-for-performance
- Per capita care management fees with gain sharing
- Tiered value-based payment schedules paying more for services with a strong evidence base for effectiveness
- Hybrid models that blend unit-based and per-case payment
- Other innovative forms of payment for specific types of services designed to reduce barriers to use of the most appropriate forms of care and to reward efficient providers of high-quality, evidence-based services

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4: Improve the health of populations through better prevention efforts

Anand K. Parekh, M.D., M.P.H.
Deputy Assistant Secretary for Health (Science and Medicine)
U.S. Department of Health and Human Services

Discussion Agenda

- Context for improving the health of populations
- Priority areas

What is Population Health?

Health of populations defined:

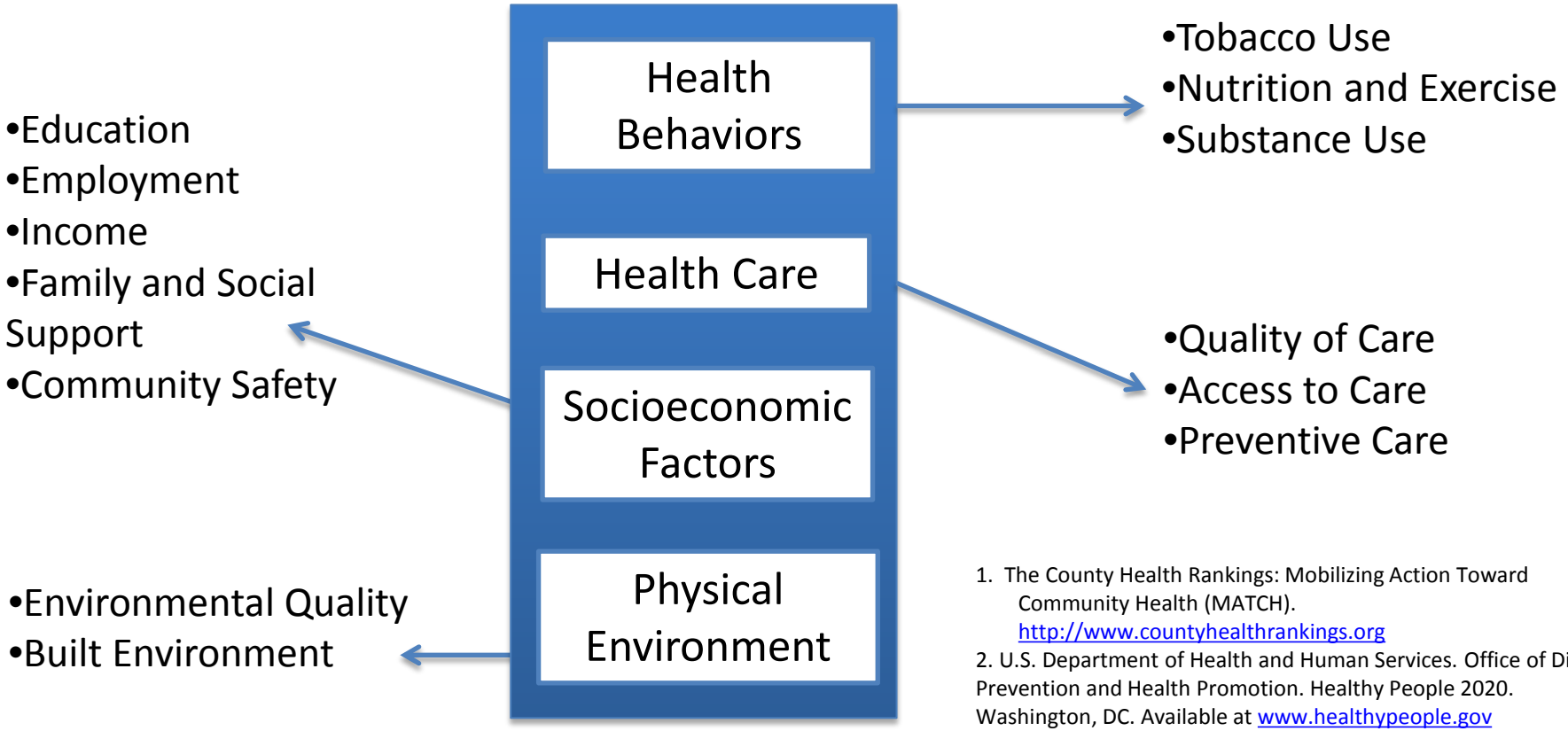
- Geographically (health of a community)
- Clinically (health of those with specific diseases)
- Socioeconomic class

Through activities focused on:

- Engaging beneficiaries
- Prevention
- Wellness
- Comprehensive care that extends beyond the clinical service delivery setting.

Key Health Factors

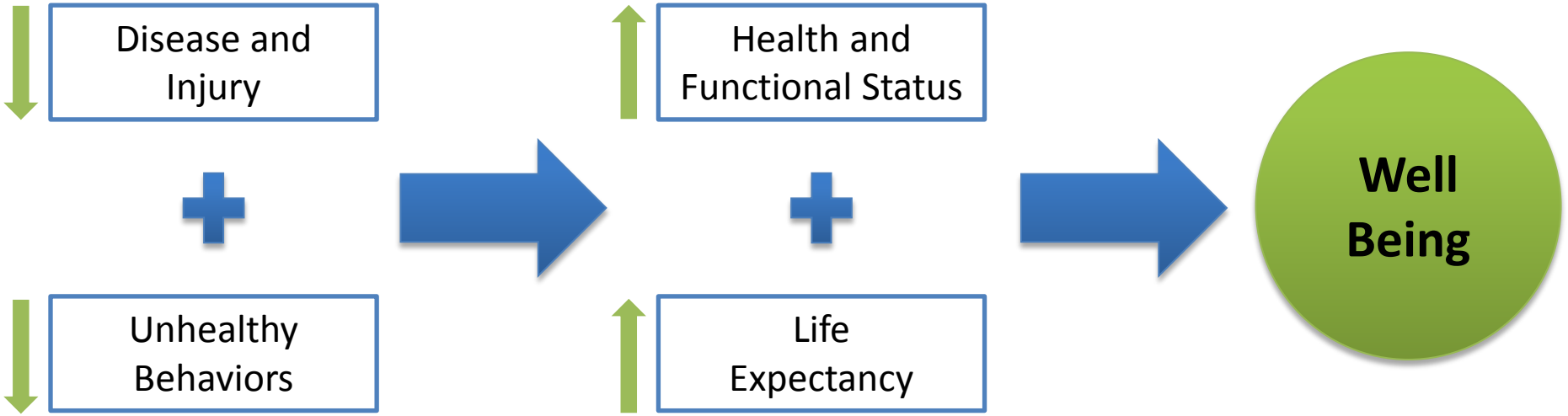
Health Factor Examples



1. The County Health Rankings: Mobilizing Action Toward Community Health (MATCH). http://www.countyhealthrankings.org
2. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at www.healthypeople.gov

Better Health - Community Health Outcomes

A Measurably Healthier Population…



1. The County Health Rankings: Mobilizing Action Toward Community Health (MATCH). http://www.countyhealthrankings.org
2. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at www.healthypeople.gov

Better Health Linked to Lower Costs

- Medicare example
  - High and rising prevalence of chronic diseases are a key factor in the growth of Medicare spending[1]
  - Per capita costs for Medicare beneficiaries with versus without specific chronic conditions demonstrate substantial differences

1. Thorpe KE, Ogden LL, Galactionova K. Chronic Conditions Account For Rise in Medicare Spending From 1987 To 2006. Health Affairs, 29, no.4 (2010):718-724.

Improving Population Health through Prevention

- Promote health behaviors
- Encourage self-management
- Enhance care management
- Ensure medication adherence
- Prevent falls

Critical Areas

- Clinical-community health integration
  - (e.g., models that links clinical and community services; accountable health communities, population health ACOs)
- Beneficiary Engagement
  - (e.g., shared decision making; self-management; value-based benefits)
- Sustainability through payment model design
  - Improve health/quality of care and reduce costs within the first six months of the award and deliver net savings to CMS within three years.
- Population Health Measurement

Improve the health of populations through better prevention efforts

Peter A. Briss, MD, MPH

Medical Director, National Center for Chronic Disease Prevention and Health Promotion, CDC

Priority Areas: High Value Targets of Change

- Prevention of Hypertension and Cardiovascular Disease, Diabetes, COPD, Asthma, HIV/AIDS
- Fall prevention in older adults
- Behaviors that reduce the risk for chronic disease
- Adherence and self management skills
- Broader models that link clinical care with community-based interventions

Priority Areas: High Value Targets of Change

- All selected because significant drivers of burden and cost and effective interventions available and underused
- Cross-cutting interventions can importantly influence these major drivers of burden and cost.
- Important issues unlikely to be optimally addressed working only within the walls of the health care system.

Preamble

- What this talk is:
  - Provides background information from population health subject matter experts on potentially useful strategies that relate to priorities in the FOA and are thought to be plausibly related to health improvements and cost savings
- What this talk is not:
  - A complete universe of service delivery options
    - Examples in upcoming slides do not relay preferences
  - A list of scoring priorities

Promising CVD Interventions (focused on high blood pressure):

- *Health care interventions*
  - Clinical Decision-Support Systems (CDSS),
    - Reminders, risk assessment, behavior change recommendations, optimize care
  - Electronic Health Record (EHR) patient lists to identify undiagnosed hypertension and target interventions

Promising CVD Interventions (focused on high blood pressure):

- *Clinical-Community Linkages*
  - Interventions in community and health care settings using pharmacists, nurses and other allied health professionals
  - Risk assessment, feedback, education and referral in worksite and other community settings
  - Self-Measured Blood Pressure (SMBP) monitoring (with appropriate support).
  - Clinical-community integration and information technology infrastructure
    - E.g., link health information systems, e.g., e-prescription, to community based networks to improve adherence
  - Telemedicine services

Promising Diabetes Interventions

- Link health care system, community, and public health systems to identify people who are at risk for diabetes and enroll them in Diabetes Prevention Programs
- Deliver interventions outside traditional health care settings by allied health professionals and nurses
- Risk assessment, feedback, education and referral in worksite and other community settings
- Encourage enrollment in diabetes self-management programs, home-based blood glucose monitoring, self-measurement of blood pressure
- Remote monitoring for home-based blood glucose management
- Telemedicine services

Promising Asthma Interventions

- Population-based comprehensive asthma care:
- *Health care interventions*
  - EHR to identify persons with asthma, assess severity of disease and level of control
  - Step-wise, strategic allocation of services
  - Guidelines-based medical management, education, self-management training
  - Smoking cessation services to persons with asthma and family members who smoke
  - Specialist referral when needed

Promising Asthma Interventions

- Population-based comprehensive asthma care
- *Clinical-Community Linkages*
  - May include community-level interventions (trigger reduction, reduced exposure to pollutants) in communities with high prevalence and severity (particularly in low socio-economic status)
  - Interactive asthma-self management training in schools, daycares, other community settings for persons with persistent asthma
  - Culturally-appropriate home visits and assessments for persons with poorly controlled asthma despite appropriate medical management and self-management training
  - Social services and support as needed to address social determinants
  - Coordinated care across settings

Promising COPD Interventions

- Tobacco cessation interventions
- Chronic disease self-management training
- Clinical decision support to improve provider adherence to guidelines
- Many of the approaches shown for asthma (except trigger reduction) might also be adapted

Fall Prevention Promising Interventions

- Incentives and reimbursement to
  - Primary care providers and allied health professionals to integrate education, risk assessment, treatment and referral into clinical practice.
  - Community pharmacists to conduct medication reviews and counseling that reduce potential drug interactions and side effects

- CME for health care providers about managing medications for older adults to minimize side effects and interactions that can lead to falls
- Annual eye checks, eye glass prescriptions
- Evidence-based fall prevention community exercise programs to improve balance, increase stretching and mobility, and reduce fear of falling
- Home modification programs to reduce or remove potential fall hazards
- Vitamin D for people aged 65 and older

Behaviors that reduce the risk of chronic disease

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Chronic Disease Management Programs

- Community-based (or on-line) programs that impart skills and improve self-efficacy
- Evidence-based
- Target various and multiple chronic conditions

Promising Tobacco Cessation Practices

- Individual, group, and telephone counseling and seven FDA-approved medications
- Brief advice to quit is effective – effectiveness increases with intensity
- Counseling and medication each effective alone – more effective when combined
- Telephone counseling increases quit rates, has potential for broad reach, effective with diverse populations
- Provider intervention with patients who smoke increase quit rates
- Insurance coverage for evidence-based cessation treatments increases use of treatments, quit attempts, and quit rates

Promising Tobacco Cessation Practices

- Comprehensive cessation services:
  - Individual, group, telephone counseling
  - All seven FDA-approved cessation medications, prescription and OTC
  - At least two quit attempts per year – four counseling sessions per attempt
  - Is heavily promoted to smokers and health care providers
- Integrate interventions into routine clinical care using tools such as provider reminder systems and electronic health records (EHRs)

Physical Activity Promising Practices

- Health Care System Interventions
  - Health care provider assessment of physical activity, encouragement of patients to increase physical activity, referrals to evidence-based physical activity programs, and assistance with finding community resources
  - Physician and health care provider counseling and referral to qualified physical activity promotion entities

Physical Activity Promising Practices

- Multicomponent community-wide campaigns to promote physical activity (e.g., mass media plus community events)
- Promotion of places for physical activity (e.g., walking trails or bicycle paths; access to school facilities such as tracks and playgrounds)
- Social support in community physical activity programs (e.g., group walking programs, buddy systems)
- Multi-component strategies to increase the amount of time spent in physical activity
- Transit and bike share programs that encourage /reward regular use

Obesity Intervention

- *Clinical–Community Linkages*
  - Train and use community health workers to link health care and public health sectors to support and educate patients and families about healthier lifestyles
  - Establish strong, reliable referral systems from the primary health care setting to community resources
  - Engage the primary health care providers and system with local and/or state departments of health and other stakeholders to develop coalitions to develop and support environments that allow patients and families to access healthier foods and increased physical activity

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Letter of Intent Instructions

Applicants may access the Letter of Intent (LOI) via the following Web site:

http://cmsgov.force.com/HCIAR2/LOIMainFormHCIA

Completing the LOI Web Form

Please note that you do not need a login ID or password to complete the LOI form.

However, you must complete and submit the LOI in one sitting. You will not be able to return to complete a partially completed LOI. If you recognize an error post submission, please submit a new LOI and use that number for your application.

Letter of Intent Instructions

The Letter of Intent contains three sections.

- **Section A** – Organizational Information and Project Summary
- **Section B** – Intervention Description
- **Section C** – Population Description

Required fields in each section are indicated with a *

Letter of Intent Instructions

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CMS will safeguard the information provided to us in accordance with the Privacy Act of 1974, as amended (5 U.S.C. Section 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp

Health Care Innovation Awards — Round Two

- Health Care Innovation Awards Round Two Home Page
- Contact Us
- Letter of Intent to Apply Instructions (.pdf)

For help completing each field, a User Guide is located here.

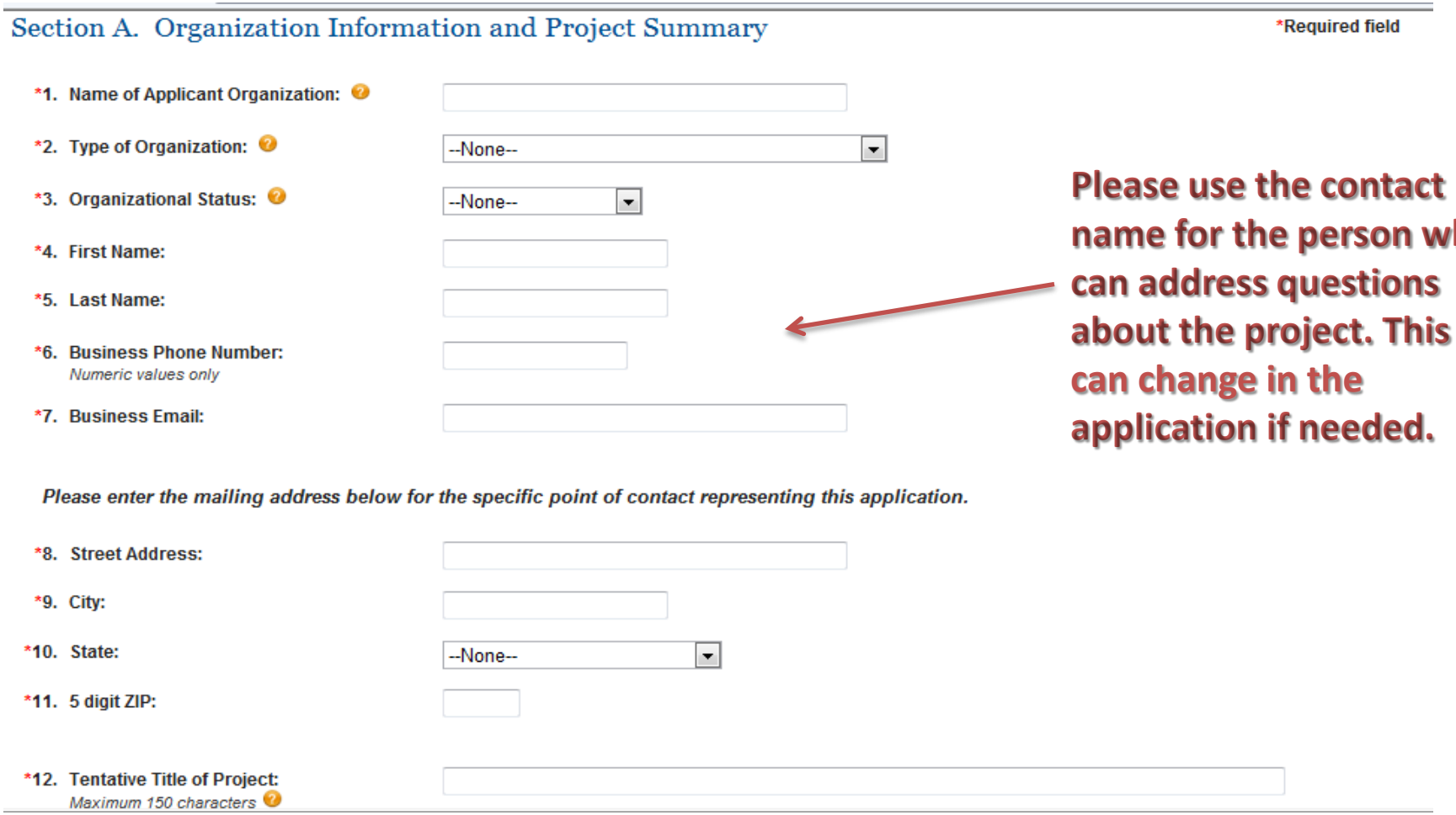
Note due date and time

Letter of Intent to Apply

Applicants must submit a non-binding Letter of Intent to Apply. Letters of Intent to Apply provide information that helps CMS in determining expertise and personnel necessary to review applications and issue awards. Letters of Intent to Apply are due by 3:00 pm Eastern Time (Baltimore time) on June 28, 2013. Failure to submit a Letter of Intent to Apply will disqualify the application from that organization from being reviewed. The information specified for the Letter of Intent to Apply must be provided through this online form. Information and detailed instructions for submitting Letters of Intent to Apply are described in the Letter of Intent to Apply Instructions (.pdf) document. Any additional information will be posted on the Innovation Center website at http://innovation.cms.gov.

****Important**:** *Please save your Letter of Intent to Apply confirmation number that will be generated following your submission. Please retain this number as it will be required in the application process.*

Organization Information



Section A. Organization Information and Project Summary

*Required field

*1. Name of Applicant Organization:

*2. Type of Organization: --None--

*3. Organizational Status: --None--

*4. First Name:

*5. Last Name:

*6. Business Phone Number:
Numeric values only

*7. Business Email:

Please enter the mailing address below for the specific point of contact representing this application.

*8. Street Address:

*9. City:

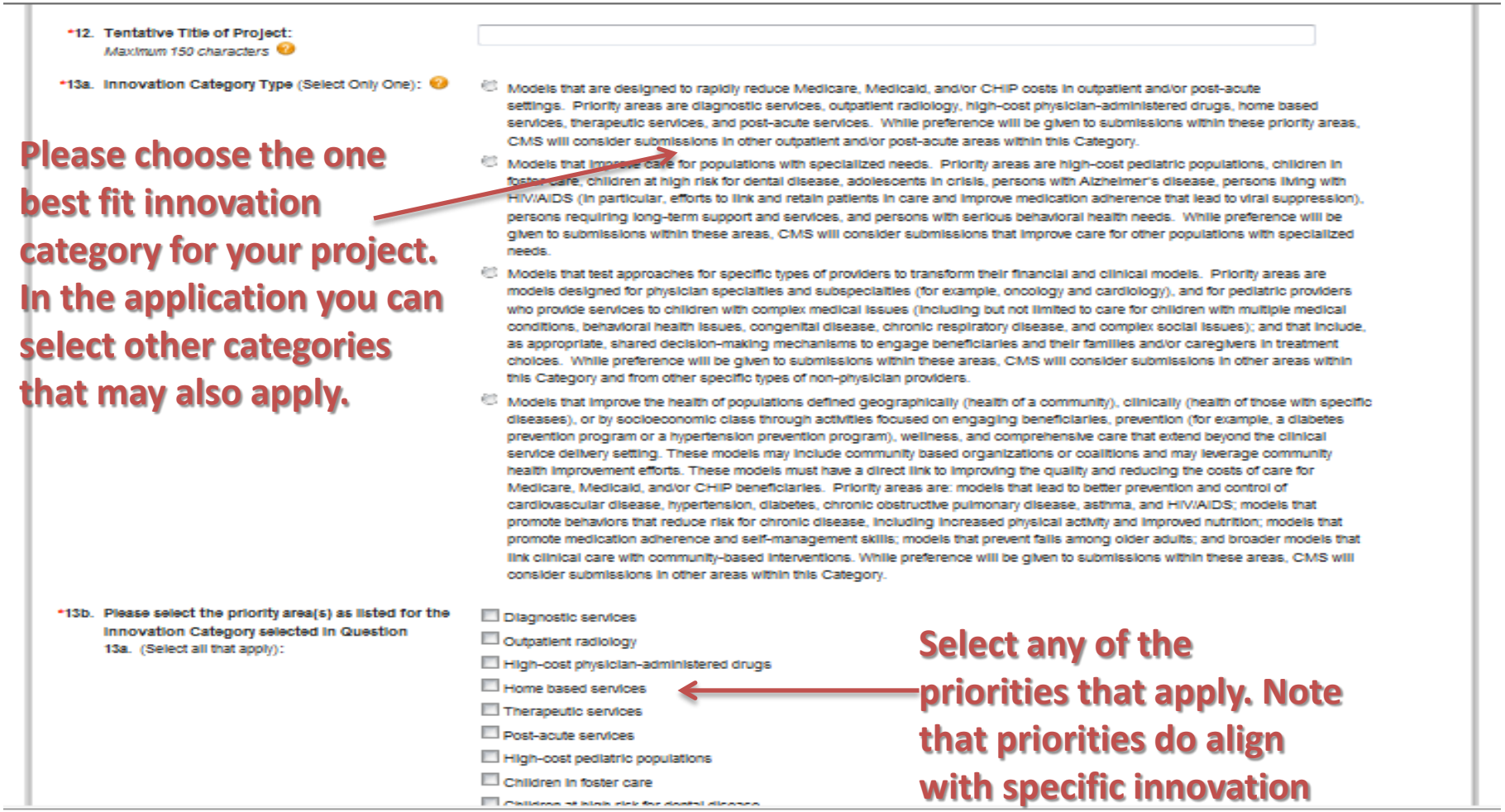
*10. State: --None--

*11. 5 digit ZIP:

*12. Tentative Title of Project:
Maximum 150 characters

Please use the contact name for the person who can address questions about the project. This can change in the application if needed.

Innovation Category and Priorities



*12. Tentative Title of Project:
Maximum 150 characters

*13a. Innovation Category Type (Select Only One):

- Models that are designed to rapidly reduce Medicare, Medicaid, and/or CHIP costs in outpatient and/or post-acute settings. Priority areas are diagnostic services, outpatient radiology, high-cost physician-administered drugs, home based services, therapeutic services, and post-acute services. While preference will be given to submissions within these priority areas, CMS will consider submissions in other outpatient and/or post-acute areas within this Category.
- Models that improve care for populations with specialized needs. Priority areas are high-cost pediatric populations, children in foster care, children at high risk for dental disease, adolescents in crisis, persons with Alzheimer's disease, persons living with HIV/AIDS (in particular, efforts to link and retain patients in care and improve medication adherence that lead to viral suppression), persons requiring long-term support and services, and persons with serious behavioral health needs. While preference will be given to submissions within these areas, CMS will consider submissions that improve care for other populations with specialized needs.
- Models that test approaches for specific types of providers to transform their financial and clinical models. Priority areas are models designed for physician specialties and subspecialties (for example, oncology and cardiology), and for pediatric providers who provide services to children with complex medical issues (including but not limited to care for children with multiple medical conditions, behavioral health issues, congenital disease, chronic respiratory disease, and complex social issues); and that include, as appropriate, shared decision-making mechanisms to engage beneficiaries and their families and/or caregivers in treatment choices. While preference will be given to submissions within these areas, CMS will consider submissions in other areas within this Category and from other specific types of non-physician providers.
- Models that improve the health of populations defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class through activities focused on engaging beneficiaries, prevention (for example, a diabetes prevention program or a hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery setting. These models may include community based organizations or coalitions and may leverage community health improvement efforts. These models must have a direct link to improving the quality and reducing the costs of care for Medicare, Medicaid, and/or CHIP beneficiaries. Priority areas are: models that lead to better prevention and control of cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma, and HIV/AIDS; models that promote behaviors that reduce risk for chronic disease, including increased physical activity and improved nutrition; models that promote medication adherence and self-management skills; models that prevent falls among older adults; and broader models that link clinical care with community-based interventions. While preference will be given to submissions within these areas, CMS will consider submissions in other areas within this Category.

*13b. Please select the priority area(s) as listed for the Innovation Category selected in Question 13a. (Select all that apply):

- Diagnostic services
- Outpatient radiology
- High-cost physician-administered drugs
- Home based services
- Therapeutic services
- Post-acute services
- High-cost pediatric populations
- Children in foster care

Please choose the one best fit innovation category for your project. In the application you can select other categories that may also apply.

Select any of the priorities that apply. Note that priorities do align with specific innovation categories.

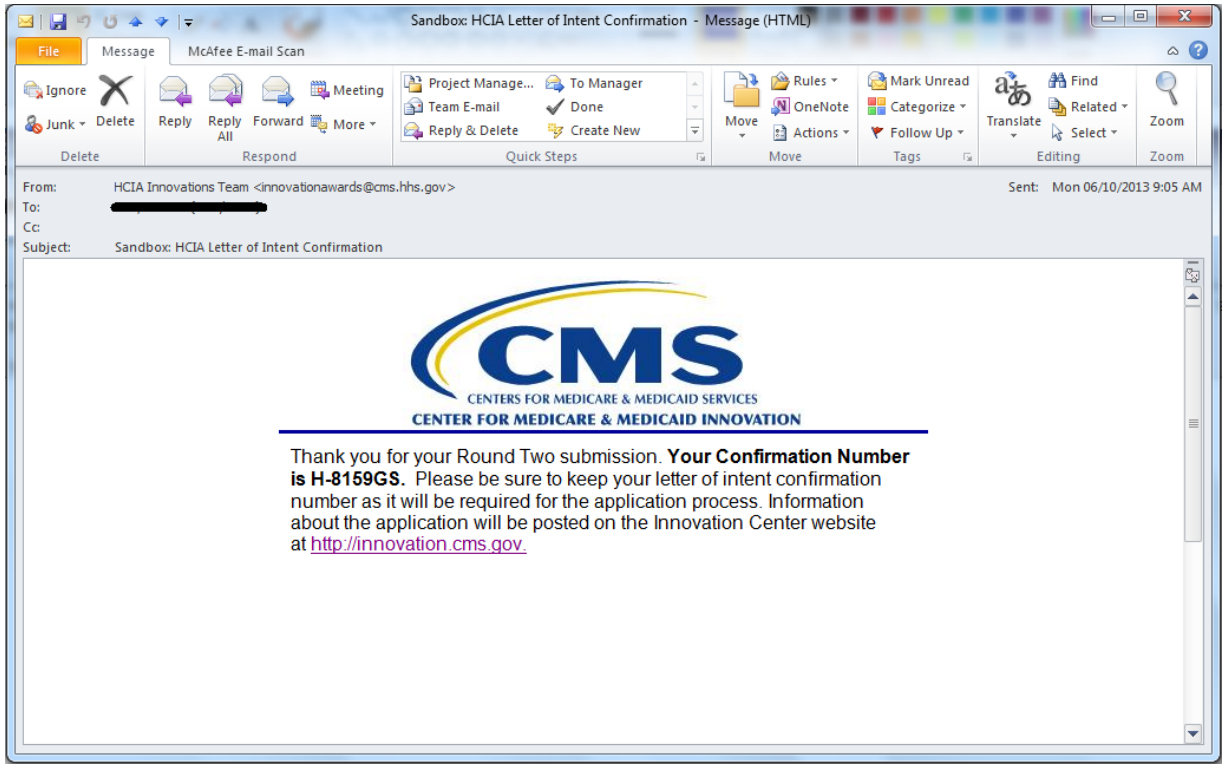
Letter of Intent Instructions

Once all fields have been completed, click on the 'Submit & Print' button located at the bottom of the LOI:

The completed Letter of Intent will be displayed in a .PDF file which can be printed off. Be sure to retain this information as it is needed for the Round 2 Application.

Letter of Intent Instructions

LOI applicants will receive an automated e-mail notification. This e-mail will include the Confirmation Number. **Be sure to retain this information as it is needed for the Round 2 Application.**



Other LOI Hints

- Several fields require one best fit answer. The application will have more flexibility in certain fields.
- Please use the “other” option to describe your answer if none of the available options work. For example this may occur in the clinical condition or type of organization fields.
- Note that some fields like number of states and population type have data validation rules so that parts add up to the total.
- Finally, CMS acknowledges that the LOI represents estimates only and the application will likely contain some variation.

LOI Support

- Refer to Instruction Guide on LOI web page. We suggest reviewing that and the FOA in advance of your LOI submission.

- Frequently Asked Questions are posted on the HCIA 2 Web site.

- Other questions can be sent to InnovationAwards@cms.hhs.gov

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Upcoming Webinars

June 20, 2013:

Webinar 4: Achieving Lower Costs Through Improvement; Cost Categories and the Financial Plan

- Demonstrating how applicants can achieve lower costs through improvement
- Describing the cost categories and completing the Financial Plan

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 are due by 3pm EDT on **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