The Affordable Care Act
Accelerating Care & Payment Innovation

Geriatrics Grand Rounds
University of Colorado

May 30, 2013

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University of Colorado
and
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Centers for Medicare & Medicaid Services

Updated: February 11, 2013
Since March 23, 2010

- 105 million Americans no longer have a lifetime dollar limit on essential health benefits
- 71 million additional Americans now receive many preventive services without cost sharing such as copays or deductibles
- 3.1 million young adults who were uninsured have gained coverage by being able to stay on their parent’s health plan
- Over 107,000 Americans with pre-existing conditions have gained coverage
- Over 6 million seniors and people with disabilities have saved more than $5.7 billion on prescription drugs

Since January 1, 2011

- Free preventive care has been available to seniors, an estimated 34.1 million seniors in 2012 alone
- The 80/20 rule (Medical Loss Ratio) ensured premium dollars were spent primarily on health care and helped deliver rebates worth $1.1 billion to nearly 13 million consumers
Challenge

Medicare’s Spending Continues to Grow

Medicare Spending as Percent of GDP, 1990 - 2020

Source: Medicare Trustees Report - 2012
Challenge
Wide Variation in Spending Across the Country

Home Health Per Capita Spending (2011)

- Miami, FL: $3,165 per capita
- Minot, ND: $74 per capita
- National Average: $546

Ratio to the national average

Home Health Per Capita Spending (2011)
Challenge
Wide Variation in Spending Across the Country

CT Scans Per Capita Spending* (2011)

*includes institutional and professional spending

National Average = $76

Honolulu, HI
$49 per capita

Fort Myers, FL
$117 per capita

Ratio to the national average

0.64 - 0.79
0.80 - 0.94
0.95 - 1.05
1.06 - 1.20
1.21 - 1.54

Map showing variation in CT scans per capita spending across the United States.
Wide Variation in Spending 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 Analysis, Medicare Claims Analysis - 2010
Major Medicare Policy Initiatives

Current Initiatives

• ACO Program
  – Medicare Shared Savings Program
  – Pioneer ACOs (CMMI)
  – Advance Payment ACOs (CMMI)
• Hospital Value Based Purchasing & Readmissions Penalties
• Medicare Advantage Five-Star Bonus Program
• Comprehensive Primary Care Initiative (CMMI)
• Partnership for Patients (CMMI)

Upcoming Initiatives

• Bundled Payment Initiatives (CMMI)
• Physician Value Modifier
Rating the Plans

Medicare health plans:
1. Staying healthy: screenings, tests, and vaccines
2. Managing chronic conditions
3. Member experience with the health plan
4. Member complaints, problems getting services, and improvement in the health plan’s performance
5. Health plan customer service

Medicare drug plans:
1. Customer service
2. Member complaints, problems getting services, and improvement in the drug plan’s performance
3. Member experience with the drug plan
4. Patient safety and accuracy of drug pricing
<table>
<thead>
<tr>
<th>Plan Name and ID Numbers</th>
<th>Summary Rating of Health Plan Quality</th>
<th>Staying Healthy: Screenings, Tests, and Vaccines</th>
<th>Managing Chronic (Long Term) Conditions</th>
<th>Ratings of Health Plan Responsiveness and Care</th>
<th>Health Plan Members’ Complaints and Appeals</th>
<th>Health Plan’s Telephone Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente Senior Advantage Gold (HMO) (H0630-016-0)</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
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<tr>
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<td>5.0 out of 5 stars</td>
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<tr>
<td>Kaiser Permanente Senior Advantage Core (HMO) (H0630-013-0)</td>
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<td>5.0 out of 5 stars</td>
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<td>5.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
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<tr>
<td>Kaiser Permanente Senior Advantage Plus Choice (HMO-POS) (H0630-019-0)</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
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<tr>
<td>Rocky Mountain Plus Plan + Rx (Cost) (H0602-019-0)</td>
<td>4.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>3.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
</tr>
<tr>
<td>Rocky Mountain Thrifty Plan + Rx (Cost) (H0602-039-0)</td>
<td>4.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>3.0 out of 5 stars</td>
<td>5.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
<td>4.0 out of 5 stars</td>
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Medicare Advantage Enrollees in 4- and 5-Star Plans

<table>
<thead>
<tr>
<th>Medicare Advantage Enrollment</th>
<th>2009</th>
<th>2012</th>
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</thead>
<tbody>
<tr>
<td>3-star plans</td>
<td>70%</td>
<td>57%</td>
</tr>
<tr>
<td>4-star plans</td>
<td>16%</td>
<td>28%</td>
</tr>
<tr>
<td>5-star plans</td>
<td>0%</td>
<td>9%</td>
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</table>

The CMS Innovation Center

The Center for Medicare & Medicaid Innovation (the Innovation Center) with CMS supports the development and testing of innovative health care payment and service delivery models.

Learn More >

Where Innovation is Happening
See where our Innovation Model Partners are located.

Recent Milestones & Updates
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...while preserving or enhancing the quality of care furnished to individuals under such titles.

- The Affordable Care Act
By William Shrank

The Center For Medicare And Medicaid Innovation’s Blueprint For Rapid-Cycle Evaluation Of New Care And Payment Models

ABSTRACT The Affordable Care Act established the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models. The goal is to reduce program expenditures while preserving or improving the quality of care provided to beneficiaries of Medicare, Medicaid, and the Children’s Health Insurance Program. Central to the success of the Innovation Center is a new, rapid-cycle approach to evaluation. This article describes that approach—setting forth how the Rapid Cycle Evaluation Group aims to deliver frequent feedback to providers in support of continuous quality improvement, while rigorously evaluating the outcomes of each model tested. This article also describes the relationship between the group’s work and that of the Office of the Actuary at the Centers for Medicare and Medicaid Services, which plays a central role in the assessment of new models.

William Shrank (William.Shrank@hhs.gov) is the director of the Rapid Cycle Evaluation Group at the Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, in Baltimore, Maryland.
CMS Innovations

Accountable Care
- Medicare Shared Savings Program (Center for Medicare)
- Pioneer ACO Model
- Advance Payment ACO Model
- Comprehensive ESRD Care initiative

Primary Care Transformation
- Comprehensive Primary Care Initiative (CPC)
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home Demonstration
- Graduate Nurse Education Demonstration

Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute Care Episode & Post Acute
- Model 3: Retrospective Post Acute Care
- Model 4: Prospective Acute Care

Capacity to Spread Innovation
- Partnership for Patients

Community-Based Care Transitions
- Million Hearts
- Innovation Advisors Program

Health Care Innovation Awards

State Innovation Models Initiative

Initiatives Focused on the Medicaid Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Incentives for Prevention of Chronic Diseases
- Strong Start Initiative

Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalizations of Nursing Facility Residents
What is an ACO?

• Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
  – Work together to coordinate beneficiary care
  – Invest in infrastructure and redesigned, coordinated care processes
  – Agree to be held accountable for quality, cost, and overall care of fee-for-service beneficiaries assigned to them.
Medicare ACOs

• **Medicare Shared Savings Program**—a program that helps a Medicare fee-for-service program providers become an ACO. Apply Now.

• **Advance Payment ACO Model**—a supplementary incentive program for selected participants in the Shared Savings Program.

• **Pioneer ACO Model**—a program designed for early adopters of coordinated care. No longer accepting applications. Organizations across the country have already transformed the way they deliver care, in ways similar to the ACOs that Medicare supports.
Geographic Distribution of ACO Assignees
(Over 4 million total assignees in all programs)
Primary Care

- Comprehensive Primary Care (CPC) Initiative
- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration
- Independence at Home
- Graduate Nursing Demonstration
- Medicaid Health Home State Plan Option
Comprehensive Primary Care Initiative

GOAL: Test a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care.

- Collaborating with public and private insurers in purchasing high value primary care in communities they serve.
  - Requires investment across multiple payers
  - Individual health plans, covering only their members, cannot provide enough resources to transform primary care delivery.
- Medicare will pay approximately $20 per beneficiary per month (PBPM) then move towards smaller PBPM to be combined with shared savings opportunity.
- The 7 markets selected: Ohio (Dayton), Oklahoma (Tulsa), Arkansas, Colorado, New Jersey, Oregon, New York (Hudson Valley)
Comprehensive Primary Care Initiative in Colorado

- Number of primary care practices: 74
- Number of providers: 369
- Estimated number of Medicare beneficiaries: 42,064

Market Payers:
- Anthem Blue Cross Blue Shield of Colorado
- Cigna
- Colorado Access
- Colorado Choice Health Plans
- Colorado Medicaid
- Humana
- Rocky Mountain Health Plans
- Teamsters Multi-Employer Taft Hartley Funds
- UnitedHealthcare
Multi-payer Advanced Primary Care Practice Model

**GOAL:** Test the effectiveness of offering providers a common payment method from Medicare, Medicaid, and private health plans.

- Medicare will participate in existing State multi-payer health reform initiatives.
- Must include participation from Medicaid and private health plans.
- Monthly care management fee for beneficiaries receiving primary care from Advanced Primary Care practices.
GOAL: Evaluate impact of the advanced primary care practice model in the Federally Qualified Health Center (FQHC) setting.

- Open to FQHCs that have provided medical services to at least 200 Medicare beneficiaries in previous 12-month period.
- FQHC receives care management fee for each Medicare beneficiary enrolled.
- 500 FQHCs selected.
- Performance year started Nov 1st 2011.
<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinica Family Health Services - People's Clinic</td>
<td>2525 13th St</td>
<td>Boulder</td>
</tr>
<tr>
<td>Clinica Family Health Services - Thornton</td>
<td>8990 Washington St</td>
<td>Thornton</td>
</tr>
<tr>
<td>Denver Health - Bernard Gibson Eastside Family Health Center</td>
<td>501 28th St</td>
<td>Denver</td>
</tr>
<tr>
<td>Denver Health - La Casa/Quigg Newton Family Health Center</td>
<td>4545 Navajo St</td>
<td>Denver</td>
</tr>
<tr>
<td>Denver Health - Lowry Family Health Center</td>
<td>1001 Yosemite St</td>
<td>Denver</td>
</tr>
<tr>
<td>Family Health Center at Union (Peak Vista)</td>
<td>225 Union Blvd</td>
<td>Colorado Springs</td>
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<tr>
<td>High Plains Community Health Center</td>
<td>201 Kendall Dr</td>
<td>Lamar</td>
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<tr>
<td>Mountain Family Health Centers-Blackhawk</td>
<td>562 Gregory St</td>
<td>Blackhawk</td>
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<tr>
<td>Mountain Family Health Centers-Glenwood Springs</td>
<td>1905 Blake Ave Ste 101</td>
<td>Glenwood Springs</td>
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<tr>
<td>Plains Medical Center - Strasburg</td>
<td>55981 Colfax Ave</td>
<td>Strasburg</td>
</tr>
<tr>
<td>Sunrise Community Health - Loveland Community Health Center</td>
<td>450 Cleveland Ave</td>
<td>Loveland</td>
</tr>
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</table>
Bundled Payments for Care Improvement

**GOAL:** Test payment models that link payments for multiple services patients receive during an episode of care for effectiveness in promoting coordination across services and reducing the cost of care.

**Four models:**

1. Acute care hospital stay only
2. Acute care hospital stay plus post-acute care
3. Post-acute care only
4. Prospective payment of all services during inpatient stay
### Bundled Payments: 4 Models

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs + post-acute period</td>
<td>Post acute only for selected DRGs</td>
<td>Selected DRGs</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All part A DRG-based payments</td>
<td>Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>Part A and B services during the post-acute period and readmissions</td>
<td>All Part A and B services (hospital, physician) and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
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### Bundled Payments for Care Improvement in Colorado

<table>
<thead>
<tr>
<th>BPCI Initiative: Model 2</th>
<th>Penrose-St. Francis Health Services</th>
<th>Colorado Springs</th>
<th>CO</th>
<th>Number of Episodes: 2</th>
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<tbody>
<tr>
<td>BPCI Initiative: Model 4</td>
<td>Exempla Good Samaritan Medical Center</td>
<td>Lafayette</td>
<td>CO</td>
<td>Number of Episodes: 1</td>
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<tr>
<td>BPCI Initiative: Model 4</td>
<td>Exempla Lutheran Medical Center</td>
<td>Wheat Ridge</td>
<td>CO</td>
<td>Number of Episodes: 1</td>
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<td>BPCI Initiative: Model 4</td>
<td>Exempla Saint Joseph Hospital</td>
<td>Denver</td>
<td>CO</td>
<td>Number of Episodes: 1</td>
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<tr>
<td>BPCI Initiative: Model 4</td>
<td>University of Colorado Hospital</td>
<td>Aurora</td>
<td>CO</td>
<td>Number of Episodes: 1</td>
</tr>
</tbody>
</table>
Capacity to Spread Innovation

- Partnership for Patients
  - Community Based Care Transition Program
- Million Hearts
- Innovation Advisors Program
- Care Innovations Summit
Goals:

40% Reduction in Preventable Hospital-Acquired Conditions
- 1.8 Million Fewer Injuries
- 60,000 Lives Saved

20% Reduction in 30-Day Readmissions
- 1.6 Million Patients Recover without Readmission
GOALS: Test methods of spreading solutions that reduce hospital acquired conditions to other hospitals and health care providers.

- 26 Hospital Engagement Networks (HENs) – serve as “mobile classrooms” bringing lessons learned to hospitals in their regions

- Core areas of focus are:
  - Adverse drug events (ADE)
  - Catheter-associated urinary tract infections (CAUTI)
  - Central line-associated blood stream infections (CLABSI)
  - Injuries from falls and immobility
  - Obstetrical adverse events
  - Pressure ulcers
  - Surgical site infections
  - Venous thromboembolism (VTE)
  - Ventilator-associated pneumonia (VAP)
  - Readmissions
GOALS: Test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries

• Open to community-based organizations partnered with hospitals
• Currently 102 participants
• $500 million total funding
• Participants in all 10 CMS Regions
Community-based Care Transitions Program (CCTP)

Source: Centers for Medicare & Medicaid Services
Community-based Care Transitions Program in Colorado (1)

• **Denver Regional Council of Governments**
  As the designated Area Agency on Aging in the Denver metropolitan area, the Denver Regional Council of Governments (DRCOG) will serve Medicare beneficiaries living in **eight counties**. A number of patients reside in Medically Underserved Area/Population. The expansive community partnership works across the care continuum leveraging two health systems and multiple downstream providers such as skilled nursing facilities, home health agencies, and various non-profit entities. The hospitals include **Exempla Saint Joseph Hospital, Medical Center of Aurora, Sky Ridge Medical Center, Swedish Medical Center, Presbyterian/St Luke's Medical Center, North Suburban Medical Center and Rose Medical Center.**
• **Upper Arkansas Area Council of Governments**
  Upper Arkansas Area Council of Governments, an Area Agency on Aging located in Canon City, Colorado, will lead an expansive partnership delivering the Care Transitions Intervention to Medicare beneficiaries in **El Paso, Pueblo, Fremont, Chaffee, Custer, Lake, and Teller counties**. Many of these beneficiaries reside in medically-underserved and rural areas, and small communities. Providers across the care continuum include acute care hospitals (Centura Health-Penrose St. Francis Health Services, Memorial Hospital Central, Centura Health – St. Mary Corwin Medical Center, Parkview Medical Center and Centura Health - St. Thomas More Hospital), critical access hospitals (St. Vincent Hospital General District, Pikes Peak Regional Hospital, and Heart of the Rockies Regional Medical Center), a Federally-Qualified Health Center (Peak Vista Community Health Center) along with the Pueblo Area Agency on Aging and Pikes Peak Area Council of Governments Area Agency on Aging.
GOAL: Prevent 1 million heart attacks and strokes in 5 years

Focus, coordinate, and enhance cardiovascular disease prevention activities across the public and private sectors.

• Will scale-up proven clinical and community strategies to prevent heart disease and stroke across the nation.

• Led by Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services within HHS.

• Partners include: American Heart Association, YMCA, and many other private and public organizations.
Health Care Innovation Awards

**GOAL:** Test 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.

- 107 Projects Awarded in 2 Batches: 5/8 and 6/15
- Awards range from approximately $1 million to $30 million for a three-year period.
- Will impact all 50 states
- Nearly 3000 applications received
  - Applications were accepted from providers, payers, local government, public-private partnerships and multi-payer collaboratives.
Number of HCIA Projects operating in each state

- 1-2 HCIA's
- 3-5 HCIA's
- 6-10 HCIA's
- 10-14 HCIA's
- 15+ HCIA's

Health Care Innovation Awards
DENVER HEALTH AND HOSPITAL AUTHORITY

Project Title: “Integrated model of individualized ambulatory care for low income children and adults”

Geographic Reach: Colorado

Funding Amount: $19,789,999

Estimated 3-Year Savings: $12,792,256

Summary: Denver Health and Hospital Authority is receiving an award to create an ambulatory care model that will provide individualized care for patients' medical, behavioral and social needs. This model will target low income children and adults with diverse health care needs. It will coordinate care and offer self-care support between visits, enabled by HIT and team-based patient navigators, and will integrate physical and behavioral health services in existing primary care settings and newly created high risk clinics. The program will reduce reliance on emergency room care and reduce avoidable hospitalizations by providing better access to outpatient and social services, better care management and self-management of care, and better coordination and utilization of existing services, as well as more individualized care for the patients' medical, behavioral and social needs. The investments made by this grant are expected to generate cost savings beyond the three year grant period.

Over a three-year period, Denver Health and Hospital Authority will hire and train 25 patient navigators and fill 20 new health information technology positions.
Project Title: “Using care managers and technology to improve the care of patients with schizophrenia”

Geographic Reach: Colorado, Florida, Michigan, Minnesota, Missouri, New Hampshire, New Mexico, New York, Oregon

Funding Amount: $9,380,855

Estimated 3-Year Savings: $10,080,000

Summary: The Feinstein Institute for Medical Research is receiving an award to develop a workforce that is capable of delivering effective treatments, using newly available technologies, to at-risk, high-cost patients with schizophrenia. The intervention will test the use of care managers, physicians, and nurse practitioners trained to use new technology as part of the treatment regime for patients recently discharged from the hospital at community treatment centers in nine states. These trained providers will educate patients and their caregivers about pharmacologic management, cognitive behavior therapy, and web-based/home-based monitoring tools for their conditions. This intervention is expected to improve patients’ quality of life and lower cost by reducing hospitalizations.

Over a three-year period, the Feinstein Institute for Medical Research will retrain nurse practitioners, physician assistants, physicians, and case managers to use newly available mental health protocols and health technology resources.
INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT

Project Title: "Care management of mental and physical co-morbidities: a TripleAim bulls-eye" 21

Geographic Reach: California, Colorado, Iowa, Massachusetts, Michigan, Minnesota, Pennsylvania, Washington, Wisconsin

Funding Amount: $17,999,635

Estimated 3-Year Savings: $27,693,046

Summary: The Institute for Clinical Systems Improvement (ICSI) of Bloomington, Minnesota is receiving an award to improve care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease. The program will use care managers and health care teams to assess condition severity, monitor care through a computerized registry, provide relapse and exacerbation prevention, intensify or change treatment as warranted, and transition beneficiaries to self-management. The partnering care systems include clinics in ICSI, Mayo Clinic Health System, Kaiser Permanente in Colorado and Southern California, Community Health Plan of Washington, Pittsburgh Regional Health Initiative, Michigan Center for Clinical Systems Improvement, and Mount Auburn Cambridge Independent Practice Association with support from HealthPartners Research Foundation and AIMS (Advancing Integrated Mental Health Solutions). Over a three-year period, ICSI and its partners will train the approximately 80+ care managers needed for this new model.
RUTGERS, THE STATE UNIVERSITY OF NEW JERSEY (THE CENTER FOR STATE HEALTH POLICY)

**Project Title:** “Sustainable high-utilization team model”

**Geographic Reach:** California, Colorado, Missouri, Pennsylvania

**Funding Amount:** $14,347,808

**Estimated 3-Year Savings:** $67,719,052

**Summary:** Rutgers, The State University of New Jersey, is receiving an award to expand and test a team-based care management strategy for high-cost, high-need, low-income populations served by safety-net provider organizations in Allentown, PA, Aurora, CO, Kansas City, MO, and San Diego, CA. Led by Rutgers’ Center for State Health Policy, the project will use care management teams (including nurses, social workers, and community health workers) to provide clients with patient-centered support that addresses both health care needs and the underlying determinants of health. Teams will assist patients in filling prescriptions, finding housing or shelter, applying for health coverage or disability benefits, handling legal issues, finding transportation, treating depression, managing chronic illness, and coordinating appropriate specialty care. After patients are stabilized, the care management team will transition them to local primary care medical homes. By improving beneficiaries’ access to ambulatory medical and social services, the project will improve patient outcomes and reduce preventable hospital inpatient and emergency room utilization.

Over a three-year period, Rutgers’ program will train an estimated 155 workers and will create an estimated 43 jobs. The new workforce will include community health workers.
SOUTHEAST MENTAL HEALTH SERVICES

**Project Title:** "TIPPING POINT: Total Integration, Patient Navigation and Provider Training Project for Powers County, Colorado"

**Geographic Reach:** Colorado

**Funding Amount:** $1,405,924

**Estimated 3-Year Savings:** $1,875,000

**Summary:** Southeast Mental Health Services is receiving an award to coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill residents of rural Prowers County, Colorado. The program will employ trained patient navigators to increase patients' access to primary and behavioral care, preventive care, and early intervention services, offering team-based education and coaching to improve both population health and self-management of disease. The results will include a reduction in emergency room visits and other high cost interventions, mitigation of the progress of chronic disease, better health habits, and better care and quality of life for these vulnerable patients. Southeast Mental Health Services will contract with Otero Junior College to develop a magnet “Health Navigator” training program to serve current and future healthcare workers across rural Colorado. Over a three-year period, Southeast Mental Health Service's program will train an estimated 62 workers and create an estimated 8.25 FTE jobs. The new workers will include health navigators, instructors, a marketing/communications assistant, and a project manager.
TRUSTEES OF DARTMOUTH COLLEGE

Project Title: “Engaging patients through shared decision making: using patient and family activators to meet the triple aim”

Geographic Reach: California, Colorado, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, Oregon, Texas, Utah, Vermont, Washington

Funding Amount: $26,172,439

Estimated 3-Year Savings: $63,798,577

Summary: The Trustees of Dartmouth College is receiving an award to collaborate with 15 large health care systems around the country to hire Patient and Family Activators (PFAs). The PFAs will be trained to engage in shared decision making with patients and their families, focusing on preferences and supplying sensitive care choices. PFAs may work with patients at a single decision point or over multiple visits for those with chronic conditions. It is anticipated that this intervention will lead to a reduction in utilization and costs and provide invaluable data on patient engagement processes and effective decision making—leading to new outcomes measures for patient and family engagement in shared decision making.

Over a three-year period, the Trustees of Dartmouth College-sponsored program will train 5,775 health care workers and create 48 positions for patient and family activators.
**UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER**

**Project Title:** "Brookdale Senior Living (BSL) Transitions of Care Program"

**Geographic Reach:** Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin

**Funding Amount:** $7,329,714

**Estimated 3-Year Savings:** $9,729,702 56

**Summary:** The University of North Texas Health Science Center (UNTHSC), in partnership with Brookdale Senior Living (BSL), is receiving an award to expand and test the BSL Transitions of Care Program which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living and dementia specific facilities in Texas and Florida. In addition, community dwelling older adults who receive BSL home health services will be included in the Transitions of Care Program. Over the course of the award the program will expand to other states where BSL communities are located. The program will employ clinical nurse leaders (CNLs) to act as program managers. CNLs will train care transition nurses and other staff on the use of INTERACT and health information technology resources to help them identify, assess, and manage residents' clinical conditions to reduce preventable hospital admissions and readmissions. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults.

Over a three-year period, the University of North Texas Health Science Center's program will train an estimated 10,926 workers and create an estimated 97 jobs for clinical nurse leaders and other health care team members.
UPPER SAN JUAN HEALTH SERVICE DISTRICT

**Project Title:** “Southwest Colorado cardiac and stroke care”  
**Geographic Reach:** Colorado  
**Funding Amount:** $1,724,581  
**Estimated 3-Year Savings:** $8.1 million

**Summary:** The Upper San Juan Health Service District is receiving an award to expand access to specialists and improve the quality of acute care in rural and remote areas of southwestern Colorado. Their care delivery model will offer cardiovascular early detection and wellness programs, implement a telemedicine acute stroke care program, use telemedicine and remote diagnostics for cardiologist consultations, and upgrade and retrain its Emergency Medical Services Division (EMS) to manage urgent care transports and in-home follow-up patient care for over 3400 patients in medically underserved areas in Southwest Colorado. The program will provide access to cardiologists and neurologists and is expected to reduce cardiovascular risk, improve patient outcomes, create healthier communities, and reduce health care costs with estimated savings of approximately $8.1 million. Over the three-year period, the Upper San Juan Health Service District’s program will train an estimated 25 paramedics and telehealth clinicians and create 13 new jobs. These workers will provide a new type of clinical team that will improve care outcomes for rural cardiovascular patients.
Strong Start: Strategy 1

**GOAL:** Test ways to encourage best practices and support providers in reducing early elective deliveries prior to 39 weeks.

3 primary activities:

1. Promote Awareness – support broad-based awareness efforts in partnership with March of Dimes, American College of Obstetricians and Gynecologists and other organizations.

2. Spread Best Practices – building on efforts of Partnership for Patients to create measurable goals and provide technical assistance in testing and implementing a variety of strategies.

3. Promote Transparency – support efforts to collect performance data and measure success and continuous improvement.
GOAL: Test effectiveness of prenatal care approaches to reduce preterm births for women covered by Medicaid or CHIP who are at risk for preterm births

• Testing 3 approaches to the delivery of enhanced prenatal care
• Targets women receiving Medicaid and at risk for having a preterm birth
• $43 million funding opportunity for providers, States, managed care plans, and conveners
Results: Early Signs of Overall Declines in Hospital Readmissions

Monthly 30-day All-Cause Hospital Readmission Rate, January 2010 – September 2012

Note that point values are given for months where the data are complete. Point estimates and confidence intervals are provided for those months in which the data are not yet completed.

Source: CMS Office of Information Products and Data Analysis, Medicare Claims Analysis
Medicare Per-Capita Spending Growth at Historic Low

Source: CMS Office of the Actuary, Midsession Review – FY 2013 Budget
Projected Health Spending, United States, 2011–21.

Cutler D M, and Sahni N R Health Aff 2013;32:841-850
We are seeking innovative ideas that:

• Improve/Facilitate Coordinated Care
• Promote comprehensive Primary Care
• Align and encourage market/economic forces
• Increase efficiency and unwarranted variation
• Foster wellness and prevention
• Actively engage/activate patients
• Support the availability and use of better information by providers and patients
Health Care Innovation Awards Round Two

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services (CMS)
Center for Medicare & Medicaid Innovation (CMMI)

Cooperative Agreement

Initial Announcement

Funding Opportunity Number: CMS-1C1-14-001
Competition ID: CMS-1C1-14-001-017996

CFDA: 93.610

Applicable Dates:
Letter of Intent to Apply Due: June 28, 2013, by 3:00 p.m. EDT
Electronic Cooperative Agreement Application Due Date: August 15, 2013 by 3:00 p.m. EDT
Anticipated Awardee Announcements: Phase 1 – January 15, 2014; Phase 2 – January 31, 2014
Anticipated Notice of Cooperative Agreement Award: Phase 1 and Phase 2 – February 28, 2014
Anticipated Cooperative Agreement Period of Performance: April 1, 2014 to March 31, 2017
Thank You

innovation.cms.gov

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