DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Supra	7-21-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000026	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Kost, Deps, CMS file * Sent to All Deps electronically	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 14, 2014

Re: The Innovation Accelerator Program

Dear State Medicaid Director:

Today, the Centers for Medicare & Medicaid Services (CMS) is launching a new collaborative initiative called the Medicaid Innovation Accelerator Program (IAP). The goal of IAP is to improve care and improve health for Medicaid beneficiaries and reduce costs by supporting states in accelerating new payment and service delivery reforms. The Medicaid IAP is an important new component of CMS's wide ranging efforts to support system-wide payment and delivery system reform innovation.

The IAP is designed to assist states through strategically targeted activities aimed at advancing Medicaid delivery system and payment transformation. The IAP builds on ideas and recommendations we have heard from states directly, as well as from the National Governors Association (NGA) and the National Association of Medicaid Directors (NAMD). IAP activities will be designed to help states take advantage of opportunities and to address common challenges in order to advance innovation. By developing resources (e.g., financial modeling algorithms, enhanced Medicaid quality metrics, rapid cycle evaluation expertise) and offering technical assistance to accelerate Medicaid-focused innovations, the IAP will enhance the effectiveness of existing grant or funding opportunities in Medicaid and enable greater alignment of innovations in Medicaid with those of other private and public payers. Our intent is to focus on the greatest opportunities to improve health, improve care and, through these improvements, decrease costs in this critical program.

What is CMS doing today and what have we heard from states?

CMS and the states together have already invested significant time, effort and financial resources toward delivery and payment reform. For example, CMS has collaborated with states on health home state plan amendments, integrated care models, shared savings under Medicaid authorities, and innovations in managed care. CMS has also made other investments Medicaid innovation through various initiatives, including a number of Health Care Innovation Awards, the Strong Start initiative, Medicare-Medicaid financial alignment models, and State Innovation Model (SIM) awards. As a result, innovation in Medicaid is already well underway – for more information about our *Medicaid Moving Forward* work, visit Medicaid.gov at http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html; to access the *2013 Medicaid Moving Forward* report directly, see http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/MMF-2013.pdf.

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Examples of state innovation success include:

- Through a statewide learning collaborative, obstetric hospitals across Ohio engaged in team-based quality improvement projects at each hospital, held monthly webinars to review data on outcomes, shared educational materials and changes in hospital policies. Ohio has reduced early elective deliveries by about 30%.[1]

- North Carolina implemented a transitional care program, providing comprehensive medication management, face-to-face self-management education for patients and families, and timely outpatient follow-up through a medical home that has been fully informed about the hospitalization and any clinical or social issues that might complicate care. Targeting beneficiaries with multiple chronic conditions who have been hospitalized, North Carolina's program decreased hospital readmissions by 20%, as compared to usual care.[2]

- The State of Washington tackled substance abuse and emergency department (ED) usage by adopting seven best practices. As a result, ED visits decreased by 9.9%; the number of people with frequent ED use dropped by 10.7%; and the number of visits resulting in narcotic prescription dropped by 24%. The state attributed savings of about $34 million.[3]

States have seen these innovations result in improved care and lower costs. Nationwide, while Medicaid spending overall has grown as more people have gained coverage, per enrollee spending *declined* by 1.2 percent – from $6,768 to $6,641 – in 2012.[4]

While notable progress has been made, states also report challenges in achieving and sustaining innovation. They cite a lack of resources to optimally integrate and evaluate data to promote program reform, too few consistent and endorsed metrics that are appropriate for the Medicaid population, and a need for further coordination among federal entities.

The NGA Health Care Sustainability Task Force highlighted many of these same challenges and offered helpful recommendations in its February 2014 report.[5] These recommendations in large part align with CMS goals to support health care delivery and payment reform. Among its recommendations, the Task Force called for development of Medicaid data analytics, quality

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[1] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf

[2] Jackson et al., Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. Health Affairs, August 2013. At http://content.healthaffairs.org/content/32/8/1407.abstract

[3] Best practices were: track ED visits to avoid ED "shopping"; implement patient education; institute an extensive case management program; reduce inappropriate ED visits by collaborative use of prompt visits to primary care physicians; implement narcotic guidelines to discourage narcotic-seeking behavior; track data on patients prescribed controlled substances; and track progress of the overall plan to make sure steps are working. Washington State Health Care Authority, Report to the Legislature: Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation, March 20, 2014. At http://www.hca.wa.gov/Documents/EmergencyDeptUtilization.pdf

[4] http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/medicaid-actuarial-report-2013.pdf

[5] http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1402HCSTFReport.pdf

metric development, service delivery model development, rapid cycle evaluation, learning diffusion, and stronger coordination across CMS components to improve communication and efficiency in our collective efforts under the state-federal partnership to advance innovation.

The National Association of Medicaid Directors similarly highlighted priorities to improve Medicaid business practices to help states and the federal government realize shared goals for the Medicaid program.[6]

While many of these activities are underway to some degree, the IAP will deepen and accelerate our collective investment.

Description of the IAP

State lessons and recommendations spurred the formation of the IAP. The IAP is designed to offer a new approach to addressing these challenges collaboratively, leveraging best practices in driving innovation in the public and private sectors.

The IAP will initially develop resources to support innovation through four key functions:

1. Identify and advance new models: The IAP will investigate, develop, and disseminate information and tools (such as financial modeling to design payment strategies that strengthen incentives to achieve greater value) that will help implement promising models of care targeting the needs of Medicaid beneficiaries. Based on consultation with states, consumer groups and health care providers, the IAP will target its efforts based on three criteria. First, the IAP will target areas of critical need, as defined by high spending, high disease burden, and/or high disparities for the Medicaid population. Second, it will target interventions that have generated evidence of improved care and/or reduced costs, either for other payers or in Medicaid, but on a smaller scale. Third, the IAP will place a high priority on complementing and supporting ongoing related work at the state and federal level in order to maximize efficiency and impact.

2. Data analytics: Ensuring real-time data-based approaches is core to successful and sustained delivery system reforms. The IAP will help states leverage new emerging data sources such as T-MSIS and the Medicaid and CHIP performance indicators, along with data sources from other payers or even other programs (such as vital statistics), to promote targets for intervention, identify best practices and maximize efficiencies. Improved measurement is critical to moving from a volume based payment system to one that incentivizes quality health outcomes.

3. Improved quality measurement: The IAP will support alignment and integration of quality measurement across health care programs and initiatives to provide a more accurate and valid picture of quality to support and drive innovation within Medicaid and across payers.

[6] http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/climate_for_innovation_final.pdf

4. State to state learning, rapid-cycle improvement, and federal evaluation: The IAP will advance effective, efficient, and timely dissemination of best practices in driving delivery system innovation, including vigorous support of rapid cycle improvement efforts underway in states and with other partners. CMS is also committed to providing more coordinated communication with states on cross-cutting issues and ensuring that the IAP work is coordinated with related activities, including the SIM initiative and the Medicare-Medicaid financial alignment models. By improving alignment across our communication channels, CMS as an agency can maximize the impact of the variety of initiatives underway and thereby enhance state-to-state learning.

Relationship of IAP to the State Innovation Models (SIM) Initiative

States participating in SIM are working on improving population health, improving health care delivery and decreasing costs across multiple payers. Many SIM states begin by developing innovations in Medicaid. Through the IAP, CMS will support both SIM states, and states not currently engaged in SIM, in working to advance Medicaid innovation. The technical assistance and support that is provided to SIM states will be coordinated with IAP to make the most of the resources that are available to states in this area. The IAP investments will complement state SIM efforts in Medicaid, while the SIM initiative will continue to provide states with technical assistance and support related to broader transformation initiatives.

Next steps

CMS is committed to launching and evolving this new initiative with input from our partners. The value and success of these efforts will be dependent on your engagement.

A critical next step will be a series of discussions that will provide more information on the initial plans for and structure of IAP and also to solicit input on identifying priorities beyond the initial IAP development. Over the next few weeks, CMS will be holding webinars and other interactive sessions to gather input from states, consumers and experts. You will hear more from us soon about these opportunities, meanwhile, if you have questions or ideas and suggestions, please email MedicaidIAP@cms.hhs.gov.

We understand the need to improve collaborations not only with our partners outside the administration, but improving our processes internally as well, so we are also committing to developing a coordinated point of contact across CMS.

Finally, we are beginning work now in an area that has already been identified as needing more investment. The need to address the prevalence of substance use disorder (SUD) has been identified repeatedly by our state partners, and we are taking steps to begin work on this issue, as outlined in more detail in our July 11, 2014 CMCS informational bulletin (see http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf). More information can also be found at: http://www.medicaid.gov/State-Resource-Center/Innovation-Accelerator-Program/innovation-accelerator-program.html.

Conclusion

The IAP represents a significant commitment to work with state leaders to take advantage of the opportunities and tackle the challenges facing Medicaid innovation. We are confident that the IAP will help achieve our shared goals of improving health and improving care for our beneficiaries, and reducing costs for our programs. We look forward to our ongoing work together with our state partners, along with NGA and NAMD, to ensure value and success.

Sincerely,

/s/

Cindy Mann, J.D.
Deputy Administrator and Director
Center for Medicaid and CHIP Services

/s/

Patrick Conway, M.D.
Deputy Administrator for Innovation and Quality
and CMS Chief Medical Officer

CC:

CMS Regional Administrators

CMS Associate Regional Administrators for Medicaid
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Dan Crippen
Executive Director
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