CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Ray Thorn
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3:00 p.m. ET

Operator: Good afternoon. My name is (Lorel) and I will be your conference operator today. I would like to welcome everyone to the Health Care Innovation Awards Round Two.

All lines have been placed on mute to prevent any background noise. After our speakers' remarks, we will have a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. To withdraw your question, press the pound key. Thank you.

I would now like to turn the call over to Mr. Ray Thorn with Centers for Medicare and Medicaid Services. Please go ahead, sir.

Ray Thorn: Great. Thank you (Lorel) and good afternoon everyone and thank you all for joining. Again, my name is Ray Thorn and I'm with the Centers for Medicare and Medicaid Services.

We are pleased that you have joined today's conference call on the Health Care Innovation Awards Round Two. This is a $1 billion initiative to test new payment and service delivery models that will deliver better care and lower cost for Medicare, Medicaid and/or Children's Health Insurance Program enrollees.

So again, thank you for joining us today.

Just a few housekeeping items at the front, this call is being recorded and will be posted on the innovation center's Web site in approximately a week. The transcript will also be posted within the week.

If you are a member of the press, this call is off the record and if you have a question, please contact the CMS press office at 202-690-6145 or via e-mail, press@cms.hhs.gov.

The purpose of today's call is to provide an overview of this morning's announcement which is the announcement of the Health Care Innovation Awards Rounds Two. Our speakers today will be Rick Gilfillan, the CMS Innovation Center Director, and Rahul Rajkumar, Senior Adviser at the CMS Innovation Center. We will also have Sheila Hanley, who is Director of the Innovation Center's Policy and Programs Group, during the Q&A session. After Rahul is finished, we will have a question and answer session.

If you do have questions that we are not able to answer on this webinar, you can e-mail us and that e-mail address is InnovationAwards@cms.hhs.gov.

And with that, I will turn it over to Rick.

Rick Gilfillan: Well, thanks Ray and thanks everyone out there who's joining us. Good afternoon, we're excited about our announcement today when and we're thrilled that you all have joined us.

This is an important call to discuss the latest steps we're taking for innovation in our healthcare system by supporting some of the most promising ideas around the country for lowering cost by improving the quality of care. Bringing down healthcare cost is a top priority and we know that the best way to do it is the same way that leading healthcare organizations do it by making care better and more efficient.

We also know that there are more great ideas out there that can help push this work forward. Innovative practices that make our healthcare system work better for everyone can come from any corner of the country. We know that there is also building momentum among providers to move more rapidly to a value-based healthcare system that's why today, we're announcing nearly $1

billion in awards to applicants who will develop new payment and delivery models to drive down cost for patients enrolled in Medicare, Medicaid and the Children's Health Insurance Program. These Health Care Innovation Awards would be given to organizations who's created solutions to our most pressing healthcare challenges have the potential to serve as blueprints for improving care and lowering cost across the country.

In November of 2011, we launched our first round of Health Care Innovation Award by issuing a challenge to America's healthcare providers, businesses, universities and community groups. We asked them to submit their proposals for how to get the most out of our healthcare dollars by delivering smarter care.

We received nearly 3,000 proposals. That challenge we build in the selection of 107 promising innovations with the strongest likelihood to create large scale sustainable result.

Building on that first round, the second round of Healthcare Innovation Award will focus on supporting innovative models in four specific areas. First, models that rapidly reduce cost for Medicare and Medicaid beneficiaries and outpatient or post acute type of setting. Second, models that improve care for populations with specialized needs such as children in foster care or people living with HIV. Third, models that quickly transforms the financial and critical models for specific types of providers including oncologist and then cardiologist. And fourth, models that link clinical care delivery to activities in the community that promote preventive health and improve population health outcome.

As with last year's awards, we're seeking out innovative practices that have a high likelihood of delivering better care and lower cost on a national scale. The last few years have seen us make tremendous strides when it comes to keeping healthcare spending in check. A lot of that is due to the innovations that have helped make care delivery and payments smarter and more efficient.

Across the country, public and private sector innovators are developing even more ideas to improve our healthcare system. Today's announcement will

allow us to take some of those most promising innovations and put them into action for the benefit of all Americans, that's good news for patients, for providers, for our economy and for the future of American healthcare.

Thank you again for joining us today. And now, I would like to turn this over to Rahul.

Rahul Rajkumar: Thank you Rick.

As Rick mentioned, CMS is pleased to be announcing today a $1 billion initiative to find applicants that develop new payment and service delivery models that drive down cost for patients enrolled in Medicare, Medicaid and the Children's Health Insurance Program.

We know there are great ideas out there that can help bring healthcare cost down and reward higher quality of care. And we know that the best way to do this is the same way that leading healthcare organizations do it by delivering better care and delivering it more efficiently. We also know that there is an increasing desire out there to rapidly move to alternative payment model that have the potential to improve care and lower cost. That's why the second round of Healthcare Innovation Awards focuses on testing new payment model to support the service delivery model funded by this initiative.

While the first round of Healthcare Innovation Awards was a broad solicitation in which the CMS Innovation Center welcomed a wide range of proposals, the second round – in the second round, CMS is specifically seeking to test new models in four categories. I know the secretary mentioned them briefly in her remarks but I'll go over them in slightly more depth.

These categories are identified as gaps in the current innovation center portfolio in those areas that could potentially result in useable model for change in Medicare, Medicaid and CHIP payment method.

In the first category, we're seeking to test models that are designed to rapidly reduce Medicare, Medicaid or CHIP cost in outpatients or post acute settings. We are interested in models that focus on diagnostic services, outpatient

radiology, high cost efficient and administered drugs, home-based services and post acute services.

In the second category, we're interested in testing models that improve care for populations with specialized needs. We're specifically interested in models that affect high cost to pediatric population, children in foster care, children at high risk for dental disease and persons with HIV/AIDS, with Alzheimer's disease requiring long-term support and services, and persons with serious behavioral health needs.

In the third category, we're interested in testing approaches that can quickly transform financial and clinical model for certain types of providers. Including physician specialty such oncology and cardiology and pediatric providers who provides services to complex – to children with complex medical issues.

Finally, the last category were the key to test models in includes models that improve the health of populations by linking clinical care to preventative health including models that lead to better prevention and control of cardiovascular disease, hypertension, diabetes, chronic obstructive pulmonary disease, asthma, and HIV/AIDS.

CMS looks forward to working with private and public sector innovators from across the country and implementing ideas to improve our healthcare system. We believe that there are organizations out there who are eager to work with us to transform in innovative ways to healthcare payments and delivery system so that we can improve care for all Americans by lowering cost.

More information on Healthcare Innovation Awards is available on the CMS innovation Web site at innovation.cms.gov.

Thank you and we'll be happy to answer any questions that you may have.

Ray Thorn: Thank you Rahul, and this is Ray Thorn here again.

Adding to Rahul's remarks, I do want to mention that the Innovation Center will be holding a series of webinars in May and June and that more information will be forthcoming on those webinars.

The first webinar will be on May 28. Again, more information will be forthcoming in the coming days through the Innovation Center website and through the listserv that you can subscribe to on the Innovation Center website. So, stay tuned for that.

At this time, operator, we are ready for questions and answers.

Operator: And as a reminder, if you would like to ask a question at this time, simply press star then the number 1 on your telephone keypad. You may press the pound key to withdraw yourself from the queue.

Your first question comes from the line of Joel Friedman with the University of Pennsylvania, your line is open.

Joel Friedman: Hi. Will investigators who were provided award last year be eligible for this round?

Rick Gilfillan: We – yes, people who received award previously will be eligible though obviously, they'd have to have very distinct programs from those funded before.

Joel Friedman: Thank you.

Operator: And your next question comes from the line of Charles Sagona with the Mountain State Health Alliance. Your line is…

Charles Sigona: Good after – thank you, good afternoon.

I work for a health system that has 13 hospitals, I was wondering, are we able to submit multiple applications as long as they meet the eligibility criteria or are we limited to just one application?

Rick Gilfillan: No, you're not limited, you can submit multiple applications, this is Rick.

Charles Sagona: Thanks. Great. Thank you so much.

Rick Gilfillan: Yes.

Operator: Your next question comes from the line of Rachael Watman with the John Hartford Foundation. Your line is open.

Rachael Watman: Thank you.

Are we able to see evidence of what's been working with the prior grants either the outcomes or the processes to help inform this round of applications?

Rick Gilfillan: Rachael, we'll have a series of webinars beginning in a couple weeks as Ray described, in which we'll talk about other things, other programs that are going on. We won't have specific results from other models necessarily to share with you but we do intend to make best practices that we've identified in prior rounds of the Innovation Awards and in any of our models test that are underway and make those widely available to folks as we learn what they are and what they are producing.

Rachael Watman: Thanks.

Operator: Your next question comes from the line on Jillian Morga with the Saint Alphonsus. Your line is open.

Jillian Morga: Good afternoon.

I come from a community that is supported by two nonprofit hospitals. One of which was a grant recipient in your last cycle. In terms of your geographic distribution for these awards, is my hospital at a disadvantage given the fact that another very sizable award was made within my community but not with my hospital as the applicant?

Rick Gilfillan: We'll be – we will, Jillian, we will be looking at geographic diversity across all the works that we're doing certainly but there's no specific consideration that would prevent a problem, I think, from a hospital in situation like yours from applying and being considered on the merit of its proposal. Ultimately, we will make a – we do want to have a diversified group of projects and

activities around the country certainly but we'll be going primarily in the merits of the proposal.

Operator: And your next question comes from the line of Walter Schroder with Kaiser Permanente. Your line is open.

Walter Schroder: Hi. Thank you.

We applied for the first round of CMMI grants and we're not funded but we were very interested in the feedback from the grant reviewers, who would we contact to obtain more information about that?

Rick Gilfillan: We would – we will have a mailbox that's focused on sending inquiries to and I would suggest that you do that – use that mailbox. We have provided some of that and some information and some feedback during the prior round. We've not gone back to look at the availability of that information at this time. We'll have to get back on that.

Ray Thorn: And, Walter, that e-mail address is InnovationAwards@cms.hhs.gov.

Walter Schroder: Thank you.

Operator: Your next question comes from the line of Michael Mayer with UES. Your line is open.

Michael Mayer: Thank you.

Question as to whether or not these four categories are distinct or if, for instance, we think that our proposal would work under both category one and category four, would that be possible?

Rick Gilfillan: Certainly, you can make – we hope everyone and we know everyone will make the strongest possible case for your proposal. So if you believe that that is a story that would be important to tell then you're certainly welcome to tell us.

Michael Mayer: Again, the question is, does it have to fall into just one category or can it carry over into more than one category?

Rick Gilfillan: No, clearly, what we understand it's quite possible for things to carry over and I'm being direct in saying you should make the best case and if you believe that your particular proposal is applicable to more than one category, certainly make that case.

Michael Mayer: Thank you very much.

Operator: Your next question comes from the line of Jennifer Hyk with Stanford Health. Your line is open.

Jennifer Hyk: Thank you. My question has been answered.

Ray Thorn: OK, thank you, Jennifer.

Operator: Your next question comes from the line of John Kim. Your line is open.

John Kim: Hi. What are the technology company that services – I mean thousands of docs that take Medicare across the country, are we eligible or do we need to be more of a provider organization ourselves? Sorry, if that's an ignorant question.

Rick Gilfillan: No, it's a fine question. I think the answer is you'll see in the FOA that's available on our Web site is a description of eligible entities. I believe – I think you will be eligible depending on exactly what your organization is like. I would only say that for technology solutions we'll be looking for them – well-embedded and part of a broader model that is delivering services and I'll reinforce what was said. In each of these proposals we are going to be asking for a payment model that goes with service delivery model. And so it's important therefore for the – any kind of technological solutions they would be part of a broader solution that talks about service delivery directory and all. It also has a payment model that we can consider information.

Ray Thorn: Thank you, John, for your question. Operator, next question please.

Operator: Your next question comes from the line of Laura Dempsey-Polan with Morton Comprehensive Services. Your line is open.

Laura Dempsey-Polan: Hi. I'm just wondering if FQHCs can participate. Are they excluded or are they allowed to participate?

Rick Gilfillan: FQHCs, absolutely, can participate.

Laura Dempsey-Polan: Thank you.

Operator: Your next question comes from the line of Raju Chavan with Cross Industry Solutions. Your line is open.

Raju Chavan: Thank you, good afternoon.

My question is we are a technology company and we are providing the EHRA model related services, so I just want to know whether the mean standard is being enforced and at this – what is the maturity level within CMS of implementing of the mean standard?

Rick Gilfillan: I'm not sure if you're talking about meaningful use standards. We don't have specific requirements around meaningful use for applicants, but we have an expectation and we will look at the fact that people are meaningful users and the fact that people are using health data exchanges and other sorts of IT capabilities that will enhance coordination and communication across the health system as criteria that we'll use in evaluating models.

Raju Chavan: Yes, because the question is because it's getting a lot of this healthcare, you know, provided from the different region and everybody had made their own solutions. So when you're talking about exchanging of that information I think that's kind of a standard. We work at HHS on their whole data governance and data harmonization issues across the healthcare service provider.

So is that standard today have been implemented and adapted at CMS or it is still not adapted?

Rick Gilfillan: As I said there's – Yes, I'm sorry, Raju, there's not a specific standard that we are requiring but we will be evaluating the proposals in light of the approach

that they are able to take in terms of health data exchanges and electronic use of data.

Raju Chavan: OK, thank you.

Rick Gilfillan: So, and it's described in the FOAs that's on the website.

Raju Chavan: Absolutely, thank you.

Operator: Your next question comes from the line of Stephen Crystal with Rutgers University. Your line is open.

Stephen Crystal: I have a two-part question on behalf of states that are looking at (inaudible) and service delivery interventions for specific populations like foster care. Would a – would an applicant – would an application organized by a consortium of states with one lead entity be – not be responsive and with regard to the cost-savings in a population like foster care, well many of the cost-savings are a longer term in nature pertaining to multiple systems. Could you say anything about the kinds of time horizons that will be considered in the cost-savings projections?

Rick Gilfillan: In terms of your first question, the answer would be yes. In terms of the time horizons we'd like for you all to make a strong case on that. We are interested and understand that in some of these instances of prevention and some of these other populations – there might be a longer timeframe.

We don't see this expanding dramatically to non-healthcare systems expenditures in terms of that evaluation. But we would look – we'll look to specific proposals and evaluate them on their merit.

Stephen Crystal: Thank you.

Rick Gilfillan: You're welcome.

Operator: Your next question comes from the line of Michael Chee with Process Property. Your line is open.

Michael Chee: Thank you, good afternoon gentlemen.

My question is simply for applicants who may have applied in round 1 but did not receive funding. Will that, in any way, shape or form work against an application being submitted again for this round?

Rahul Rajkumar: Applicants from round 1 are eligible to apply again in Round 2 provided that they meet the eligibility requirements and criteria described in the funding opportunity announcement.

Michael Chee: Thank you.

Operator: And your next question comes from the line of Joanne Handy with LeadingAge California. Your line is open.

Joanne Handy: Hi. As I recall in the first round, one had to have some evidence that the intervention that they were proposing had already showed some cost savings either on a pilot basis or a smaller basis, is that the case with these two?

Rick Gilfillan: We will be looking for and considering certainly evidence in the history of demonstrating results. We're interested certainly surely in the history of the organization in terms of being able to demonstrate the capacity to carry out the proposal and we understand that many of the proposals may not be in a position at this time have demonstrated savings but we'll be looking at the evidence base that might exist elsewhere for a particular intervention and evaluate the case, the story that's presented by the applicant.

I will say we'll have specific forms available for folks to use to tell their financial return on investment story. We will provide seminars to give them background on use of those forms then we'll also and we will be expecting folks to be – to present rigorous financial analysis in support of their model and for awards that are over $10 million we're asking people obtain actuarial of certification of their proposed financial model.

Operator: And your next question comes from the line of Jeanne Gibbons with Saint Louis Hospital. Your line is open.

Jeanne Gibbons: Good morning.

I would like to know what the ceiling is, what the floor is, and what the timeframe is for the mechanism.

Rahul Rajkumar: In the funding opportunity announcement, we described a range of $1 to $30 million and we expect it to make an award announcement around January of 2014. The letter of intent is due on June 28 and then the application is due on August 15th.

Jeanne Gibbons: Can you still hear me, sir?

Rick Gilfillan: Yes.

Rahul Rajkumar: Yes.

Jeanne Gibbons: Oh, great. I mean, what is the timeframe for the actual project, at least?

Rahul Rajkumar: We're looking at a three-year performance period with a projected performance period starting in April 2014.

Jeanne Gibbons: Thank you.

Rick Gilfillan: Thank you.

Operator: And your next question comes from the line of Martha Davidson with Trenton Health Team. Your line is open.

Martha Davidson: Thank you, mine's just similar to – tied to the previous question. In the funding opportunity announcement, it talks about phase 1 and phase 2 announcements in January. How – what do those phases mean, what do they refer to?

Rahul Rajkumar: Merely that we intend to announce awardees in batches and so there will be some awards announced in the first phase and then subsequent awardees would be announced in the second phase.

Martha Davidson: OK, I just didn't know if it had to do with geography or type of model or something like that. OK, thank you.

Operator: Your next question comes from the line of Lynn Barr, pleas state your organization, your line is now open.

Lynn Barr: Hi. This is Lynn Barr from Telford Hospital District.

I was wondering, where you thought the opportunity might lie for rural providers in this announcement?

Rick Gilfillan: Well, we think there's plenty of room for rural providers given that specific innovation category is described in the FOA. Certainly, we would look at specialized population as an area. Certainly, the different provider statement are – would be applicable for this group as well as community-based approaches to prevention and population health. So we expect – we hope that we'll get, you know, very healthy engagement from rural providers, probably in all of the four categories.

Lynn Barr: Great, so when you were talking about providers like cardiologists and oncologists you would also consider critical access hospitals as being a provider group that you would entertain as an applicant?

Rick Gilfillan: There are different providers – the – again look at the wording in the FOA but the provider statement opportunity would be available for different segments beyond just the ones we've mentioned, yes.

Lynn Barr: OK.

Operator: And your next question comes from the line of Sarah Scharf with the Ross Medical Corporation. Your line is open.

Sarah Scharf: I have a question with regards to the performance period. I see that it said that it's in a 12-month budget cycle over the course of three years. Would you accept any awards that would be a short term.

Rick Gilfillan: As I mentioned earlier, we expect every award – I'm sorry, every application to include a proposed payment mechanism that would be the road to sustainability, if you will, for the new service model. And so that new payment model can be proposed to start right in the beginning, it could be

proposed to start year one, year two, year three. If someone came in with a proposal which had a payment model that was, you know, they want to use a cooperative agreement funding to get something started and then move rapidly to payment model, we would certainly consider that.

Sarah Scharf: OK, thank you, and you said that the advantage (inaudible).

Rick Gilfillan: Your – yes, we're having a real hard time hearing you. The limits were $1 to $30 million.

Sarah Scharf: OK, thank you very much.

Ray Thorn: Thank you.

Operator: Your next question comes from the line of Nahid Fyed, please state your organization and your line is open.

Naheed Fyed: Yes, my name is Naheed Fyed and I'm in Innova Healthcare, and I want to ask for each category do we submit a separate application or can we submit one application for all categories?

Rick Gilfillan: I think, as we said before, if you have a particular service delivery model and associated payment model that you think is applicable or fits within more than one category, you can certainly make that case for it. If you have distinct model that you believe are targeted at each individual category, they should be presented in separate category in separate proposal.

Naheed Fyed: And you already answered the question earlier that you can submit multiple applications as needed.

Rick Gilfillan: Yes.

Naheed Fyed: Thank you.

Operator: Your next question comes from the line of Denise Henry with Telemedics and Healthcare Technology. Your line is open.

Denise Henry: Yes, thank you. It's Denise Henry, Telemedicine & Telehealth Technologies.

I was wondering, is the project open to pilot programs?

Rick Gilfillan: I think everybody has their own definition of pilot programs, but what we're looking for are specific service delivery models that are relevant for a – I think, population of patients, a set of providers, and that ultimately are things that could be scaled to become national programs for those populations or types of providers. We expect them to be accompanied by a proposal for a payment model. So at a minimum, we'd expect proposals to meet those criteria, what about a particular approach that you're taking fits those criteria is more a kind of, you know, standalone small-scale pilot project in your mind. We'll have to leave you to decide. We know – we're OK with starting something starting small but it has to be something that has a payment model and has – ultimately broad-out stability.

Denise Henry: OK, all right. Thank you very much.

Operator: Your next question comes from the line of Brad Stewart with Center Health. Your line is open.

Brad Stewart: All right, thank you very much.

In the first round you deliberately or specifically targeted not just individual organizations but convener organizations as well that might be able to bring together say a standardized model across a number of different providers or geographic areas. Are you considering convener applications in this round as well?

Sheila Hanley: Yes, we are entertaining applications from conveners.

Brad Stewart: Thank you.

Operator: Your next question comes from the line of (Darrell) (inaudible) with (Polsinelli). Your line is open.

(Darrell): Hi. I was wondering if there were any types of entities organizations that were categorically are explicit – explicitly excluded from submitting an application.

Rick Gilfillan: We don't have specific exclusions I believe, but one thing that I think is a little bit different this time around is we're not focused in this initiative on models of care that specifically on its highly focused way address the use of inpatient – acute care inpatient facilities that are reimbursed under inpatient perspective payment system. That's to say those in hospitals are ruled out but I'm speaking specifically of the types of services we're interesting in addressing, and as I described earlier, we're interested in things that get more of the outpatient side rather than the acute inpatient side of our care system.

(Darrell): All right, thank you.

Operator: Your next question comes from the line of Jim Mingle with MyCareTeam Incorporated. Your line is open.

Jim Mingle: Good afternoon everyone.

We are privately owned company that manages people with chronic diseases specifically – have proven results of diabetes. We have multiple hospitals that are reporting now when the initial phase of the round that didn't have results, they do now. The question is, there seems to be addressing payment models in how they would approach the system with CMS. Do you have any guidelines regarding the payment models that I could share with them that you have in mind or are they supposed to come up with these new models?

Rick Gilfillan: All right, so we're broadly open to a number of different ideas on that front. I would direct you to two sources. One is there is quite a bit of specific language on this in the funding opportunity announcement and we'll also be doing a series of webinars, one of which that will be focused on the development and design of payment model.

Jim Mingle: And I have a follow up question if that's OK?

Rick Gilfillan: Yes.

Jim Mingle: The follow up question is, I believe they definitely have result below HbA1c, you know, dramatic changes with the patient population. The questions is

how that correlates to obviously saving money would have to be put in to the payment model calculation that you would have to approve. My assumption is that how long of a timeline is the cost savings for this grant to achieve that because there'd be obviously some ramp up cost initially?

Rick Gilfillan: Yes, so generally – we understand that. Generally we expect there to be evidence of a pay back within the performance period. And so that generally has been the case as where – we know we're looking at models that might have a little bit – that do have a longer time horizons in some cases and certainly I'm talking about prevention models. So we're open for looking at models that have a little bit longer time horizons certainly in terms of pay back. We'll look to you all to marshal the evidence and to tell us a strong story on why that makes sense in your particular case and look to your financial model and the certification of it if it's, as I said, over 10 million dollars.

Jim Mingle: OK. Can I follow up with one more question?

Ray Thorn: I'm sorry, we have to get to the next question, please.

Jim Mingle: OK, no worries. Thank you.

Operator: Your next question comes from the line of John Schlichter with OPM Experts. Your line is open.

John Schlichter: Hello? Can you hear me?

Rick Gilfillan: Yes.

Ray Thorn: Yes.

John Schlichter: OK, thanks.

So you just answered a couple of questions. This is about – I'm wishing for you to elaborate what you mean by the term design and your request for a design of a payment model that's consistent with the new service delivery model. Do you have – so you said that there's going to be an upcoming webinar but can you give us an operational definition of a design? I'm really

asking along the lines of, you know, what essentially are you requiring, how fully baked does it need to be? If we're doing something that's going to be research-based, it's kind of discovery, do we already have to base it on empirical data or can we propose to you something that is a compelling internal logic or although it's not without existing empirical data?

Sheila Henley: Yes, so we expect applicants as part of their application to submit the design of a payment model, and by design we mean a few elements. One is the payment details, so how funds would flow under the payment model, and the payment principle, so what specific providers or beneficiary incentives the payment model would create, a description of risk parameters, how the payment model adjust insurers and/or limits risk, the return on the investment, how the payment model would deliver a positive return on the investment for CMS, and how it will result in net programmatic savings for CMS.

A statement on the application, so a description of the services or providers to which the payment model would be applied. Scaling, how the payment model can be made available to other providers and potentially serve as a basis for a subsequent solicitation by CMS. And then finally the progression, how the parameters of the payment model will progress over time.

Rick Gilfillan: I would add to that that we understand and fully expect that we will see quite a spectrum of responses with regard to payment model. And some will be very baked based on good empirical information. Others may be highly speculative. We are – we welcome all in the context of a delivery model proposal that, you know, we will evaluate as well.

So we will – we understand that not all proposals can come with everything about the payment model fully baked, but we'll look at kind of the proposal's entirety and make – the selecting official ultimately will have the ability to consider these different dimensions of the proposal. And we'll, no doubt, have some that looks like they're fully baked and some that might be more speculative that come with a very impressive proposal on the delivery system side. So we expect a full range of ultimately awardees to be selected on this score.

What we do want to make sure happens though is if people understand they need to think through very concretely the service delivery model, the ability of that model to impact significant areas of the patient's experience resulting in improved quality outcomes and to improve cost outcomes, and then being able to the link that expectation to some way for CMS, and frankly other payers because we will be looking for multi-payer engagement, to be able to pay – make a payment that creates a sustainable model.

John Schlichter: Excellent, that's very helpful. Have you decided the dates of the webinar on this topic?

Ray Thorn: The first webinar will be on May 28, and information will be forthcoming on the Innovations Center website early next week and also through the Innovation Center listserv early next week.

John Schlichter: Thank you.

Operator: Your next question comes from the line of Anthony DeFranco with ACS. Your line is open.

Anthony DeFranco: You've just answered my question, thank you.

Operator: Your next question comes from the line of Shawn Rogers with Rogers EMS Consulting. Your line is open.

Shawn Rogers: Hi. Can you – can you describe a little bit the selection process and how you evaluate and score the application?

Rick Gilfillan: Sure, we'll have a set of independent reviewers that include external folks as well as folks internal for the government, but the criteria need to be spelled out. In the FOA I won't recapitulate the distribution of points but we'll look at the design of the model and the payment model, the service delivery and payment model. We'll look at the organization. We'll look at the financial proposal and return on investment. We'll look at the plan for monitoring and reporting to evaluate the proposal. And then we'll also look at the financial model in greater detail for larger proposals. As I mentioned, we'll look over the actuarial certification of the companies in the proposal. We may have our

own actuaries or having the actuarial review done on some of the smaller proposals that don't include one in the proposal. And then we all look at a variety of other criteria that are contained in the FOA that you can get online in our Web site.

Shawn Rogers: Very good. Thank you very much.

Operator: And your next question comes from the line of Keith Busch, please state your organization. Your line is open.

Keith Busch: Hi, I'm with Align Care and we're a care coordination company and we're out of Denver.

My question is, will it impact if we're – currently we're private pay, will it impact if we associate with a hospital or with other physicians – physician groups, or can we be standalone and still get the same weight in the decision making?

Rick Gilfillan: I think, we're going – you know, as I mentioned, like, one of the criteria would be the design of the model, the design of payment system, and among other criteria. Within that, we'll look at the likelihood that it will produce results, the quality outcomes that we're looking for. As always we're looking for improved health outcomes. We're looking for improved experience of care. We're looking for improvement in the cost of care.

And so the evaluation will be whether or not – it will be based on whether or not the model and the participants in the model appear to bring together the right set of capabilities to deliver those outcomes. And we'll look for those proposals that seem to bring the right mix to deliver on those metrics.

Keith Busch: Great, OK thank you very much.

Rick Gilfillan: One thing I would say also, we will look specifically for multi-payer options. And our belief is that oftentimes our experience has been that by having more than one payer engaged in an initiative in a community, the more payers hence the more patients who are benefitting from a proposed intervention with a set of providers, the greater the percentage of the providers' patients that are being

supported by this healthcare model. The greater likelihood there is that we'll get the results we're after. And so we will favor multi-payer proposals.

Rick Gilfillan: I should add one other thing, we'll also look at magnitude of impact. So, we'll – we understand and we will look favorably upon, you know, applications from small rural areas for sure, and we understand that at times they may not be able to bring as much impact in terms of total savings as CMS as folks with larger population. But where there are larger populations we will be looking for initiatives that have large scale impact.

Keith Busch: OK. Thanks.

Ray Thorn: Thank you. Operator, we have time for two more questions.

Operator: OK, your next question comes from the line of Parul Sinha with Washington University School of Medicine. Your line is open.

Parul Sinha: Good afternoon.

The Head of Oncology Department at my institution is planning conduct of a trial which is prospective, randomized, and a phase three clinical trial in design. And it is randomizing patients with a specific type of (adenoid) cancer. The incidence of – which is rapidly rising. And it randomizes them into two treatment arms. And the study is designed to make treatment invasions based on preliminary retrospective data which has shown that one of these arms has a potential to decrease the treatment intensity, the toxicity and cost. But it has equivalent disease outcomes. So, what's this study be eligible for the category three or any other categories of these awards?

Rick Gilfillan: That – thank you for that question. And I think, I think from what you described quite honestly it sounds like that is something that would be more appropriately within the NIH portfolio of research. We're not specifically asking for a randomized control trial. If...

Parul Sinha: OK.

Rick Gilfillan: ... for some reason that would seem to work and be the right thing to do in a particular instance, we'd certainly would consider it. But we're not in this phase of evaluating specific clinical treatments for, you know, identified differentiated types of cancer. We're more interested in kind of the service delivery broader approach of what might, how might an oncology practice take care of their patients not in terms of which chemotherapy agents to use but what models of care can they provide that would overall improve their outcomes and decrease the cost of care.

In the realm of selecting chemotherapy agents or intervention approaches at that level that's – to us, that's more an NIH field.

Parul Sinha: OK, quickly. This was not for selecting which chemotherapy regimen actually, but it is between two (radiate) therapy and chemo radiotherapy.

Rick Gilfillan: Now, my statement would stand I believe for the two.

Parul Sinha: OK. All right. Thank you very much.

Rick Gilfillan: You bet. Thank you for that question.

Ray Thorn: Thank you, and operator this will be our last question for the call.

Operator: Your last question comes from the line of John Whitman. Please state your organization. Your line is now open.

John Whitman: The questions have been answered. Thank you very much.

Ray Thorn: OK, let's take one more.

Operator: OK. And your next question comes from the line of Sandy Jamet. Please state your organization. Your line is now open.

Sandy Jamet: Sure. Great. My organization is the Corporation for Supportive Housing, and I had a two part question. The first is we're focused on frequent users, homeless individuals who are frequent users of emergency room and inpatient hospitalization. That sounds like the inpatient hospitalization part of this, reducing cost from that area is not of interest for this round, but I did have a

question about whether emergency rooms, detox services and other types of costly services, in and reducing those costs are of interest? That's the first part.

And then I'm wanting to know if you could speak to the difference in this round between this round and the past round in terms of the focus on new payment models and how that's different than what you looked for in the last round?

Rick Gilfillan: Yes. Answer to your first question, yes. We are as – spoke to interested in outpatient services and ways of improving them and decreasing the cost of outpatient services that could be avoided by better community-based care. So, yes we are interested in that.

In terms of the differences, I think we want – we're asking for a very direct proposed payment model in this instance. And in the prior – in the first round, we did ask people to describe and speak to a past sustainability. In this instance, we are looking for and we think we will receive proposals that have very specific payment model opportunities as a key part of the proposal and we expect to weight those payment model proposals heavily. As I've said, we understand that some will be more or less speculative and, you know, and are fully baked based on empirical – good empirical data. We'll weigh all that and consider all that. But we are looking for you all, frankly, to think real hard about how we can connect the service delivery model you're speaking of to a payment approach. And the second major difference is, in this instance, that payment approach can start during the period of the cooperative agreement or during the three-year performance period.

Sandy Jamet: Thank you for that.

Ray Thorn: Great thank you, Sandy. Rick – any closing remarks you would like to make?

Rick Gilfillan: Yes. Yes. Thanks, Ray.

First I want to just thank everybody again for joining us today. It's great always to hear from so many people who are thinking hard about how to address this issue we have about improving our healthcare system to deliver

better health for patients, better experience of care for patients, better cost experience, and over time, improving access and that's exactly the mission of CMS.

That's why we're excited to be able to work with you. We appreciate the fact that more and more people are thinking hard about these issues. We know we've raised the bar a bit with this round looking for more definitive information on your proposed model and the payment model to go with it. And we appreciate you all thinking hard about that. I appreciate you spreading the word out there. We're going to provide a bunch of seminars to try and provide more information, provide a learning opportunity for everyone to understand in more detail what we're looking for. And we really look forward to working with you all over these next few months to support the excitement we hope is out there for this next round of innovation award.

Thank you again for joining us today.

Ray Thorn: Great. Thank you, Rick. And just a quick reminder, though I think Rick has one more thing to say…

Rick Gilfillan: I'm sorry. I should add, one other thing, I'm sitting around the table with a team of people here at CMS who have worked hard to get this proposal to you all, and I just want to publicly in front of the team and everybody who's on the phone, thank you and let you know that you have a set of very hardworking federal employees who are dedicated to working with you and making this a very successful program. We'll introduce them well during the webinars, but I just wanted to take note of that today.

Go ahead, Ray.

Ray Thorn: Great. Thank you, Rick. And just a quick reminder, we will be having more information on the webinars forthcoming early next week. The first one will be on May 28th. So stay tuned for more information via the CMS Innovation Center website and for the CMS Innovation Center listserv.

And with that, thank you all for joining today's call, and we look forward to seeing you on May 28th.

Operator: This concludes today's conference call. You may now disconnect.

END