Health Care Innovation Awards Round Two – Overview of Categories One and Two

Webinar Transcript

This is Andrew Rushton from the CMS innovation Center and I will serve as the moderator for this webinar on the Healthcare Innovation Awards Round Two with specific focus on categories One and Two. Before we proceed, there are a few important housekeeping items to address. This webinar is being recorded and slides and transcripts of this webinar will be posted to the Innovation Center's website within the next week. If you are a member of the press, this webinar is off the record and if you have a question, please e-mail press at CMS.HHS.gov or call (202)690-6145. Furthermore, it should be noted that the comments made on this call are only for general informational and educational purposes. The Innovation Center's comments are not offered and do not constitute legal advice or legal opinions and no statement made on this call would preclude the agency and/or its law enforcement partners from enforcing any and all applicable laws, rules and regulations. Applicants are responsible for ensuring that their actions fully comply with applicable laws, rules and regulations and we encourage you to consult with your own legal counsel to ensure such compliance. Furthermore, to the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. The Innovation Center is not seeking group advice. The main purpose of today's webinar is to focus on Categories One and Two of the healthcare Innovation Awards Round Two. Subject matter experts will be presenting information relevant to Categories One and Two in addition to being available to answer questions. The agenda for this webinar is a hefty one. So, I will provide a brief overview now for our attendees. After I conclude my remarks, Sheila Hanley, group Director of the Policy and Programs group at the Innovation Center will discuss the goals and measurements of success for Round Two. Mike Rapp, Senior Advisor at the center will start speaking on Innovation Category One and include John Kane, senior analyst for the Division of Institutional post-acute care, John McGinnis, Director of the Division of Outpatient Care, at of the Centers for Medicare and Joseph Hutter, Lieutenant Commander in the United States Public health service. Following will be Bryan Samuels, Commissioner of the Administration on Children, Youth and Families, Mimi Toomey, Director of the Office of Policy Analysis and development at the Administration for Community Living, and Suzanne Fields, Senior Adviser on Health Care Financing at the Substance Abuse and Mental Health Services Administration. Immediately following the category presentations a question-and-answer session will

conclude the webinar. During the question and answer session, questions will only be accepted through the submit your questions box that is located in the lower left of the webinar portal appearing on your computer screen. Please note that no questions will be accepted by phone. If you do have questions that we were not able to answer on this webinar, you can always e-mail us at innovationawards@cms.hhs.gov. Lastly, the Innovation Center will be doing further webinars on the Healthcare Innovation Awards Round Two. More information will be forthcoming on how to register for this webinar through the innovation center website and listserv. With that, I will turn it over to my colleague, Sheila Hanley. Sheila?

Hello everyone and thanks very much for joining us this afternoon. This is the second in a series of eight webinars we will be offering to support applicants for Round Two of the Healthcare Innovation Award. I'm Sheila Hanley with the Healthcare Innovation Awards team and I'd like to take just a moment to set the stage for this afternoon's discussion. As you may know, the mission of the Innovation Center is to test innovative payment and delivery models with the objective of reducing expenditures for Medicare, Medicaid and CHIP. CMS appreciates that there is extraordinary innovation in delivery system and payment approaches occurring across every corner of our country. The awards are designed as a partnership to collaborate in testing new service delivery and payment models that hold promise for achieving better care and lower cost for Medicare, Medicaid and CHIP enrollees. In our first round of healthcare innovation awards, that was announced in November of 2011, we funded 107 models selecting those with the greatest chance of delivering better care at lower cost and that had the greatest chance of creating larger scale, sustainable results. The awardees from the first round of the Healthcare Innovation Award are doing extraordinary work and have begun to impact care and cost across a broad cross-section of services within diverse communities in urban and rural areas in all 50 states, the District of Columbia and Puerto Rico. In Round Two of the Healthcare Innovation Awards, we hope, again, to build off the best innovations occurring in the field. To do so, by targeting priority areas in key categories. The objective of Round Two of the Innovation Awards is to expand our partnership with innovators in the field so we can identify new payment and service delivery models, in four specific categories and, to develop a clear pathway to new Medicare Medicaid and CHIP payment models for the service delivery models. As in the first round, we are looking to engage a very broad cross-section of healthcare stakeholders, including hospital systems, integrated systems that include physicians and others, multispecialty medical groups, large and small, post-acute providers of all types, nursing home, rehab facility, home health, etc. And many other types of providers in addition to state and local governments, business, communities, academic and research organizations and other eligible organizations interested in achieving better care and lower cost. We will measure the success of the projects we select in Round Two based on the ability of these initiatives to rapidly reduce cost for Medicare, Medicaid and/or CHIP beneficiaries. And, their ability to improve care for populations with specialized needs such as children in foster care or people living with HIV. Success will also be measured on the ability to rapidly transform financial and critical models for specific types of providers and again we anticipate a broad range of providers, and to improve health of population through prevention and linkage between clinical care with community-based intervention. We are looking to the field for true innovations and service delivery and payment approaches of business models that will help us to achieve these results. Round Two of the healthcare Innovation Awards focuses on supporting

innovative models in four areas. Models that rapidly reduce costs for Medicare, Medicare, Medicaid. Models that quickly transform clinical models for specific types of providers, including, for example, oncologist and cardiologist and other specialist such as subspecialist. Potentially other types of providers as well. And models that improve the health of populations through prevention and linkages of clinical medicine to community-based services. In today's webinar, we are focusing on the first two innovation categories. Models that rapidly reduce cost for Medicare, Medicaid and CHIP beneficiaries in the outpatient or post-acute setting and models that improve care for populations with specialized needs. We are fortunate to have with us today subject manner experts from across CMS and HHS in addition to our Innovation Center team. Each speaker will be providing contextual information on these categories and priority areas including a brief explanation of each category and several other priority areas. The very high-level descriptive information about the population or services in each category and, importantly, the rationale for why we are seeking innovation in these categories. As we provide examples of types of services, types of providers and delivery system and payment issues, please be mindful that the examples described in today's webinar are illustrative only and not intended to convey a preference or preferred approach. We also want you to be mindful that applicants will be asked in the LOI and in the application to identify a primary innovation category. Applicants have the option of using narrative sections of the application to describe how their models may impact other categories or priority areas if they choose to do so. We also want to remind you that to support sustainability of intervention, applicants will be asked to propose a payment or business model to support their proposed service delivery model. Last, and importantly, we want to thank you for the innovative and important work you do each day to make care better and more affordable. We look forward to partnering with you in Round Two of the Healthcare Innovation Awards. I'd like to now introduce my colleague Dr. Mike Rapp.

Thank you, Sheila. Sheila indicated, I'm Michael Rapp, Senior Advisor in the Office of the Director here in the Innovation Center. I am joined by colleagues from the Center for Medicare and Center for Clinical Standards and Quality who have been already been introduced, John Kane from the Center for Medicare and Dr. John McGinnis also from the Center for Medicare and Dr. Joseph Hutter from the Center for Clinical Standards and Quality. They will be speaking about particular areas. So, category one, as Sheila indicated, and as this slide shows, is the outpatient and/or post-acute settings. Within this broader category, there are particular priority areas which are listed here. As Sheila indicated, priority means that preference will be given to submissions for these areas. However, CMS will consider submissions in other outpatient and/or post-acute areas within this category. So, the next slide -- we talk about, why did we pick these areas? There are three important reasons listed here. First is growth in spending. As subsequent slides will indicate, outpatient spending is larger than and growing more rapidly than in the inpatient setting. The next reason is geographic variation. Here, one will find that post-acute spending is the biggest contributor to geographic spending variation. Finally, we are trying to balance our portfolio, which is well-developed in the inpatient settings. So, now, I'd like to turn to slides that will illustrate this point, these points. You will see here, the Medicare Overall Spending. So, for part A, which covers the inpatient services, you see that's about one third or so of the overall spending. Part B which covers the outpatient arena, Medicare Advantage, which covers both and part D for prescription drugs. The next slide, you will see where the acute inpatient spending is demonstrated with the blue color on the

bottom. So, this is the inpatient hospital. As you can see on this slide, the growth here is relatively flat. Compare that with the red portion of the bar graphs, which show the skilled nursing facilities. So, that's the post-acute and shows relative to the inpatient -- the inpatient hospital. There is more growth. The next slide shows the Part B or outpatient overall. What you will see here, is that there is a general growth here, but particularly, if you look at the purple portion, there, in the outpatient hospital area, it has grown more rapidly. The next slide will show, more specifically, what the preventive beneficiary per month growth has been over the past several years. As you see, for outpatient hospitalist's, 42%, the sort of norm is around 14%, inpatient hospital you will see has only 5%. So, that is quite different than the outpatient area. Hospice also has grown significantly with 31%. The growth, in terms of the volume, is not dramatic for the skilled nursing facility or home health. These post-acute areas -- that as you'll hear in a second, there is quite a bit of geographic variation in these. So, for this next couple of slides, I will turn it over to John Kane.

Thank you, Mike. Slides 15 and 16 provide an additional example of the type of variation that we have witnessed through our nation's health spending and why we feel that post-acute care is among those areas deserving of focus. The example on slide 15 is specific to Medicare spending in 2010 for MSD RG 291, or heart failure and shock of major complications. As you can see, the inpatient spending on this chart is stable across the five different locations. The spending areas that are driving the variation, among the different locations, from most notably post-acute care spending, and readmissions. Slide 16 looks more in depth at the post-acute spending identified in slide 15. By each of the various post-acute settings. What we see, is that variation in the utilization of a particular setting such as skilled nursing facilities, for example, drives the variation in payments. This is obviously just one example, but we have seen familiar and similar trends with other diagnosis groups. Whereby the variation in post-acute spending and readmissions is primarily responsible for driving increased cost to both the insurer and the beneficiary. I will now turn it back over to Mike to provide greater clarity on what we mean when we speak about the outpatient and post-acute setting.

The next slide shows, generally, what is included in the outpatient post-acute setting. So, as stated in the opportunity, the funding opportunity award announcement, the proposal that one submits needs to indicate which innovation category the model falls within, as well as which priority areas, if any, are addressed. What we are going to try to do now for you, is really define what falls within these categories. In the outpatient settings, of course, a large component of it and the largest growth area is what I already mentioned. That is, the hospital outpatient area. In addition, the specific priority areas or some of the -- specific priority areas are outpatient, as well. While we exclude acute inpatient care as the principal focus of the round two awards we do not exclude all inpatient care. With regard to the post-acute settings, the inpatient rehabilitation facilities, skilled nursing facilities and long-term care hospitals, specifically, are, of course, inpatient facilities. The home health agencies are not. Now, I do want to mention one other thing, too. We don't have it listed on this slide, but hospice is considered one of the post-acute settings or post-acute service. So, in the next several slides, we will discuss the priority areas and give examples of them, settings for these services and some payment and service delivery issues. As we talk about them, we will use Medicare examples. But, as Sheila indicated, we want to reiterate that an important focus of these awards is Medicaid and CHIP. Consider these service delivery

and payment issues only as examples. Now, for the first task priority areas, I will turn it over to Joe Hutter for diagnostic services and outpatient radiology.

On slide 18, the category one, the first two priorities as mentioned were diagnostic services and outpatient radiology. Examples would include radiology and other imaging, EKG, cardiac monitoring and laboratory test. Examples of settings include hospital outpatient ambulatory surgical centers, physician offices, skilled nursing facility outpatient and independent diagnostic testing facilities. As for payment and service delivery issues, will use radiology as an example, because of the biggest sandbox within diagnostic services. A better term perhaps in radiology would be imaging, as other specialist do imaging is well. Imaging is important, but it has special challenges. First and foremost it's a class cutting clinical service. In a bundle for CABG or hip replacement, the central players are all internal to the bundle. The contained box more or less. In imaging there are multiple players operating in multiple boxes preferences, positions of every type will order the studies. As a technical arm that produces the images, professional arm that interprets them. On the payment side are technical fees, which are the lion's share, separate professional fees and sometimes combined into global fees. A second factor which really is an opportunity than an obstacle, is that operationally, there is no set wall between outpatient and inpatient imaging. What I mean by this, any delivery system model that improves the efficiency, quality and/or safety of outpatient imaging will generally be applied to inpatient imaging, as well. Also, any improved communication, data sharing, shared decision-making or decision support tools ideally involve prior studies, regardless of which setting the studies were obtained in. Now, as far imaging system-level problems to be solved, you tell us what the problems are but here's three well-known examples. First, inappropriate use. Some say that as much as 30% of all imaging is unnecessary. Second, would be duplication of the same test, as generally there is little sharing of studies at the local or regional level. Third, stocking of test which refers to multiple different tests when perhaps one would do. Some well-known delivery system reforms and, here again, these are just examples, come up with their own, include things like one, continuous quality improvement using evidence-based clinical guidelines to identify and eliminate wasteful processes, would represent the latest variation of the QI theme. Computer decision-support tools for ordering physicians as well as images and finally HIT systems that track and share information and allow for expert consult at the local and regional levels and across the spectrum of care.

Thank you, Joe. So, the next one of the priority areas that we will discuss is physician administered drugs. This does, in terms of examples, tie directly into the Medicare program, where physicians administer drugs and they are covered under part B of our program. They are different than prescription drugs, which are covered under Part D. So, there are certain requirements for physician administered drugs, principally that they be normally not something that is self-administered. So, it's not something that the patient can take care of for themselves. This is a coverage limitation. If you deal with the Medicaid or CHIP program, this is not how the coverage is organized. So, at any rate, this is by way of example. And the Medicare program, the examples of physician administered drugs would include the things listed here. Chemotherapy, rheumatology, ophthalmologist it drugs, certain vaccines and erythrocytes stimulating agents. These physician administered drugs can be administered or obtained in a variety of settings. They're listed here, including physician offices, pharmacy, durable medical

equipment, suppliers and so forth. I won't read through each one of them. Instead, I'd like to address some of the payment and service delivery issues that are encountered. A principal one of these is the drug pricing. The medication is physician administered so if they are going to do this in their office, asked to obtain the medication. How do they do that? They purchase it. When they purchase it, how will it be paid for under Medicare? This caused quite a bit of issues, in terms of whether payments were more than they should have been and there was some changes to this in the last several years. But, that still continues -- it's somewhat of an issue as to exactly how much the physicians would be paid for the medication and how much profit, if you will, would be built into that. The second component is to pay for the actual administration of the medication. There are certain fees built into that. Kind of the overall context in this is, okay, when you have a situation like this, whether it's covered only in this particular category, how to do with these sorts of issues and other different approaches both in terms of service delivery and in terms of payment that might be useful and -- principal goals which we have are to reduce cost while improving or maintaining quality. Now, I'm going to turn it back over to John Kane.

Thanks, Michael. Home-based services represent perhaps one of the more unique service categories in that the services are provided to the patient in the patient's home. That being said, some of the service and delivery issues and home health are similar to those to post-acute more broadly. For example, home health payments under Medicare are tied to the volume of services whereby payments may be augmented by the number of therapy visits provided to the resident. As a result, some home health providers may focus on these payments inherent in the system rather than what is best for the patient. Similarly, with regard to post-acute services generally, we see that payment incentives can determine the type of care provided. For example, you might see the same patient with the same illness requiring the same basic treatment in various post-acute settings such as a rehab patient and skilled nursing facility and inpatient rehabilitation facility. You might find that the care provided in these settings is vastly different, merely on the basis of differential payment incentives. It can drive how much and what type of therapy the patient receives and how long the patient is kept within the care setting. This, along with avoidable hospital readmissions is the potential for poor care coordination among post-acute providers and between the hospital and post-acute settings, which ultimately means that the one suffering the most is the patient. Obviously, these are just a few examples of potential service and delivery issues within post-acute care, but they all have at a more global and systemic level to lower health care cost. I will now turn the call over to Dr. McGinnis -- to discuss healthcare services.

The next category services described here generally is therapeutic outpatient services. These primarily refer to surgical procedures and radiation therapy in all the different varieties. The settings that we referred to in terms of outpatient in this context refer to the hospital outpatient department, ambulatory surgery centers, and the physician office. These are typically viewed as three different levels with physician office being sort of the lowest level of intensity and ambulatory surgery center in the middle and the hospital outpatient department at the top. Typically, the payments in the hospital -- they are always higher than ambulatory surgery center in most cases, but not in all cases higher than the physician office setting for the same surgical procedure. In terms of some of the service delivery and payment issues, that we are interested in and others are interested in, as Dr. Rapp showed in a prior slide, in terms of these different payment systems, the hospital outpatient department or the

outpatient payment system -- payments from 2008 to 2012 have exploded in the hospital outpatient, significantly as compared to other areas, particularly inpatient. This is due to advances in technology. Other reasons which we are actively working on. In terms of the payments, in the hospital outpatient department, there is really an intermediate hospital outpatient as a prospective payment system. It's not as much of a prospective payment system as the DRG payment system but also not a fee schedule like the physician fee schedule where payments are made -- individual payments, for each coded procedure. It's sort of intermediate. These groupings are called ambulatory payment classifications. There is payment for service. It's generally not based on outcomes or efficiencies although there is a penalty for hospitals that fail to satisfy quality reporting standards. Finally, on slide 22, refers to an issue that has gathered much attention recently and that is of a hospitals that typically by either surgery centers or physician practices and convert them to off-campus provider based facilities and capture buyer payments that go with being a hospital, but in some cases, as reported, providing basically the same services that the physician offices were offering, prior to the change in ownership. That's been an area of interest. With that, I will turn it back over.

Thank you, John. So, we are at the end of our discussion of category one. I would just like to spend a couple of moments summarizing what we were hoping to provide for you, here. As we've indicated, it's important for you to indicate which categories your proposal would fit into and also, what priority areas, if any. We want to be sure that we defined for you clearly what those were. Our general overall categories are outpatient and post-acute settings. Within those, there are the priority areas. In the outpatient arena, we've got diagnostic services, but we've also got therapeutic services. So, anything considered therapeutic would be included in there. So, it includes physical therapy, speech and language therapy, occupational therapy. Also, other therapy, surgeries, and so forth. It's important to recognize how broad those priority areas are. Secondly, we've listed even more specifically certain areas in the outpatient arena, such as outpatient radiology, high-cost physician administered drugs and, as I mentioned, therapeutic services. Within the post-acute setting, it includes all of the usual post-acute settings that we think about and it also includes hospice, although we do not have that indicated on the slides. Although the priority areas are important and important for you to know, in terms of being able to define it, CMS will, of course, consider submissions in other outpatient and post-acute care settings. With that, I will now turn it back.

Great. Thank you. Now, before we proceed, I have a quick technical update for you. Some attendees may be having difficulties viewing the slides on their computer. We suggest pressing the F5 button on your computer keyboard and that should alleviate the problem. If you have trouble seeing the slides, press F-five on your computer keyboard. Next up, as we move along, is Mark Wynn, Senior Analyst from the Innovation Centers Demonstration Group. Mark, it's all yours.

Thank you very much, Andrew. I'd like to briefly discuss category two. Improving care for populations with specialized needs. First, I will run over the priority areas and then talk about the first four of the priority areas and a little bit more detail before turning the presentation over to colleagues from other agencies to describe priority areas. The priority areas are the pediatric populations that require high cost services. Persons with Alzheimer's disease, persons living with HIV/AIDS, children at high risk for dental disease, children in foster care, adolescents in crisis. Persons requiring long-term supports and services,

persons with serious behavioral health needs. Just as Mike Rapp mentioned for category one, we will also consider submissions that improve care for other populations with specialized needs, although these are our priority areas. Why are these areas specified? First of all, we believe there is a high unmet need in these areas. Significant opportunities to improve care. Secondly, we've seen significant growth in spending in these areas, especially for those populations with complex care needs and in relationship for example, with inpatient hospital, whether growth has been a little bit less. Third, there's a need for delivery systems change. That is a need for significant amounts of policy work to integrate healthcare models and payment levels together in the appropriate manners. Finally, in comparison with other work that the innovation center is already sponsoring, we believe that there is a need for a portfolio expansion into some of these areas, so that we can create new models and cover these patient populations. So, the first of these areas, then, is pediatric populations that require high-cost services. This population includes children with multiple medical conditions, behavioral health issues, and general diseases, chronic respiratory diseases, complex social issues and in all too many cases, combinations of all of these things. We noted that Medicaid and CHIP pay for about half of pediatric ambulatory care visits and inpatient care for children. This is a huge issue for the Medicaid and CHIP programs. The examples of cost drivers include lack of integration of care across settings, social determinants of health, which are inadequate, inappropriate use of specialist's, where we believe that primary care services can provide a better integrated and overall type of care for the patients, and fragmentation of services. For example, services provided by physical and occupational therapists in relation to developmental psychologists. Examples for opportunities in this area include improving early screening, assessment and diagnosis. Increasing compliance to care plans. Coordination of community settings. Slowing the progression of chronic diseases and reducing services that, especially those including hospitalizations, readmissions and as just mentioned, outpatient hospitalizations, as well. Next category, is persons with Alzheimer's disease and related dementia. This population is a huge and difficult population to deal with. Something like 5 million people currently have Alzheimer's, with the large majority of these cases, diseases that occur after age 60. According to recent statistics, about 13% of men and women age 65 and older have Alzheimer's disease and there is an increasing incidence of that disease for the very old. Groups that are challenged, especially by Alzheimer's disease, include racial and ethnic minorities, people that start with intellectual disabilities in the first place, and especially difficult for persons with a younger onset of the disease, before age 60. Cost drivers can include a number of things, but that includes the fact that care is not always provided in settings that are best for the beneficiaries, including community care as opposed to institutional care. In many cases, providers may be providing duplicate services that are not properly coordinated. Opportunities in this area include the possibility of implementing new models of care for these patients, focusing on identifying those with these diseases, specialized dementia care, and better care coordination. Finally, the area which needs a lot of attention, caregiver support. The next category is persons living with HIV and AIDS. The description includes the population of nearly half the people who have HIV AIDS receive their regular care under the Medicaid program. So, this is an especially important area for CMS attention. Many people who are living with HIV and AIDS, historically, have had inadequate access to care. They are coming from disadvantaged social classes and areas, maybe. Some of the cost drivers are uncoordinated care, -- the need for better behavior coordination of healthcare. And other supports. Opportunities in this area include improving early screening and diagnosis of treatments, improving care coordination with social services and other

services, improving efforts to link and retain patients in care, and finally, improving adherence with medication and addressing problems with drug resistance. Another area of priority in this overall category includes children that have high risk for dental disease. This population includes Medicaid and CHIP beneficiaries, who identified with having high risk through risk assessment tools. Examples in the cost drivers, all of which can be greatly reduced with good preventative services, include emergency department visits, surgery in the operating room, and overutilization of restorative services. As I mentioned, these things can be greatly reduced through improved prevention and maintenance. Some of the other opportunities in this area include intense prevention and chronic disease management.. Fewer surgical interventions and lower per capita cost. I will now turn this back to some of my colleagues to describe some of the other areas in this innovation category.

Thank you very much, Mark. Next, we are fortunate to have, today, Bryan Samuels, Commissioner of the Administration on Children, Youth and Families. Commissioner Samuels?

Thank you. Good afternoon to everyone.

Children known to child welfare system, as well as adolescents in crisis, have complex healthcare needs. For example, of the 400,000 children who are in the child welfare system, 23% of them have at least one chronic health condition. Moreover, children who have any mental health services have a much higher prevalence of chronic health disease. For example, in the age group of six to 10 year olds, children have a chronic health condition rate of almost 54%. Trauma and maltreatment have a particular impact on both health and development of children. The literature suggests that child trauma can present with many of the same symptoms as children who have a mental health diagnosis. Treating trauma first, rather than starting with a mental illness diagnosis, may yield better outcomes for children who are in foster care or adolescents in crisis. Children in foster care and adolescents in crisis are served by multiple public systems, but they share very high prevalence of maltreatment experiences, as well as having had multiple types of maltreatment.

Psychotropic medication is also very prevalent in the child welfare population. Children who are in the child welfare system are three times more likely to be using psychotropic medication than the general Medicaid child population. In addition to that, there is significant geographic variation in the rate of prescription of psychotropic medication across the states, with the range being from 1% to 22% and the median being approximately 13%.

Children in the foster care system represent about 3% of the Medicaid child population. However, they represent 38% of the total Medicaid expenditure for children. An average state spends three times more on this population than on the general Medicaid population. Children in child welfare had approximately $4336 for their Medicaid costs of care in 1 year, versus less than $1400 for the general child population. Moreover, the cost of psychotropic medications exceeds $1400 annually, which is 50 to 75% more than non-foster care Medicaid children or enrollees.

For improving outcomes, we see this grant (Innovation Round 2) as a unique opportunity to transform and focus on positive outcomes for children who are in the foster care system, or adolescents who are in crisis. Improving outcomes for both of these populations is possible. These outcomes include things like

reduced trauma symptoms and improved functioning in physical, social, emotional and cognitive domains. Again, for example, a trauma first approach may, in fact, produce better results than usual care. An intergenerational approach may produce better outcomes than usual care, or evidenced-based approach to behavioral health services may produce better outcomes for both children known to the child welfare system, as well as adolescents in crisis.

By using data to drive decision-making and innovation, we would expect proposals to be able to address the complex clinical needs, integrating both physical health and behavioral health, leveraging EP DT to provide validated trauma-informed screening and assessment, intervening effectively by implementing evidence-based or evidence-informed psychosocial interventions, improving quality by using standard measures of care, and, sharing information across child serving agencies. We think all of these options are represented in this opportunity and we are really excited about and expect to see some really innovative approaches to meeting the needs of children who are involved in the foster care system or who are adolescents in crisis. Thank you.

Thank you, Commissioner Samuels. Next, Mimi Toomey, Director of the Office of Policy Analysis and Development at the Administration for Community Living will present on long-term services and support. Mimi?

Thank you very much. The Administration for Community Living is a newer operating division within the Department of Health and Human Services. It brings together the long-standing efforts and achievements of the Administration on Aging, Administration on Intellectual and Developmental Disabilities and the HHS Office on Disability.

So, what are long-term services and support? Well, they basically assist older adults and people with disabilities accomplish their everyday tasks. Tasks include assistance with daily activities, personal care such as eating and bathing, instrumental activities of daily living such as shopping, laundry and transportation. Medicaid is primarily the largest payer of LTSS but not the only payer. Other payers include the VA, the Administration on Aging through the Older Americans Act, and private pay. Much of this is fragmented and could be more coordinated within the community. Also, many states under the Medicaid side are rethinking their delivery systems under Medicaid -- LTSS for services including Medicaid managed care. A variety of organizations groups provide LTSS in the community and include for-profit to nonprofit, Independent providers of personal care, homecare agencies, Centers for Independent Living, and Area Agencies on Aging to name a few.

LTSS is acronym for long-term services and support and they are directly related to health and health outcomes. We've heard a lot of discussion around avoidable, preventable hospital readmissions. This is a major focus within HHS. A number of studies have demonstrated that social determinants of health

impact readmission. In fact, one studied found that 40% to 50% of readmissions were link to social issues and the lack of community coordination and linkages.

Next slide, please. So, who are the LTSS users? This slide depicts the distribution of community residents and health care spending by select groups. The co-occurrence of chronic conditions and functional limitations have wide reaching consequences for the healthcare system, the individuals and the economy. You can see from this slide, 14% of the population represent 46% of the spending. Effective treatment coordination across health care and social service systems may offer a high yield strategy to improve lives and control spending.

Next slide, please. How do we do this? As you can see, through partnerships we do outreach and education to professionals and through services we do outreach and education to consumers and caregivers. This is just a snapshot of the types of partnerships and services that take this and the community. Others include -- adult protective services and protection and advocacy organizations. These services could be legal assistance and financial aid. There are a wide range of LTSS providers that through coordination, can be person centered.

Next slide, please. Through the Administration for Community Living's Aging and Disability Resource Center (ADRC) program we tested evidence based care transition programs. We found there is critical connections are needed to long-term services and support for the community post hospital discharge. This slide provides a snapshot of data from sites that served over 700 people who ended up needing over 2,000 different types of long-term services and support. You can see from the slide the types of services that they need, including caregiver support. We know from research that 50% of Medicare beneficiaries who are readmitted within 30 days do not see their primary care physician after the first hospitalization. The LTSS providers doing evidenced care transition are also trained in the community to ask additional questions like how are you going to get to your appointments and do you need transportation and provide those linkages to the resources to reduce the community bearers for transition.

Next slide, please. This slide shows the high risk Medicare beneficiaries without Medicaid look like those with Medicaid except they are hi health cost and put them on the fast track to Medicaid spend down and more expensive cost to states. Their status can change very quickly with just one health episode.

Next slide please. There are a lot of opportunities for long-term services and support. We need to better integrate the health systems with families and community support by setting up high-performing

systems that support the infrastructure and coordinate with a long-term service support systems. We need less fragmentation for consumers. They need understandable language and the individuals and their families all have timely and clear information to make good decisions. We are looking at this as no wrong door models for all populations for information and access to both their community and health needs. Strong long-term services and support allows for individuals with disabilities to gain meaningful employment and be a contributing member of society through the right support at their home and community. Using evidenced based practices and quality person centered approach will allow people with needs in the community to receive services in the setting of their choice, preferably in their home and community-based settings. Or, live in the best setting for them. From the providers they choose and regardless of the source of payment or location.

So, with that, thank you very much.

Thank you, Mimi. Moving along, Suzanne Fields, senior adviser on health care financing at the substance abuse and mental health nervous his administration will next go over integration for persons with serious behavioral and physical health needs. Suzanne?

Thank you very much. I will be highlighting information regarding persons with mental health and substance abuse needs and providing some data related to those needs. We've categorized this information, separated information by adults, as well as children and youth, while there are some similarities between those age groups, related to behavioral health and physical health integration, there are also some important differences that I want to highlight, in terms of your planning. First, looking at data related to adults, over two thirds of adults with a mental illness have a comorbid physical health condition such as diabetes, heart disease, or COPD. Additionally, we know that adults over the age of eighteen with any mental illness, within the past year, were more likely to have high blood pressure, asthma, diabetes, heart disease and stroke. In addition, we have very compelling data of specific certain types of behavioral health conditions and the co- occurring physical health conditions, such as individuals who are experiencing major depression. We also know that persons with mental health issues are more likely to use an emergency room or be hospitalized than individuals who do not have a mental health issue. Now, moving to slide 48. This particular table provides some additional detail related to certain types of physical health conditions and their presence among people who have any type of mental illness. Persons who may have a serious mental illness and then, again, specific to the behavioral health condition of depression, we can specifically add the data related to comorbid physical health conditions. Moving onto slide 49, we've provided, also, from our national surveys on drug use and health data, information related to past year emergency room use, as well as past year hospitalization rates. Again, among adults with some type of serious mental illness. As you can see from this particular data, persons with a serious mental illness are presenting at emergency rooms more frequently for both physical health and behavioral health conditions, and are being hospitalized at greater rate. Moving onto slide 50, this slide presents some information, again, specific to adults related to cost. For both physical health conditions, as well as the presence of one, two, or three chronic health conditions, comparing metal health service users, substance abuse services is, compared to all other

Medicaid beneficiaries. As you can see from this particular cost data, there are important and significant opportunities to be looking at health outcomes and cost for persons with mental health and substance use. On the next slide, slide 51, I wanted to highlight some information specific to children and youth. Again, there are some similarities and needs with adults, but there are some important differences to consider, as part of planning and opportunities. From our data, we know that approximately one in five young people have a mental, emotional or behavioral health disorder and an estimated annual cost of $247 billion. We know that approximately one in every four pediatric primary care office visit involves some type of behavioral or mental health problems that a youth, child or family is seeking support for. We know that about one in every three Medicaid enrolled children who use behavioral healthcare also have some type of medical condition. The data shows primary condition being asthma, but there are a range of other conditions that children also do present with. In contrast to adults, Medicaid expenditures for children with comorbid conditions are not necessarily driven by physical health needs. They tend to be driven more by behavioral health needs. So, it's an important distinction. It makes sense given the developmental trajectory of children, given that many chronic conditions are not yet present in children. So, we do know that while child visits addressing acute care needs and in some instances such as asthma, chronic health care needs are important integrative focuses, areas of focus. It's also important to know that the data shows its behavioral health issues and expenditures that and to drive the Medicaid cost. As such, as planning and consideration for opportunities occurs, integrated care strategies for children need to differ slightly from adults and need to focus more on the social support, community support, positive educational opportunities and success, in addition to physical health care coordination. Moving on to the last slide related to opportunities, to address the needs of persons with behavioral health conditions, new financing models, again, to focus on integrated care for persons with serious behavioral health needs. As the data demonstrates, there are many opportunities to improve both physical health outcomes, behavioral health outcomes and of course, address cost. Additional delivery models to coordinate and integrate those physical health and behavioral health treatment needs with a particular focus on the inclusion of broader social, educational and employment supports. In addition, given the data about hospitalization use and ER use, and emphasis on crisis services, crisis stabilization, mobile outreach teams, are also very important in terms of addressing the healthcare needs of this population. Time on this particular webinar limits our ability to highlight a range of data that we have available on the SAMHSA website, but similar data is available related to persons experiencing substance use and there are significant opportunities to address the needs of persons with substance use disorders, related to their physical health outcomes and their behavioral health outcomes and improving cost in the system. Opportunities need to include or can include a focus on the patient or the client primary needs, inclusion of family and other social support to help reinforce and help them meet their health outcome goals. Finally, as data and outcomes are considered, there is also an important opportunity to include functional outcomes. In addition to looking at physical health outcomes and behavioral health outcomes, such as stability of those particular diagnoses, it's also important to be thinking about stable living situations, success or -- employment opportunities and finally, meaningful ties to the community, to families and to friendships versus social isolation. Thank you.

Great. Thank you, Suzanne. I want to thank all our guest speakers.. Our final presenter will be Aparna Saha, Senior Advisor in the Policy and Programs Team at the Innovation Center. She will preview the upcoming webinars for Round Two.

Thank you, Andrew. Today, we provided an overview of categories One and Two. As many of you have seen, next Tuesday, the 18th, we will provide an overview of Category Three and Four. We would like to also announce the remaining webinars for the series. We will be presenting on the total cost of care and how to achieve lower costs through improvement. We will also provide information on the cost categories in the financial plan and submitting a letter of intent. Next, we will present on performance measures and how to develop an operational plan. We will also host a webinar on payment models and another one on the application narratives and other components of the application. Finally, we will provide technical assistance on submitting an application on the last webinar. The dates and times will be announced on our listserv and website at innovations.CMS.gov. In terms of next steps, letters of intent are due June 28. The LOI, which is a web-based form is currently available online on our website. Please don't wait until the last minute, in case there are issues that arise as you try to submit your LOI. In addition to the LOI, we will provide additional resources on innovation categories, payment models and frequently asked questions. We will post these on the website at innovations.CMS.gov. Please check back frequently. If you have not registered for your Dun & Bradstreet number, please do so immediately. We have heard there may be a lag time to get this number and it is required for submitting your application. Similarly, please register in the system for award management at the website listed on the slide. If there are any questions we were not able to get to today, please do not hesitate to e-mail the team at innovationawards@cms.hhs.gov. With that, I will turn it back to Andrew.

Thank you, Aparna. Next up we will begin the question and answer section of the webinar. Before we get to our first question, there is another important bit of information to emphasize. We are unable to provide you or your organization with feedback regarding proposals or ideas during this procurement sensitive time period. We are also unable to meet with any applicants during this time period. This is to ensure the integrity and equity of this competitive funding opportunity. If you meet with CMS innovation center staff during this time period, you may be deemed ineligible for funding in Healthcare Innovation Awards Round Two. Now, we are ready to begin with the first question. First question reads, the FOA states that models primarily focused on acute hospital inpatient care are excluded from this round and will not be reviewed. Can you clarify?

I'm going to hand this to my colleague Sheila Hanley. Sheila?

This funding opportunity is focused on innovative payment and service delivery models in non-inpatient settings. We expect that proposals falling within any of the four innovation categories may result in improved outcomes and reduced cost in the inpatient settings.

Thank you, Sheila. We will go to the second question. If a proposal projects that most or all savings to the total cost of care will accrue from reduced inpatient cost, due to our proposed outpatient care model, are we still eligible to apply for this round? Sheila, I'm going to hand this to you.

The funding opportunity announcement clarifies that we are not seeking applications that are primarily focused on service and payment reforms occurring in the inpatient setting. If the primary focus of your model is on acute hospitalization, then it does not meet the criteria of the FOA. We do expect that proposals falling within any of the four innovation categories may result in improved outcomes and lower cost in the inpatient settings. Reductions in inpatient cost may be counted in projecting your total cost of care savings.

Great. Thank you, Sheila. Next question. In the FOA it states organizations may apply as conveners that assemble and coordinate the efforts of the group of participants. Can you help us better understand the role of the convener? Aparna?

Sure. Thank you. So, organizations that assemble and coordinate the efforts of groups of participants may apply as a convener. In this case the convener is synonymous with the primary applicant, and will take on direct risk of the award.

Thank you, Aparna. Moving to the next question. Is it advisable for organizations requesting less than $10 million to obtain and submit an external actuarial certification of their financial plan? Aparna, I will give this to you, as well.

Applicants that request less than $10 million in funding are encouraged but not required to submit an external certification. The financial plan must be reviewed and certified by the Chief Financial Officer of the applicant's organization and the Chief Financial Officer cannot be the executive director.

Okay. Moving along to the next question. Will preference be given to applicants to submit an application that cuts across multiple innovation categories? Sheila?

Applicants are asked to identify a primary innovation category in which to be considered, and may use the narrative section of the application to identify other innovation categories that may be relevant to their model. The FOA doesn't indicate either an advantage or disadvantage for proposals that relate to more than one innovation category. Your application will be reviewed against the criteria listed in the FOA.

Okay. Next question going to -- it looks like Suzanne Fields. What does the $247 billion cost associated with one in five youth that have behavioral health disorder entail? Is this spending on mental health services? Or, is it total health care costs for this population? Suzanne?

Yes, thank you. That particular cost references total cost to the system for children. It is not specific to mental health or substance conditions.

Great. Thank you, Suzanne. Moving along. Can the organization that initiates the letter of intent change the AOR and the lead organization for the proposal in the final submittal?

I'm going to aim this question to Christy. Christy?

The name of the organization that submits a letter of intent can be revised in the final application. We just ask that you use the confirmation number assigned when you submitted your letter of intent a when you submit your application.

Great. Next question. Are the dual Medicaid Medicare beneficiaries to be included as a specific category of its own? Or not? Going to turn this over to Sean.

Are dual Medicare and Medicaid beneficiaries included as a specific category on its own? Or not?

They are not specifically identified in the innovation categories in the FOA. However, I would say this is a population that is important to the innovation center and CMS. These are populations that are eligible for this FOA. If your model otherwise fits to one of the four innovation categories and they are the target population, you would be eligible.

Moving along. The next question, the LOI asks for a list of partners. Is preference given to applicants with multiple partners?

Sheila?

Yes. The FOA directs that preference will be given to applications with multiple payer partners.

Great. Another question for you, Sheila. Since the emphasis in this round is payment models, do we have to have a payor involved with our application to CMS?

The applications will be reviewed against the preferences and the scoring criteria in the FOA. The FOA states a preference for strong payer involvement and the requirements for the submission of payment models. The absence of payer involvement may be a factor in the competitive proposals.

The next question. Looking at the relationship between trauma and health presented by Commissioner Samuels, will applications that prevent trauma to early childhood before entry into foster care meet this priority be eligible? Or is the goal to reduce cost of treatment in foster care?

Commissioner Samuels, you want to take a stab at this one?

Sure. Again, our primary interest is recognizing the significant cost for children who have already been maltreated and for a particular set of interventions that are needed to move them back to positive functioning. Beyond that, it's not clear to me that simply preventing maltreatment is, in and of itself, a category of spending where there is significant cost currently going. That's not clear to me that it would qualify. I'm certainly open to a discussion with folks at CMMI on that.

Okay. Thank you, Commissioner. Next question. Is the innovation center interested in projects that are small in scope and population with a model that can be widely replicated? Aparna?

Yes, absolutely. Please submit your application to make the best case for your model and we will consider the application regardless of the size as long as it meets the criteria listed in the FOA

The next question -- can more than one priority area be addressed within one innovation category? We will go to Christy.

Yes. You can address more than one priority area as listed in the funding opportunity announcement within one category.

Great. Thank you. Next question. Please describe the level of detail that is required for the new payment models that must be included in our application. Sheila?

So, all applicants must submit, as part of their application, the design of a payment model that is consistent with the new service delivery model that they are requesting funding for. The payment model design must include Medicare, Medicaid and/or CHIP, though; it should ideally include other payers, as well. The payment model design should include a description of how funds would flow into the model, the description of the specific provider or beneficiary incentives the payment model would create, a description of risk parameters, the description of how the payment model would deliver, a positive return on investment for CMS and a description of how the parameters of the payment model would progress over time. Those are listed in the FOA. We also would remind you as Aparna mentioned a few minutes ago, we will be having a specific webinar on the payment model with additional information.

Great. Thank you, Sheila. Moving to the next question. At what point must the new payment system be in place from inception of the three-year period? Or what period of time, exactly? Sheila?

Sure. So, applicants must submit the design of a payment model as part of their application. Applicants have the option to submit, as part of the application, a detailed and fully developed payment model, as well as a list of payers interested in testing the new payment model and the service delivery model. However, there is no assumption that a model would be operationalized within the performance period.

Okay. Thank you. Moving along, we will go to Christy for this one. On page 11 of the FOA, it is stated that the metrics will be jointly developed by awardees and CMS. How do applicants include a list of measures up front in the application? Christy?

Sure. We will be covering this later in future webinars for the application. One of the supplemental materials is operational plans, which include the measurement section and it allows you to pick the measures from an approved CMS list, as well as stipulating your own measures. In addition to the application, there is a narrative around that. There are a couple places for you to describe the measures you will include in your application.

Great. Moving along. Another question. The LOI instructs that one category be selected, but in prior webinars, we were told that all categories could be addressed in a strong application. Could you please clarify?

Sure. In the letter of intent, we do advise you to select the one best answer for your project in terms of the innovation category. However, in the application you will be able to select a secondary category, so that you can describe the full scope of your project. In order to get information on the type of project, we are asking for a single entry on the LOI.

Okay. Next question. If a proposed project includes -- sorry about that -- if a proposed project includes incentive payments to providers to change behavior, should the funding request include an estimate of the total amount of estimated incentive payments?

The answer is yes. Your budget should include all expenses that are not otherwise billable to Medicare, Medicaid or CHIP, including that. We would caution that any time we are providing payment such as this, people should be aware of applicable Federal program integrity fraud and abuse laws. Thank you.

Okay. Next question. Do both companies intending to partner on a proposal need to file an LOI?

Organizations can submit multiple proposals, provided they submit a separate letter of intent for each proposal. However, if two companies are partnering on one project, only one letter of intent is needed for that application. One organization will take the lead on the proposal and be identified as the primary applicant and others will be considered as partners to that application.

Thank you, Christie. Another question. Will CMS provide a list of recommended financial actuaries? Aparna?

CMS will not provide a list of recommended financial actuaries. However, the actuary must be a qualified member of the American Academy of actuaries.

Quite a few questions coming in. Next question. Is there a certain amount of money allocated to each category? Christy?

No specific amount of funding has been allocated to any category, at this time. CMS estimates that there will be approximately 100 awards with the range of approximately 1 million to $30 million per award. CMS is not obligated to fund the minimum number of applications, nor are we required to distribute a minimum amount of funds available for the second round of the healthcare innovation award.

Thank you, Christie. Next question. What if we don't have multiple payers signed on at the submission of our application? Sheila?

Applications must include a feasible approach to securing participation of multiple payers for their proposed payment model. We will be giving preference to applications that include participation by non-CMS payers at the outset of the model's implementation.

Okay. Another question. I know that you can to see funding for any model being tested under another CMS initiative. But, if you are expending a model funded under round one to reach a different population and add major new components, would that be acceptable?

Yes. Expansion of a model funded under round one to reach a different population and with major new components would be considered eligible. We would draw your attention, though, to the FOA and the deciding, official criteria, which include the range of service delivery and payment models proposed and the fit with the current CMS portfolio and encourage you to make your strongest case.

Thank you, Sheila. Based on the letter of intent, can a potential proposal serve as multiple insurance status types? For instance, could a proposal be directed towards both Medicaid and uninsured customers? If so, is there a threshold for the percentage that must be CMS beneficiaries? For example, what are proposal that contains 55% Medicaid recipients and 45% uninsured be acceptable?

Aparna, I'm going to hand this to you.

Sure. Proposals may indirectly benefit patients other than those covered by Medicare, Medicaid and CHIP. However, CMS funds are to be used to directly support Medicare, Medicaid and CHIP beneficiaries. CMS understand that some investments made to benefit the Medicare, Medicaid and CHIP patients may have spillover benefits to other patients. If a proposal specifically targeted other populations, CMS would want to see if other payers are contributing proportionally to the cost of the model. We do emphasize that an intervention or proposal that directs funds explicitly towards non-Medicare, non-Medicaid and non-CHIP patients is not allowable.

Thank you, Aparna. Next question. Regarding scope. Is the innovation center interested in projects that are relatively small in scope, population served, but with a model that can be widely and successfully replicated?

Sure. I'm sorry; I think we already went through that one. Yes. We will be looking at applications that are small in scope, as long as the can be replicated and adhere to the criteria in the FOA. We don't have a bottom threshold on the size.

Great. Thank you for that. Moving along. Next question. The letter of intent form -- excuse me, the letter of intent form asks for list of partners. Is preference given to applications with multiple partners?

I think we already answered that one.

In response to the question, yes, preference is given to applications with multiple payer partners.

Next question. Can you please define SMI?

Suzanne, can you take this one?

Certainly, I can. SMI stands for serious mental illness. Other terms for children would be specific to serious emotional disturbance. There are definitions for both of those within the public health service act. Those definitions can be found at our website, SAMHSA.gov. For both SMI, for serious emotional disturbance and children, as well as a definition for substance use disorder. Again, the website is SAMHSA.gov.

Thank you, Suzanne. All right. So, we are starting to run short on time. With that being said, we are going to have to wrap up the question and answer segment of the webinar. Before we do that, I'm going to hand it over to Sheila for a closing statement. Sheila?

I just want to end by thanking our colleagues from CMS and HHS for joining us for today's webinar, as well as all of you who have taken the time to join us this afternoon. We appreciate the important work

that you are doing to transform our health care system and we look forward to receiving your innovative proposals and ideas to address the innovative categories that we've discussed this afternoon. Thanks very much for joining us today.

Thank you, Sheila. This concludes the question-and-answer session of the webinar. We ask the attendees to please fill out the participant survey accessible via the link appearing now through their webinar portal. We value participant feedback throughout the webinar process. The CMS innovation center will host additional webinars related to specific aspects of the healthcare innovation award round two application process. We encourage all potential applicants to sign up for the CMS innovation center list serve on our website to stay abreast of the latest webinar announcement dates and details. Thank you all for attending today and have a good afternoon. Goodbye. [Event concluded]