Health Care Innovation Awards Round Two – Overview of Categories Three and Four

Webinar Transcript

Thank you and good afternoon. This is Andrew Rushton from the CMS innovation Center and I will be serving as the moderator for the webinar for the Healthcare Innovation Awards Round Two with a specific focus on Categories Three and Four. Before we proceed there a few housekeeping items to address.

This item is being recorded and Power Point slides and a transcript will be posted to the CMS Innovation Center 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@CMS.HHS.gov or call 202-690-6145.

Furthermore, it should be noted that the comments made on this call are offered only for general informational and educational purposes. The Innovation Center comments are not offered as and do not constitute legal advice or legal opinions and no statement made on this call will preclude federal agency and/or law enforcement partners from enforcing any and all applicable laws and 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 main purpose of today's webinar is to focus on category three and four of the Healthcare Innovation Awards Round Two. Subject matter experts will be presenting information relevant to Categories Three and Rour, in addition to being available to answer questions.

I will provide a brief overview now for attendees of today's webinar agenda. After my remarks Sheila Hanley, group director of Policy and Programs at the Innovations Center with an extensive background in private sector delivery and payor organizations prior to joining CMS, will discuss the goals of Round Two.

Dr. Jeff Clough of the Patient Care Model Group at the Innovation Center will join Sheila to review Innovation Category Three and following them will be Naomi Tomoyasu, Deputy Director of Prevention and Population Health Care Models Group at the Innovation Center who will kickoff the Category Four presentation. And Deputy Assistant Secretary for Health Science and Medicine at the US Department of Health and Human Services, Anand Parekh, will be joined by Peter Briss, Medical Director of the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control. Christy Meyer, Program Team Leader for the Healthcare Innovation Awards at the Innovation Center will provide technical assistance for the letters of intent submission process.

Immediately following the presentation categories a question-and-answer session will conclude the webinar. During the session questions will be only be accepted through a box entitled submit your questions that is located in the lower left of your computer screen. Please note that no questions will be accepted by phone. If you have questions that we are 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 these webinars through the Innovation Center website and listserv, and with that I will now turn it over to my colleague Sheila.
Sheila Hanley

Hello everyone and thanks for joining us this afternoon. This is the third in a series of eight webinars we're offering to support applicants for the Healthcare Innovation Awards Round Two. I am Sheila Hanley with the Healthcare Innovation Awards team and I would like to begin by providing you with a brief overview of the objectives of the Health Care Innovation Awards. For those of you who have attended our prior webinars, the discussion on the first few slides of today's webinar will be a bit of a refresh of information you may have heard previously but for the benefit of those attending for the first time this afternoon, we want this information to be available to everyone interested in Round Two of the Health Care Innovation Awards.

As you know, the mission of the Innovation Center is to test innovative payment and delivery models with the objective of reducing expenditures under Medicare, Medicaid, and the Children's Health Insurance Program. CMS appreciates that there is extraordinary innovation and transformation occurring in delivery systems throughout our country.

The Healthcare Innovation Award is designed as a partnership with innovators in the field to collaborate and test new service delivery and payment models that hold promise for achieving better care at lower costs for Medicare, Medicaid, and CHIP beneficiaries. In our first round of the Healthcare Innovation Awards announced back in November 2011, we funded 107 tests and selected those with the greatest chance of delivering better care at lower costs and the greatest chance of creating larger scale sustainable results. These interventions have begun to impact care and cost across a broad cross-section of services in all 50 states and the District of Columbia and Puerto Rico. In Round Two of the healthcare innovation awards, we hope to build the best innovations occurring in the field and to do so targeting priority areas and key categories.

The objectives of Round Two of the Innovation Awards are to expand the partnerships with innovators in the field so we can identify new payment service delivery models in Four Innovation categories and to develop a clear pathway to new Medicare Medicaid, and payment models for these service delivery models. We will be awarding close to $1 billion to applicants that develop models that drive down costs using creative solutions to our most pressing healthcare challenges and that have the potential to serve as blueprints for improving care and lowering costs across the country. As in the first round we are seeking to engage a very broad cross-section of healthcare stakeholders including hospital systems, integrated systems, and physicians and others in multispecialty groups, including large and small providers of all types in business communities, academic and research organizations, labor and other eligible organizations interested in working with us to achieve better care at lower costs.

Round Two of the Healthcare Innovation Awards focuses on supporting innovative models in four categories. These areas were chosen to address gaps in our current Innovation Center portfolios and areas we believe can result in potentially usable models for change and how Medicare and Medicaid pay for services. The four categories are: models that rapidly reduce costs for Medicare and Medicaid beneficiaries in outpatient or post-acute settings, models that improve care for populations with specialized needs, such as children in foster care and people living with HIV/AIDS, models that can transform financial and clinical models for specific types of providers and finally 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 last two innovation categories.

In addition to our Innovation Center team, we are fortunate to have with us today colleagues from the Health and Human Services Department and the CDC who are subject matter experts. Our speakers will be providing contextual information including a brief explanation of the category of priority areas, high-level descriptive information about the priority areas, and the rationale for why we are seeking innovation in these areas.

We will measure the success of the projects that we select based on the ability of these initiatives to improve care, rapidly reduce cost, rapidly transform clinical models, and improve population health status. We are looking to you in the field for true innovation and service delivery and payment approaches and to invest in new business models that will help us to achieve these results.

As we provide examples of types of services, provider delivery systems, and payment issues throughout the webinar this afternoon, please be mindful that the examples described in today’s webinar are illustrative only and not intended to convey a preference or preferred approach. Also applicants will be asked in the application to identify a primary innovation category. Applicants have the option of using narrative sections of the application to describe how the model may impact other categories in priority areas if they choose to do so.

We also want to remind you that to support sustainability of their intervention, applicants will be asked to propose a payment or business model to support their proposed service delivery model. We would like to jump in now to a discussion of Category Three.

Category Three is seeking innovative approaches that will transform the financial and clinical models for specific types of healthcare providers and suppliers and we are interested in testing approaches that will quickly transform the way services are delivered and paid for by specific types of providers, including specialties such as oncology, cardiology, and pediatric providers that provide services for complex medical issues. The reference to oncology and cardiology is intended to be illustrative only and we are interested in testing approaches for all physician specialty types. We also want to underscore the language that states that CMS will consider submissions in other areas within this category and from other specific types of non-physician providers. All provider types are welcome to apply. Also in this category and priority area the FOA states that we are interested in models that include shared decision-making mechanisms that engage beneficiaries and their families or caregivers in treatment choices

So why did we choose to focus on the provider specific models identified in category three? We believe there are provider organizations of all types that are eager to transform healthcare payment and delivery and to work with us to test new approaches. Bringing down health care costs is a top priority and the specialty areas account for a large proportion of healthcare needs and costs and there is a clear need for investment in broad scale delivery system transformation. Geographic variation also represents an opportunity with widely recognized differences in utilization outcomes and delivery models. We are also seeking to complement the current portfolio which is better developed a primary care and inpatient focused models. I would like to introduce my colleague Dr. Jeffrey Clough also from the Innovation Center who will provide you with more details on category three.

Thank you, Sheila. Included in the slide is a list of potential components of category three models. This is not intended to be a required list or an exhaustive list but a set of example components. Category three models are expected to result in transformation of the payment of service delivery models for a provider or a group of providers. Category three models should promote comprehensive care of patients in coordination with other providers, particularly primary care providers who may or may not be a direct participant in the application. Category three models include shared decision-making mechanisms and other strategies that promote patient centered care. Category three models should promote evidence-based care with mechanisms such as appropriate use criteria, diagnosis and management pathways and clinical decision support tools. Category three model should include outcome data and provide rapid cycle feedback to providers in order to facilitate ongoing quality improvement.

The first priority area for category three is specialty and subspecialty models. This is a broad category and a consistent theme is that the model should address a large enough proportion of provider services to promote transformation of the delivery and financial model for that provider. This may require the involvement of multiple payers and should address high-volume services delivered by providers. Physician and nonphysician providers such as psychologists, nurse

practitioners, physical therapist, as well as multispecialty groups are encouraged to apply. Examples of models in this area would include models that promote evidence-based care for an ambulatory episode of care and models that broadly address all services in a specialty area. Some examples of the issues and opportunities for category three models are models that may improve the degree to which services are evidence-based and consistent with patient preferences. These models may address preventable complications of an illness or a treatment. These models may reduce utilization of high cost sites of care when equally efficacious alternatives exist.

The second priority area for this category is pediatric providers targeting pediatric patients with complex medical issues. Examples of complex medical issues are multiple medical conditions, behavioral health issues, congenital diseases, chronic respiratory diseases and complex social issues. Examples of models are those that target care for a specific pediatric condition. Other models may apply to a broad set of services delivered by a specific type of pediatric provider. This would also include models such as accountable care organizations, medical homes which promote comprehensive and coordinated care for this population of patients. Examples of payment service delivery issues to be addressed by this category are lack of integration and coordination across settings, unnecessary or inappropriate use of specialists to provide primary care services and a more specific example is fragmentation of services provided by physical and occupational therapists and developmental psychologists.

In contrast to the Healthcare Innovation Awards First Round, the Second Round requires applicants to propose a payment model. A future webinar will further address the types of payment models, components of the payment model, and a description of a fully developed model. Included is a list of example payment models that may be particularly relevant to category three. These include models such as a bundled or episode-based payment, capitation, contact capitation and pay for performance, per capita care management fees with gain sharing, Value-based payment schedules, hybrid models, and then any other innovative payment model which supports the service delivery model that is being proposed.

Thank you. Next, the Deputy Director for the Preventive and Population Health Care Models Group at the Centers for Medicare and Medicaid Innovation Center will go over population health and prevention efforts.

Dr. Naomi Tomoyasu, Deputy Director of the Preventive and Population Health Care Models Group:

Thank you. Good afternoon everyone. I'm very excited to introduce today's presentation on population health, the fourth category in the second round of the Healthcare Innovation Awards. This is truly a momentous occasion.

In this round, the Innovation Center will be seeking innovative and exciting models, which focus on improving the health of populations by targeting areas of need that may be underrepresented in our current portfolio of model tests.

We are especially looking for a mix of population health models that represent the onset of a chronic condition or reduce the prevalence of chronic conditions that impact the community or region, as well as models that slow the progression of chronic conditions. Prevention models may include community-based organizations and may involve community health improvement efforts.

These models, however, must have a direct link to improving the quality and reducing the cost of care for Medicare, Medicaid, or CHIP beneficiaries. Today's webinar on population health will describe the priority areas solicited and I am very excited to introduce our guests: the Assistant Secretary for Science and Medicine for the Department of Health and Human Services, and the Medical Director for the National Center for Chronic Prevention and Self-Promotion at CDC.

Dr. Anand Parekh is the Deputy Assistant Secretary for Health at the U.S. Department of Health and Human Services. In this capacity he provides oversight, direction, and coordination of activities pertaining to a range of emerging public health and science issues in the continuum of medical research, including but not limited to clinical science and health services research.

Specifically, he has provided leadership on a variety of health issues, including quality of care improvement, chronic care management, and disease prevention. He served as the first acting group director of the Population Health Care Models group in 2011 at the Innovation Center.

We are fortunate to have Dr. Parekh joining us to present on population and preventive health. Our second presenter is Dr. Peter Briss, the Medical Director of the National Center for Chronic Disease Prevention and Health Promotion. As many of our current innovation awardees know, he is a friend and colleague who has presented on several occasions in our population health webinar series this year. In addition, he has participated in a broad range of cross disciplinary research and services. He has been involved in evidence informed practice programs, evaluation policy analysis, systematic reviews, and research translation. He has applied these interests across a broad range of health and behavioral topics, ranging from healthcare to community prevention, and has participated in public health teaching practices and research at the state and federal levels in the US and internationally. Without further ado, I would like to introduce Dr. Parekh who will begin the webinar with an overview of population health to be followed by Dr. Peter Briss who will address specific priority areas within population health.

Dr. Anand Parekh, Deputy Assistant Secretary for Health at the U.S. Department of Health and Human Services:

Thank you for the introduction. It is great to be with all of you today. We are excited to see the interest and the enthusiasm around population health, and I want to acknowledge the Innovation

Center for hosting this important webinar. The agenda for this portion of the webinar is to briefly provide context for the Innovation Center's interest in population health and to provide an overview of the opportunity in this area. This will be followed by a more in-depth discussion of the priority areas under population health listed in the Funding Opportunity Announcement.

We will start with some level setting. There are, as many of you know, a variety of definitions of population health – one of the most well-known definitions was published in the American Journal of Public Health in 2003: the health outcomes of a group of individuals, including the distribution of such outcomes within the group." This definition includes health outcomes, health determinants, policies, and interventions that link them along these lines.

With the intent to be broad and inclusive, the Funding Opportunity Announcement focus on Models that improve the health of populations – defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class (particularly groups that are vulnerable to poor health outcomes) – through activities focused on engaging beneficiaries, prevention (for example, a diabetes prevention program or a hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery setting. This last point is a key overarching theme of this category.

The Innovation Center recognizes population health as reflected in Healthy People 2020, the Nation's health objectives framework, as optimal health that is predicated upon the social determinants of health. Healthcare is but one health factor, but rather there is an array of other factors from socioeconomic factors to the physical environment that could impact overall health.

All of these factors or determinants directly or indirectly lead to improved health or improved well-being by impacting diseases and behaviors in the U.S. These behaviors are impacted through reducing disease and reducing unhealthy behaviors through upstream or downstream activities that will be able to achieve optimal health or better health. If that weren't reason enough to focus on prevention, consider the fact that reducing disease and reducing unhealthy behaviors should also have an additional benefit— lower healthcare costs.

Using Medicare as an example, the principle can also be extended to Medicaid, the rising prevalence of chronic diseases are a key factor in the growth of Medicare spending and two out of three Medicare fee-for-service beneficiaries now have two or more chronic diseases. This accounts for close to all of Medicare spending and one out of seven Medicare fee-for-service beneficiaries have six or more chronic diseases, accounting for half of Medicare spending. In addition, internal analysis has revealed that when comparing per capita costs per Medicare beneficiaries with a particular condition, such as individuals with hypertension versus without hypertension or with a condition such as COPD versus without, there is a difference in average program expenditures which illustrate the hefty financial burden of chronic diseases on the Medicare program. In addition, achieving better chronic disease control should help control costs.

Category four focuses on improving population health through prevention. There are a number of ways the Innovation Center has laid this out in the Funding Opportunity Announcement. For

example, by reducing unhealthy behaviors such as tobacco use, inactivity, and poor nutrition while simultaneously encouraging self-management there are an array of evidence-based research that community self-management programs improve outcomes by enhancing care management.

For example, there are many areas for innovation priority areas, such as by assuring medication adherence and by preventing falls, which Dr. Briss will further discuss. Finally, a few additional points to keep in mind as one considers applying for an award in this category: clinical community health integration is a critical theme, and the Innovation Center seeks proposals for models that link clinical and community services, in which clinical and community health and public health stakeholders work collaboratively.

Recently multi-stakeholder entities, called Health Outcomes Trust, have been mentioned as a means to achieve accountable health in the community. This example includes population health and ACO's simply beyond providing preventive care and care management for their patients and actually reduce prevalence of unhealthy behaviors and incidence of disease by partnering with public health and community stakeholders. The Innovation Center welcomes testing of models such as these that link the clinic and community. Second, beneficiary engagement is an important element of this category particularly focused on shared decision-making, self-management, and value-based benefits such as incentives for beneficiaries to engage in healthy behaviors.

Applicants will need to keep in mind that although a number of population health interventions which improve outcomes exist, sustainability and payment model design is also required of the successful applicant. Innovation Center staff can discuss this in more detail, but cost savings are expected of applicants and identifying metrics for better health is not always a straightforward task.

Applicants have an opportunity in this category to aggregate various types of data from various sources to demonstrate improvements of population health. The Innovation Center looks forward to working with successful applicants and measuring population health improvement. At this time I will turn it over to Dr. Peter Briss, who will go into greater detail around each of the priority areas for the preventive category listed in the Funding Opportunity Announcement.

Dr. Peter Briss, Medical Director of the National Center for Chronic Disease Prevention and Promotion:

Good afternoon. I am delighted to be here, and am delighted by the level of interest in population health represented by the numbers of people that are participating in this webinar. You have heard of this Funding Opportunity Announcement with five priority areas: prevention of hypertension, diabetes, COPD, HIV/ AIDS and fall prevention of older adults, behaviors that reduce the risk for chronic disease adherence, self-management skills and broader models that involve community care based interventions? These areas represent significant drivers of public

health, pose burdens and costs to the health care system, and because current effective interventions are available but underused. Crosscutting interventions can importantly influence these major drivers and cost, and all these areas emphasize the need for clinical and community linkages. These important issues are unlikely to be fully addressed by working only within the walls of the health care system. This talk is intended to provide you with background information, from public health subject matter experts, on potentially useful strategies that relate to priorities in the FOA and are thought to be positively related to health improvement and cost savings. As Sheila Hanley has already said, we are not presenting a complete universe of delivery options and we are not presenting scoring priorities, which are not intended to relate preferences in terms of scoring.

I will begin by walking through the priority areas. First we will talk about some promising interventions related to cardiovascular disease. At first I should say, among the many drivers of cardiovascular disease, the one that is most likely to generate the greatest health improvement is control of high blood pressure. There are a number of interventions and healthcare systems, including clinical decision support and associated interventions like reminders, risk assessment, behavior change recommendations, and optimization of care that can generate improvements in addition to electronic health records, which generate a patient list of identified people who are undiagnosed enabling providers and healthcare systems to target this population in interventions.

There are also a number of interventions focused on blood pressure control that can better link clinics and communities. These can include interventions in communities and other settings that use pharmacists, nurses, and allied healthcare professionals to improve blood pressure control. These can include risk assessment, feedback, education, referrals, work sites and other community settings. These can also include increased used of self-measured blood pressure monitoring with appropriate support, as well as clinical and community integration, technology infrastructure, and telemedicine service. For example, linking health information systems to track prescriptions can improve adherence.

A similar list of clinical and community linkage interventions can be deployed to address diabetes and other high burden target areas. Again, these healthcare systems, communities, and public healthcare systems can identify people at risk and enroll them in diabetes prevention programs. These are programs that improve lifestyle risk behaviors and have been shown to reduce the onset of diabetes and diabetes related costs and, as with hypertension examples, they can be delivered outside traditional healthcare settings by allied health professionals and nurses.

In addition, programs within community settings have deployed risk assessments as part of the interventions such as home-based glucose monitoring healthcare-based interventions. Other evidenced based interventions have involved smoking cessation services to persons with asthma and have included family members as needed. Population-based services can also be linked. These can include community level interventions that trigger reductions in particularly high prevalence, high need, or low socioeconomic status communities. For example, you can include interactive asthma self-management training in schools and day care facilities in the community setting, culturally appropriate home visits and assessments for individuals who are poorly

controlled for various chronic conditions, as well as support services to address social determinants of health and coordinated care across healthcare settings. Interventions to address pulmonary disease can include many of the approaches that I mentioned, and other areas addressed could include tobacco cessation information, chronic disease self-management training, and clinical decision support.

To prevent falls in the elderly, some tools that could be utilized include the use of incentives and reimbursements to primary care providers and other health professionals to integrate education, risk assessment, treatment, and referral into routine clinical practices, incentives and reimbursements to community pharmacists to address potential drug interactions, and continuing medical education for healthcare providers about medication management. In addition, programs that include annual eye checks and eyeglass prescriptions, evidenced-based fall prevention, community-based exercise programs, home modification programs and vitamin D have been shown to be promising strategies and approaches.

For example to encourage tobacco cessation, you have a number of known effective promising strategies that you can select from. These can include individual group telephone counseling, the use of approved medications for smoking cessation as well as better counseling. Although medication and counseling each alone is effective, when they are combined there is an increased potential for greater effectiveness and promote a broader reach, especially in diverse populations.

Comprehensive services can also be used to increase quit rates and improve health outcomes. In addition you can support the use of effective tobacco control practices by integrating interventions into routine clinical care using tools such as provider reminder systems and clinical decision support using electronic health records. To promote physical activity you also have a number of available healthcare interventions, including provider assessments with physical activity encouragement of patients to increase their levels of activity and referrals to programs in the community.

In addition, healthcare provider counseling and referrals to qualify community resources can be utilized. Multicomponent communitywide campaigns, such as mass media and community events, and promotion of places for physical activity, such as walking trails and bike paths and social support like group walking programs and buddy systems, can be utilized to facilitate behavior change. Multi-component strategies in schools and other settings that increases the amount of time spent in physical activity and transit are all useful parts of the puzzle as well.

For obesity, there are a number of strategies to promote better clinical linkages. Training in using community health workers to link health care public health sectors to support and educate patients about healthy lifestyles can be utilized in numerous settings. In addition, a strong reliable referral systems for primary health care, community resources, and the engagement of primary health care providers with local and state health departments and other stakeholders to develop and support environments that support patients and their families in making healthier food and physical activity choices.

Thank you very much. The final presenter will be Christy Meyer, the program lead for the Healthcare Innovation Awards and she will provide technical assistance for the letters of intent submission process to the Healthcare Innovation Awards Round Two.

Christy Meyer

Thank you. Applicants may access a letter of intent on the Innovation Center website. There is a direct link to the letter of intent on the website which is a web form. You will not need a login ID or password.

However, you must complete and submit the letter of intent in one sitting. You will not be able to return to it to complete a partially completed LOI.

The letter of intent contains three sections. Section A is the organization information, a project summary. Section B contains a description of your intervention. In section C is a description of the population. Not all fields of the letter of intent are required but are noted with an asterisk. On the letter of intent instructions you will see one of the first links as a user guide has a description of all of the fields and some helpful hints you'll want to take a look at that guide before beginning your letter of intent.

Also please note the due date and time on June 28, next Friday by 3 PM eastern time. You want to make sure to try to submit your letter of intent in advance of that due date due to the high volume that we expect.

You want to include the contact name for someone that can address questions about your project. It could happen that the name of the person or the organization may change in the application phase and that is acceptable as long as you use the same letter of intent number you will receive at the end of your LOI submission.

Innovation category of priorities is an important component of the letter of intent. For purposes of the letter of intent, we are asking you to choose the one that best fits the innovation category for your project. At application phase you will be able to select a primary category and also talk about other categories in the narrative that may apply to your project.

We also want you to select priority areas that were mentioned today that will apply in the application. Please note that specific priorities align with specific innovation category so if you select model category one, you also want to select priority areas that align with category one. Once all of the fields have been completed you will want to submit and print your application. There'll be a button at the bottom to do so. Once that is completed you will receive a PDF file that contain the LOI number that is required for application phase. In addition, in the letter of intent,

applicants will receive an automated notification that will include a confirmation number. Be sure to retain this information as you will need it in the application.

A few other helpful hints we wanted to pass along on the letter of intent. There are several fields that require one best fit answer. You have more flexibility in the application to describe your project but for the purposes of the letter of intent please do your best to select the one best fit answer. Some of the available options may not fit your project. For example this may occur in the clinical condition field or the type of organization. If you don't see an option that best fits for you please select other and a box will pop up that allows you to describe your clinical condition and the organization type. Several fields have data validation rules so the number of states and population type require that they add up to the total. So if you select 5 states we want to make sure you're checking off each of those five states in your letter of intent and finally, we acknowledge the letter of intent represents estimates only and your final on the application will vary. We are not checking specific eligibility rules in the letter of intent but we need to make sure you have a letter of intent submitted. There could be some variation in application. So for support we want to refer you to the instruction guide on the webpage. We suggest reviewing that in advance as well as a funding opportunity announcement to make sure you have all of the information you need to complete the LOI in one sitting. If you have any question, the frequently asked questions are available on our website. Any other questions you have can be addressed to the innovation e-mail box, innovationawards@CMS.HHS.gov.

For today's presentation we will wrap up with some next steps. This Thursday we will be having our next webinar series, webinar 4 around achieving lower-cost for improvement. We will go through the financial plan that is covered in our supplemental application materials and this will be important to demonstrate how applicants can achieve lower cost and describe the cost category in the financial plan and what we mean by total cost of care.

Please also check our website and our listserv e-mails for future webinar announcements as we do have several more planned. Finally as a reminder, letters of intent are due by 3 PM on June 28, 2013 eastern time.

The LOI is available online through our website and it is important also that you take steps to prepare for the application submission by registering for your DUN number as well as registering in the system for award management. We cannot stress enough how important it is to start these activities right away. Make sure you are submitting your application well in advance of the deadline because of the volume we expect. We want to make sure you are not hindered by any system issues so if you are intending to apply take the necessary steps to apply in advance and if you have any questions e-mail our innovation awards mailbox at innovationawards@CMS.HHS.gov.

Great, thank you. Before we move on to the question and answer segment I just wanted to thank our stakeholders for their feedback as we understand there were some technical issues experienced by some when registering for the next webinar which is on Thursday. We were able to remediate the issue. We sent out a reminder e-mail late this morning and we also have the

correct information posted on the webpage on our website for Thursday's webinar so we appreciate everyone's patience and hope that everyone who is joining us for this webinar will sign up for the one on Thursday.

As we move along we will begin with a question and answer segment of the webinar. Before we get to our first question, there is another important bit of information that we want to emphasize. We are unable to provide you or your organization with feedback regarding proposals or ideas during this procurement sensitive time. We are also unable to meet with any applicants during this time. This is to ensure the integrity and equity of this competitive funding opportunity. If you meet with any Innovation Center staff during this time you may be deemed ineligible for funding of the Healthcare Innovation Awards Round Two.

Q&A

With that we are ready to begin with our first question. First question reads, if we plan to propose two different service delivery models, do we need to submit two separate LOI's and two separate full applications. Christy?

Yes, if the organization intends to propose different service delivery models we ask you to submit a separate cover-letter of intent for each model proposed.

Thank you. Okay. Can proposers asked for claims data to help with their applications?

During the application process we cannot make individual claim data available. However, during the round two webinar that will be forthcoming we will direct applicants to various publicly available sources online for cost estimates that may be obtained. Once awards have been made there will be an opportunity to receive Medicare fee-for-service data through the program. It is important to note that there are cost limits to the amount of claims data we provide applicants. Applicants should have an alternative plan for obtaining needed data to support their projects.

Thank you.

Moving along, how many Medicare, Medicaid, and CHIP beneficiaries should models propose to serve if the proposed project directly or indirectly improves the quality of care and lowers cost for an additional population? Going to turn to my colleague for this one.

Thank you. No specific number or specific percentage of Medicaid, Medicare, and CHIP beneficiaries are required; however, the project should be designed so the interventions contribute to improving the health and lower total cost of care for the CMS population.

Thank you. Moving along to the next question, if CMS is giving preference to models that reduce costs in six-month how is an applicant considered if their prevention models have longer ROI, potentially beyond the three-year period?

We recognize that some models may be able to generate ROI's for Medicare and Medicaid in a shorter timeframe but please remember that CMS is looking for a final portfolio of awards with representation from all four categories. Therefore we encourage applicants to submit prevention and wellness models for consideration.

Can LOI's be saved as a draft before it is submitted?

No unfortunately, it cannot be saved as a draft. We ask you to complete it in one sitting and to plan ahead so you can prepare your answers ahead of time before you complete the LOI.

Terrific.

Okay. Another question reads, if the agency does not have a person titled as a CFO, how should we proceed regarding the certification or approval of the payment model? Jim?

Individual submitting the financial plan need not have a title but should be the organization's senior officer responsible for financial matters.

Thank you. Next question, how will the LOI be used in the application evaluation process. For example, how complete does it need to be if we have partners we are engaging right now who have not signed up yet; is it a problem in the LOI?

The letter of intent is used to understand the type and number of applications we are expecting. We understand it will not reflect in many cases the final application and there are no specific eligibility requirements we are looking for in the letter of intent but it is required that you submit one for your application.

Thank you. Next question Is it preferable for an applicant to propose a model that focuses on primary prevention or secondary prevention?

CMS is looking for a portfolio of awards including both primary and secondary prevention strategies. CMS will not fund proposals that are duplicate models of CMS or other HHS initiatives. As many are aware there are ongoing initiatives across HHS in secondary prevention such as an diabetes and smoking cessation. We ask that your organization familiarize yourself with ongoing initiatives through the HHS website and propose a model that is different from ongoing initiatives.

Thank you. Okay. Next question. Can an organization submit two different proposals and if so does it require separate letter of intent document?

Organizations may submit multiple proposals provided they submit a letter of intent for each proposal. So for every model you want to submit a proposal for, make sure you fill out a separate letter of intent.

Thank you. Our next question, I'm going to hand it over to Christie, are Indian tribes eligible to apply for Health Care Awards Round Number Two?

Yes, tribal governments and organizations are eligible to apply for the second round of the Healthcare Innovation Awards.

Great thank you.

Okay. Next question. Can you confirm must a project address all three programs Medicare, Medicaid and CHIP beneficiaries or can they focus on just Medicaid and CHIP for example?

They must address any one or more of these programs.

Okay thank you.

To document improvements to population health would you include rural populations in that category?

Sure. Yes proposals and can include a rural population.

What is the difference between models designed to serve patients with special needs and models designed to serve populations including populations with special needs, for example, what is the difference between models designed to serve people living with HIV as patients with special needs and a model designed to serve a population with beneficiaries living with HIV? I'm going to hand this over to Sheila.

The primary difference-- models that include populations with specialized needs are expected to be primarily focused on the clinical care of an individual patient while models that improve the health of a population should be focused on engaging beneficiaries in prevention ,wellness and caring -ways that extend beyond the care of an individual patient and a clinical service delivery setting.

Is there a certain amount of money allocated for each category?

No specific amount of funding has been allocated to any category at this time. We estimate there'll be awards within the range of $1 million to $30 million; however, CMS is not obligated to fund a minimum number of applicants or to distribute a minimum number of funds available in the second round.

Next question reads- will proposals be considered that impact other populations other than that impact current enrollees in Medicare, Medicaid, or CHIP and I will hand this over to my colleague Sheila.

Proposals may indirectly benefit patients other than those covered by Medicare, Medicaid, and CHIP; however, they must directly target and benefit Medicare, Medicaid, and CHIP beneficiaries. CMS cannot allow expenditures that do not directly benefit Medicare, Medicaid, and CHIP beneficiaries. Great. Thank you.

Okay another question. This one is regarding the FOA. Since CMS is not going to fund proposals of duplicate models that are currently being testing and other initiatives being investigated elsewhere in HHS, will a list of all initiatives be made available to applicants so they know the models to be excluded from testing?

A list of Innovation Center initiatives can be found by visiting the innovation.cms.gov website. We encourage you to visit the HHS website and other agency components, such as AHRQ, for more details on initiatives currently being investigated.

Thank you. Okay our next question, if CMS is giving preference to models that reduce costs within six months, how may applicants be considered if the prevention models with longer ROI's potentially beyond the three-year award timeframe. Sheila?

We recognize that prevention and wellness models may take longer to generate ROIs and that other innovation categories may be able to generate ROIs sooner. We encourage applicants to submit their prevention models for consideration.

Okay will LOIs be reviewed for meeting the basic criteria for applications and will parties be notified if the proposed demonstration does not meet the criteria for round two prior to the start date?

Thanks. We do not provide feedback; letters of intent are as they are submitted, so there will not be a notification if the proposed project does not meet a certain criteria.

Great, thank you.

Our next question, category three-- you mentioned oncology, cardiology, etc. what about psychiatry and behavioral health and primary care? I'm going to turn it over to Jeff for this one.

Just as a reminder those specialties that were mentioned were for illustrative purposes only. We will be accepting applications for all types of specialties, including those listed in this question. There have been a number of other people who have asked about their particular specialty. It can be included as long as the organization meets the eligibility requirements and of course the application will be based on the criteria laid out in the FOA.

Okay. The FOA states that applicants must implement the service models to begin care improvement activities within six months. Would you please elaborate on this requirement? What does supplement the service delivery model or begin care improvement activities mean to CMS?

We consider implementation of the service delivery model as providing intervention to your population. That is, delivering your care intervention or innovation directly to patients or if it is a substantial aspect of your program, technology or training, then the delivery of these components would constitute implementation. We do not expect all aspects of your program would be necessarily fully implemented within six months.

Thank you.

Our next question, what if we don't have multiple payers signed on at the submission of our application? Do you want to answer this one?

Sure. Applications must include a feasible approach for securing participation for the proposed payment model. Preference will be given to applications that include participation by non-CMS payers at the onset of the implementation.

We have a few more questions regarding payment models; can you explain what global capitation means?

Questions of payment models will be addressed in an upcoming webinar. Please monitor the Innovation Center's webinar listserv and website for the date. At that time we would be happy to answer any questions regarding payment models so please register for that webinar when a link becomes available on our website.

The next question reads is it possible to have a mix of non-healthcare organizations and providers or other organizations in an effort to address primary prevention strategies?

Applicants can use a combination of non-healthcare and healthcare provider in their applications to address primary care strategies.

Is it advisable for organizations requesting less than $2 million to obtain and submit the actuarial certification for their financial plan?

Applications with less than $10 million in funding are encouraged but not required to submit an actuarial review. The plan needs to be certified by the chief financial officer of the applicant organization .They cannot be the Executive Director.

Thank you. Our next question reads as follows, what will be the evaluation process and evaluation factors to select a successful application? Jim?

Detailed information regarding the evaluation process can be found in the FOA.

Thank you.

Our next question, do both companies intending to partner on a proposal need to file an LOI?

Organizations that intend to partner on the same proposal only need to submit one letter of intent. One organization will have to take the lead on the proposal and identify itself as a lead in application material. It's also acceptable for key partners to change. We expect that may happen.

Okay. And on a related question will the confirmation number identify the applicant for the application?

When you receive the confirmation number hold onto that. In the application process there'll be a space to put that number into one of the standard forms required in the system. Once you submit your application you will receive a new application number which will be used to identify your application moving forward. The LOI will be linked to your application but it is not the application identifier that will be used moving forward.

Thank you, Christy. Moving along, our next question for patients who participate in the proposed models, will providers continue to bill Medicaid, Medicare, or CHIP for services provided or will the Innovation Award fund be expected to cover the cost of services? Going to turn to Sheila for this one.

Providers will continue billing Medicare and Medicaid or CHIP and the Innovation Award will not cover services that are billable to Medicare and Medicaid or CHIP.

Thank you Sheila.

The next question, will preference be given to applicants who submit an application that cuts across multiple innovation categories?

Applicants must identify a primary innovation category in which it will be considered but the narrative section will identify other categories that may be relevant to the model. This does not indicate an advantage or disadvantage for proposals. Applications will be reviewed against the criteria listed in the FOA.

Thank you. Following question reads and relates to the LOI. Can the principal investigator change after the LOI is submitted?

Yes, it is possible for the principal investigator to change after it is submitted. We will ask your organization to keep the same LOI number.

Okay. The next question, does the proposal have to be for a specific disease under category 4—or can it be for a group of people at risk based on age or multiple chronic conditions?

The proposal can be for a specific disease or a group of people at risk based on age or chronic condition.

Thank you.

The next question, can we assume that CMS will respond to questions asked on the webinar through the Innovation Center's website or should we submit these questions again through your mailbox?

CMS is working diligently to identify questions being asked on these webinars and we will address these issues in the FAQ on our website. If you have a question that has not been addressed, please send your question to innovationawards@CMS.HHS.gov. We will try to respond as quickly as possible but due to a high volume of e-mails it may take us a few days to provide you with a response.

Thank you. Our next question reads can an LOI be modified or resubmitted after the June 28 deadline?

No, you are not able to make any modifications or resubmit after the deadline has closed. If there is some anticipated issue please contact us by e-mail after that date.

Thank you. Okay our next question, regarding the June 12 webinar and the materials from it. Are they going to be posted online?

The materials for the June 12 webinar have not been posted yet but we will post them by the end of this week. Thank you.

Next question regarding the letter of intent, the proposal summary says 100 characters is the limit does that mean words or letters? I'm going to turn to Christy.

It is actually 1000 characters. It could be letters, symbols, numbers, or spacing so you will want to perhaps do that off-line to check whether there is an issue with the length.

Thank you. The next question reads, the FOA states the models primarily focused on hospital inpatient care is excluded from this round and will not be reviewed- can you clarify this position ?

This funding opportunity is focused on innovative payment and service delivery models in the Four Innovation Categories. We do expect proposals in any of the given innovation categories may result in improved outcomes or reduced cost in the inpatient setting.

Okay. The next question I will handoff to my colleague and it reads can rural populations be targeted in category two and three as well as category four?

This is a simple answer. Yes, rural populations can be served in all four categories.

Great, thank you.

The next question reads, could a national or state chapter of the medical profession such as AARP be considered a convener and propose a multiple state or multiple sites within one application?

Yes. These organizations can apply as long as they take responsibility for terms and conditions of the cooperative agreement. They will be considered the lead applicant.

Okay. Thank you. If we are collaborating with partners for our proposal, do all partners need to be named in the letter of intent?

We understand that not all partners may be engaged by the time the letter of intent needs to be submitted. We ask you to submit as many names you know as possible. We understand not all may be in place and that others could be added at the time of application.

Okay. The next question is: are hospitals eligible to apply for funding in round two of the healthcare innovation awards?

Yes. Hospitals are eligible to apply if they propose a model that meets the criteria specified in the FOA.

Great thank you. Okay. The next question reads, would we have to identify the exact amount we are requesting in the LOI? Assuming that is referring to funding what about the application? I'm going to turn to Christy for this one.

The non-binding letter of intent will ask you to only estimate what you think you will be requesting in the application.

Okay we are going to turn to Jeff and the question reads, will you consider a group of primary care providers as included in category three for specific types of providers to transform the financial and clinical models or are specialty providers only considered?

Thank you primary care providers are eligible to apply for category three.

Okay. Since the time for the webinar is winding down we will have the following serve as the last question for the webinar. And the last question reads, what is it that CMS is hoping to accomplish with this round two that has not been accomplished through other Innovation Center models? Sheila?

The Innovation Center has launched a variety of models in partnership with CMS that address many needs within the healthcare system but with Round Two we are interested in addressing gaps in our healthcare portfolio and especially high opportunity areas for better care at lower

costs. We are very interested in improving care delivery and quality for high risk beneficiaries in specific populations all at the same time reducing the cost of their care. We want to take full advantage of the wide range of innovative ideas being generated by the healthcare industry, the provider community, and the community at large, and encourage more innovation from the healthcare system in regard to payment models to build on the good work already occurring in the field.

We are interested in addressing a number of important aspects of healthcare payment and delivery systems that could result in potentially usable models for change and how we pay for Medicare, Medicaid, and CHIP services. We especially want to encourage a strong focus on Medicaid and CHIP populations and we are very interested in new delivery and payment models that address gaps or areas where we may have limited models in our portfolio.

In round two we will be able to speed innovation and testing of innovations in healthcare delivery payments and the healthcare system at large so that improvements in care and payment can be spread quickly and more efficiently. We want to recognize the critical role of the people on the phone this afternoon and healthcare transformation.

We do know that you are doing important work each day to make care better and more affordable. The last few years have seen large strides when it comes to keeping healthcare spending in check and much of the success is due to innovations originating in the field that have helped make care delivery smarter and more efficient and we look forward to partnering with you in Round Two of the innovation awards and continuing this work.

Thank you. That concludes the question-and-answer session of this webinar. We ask that you fill out the participant survey accessible via the link in the webinar portal. We value participant feedback throughout this series. The Innovation Center will be hosting additional webinars related to specific aspects of the Healthcare Innovation Awards Round Two application process. We encourage all potential applicants to sign up for the listserv on our website to stay abreast of the webinar announcement dates. Thank you for attending today I have a great afternoon. [Event concluded]