# Health Care Innovation Awards Round Two – Achieving Lower Costs Through Improvement

## Webinar Transcript

ANDREW RUSHTON: Thank you and good afternoon, everyone. This is Andrew Rushton from the CMS Innovation Center, and I'll be serving as the moderator for this webinar on the Health Care Innovation Awards Round Two, with specific focus on achieving lower costs through improvement. Before we proceed, there are few important housekeeping items to address.

This webinar is being recorded, and the slides and transcript 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 email 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's comments are not offered, and do not constitute legal advice or legal opinions.

And no statement made on this call will 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.

Finally, the extent that we may seek to gather facts and information from you during this call, we intend to gather your individual input. Innovation Center is not seeking group advice. The main purpose of today's webinar is to focus on achieving lower costs through improvement. Additionally, subject matter experts will review components with a financial plan and make themselves available to answer questions.

I will provide a brief overview now for our attendees of today's webinar agenda. After I conclude my remarks, Christy Meyer, team lead for Health Care Innovation Awards at the

Innovation Center will start the discussion on the total cost of care concepts. Joining her will be Jay Desai of the Innovation Center, who will help to explain how baseline costs can be calculated.

Andrew Keenan, also from the Innovation Center, will review components of the financial plan that is a required supplemental form in the Health Care Innovation Awards Round Two application. Immediately following these presentations, a question and answer session will conclude the webinar.

During the question and answer session, questions will only be accepted through the box titled Submit Your Questions that is located in the lower left corner of the webinar portal appearing on your screen. Please note that questions will not accepted by phone. For any attendees of today's webinar that may have difficulty viewing content on the presenter slides, they're encouraged to click the button on the web portal titled Enlarged Slides to assist in viewing the slide presentation materials.

If you do have questions that we are not able to answer on this webinar, please email us at innovationawards@CMS.hss.gov. Lastly, the Innovation Center will be doing further webinars on Health Care Innovation Awards round two. More information will be forthcoming on how to register for these webinars through the CMS Innovation Center website and listserv. And with that, I will now turn it over my colleague, Christy Meyer, Christy?

Christy: Thank you, Andrew. Good afternoon, and thank you for joining us today in this fourth installment of our webinar series. This is one of the latest steps we're taking to spur innovation in our Health Care system by supporting some of the most promising ideas around the country for lowering costs and improving quality of care. The Health Care Innovation Awards Round Two supports the mission of the CMS Innovation Center.

The awards are designed as a partnership with innovators in the field to collaborate in testing service, delivery and payment models, and the whole promise for achieving better care and lower costs for Medicare, Medicaid, and the Children's Health Insurance program. This common purpose of affordable care is today's webinar regarding the total cost of care is especially relevant for potential applicants.

As in the first round of Innovation Awards, and the second round will continue to partner with innovators and engage them to identify new service delivery models. We will focus on testing models in four specific innovation categories, and clearly develop a new pathway to new Medicare, Medicaid, and CHIP payment models.

Finally, the success for the Health Care Innovation Awards Round Two will be measured by delivering better care, lower costs, and improved health status. We want to remind you of some key dates that are fast approaching. This past Friday, June 14, application materials were posted on our website and grants.gov.

We have posted a very slight revision to one of the templates in the operational plan, so please be sure to use this template in your submission. Next Friday, June 28th, our letters of intent are due on Friday at 3:00 PM Eastern time. Please try to submit your letters prior to the due date to avoid any website traffic related issues. We recognize that model design will change from the time you submit your letter of intent to the actual application.

Applications will be due August 15th. Please make sure that you submit well in advance to avoid any traffic related issues. And finally, we anticipate the announcements of award in early 2014, with a performance period starting April 1, 2014. With that, I'll turn it back to Andrew.

ANDREW RUSHTON: Thank you, Christy. Next up, Jay Desai of the Innovation Center will present on baseline cost calculations. Jay?

JAY DESAI: Thank you, Andrew. I'm very pleased to be able to talk to you today about total cost of care as a concept broadly, but also the pathway by which you can demonstrate your initiative's ability to lower total cost of care. So it's no mystery at this point that Medicare costs have been growing every year, and are projected to grow into the future.

When you break that cost growth number down into some of the categories that are driving that spend, the increase in expenditure does vary. So inpatient hospitalization over the period from 2008 to 2012 has actually grown fairly modestly, but particularly when compared to outpatient hospitals, in which has been growing at 42% there in the middle.

And also spending does vary fairly dramatically by the region of the country that we're in. In this first example on this chart, the national average per capita home health spending is $546.

But in some markets, for instance, Miami, Florida, it can be as high as $3,165. Among others, it's as low as $74 per capita in North Dakota. We're going to talk a lot about some of the contributing factors to why this could be the case as we explore the components behind these numbers. Another example I'll show to you, the variation in CT scan expenditures with the mean being $76, but in Honolulu that spending is $49, compared to Fort Meyers, Florida at $117.

Now let's jump into the content of this slide deck around total cost of care. So we're going to start with what we mean by total cost of care as a concept, then we're going to explain how you can compute your baseline total cost of care for your population. Then we'll move into how your intervention can reduce total cost of care, and then we'll spend some time talking about your budget and your financial plan.

So what do we mean by total cost of care? Total cost of care means many things to many people. Throughout this presentation, when we say total cost of care, we're talking about payments by health care payers to service providers to comprehensive basket of health care services utilized by location or population. Health care payers includes the government, private insurance companies, employers, and patients, among many others.

These payers pay health care service providers for the care they deliver patients. The providers include the hospitals, community health centers, physicians, and a variety of other community based providers. So let's say you're one of those providers, and you operate a nurse-run clinic focused on providing chronic care management services for the frail elderly population.

Maybe Medicare or Medicaid reimburses you for the services you are providing your patients. You may get an additional amount from your patients in the form of a copay. That total amount that you're getting paid from us, Medicare, and patients isn't total cost of care. It's just a piece of it. When we talk about total cost of care, we're talking about something much bigger.

Where else do your patients go for services? The hospital down the street, the community health center, the pharmacy, the dialysis facility around the corner. Total cost of care includes all of that. It includes what payers pay for the complete basket of services your population uses. So let's use Medicare as an example of a health care payer, and we'll be using Medicare as an example throughout this presentation.

Although we know that there's a number of other payers that are purchasing the services that you're delivering in your market. In the FOA, though, we put an emphasis on those applicants who are serving Medicare, Medicaid, and CHIP patients. So again, using Medicare as an example, after we include the contribution by Medicare beneficiaries, which would be about 20%, we, Medicare, pay $1,245 per beneficiary per month.

Per beneficiary per month is a critical metric to describe total cost of care that will be a focus throughout this presentation. So what does that $1,245 include? Looking at the pie chart, you can see that the bulk of it pays for the time our beneficiaries are in the hospital, or 336 on inpatient utilization. We spend another $239 on prescription drugs to as part of the Part D benefit. Another $110 on outpatient services.

And the rest is on a variety of service categories, including skilled nursing facilities, home health services, durable medical equipment, and hospice centers. So, let's talk about the main elements of total costs of care. And I'm going to start with a very simple example, if you'll bear with me.

If you owned a pizza restaurant, for instance, and we're trying to compute your total revenue at the end of the year, you would look at how many pieces we sold and multiply that by how much we charge per pizza. Price per pizza times volume of pizzas equals total revenue. Price times volume equals revenue. In going back to health care, you can think of the pizza restaurant as a health care service provider.

In using our example of the nurse run clinic from before, this provider's total revenue is the health care payer's total cost. The Center for Medicare and Medicaid Services is the largest payer of health care services, and we think very deeply about our total cost of care. The payers like to use some common terms to describe price, volume, and cost. For price, we use a unit cost, and the rate we use is expenditure per service.

Going to the nurse run chronic care management facility, let's say a nurse sees a patient for an evaluation. We may reimburse a set amount for that service, and that expenditure per service, that is the expenditure per service, or the unit cost. Looking at the second row on the table on the slide, under Outpatient, Medicare may pay $264 for an average visit. This $264 is the expenditure per service.

For volume, we say total units and the rate we use is services per 1,000 beneficiaries. To keep that simple, let's say that nurse run clinic treats 1,000 beneficiaries. Then someone at your nurse run clinic looks at the medical records and sees your clinic had 3,929 visits last year. So your total units would be 3,929 visits per 1,000 beneficiaries. From here, it's really as simple as the pizza restaurant example.

Remember how we multiplied price per pizza times number of pizzas? Here we do the same thing. We multiply each of the visits by the total number of visits. Sorry, the price of each of the visits by the total number of visits per 1,000 people. That gets us to about a million that Medicare spent for 1,000 beneficiaries for these outpatient services. We do some quick math, divide by 1,000 beneficiaries to get to the per beneficiary per year cost of the evaluation, of outpatient visits.

And then by 12 months to get to a per beneficiary per month cost for nurse evaluations. It doesn't stop there. You find out that your average patient uses a lot of other health care services. Hospitals may cost $263 PBPM. Skilled nursing can cost $80 PBPM, and a range of other services that cost $409 PBPM. This gets you to $838 PBPM total cost to care for your population.

This is a critical metric. It turns out that this is about the average that Medicare paid for services in 2011 per beneficiary per month. And as I said before, health care payers think long and hard about their per beneficiary per month cost of care across service categories, and overall. And you don't need to hear about how that number is going up, and we are looking to you to help us bring that number down.

So that was Medicare's fee for service average total cost of care for the whole country. Almost 40 million beneficiaries in part A and B. But the total cost of care varies for different populations for a lot of reasons, as we saw in the earlier map. When you think about it, though, because unit costs times total units equals total costs of care, there really can only be two categories that cause variation, either unit costs or total units.

On the unit cost side, we do have a lot of adjusters to account for nuances in local markets. But generally speaking, Medicare and Medicaid pay the same for any given service. But in any given region, total units may vary dramatically. Your population may need more health care. For instance, there may be more overweight folks, or more smokers. You may have more asthmatics or folks with heart failure.

Furthermore, nurses from that region may have different habits by which they treat their patients. You may have more hospitals in your community than your neighbor. The list goes on and on for why PBPM can vary for different populations. In the example on this slide, we show how the PBPM may be much higher for population A than population B, because population A has a higher rate of inpatient utilization, even though it has less outpatient and other business.

So now that we understand what total cost of care means and how to compute it, how can you compute the baseline total cost of care for your population? Your baseline total cost of care is something you need to determine based on what you know about your population. It can be tricky to determine what is and isn't included in total cost of care. And to simplify this, know one major fact.

A big goal of the Innovation Award is to reduce total cost of care to Medicare, Medicaid, and CHIP. We want you to really try hard to think through all the money that we, Medicare, Medicaid, and CHIP are spending to serve the patients you are helping. So focus on getting a thoughtful, comprehensive baseline and compare that to national data to make sure you're in the ballpark. So how can you do that?

Well first, define your populations. Who are they? How many people are in that group? What are their characteristics? Then determine the full basket of services that your population uses. From here, determine how many total units of each of those services categories that they're currently using. That's based on what the underlying health characteristics, what is the disease prevalence of the population?

What types of providers exist in that market, what type of health systems are available in a region, and then finally, determine the unit cost of those services. Now, we know this is hard work. Understanding what services your population uses, how much they use, and what those services cost may be difficult, and will require significant research. And for some organizations, it may be much harder than others.

Some of the sophisticated health systems may have this data within their health practices. We know there's a lot of community based providers out there that may not have all this information, and we want to be very clear by saying applicants that develop good, thoughtful data through to estimates will be viewed as favorably as those applicants who have access to actual data.

We understand that this may be a new approach for a lot of folks out there, and not all information they would like to have is available. Your application will be scored on a variety of different dimensions, and this is an important one. The key is to demonstrate a thoughtful approach to impacting total cost of care, not necessarily an absolutely accurate prediction, because in the end, it really is just a prediction.

So how can you go about getting the information to make these good predictions? Well, you can start with your own data. You can form partnerships with organizations in your community

that provide this data. You can obtain data from purchasers of the services that you're currently providing, and then there's a lot of publicly available data that we're going to help you find through our application guide.

So now that we've talked about thinking about the baseline total cost of care and how you can compute it, this is really the fun part. And we can talk about how you your intervention will impact total cost of care in the next few slides. So once you complete baseline total cost of care analysis, we want to see how your initiative is going to lower costs. We want to provide funds to those organizations that are driving meaningful reductions to total cost of care along two dimensions. This is important.

We want to see total cost of care reductions over the term of the three year award, so that would be a net savings over three years. But that's only one part of it. We also want to see savings on a continuous basis, year over year after the cooperative agreement period is over. Some people call this a run rate.

And we know for some interventions, for instance, some of the highly preventative focused measures, you're not going to see savings for many years out. So we take that into consideration, and we know that there's no absolute threshold of a return, or in a savings number that we're looking for. This is all very much deeply connected to the nature of your intervention.

But we want you to show us over the three years what you're going to be able to achieve, and then also on an ongoing basis what you're going to able to achieve. And the way that we are going to see you guys reduce total cost of care is through improvement. This is a very important slide.

Fundamentally, we're seeking to provide awards to organizations that are going to enable reductions in health care costs through improvement, better coordination, improved safety, better use of health IT, improved chronic disease management, improving workforce efficiency.

This is just a handful of examples. And then those portfolios may demonstrate how those types of innovation will drive reductions elsewhere in the health system. So for instance, reducing avoidable ED visits, reducing overall preventable extra care costs for doing the unnecessary procedures.

So to be very clear, we're about to spend new money. We're going to actually increase total cost of care with this billion dollar solicitation. And the reason we're spending new money is because we're going to see improvement that will reduce costs downstream. So we're paying money to get a reduction in total cost of care. And it's really important that you show ways that you can reduce total cost of care.

For instance, you can just cut rates. You can put into place higher authorization procedures. That's not what this solicitation's about. It's about enabling reductions in costs through

improvement. So we want you guys to tell us a story of how you are necessarily asking for additional funds so that we can see cost reductions later on down the road. And the next slide's going to walk us through an example of that.

So on this page, we have the hypothetical that we've been talking about all throughout this presentation of a nurse run chronic care management clinic treating the frail elderly. So for the populations that this clinic serves, the baseline total cost of care is $3,609, which you can see in the bottom right corner of the chart to the right. How did we arrive at that number?

And this chart really pulls together all the elements of the presentation that we've covered so far. So the chart on the right, you can see four main columns. And those four main columns follow the four steps that we talked about to compute baseline totals cost of care. The service basket, the total units, the unit costs, and then the total cost of care. The service basket column lists all the categories of services the population utilizes.

And here we have three major categories and a number of subcategories underneath that. The three major categories are inpatient hospital, post-acute care, and a variety of other services. Under total units, there's a column titled baseline. This is how much of each service they're currently using. Now, let's use acute inpatient admits as an example. For total units, these 1,000 patients go to the hospital about 2,200 times per year, or 2.2 times per beneficiary.

That seems pretty high, but this is a frail, elderly population. So having them go to the hospital two times a years doesn't seem all that unreasonable. Under unit costs, the price per inpatient hospitalization is about $2,460. After some math, this translates to a baseline PBPM total cost of care of $1,918 per inpatient hospitalization. You add up all the service categories, and that gets you to a baseline PBPM of $3,609.

Let's say you were to do this analysis based on estimates received from hospitals and other providers in your market. From there, we can check this number against publicly available data. It turns out that the PBPM of $3,609 is roughly how much Medicare pays for the top 15% most expensive beneficiaries. The nurse-run clinic knows they treat a complex, high risk, and high cost population, so this seems accurate.

Now that we know the baseline total cost of care and what it’s comprised of, we can see how the intervention will change things for the health care payer. Let's start with the increases in cost. All the numbers in green are new or additional costs to health care payers. So our nurse run clinic does home visits, a lot of primary care, and other services like medication adherence, phone calls, text message reminders for folks to take their medication.

They may have peer support networks that Medicare doesn't reimburse. They also may have tele-health services or remote monitoring services to better manage this frail, elderly population. These increases are reflected by the green percentage increases that are highlighted in yellow. We expect to see a 10% increase in home health visits, a 15% increase in evaluation and management visits. This includes primary care.

And a 55% increase in other services that are not currently reimbursed by Medicare. This total increase is $77 PBPM, as you can see in the second blue box to the left. But the beauty of this intervention and the reason that we want to fund it is that through this initiative, it will reduce hospitalization, nursing home usage, and ER visits. That's reflected in the percent decreases in red, that are also highlighted in yellow.

We see a 10% percent reduction in hospitalization, 7% reduction in nursing home visits, and a 7% reduction in the emergency room visits. We aren't changing unit costs here. The clinic's purchaser-- let's say it's Medicaid-- pays what it pays. It's not going to pay anything different before or after per unit. But all these reductions in utilization translate to a gross reduction of $236 per beneficiary per month.

That impact is a new sustainable PBPM of $3,449 compared to the original PBPM which represents a 4.4% savings. So you see that unit cost doesn't change. The increases in utilization are driven by new costs that we're putting into the system, but they're outweighed and balanced, and overruled by those reductions that we see in other utilization, more expensive utilization categories.

But that story is not as important as the evidence that you use to support your claim, and prior performance is a very strong indicator of future performance. So if you can show us that you have demonstrated these results in the past, that's great. And even better would if you could support your prior performance improvement with published hard research. So with that, I'll turn it over to Andrew Keenan too walk us through the financials.

ANDREW KEENAN: Hi. I'm gonna turn it over to Andrew Rushton for a quick administrative piece.

ANDREW RUSHTON: Thank you, Andrew. We understand a few of our attendees are having some difficulty seeing the current slide that's matched with the speaker's talking points. So I'd just encourage folks who are having difficulty to press F5 on their computer keyboard. And that's F5. So it should refresh, and you will be able to follow along in real time with our speakers' points as they're going through them. And with that, I'll hand it over to Andrew Keenan.

ANDREW KEENAN: Thanks, Andrew. And I want to thank you, Jay. Now we're going to talk about how some of the things that Jay showed can actually be put into practice, ways you can demonstrate them in your financial plan. The financial plan template offers you the opportunity to map out your cost savings. It can be found in the Innovation.gov website and grants.gov website.

All the necessary definitions, as well as the additional resources that are populated in that template can be found in your application user guide, which is available at the same sites. The first sheet of your financial plan, savings analysis combined, is a new platform for you, as the

applicant, to more fully demonstrate, in enhanced detail, and where and how you intend to show your savings. The sheet ties back to cost categories discussed earlier.

Please insert values into the blue boxes. Clear boxes will auto populate based on inputs you make on the sheet. Also, please do not try to manipulate the column or row width, as this could adversely affect your submission length. The second sheet of your financial plan is the financial plan summary. It's the section where you input total baseline and proposed costs per year for years one, two, and three.

You can also re-estimate your target population. Again, please insert values into blue boxes. Clear boxes will auto populate based on inputs you make in your financial plan summary, as well as the savings analysis sheets. Please note, total costs should in large part reconcile with combined expenditures shown on the Savings analysis combined. Also, the four years shown are estimated costs going out, consisting of a baseline year and three years of program performance. The baseline will not be eligible for federal funding. Additionally, all cents are rounded to the nearest dollar in the spreadsheet, but are stored as cents in the application.

Here we have the categories. This sheet is fairly detailed, and may be tough to read. If you haven't increased the size of your slides, you may want to now. This is the list of cost categories we're asking you to populate.

For the second round of the Health Care Innovation Awards, we've tried to capture all the major cost categories within the cost categories template. The innovation center engaged with our partners in CMS and the office of the actuary to create a comprehensive category list. We used allowable Medicare costs as the base for this template and incorporated areas that align more closely within other CMS beneficiary groups, specifically Medicaid and CHIP. Our hope is that you, as applicants, will be able to fill out the greatest amount of detail with the greatest specificity. We realize that some of the categories may raise some concerns. So whenever possible, boil down your costs to the most specific category. As Jay stated previously, we recognize that there will be different degrees of specificity in the categorization.

We're asking you to focus special attention on the categories that most directly impact the priority areas we are targeting.

This is just a second sheet of the same.

Summary sheet. This is the summary sheet. In order to best understand the payment model expense versus service delivery, we're asking you to estimate total proposed costs on the following categories. Direct patient care, payments providers, initial development, ongoing operations, and other.

Proposed model savings automatically calculate for all three years. Please review the numbers and validate the calculated totals to ensure the sheet is showing the same as you expect. If it

isn't, please go back and validate your inputs. Next we're going to show the service category hints.

When categorizing costs, it is both possible and likely you will have areas not specifically captured on your list.

A good example is behavioral and mental health. This service, which is generally not covered in Medicare, may be an intrinsic element to your plan. So it's important that the costs of these services are captured.

In such cases, the categories “other covered” and “other not covered” are provided to allow you to express these costs. In the event you populate these with non-specified costs, please include an explanation and definitions in your narrative. In some cases, you may have questions about how to categorize costs due to the category overlap. We suggest that you provide costs at the greatest level of specificity possible.

For example, for a cost we have a cost that is either outpatient hospital, or, for example, emergency services, please associate as much of the cost as possible to the most specific area, in this case emergency services. It's also recommended that you focus on attributing with the greatest specificity cost to areas that are most targeted by the award priorities.

Category definitions, explanations, and examples can be found on page 5-7 of the HCIA 2 application guide. Additionally, page four of the application guide includes CMS resources to help determine baseline costs in these categories.

The next two slides provide a list of internal and external CMS data sources you can use to baseline you costs when populating a financial template. Now I'd like to turn it back over to my colleague, Christy.

Christy: Thank you, Andrew. In the application narrative, you'll want to explain the rationale behind your budget and potential savings estimates. For every data point on the SF 424A and the financial plan, applicants are encouraged to explain either through the narrative or supporting material how that number was computed. For example, what is included in your budget figure per personnel?

How did you arrive at your total cost of care estimate? And how did you compute your potential for reductions to total cost of care? Clearly explain the rationale for your estimates to add credibility to your funding request. And we highly encourage you to use rigorous research to support the evidence provided. And now let's cover some final next steps as we head into the LOI and application process.

Applications can be submitted electronically at grants.gov. In order to apply, applicants must obtain a Dun and Bradstreet Data universal numbering system number, as well as be registered

in the system for award management. We really encourage you to obtain these numbers well in advance, and to make sure that you apply well in advance of the due date of August 15th.

Our next upcoming webinar will be next week, on June 26th, and we'll be covering measurement for success and developing an operational plan. Please look for future announcements from our listserv, as well as checking our website for more information about these upcoming webinars.

Finally, for any additional information about the Health Care Innovation Awards round two, please check our website at innovation.cms.gov, or email us at our innovation email box, innovationawards@cms.hhs.gov. Thank you very much for your time, and we'll turn it over to Andrew to start the Q&A portion.

ANDREW RUSHTON: Great, thank you, Christy. All right, we're moving along now and transitioning to the question and answer section of the webinar. Before we get to our first question, there are a couple of important bits 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're also unable to meet 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 for the Health Care Innovation Awards round two. And with that, we're now ready to begin with our first question.

OK, our first question reads, can we have organization number one on the LOI, and if during the grant process it is more logical to have organization two be the convener, would it be possible to switch? Should we submit duplicate LOIs just in case? Christy I'm going to turn this to you.

CHRISTY: Sure. So there are really two options to address this situation. If the organization changes, you can update that in the application process, as long as you use the same LOI number for that application. Alternatively, you can submit another LOI if that's easier to update the information, but that would have to be done prior to the LOI due date of June 28th.

ANDREW RUSHTON: Great. Thank you. Another one, next question reads, do both companies intending to partner on a proposal need to file an LOI? Christy I'll give it to you.

CHRISTY: Yes. Organizations that intend to partner on a proposal should submit only one letter of intent and one application. One organization would take the lead on the application and identify itself as the lead on those materials.

ANDREW RUSHTON: Next question reads, another LOI. Will LOIs be reviewed for meeting the basic criteria of applications, and will parties be notified if their proposed demonstration does not meet the criteria for the Innovation Center round two prior to starting their proposal? Christy?

CHRISTY: No, the LOI is really used to understand how many applications we will receive, and the types of content in those applications. We do not use it to review or provide feedback on an idea.

ANDREW RUSHTON: OK, thank you. Our next question reads, it takes time to create new infrastructure and care models. Must a proposal pay for itself by the end of year three? I'm going to turn this over to my colleague, Jim Gerber. Jim?

JIM GERBER: CMS will require applicants to complete budget form SF 424A and a Financial Plan demonstrating their ability to achieve both total cost of care savings and a strong Return on Investment (ROI) over the three-year performance period for the award, as well as both net programmatic savings and a positive ROI on a projected annualized basis after the term of the award is finished. There are no minimum thresholds for a required ROI; proposals will be evaluated in light of credible, favorable performance shown by the proposed model, and in the context of criteria specified in the Funding Opportunity Announcement. (Note: The transcript for this response has been edited)

ANDREW RUSHTON: OK, our next question reads can an LOI be modified or resubmitted after the June 28th deadline? Christy

CHRISTY: No, a letter of intent cannot be modified or resubmitted after the June 28th deadline.

ANDREW RUSHTON: Next question. What if CMS currently doesn't pay for the services I provide? Should I include that in the total cost of care? I am going to turn this over to Jay. Jay?

JAY DESAI: It wouldn't be included in your baseline expenditures, but it would be included in your intervention costs. So any new expenditures that CMS currently doesn't reimburse should be part of the calculation that you provide to show how your intervention will increase expenditures. So presumably, this increase in expenditures is also part of your suggested new payment model. And we do expect productions and costs that outweigh the increases over time.

ANDREW RUSHTON: Next question. Can the LOI be saved as a draft before it is submitted? Christy?

CHRISTY: No, the letter of intent cannot be saved as a draft. It is an open website, and you have to complete the letter of intent in one sitting. You're not able to save it and return to it to edit.

ANDREW RUSHTON: Thank you, Christy. OK, our next question, I'll hand over to my colleague Andrew Keenan. It reads, how many pages should the financial plan result in? Andrew?

ANDREW KEENAN: That should be about three pages long. Well, exactly three pages. It's important that you don't change the column width or the row width, because if you do, that

could throw off the eventual conversion of PDF. And while I recognize it's important that we stay within the 50 pages, this is going to always be three pages.

ANDREW RUSHTON: OK, thank you. Moving along. Next question reads, where can I find definitions for the cost categories on the financial plan? Christy this is one for you.

CHRISTY: Sure. We had an application user guide that we put together. It's available both on the website for round two. So that guide will have some helpful hints on each of the supplemental materials in that application, as well as some significant detail on the various definitions of the service categories in the financial plan.

In their user guide, you'll also find a list of potential resources that you can go to to get publicly available estimates for some of the cost values needed in the financial plans.

ANDREW RUSHTON: All right, thank you, Christy. Moving along, next question reads, when you say preference is for Medicare, Medicaid, CHIP, are you suggesting that applicants should be able to impact all three payor sources? I'll turn this over to Jim Gerber. Jim?

JIM GERBER: This funding opportunity requires that proposals focus on improving the quality and reducing the cost of care for Medicare, Medicaid, and or CHIP beneficiaries. Any one or more of these CMS programs.

ANDREW RUSHTON: Next question, where do I describe the assumptions and references that went into our cost savings model in the financial plan? Christy?

CHRISTY: The application narrative section on return on investments is one of the required sections in the application narrative. That's the section that should include the detailed overview of your assumptions and references used to fill in your financial plan, so that's the section in the application narrative that you'll want to use to describe your assumptions and references as it relates to your cost assumptions.

ANDREW RUSHTON: OK. Next question reads, can an organization be a lead applicant on more than one LOI? Christy- that's another one for you.

CHRISTY: Yes, an organization can be a lead applicant on more than one letter of intent.

ANDREW RUSHTON: Great. Our next question reads, I don't see an area of expenditure that I can contribute to my cost category on the financial plan. What should I do? I'll turn this over to Andrew. Andrew?

ANDREW KEENAN: In that event, you can use those “other categories” in financial plan cost categories sheet- other covered and other not covered. Just make sure that you include a description and an explanation in your narrative. Thanks.

ANDREW RUSHTON: Thank you, Andrew. All right, next question. What if I'm doing a prevention intervention that won't reduce costs for a very long time? Jay, do you want to answer this one?

JAY DESAI: CMS will require applicants to complete budget form SF 424A and a Financial Plan demonstrating their ability to achieve both total cost of care savings and a strong Return on Investment (ROI) over the three-year performance period for the award, as well as both net programmatic savings and a positive ROI on a projected annualized basis after the term of the award is finished. There are no minimum thresholds for a required ROI; proposals will be evaluated in light of credible, favorable performance shown by the proposed model, and in the context of criteria specified in the Funding Opportunity Announcement. (Note: The transcript for this response has been edited)

ANDREW RUSHTON: Great, thank you Jay. OK, moving along to the next question, it reads, with the LOI, does non-binding mean both that the applicants are not required to then submit an LOI, and that applicants may change their plan between the LOI and the application submission? Christy, do you want to answer that?

Christy: The letter of intent is required to apply, but if you choose not to apply after you've submitted a letter of intent, that's fine. You're not required to submit an application if you have submitted a letter of intent. We fully recognize that your plans and potential partners may change between the letter of intent and the application submission, and that is also acceptable.

We just remind you that the letter of intent is required, and that you will have to use that letter of intent number in your application process, regardless of any changes that occur.

ANDREW RUSHTON: Thank you, Christy. The next question reads, we are an independent provider of home health services. We can only have data for those services provided in our setting. How do I get access to the cost of services provided to my patient from other providers? Jay?

JAY DESAI: So please refer to the slides in the presentation about these publicly available data sources. Also, the application user guide has many other information sources to get this census data. And keep in mind that the total cost of care numbers are estimates, and we want you to use as much information as you possibly can to try to get to as good of an estimate as you can.

ANDREW RUSHTON: OK, next question. Is the certified financial plan posted on the CMS Innovation Center website? I can answer that one. The answer is yes, it is posted on the innovation center website. If you go to the Health Care Innovation Awards round two page, or if you just search for Health Care Innovation Awards round two, you will see the page.

Just click on the link, and it's on the page, a bullet point that lists the documents, there and you can access it to download. Next question. On the LOI, where it asks for the number of partners and names of partners, should that include potential partnering payors, or just other partners? Christy?

CHRISTY: We are very interested in learning about your potential payer partner, so please do include them in the partners section. It can be any payers that you intend to engage with, as well as other partners, or facilities, that may be a part of your project.

ANDREW RUSHTON: OK, moving along, our next question. Christy, it's another one for you. If awarded, how is it funded? Certain amounts up front, and then funded based on reporting periods? How is that handled, the distribution of funding over time?

CHRISTY: The funding opportunity announcement is for a three year project, but awards are only given one year at a time. And there's a very detailed process around that, and specific rules exist around how that money is accessed and drawn down. So you will be notified of the total award amount over the three years, but your access to it is on an annual basis.

ANDREW RUSHTON: Very good. OK, moving along to our next question. Next question reads, in reference to a prior webinar, there was an understanding that the innovation must take place in an outpatient setting, and must reduce operation costs. Now in the total cost webinar, it appears that CMS is fine with both reductions in the outpatient and inpatient side. Is there any way you could please clarify this? Are those kind of innovations eligible for funding in this round? Jim?

JIM GERBER: Applications that focus primarily on acute hospital inpatient care will not be reviewed, as provided in the FOA. But models that do not focus primarily on the acute inpatient setting and increase outpatient costs and decrease inpatients costs are eligible.

ANDREW RUSHTON: Thank you, Jim. OK, our next question says the user guide indicates that we are to upload in native format. But one of the speakers said something about converting the financial plan to a PDF might corrupt if the column widths are altered. So should we PDF the document, or should we not? How do we handle this? Andrew?

ANDREW KEENAN: Yeah, let me clarify. You're going to upload in native format. It helps everyone when it's in Word when it's being pulled down and then compiled. Here at the Innovation Center, we're going to be converting it to PDF. So we need it to maintain the integrity of the native format that we're providing it in, and then we do the PDF conversion.

ANDREW RUSHTON: Thank you, Andrew, for that clarification. OK, our next question. Is the financial plan and savings analysis required at the time of LOI submission? Christy, you want to answer this?

CHRISTY: No. The financial plan and savings analysis pieces that are only required just in the applications. They are not required at the time of the letter of intent. On the letter of intent, there is a question around theoretically how your project will impact the total cost of care that we ask you to respond to. This response does not require a full financial plan and savings analysis. Those pieces are only required in the applications.

ANDREW RUSHTON: Thank you,  Christy: Our next question, to assist applicants in preparing the financial plan, will CMS provide national averages for common unit costs? Jay, want to answer this one?

JAY DESAI: National averages for common unit costs on the Medicare side are available publicly, and will be cited on the application user guide. So that will be made available, yes.

ANDREW RUSHTON: All right, thank you, Jay. Moving along to our next question, it reads, if our project includes people with not just Medicare, Medicaid, and CHIP, but also those covered by the commercial insurance, do we include treatment costs for all of these populations in the baseline estimate? Christy?

Christy: Sure. In this funding opportunity announcement, we're really interested in funding projects that are actually targeting CMS beneficiaries. And so the grant money in this round is really going to be focused on Medicare, Medicaid and CHIP. However, we understand that some projects may indirectly impact other types of beneficiaries, including those impacted by commercial insurance.

And so we have allowed space for you to describe your costs and savings in those populations, but they are not eligible for direct funding as part of this announcement.

ANDREW RUSHTON: OK, thank you, Christy We're starting to get down to the top of the hour, so we have a couple questions to go. Next one will be for Jim Gerber. And the question will be, I thought that the earlier answer to a question that was stated that applications must show ROI within three years, but recent responses indicate that this is not a requirement. Can you please clarify? Jim?

JIM GERBER: CMS will require applicants to complete budget form SF 424A and a Financial Plan demonstrating their ability to achieve both total cost of care savings and a strong Return on Investment (ROI) over the three-year performance period for the award, as well as both net programmatic savings and a positive ROI on a projected annualized basis after the term of the award is finished. There are no minimum thresholds for a required ROI; proposals will be evaluated in light of credible, favorable performance shown by the proposed model, and in the context of criteria specified in the Funding Opportunity Announcement. (Note:  The transcript for this response has been edited)

ANDREW RUSHTON: The time for this webinar is winding down. The following question will serve as the final question for the webinar, and it reads, the FOA states that the actuarial review form is optional for awards under $10 million. However, now that you've put the other attestations for CFO and Awarding Official in there, is it now required of all applicants? Christy?

Christy: You'll see when you review the supplemental application materials that we have made a slight modification. The actuarial review form is a place where you can collect all the required signatures, the signature for the CFO, and for your authorizing official. The actuarial portion of

the form is not required, but definitely encouraged from applicants who are requesting under $10 million.

ANDREW RUSHTON: Very good. Thank you for that, Christy. OK, that concludes the question and answer section of this webinar. We ask that attendees please fill out the participant survey accessible via the link appearing now through the webinar portal. We value participant feedback throughout this webinar series, and greatly appreciate you filling out the short survey.

The CMS innovation center will be hosting additional webinars relating to specific aspects of the Health Care Innovation Awards round two application process. We encourage all potential applicants to sign up for the Innovation Center listserv on our website, and stay abreast of the latest webinar announcement dates.

We thank you for attending today, and encourage you to have a good afternoon. And one last final question before we let you go. One more. Christy take it away.

Christy: So, last and most importantly, we want to thank everyone for their engagement today on today's webinar, and all our previous webinars in this series. And most importantly, thank you for all the work that you're doing every day to make care better and more affordable.

Over the last few years, we've made great strides in partnering with you, and we're looking forward to continuing to do so in round two of the innovation awards. Thanks again for joining this afternoon, and we hope that you will join us on Wednesday of next week for our next webinar.

ANDREW RUSHTON: Great. Thank you, everyone, for attending. Good bye.