
# Health Care Innovation Awards Round Two – Developing Payment Models

APARNA SAHA: Good afternoon, everyone. This is Aparna Saha, Senior Advisor to the Policy and Programs group at the CMS Innovation Center I'll be serving as your moderator for today's webinar on payment models.

Before we proceed, there are a few important housekeeping items to address. This webinar is being recorded, and the slides and transcript from this webinar will be posted to the Innovation Center's website within the next week, barring any technical issues. 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. CMS's comments are not offered as 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.

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. CMS is not seeking group advice.

The main purpose of today's webinar is to focus on payment models. After I conclude, Dr. Rahul Rajkumar, Senior Advisor to the Center Director at the Innovation Center, will highlight the goals of the second round of the Health Care Innovation Awards. He'll be followed by Jim Gerber, who leads portfolio management and is a senior advisor in the Policies and Programs Group.

Jim is a former Wall Street health care analyst and an attorney. Jim will provide background on the payment model requirements for the round two applications and will be joined by Andrew Keenan, an analyst with the Policy and Programs Group. Prior to joining the Innovation Center, Andrew worked on numerous elements of Medicare C and D policy and payment. Following Jim, Dr. Jeff Clough from the Patient Care Models group will provide an overview of the different elements of a payment model design.

Immediately following these presentations, we'll have a question and answer session. As a friendly reminder, during the question and answer session, questions will only be accepted through the web portal. Please note that no questions will be accepted by phone. On a technical note, if you experience any difficulty viewing the presentation today, please use the enlarged slides button on the webinar portal screen. Also, if at any time during today's webinar if you believe there's a delay in the slides,

please press the F5 button on your computer keyboard to refresh the webinar portal screen. This should ensure you are viewing the slide being discussed.

If you do have questions that we're not able to answer on today's webinar, you can always email us at innovationawards@cms.hhs.gov. And with that, I will turn it over to my colleague, Dr. Rajkumar.

DR. RAHUL RAJKUMAR: Thank you, Aparna. As the Secretary described when she unveiled round two of the Health Care Innovation Awards, there is tremendous momentum to move our health care delivery system to one that rewards value. That's why we launched this program, to help health care innovators to bring their best ideas forward. The aim of this program is to identify new payment and service delivery models that result in better care and lower costs for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. And specifically to test models in four innovation categories.

A key element of this program is that we are asking applicants to develop and propose new payment models for Medicare, Medicaid, and CHIP. So what is a payment model? What are the key requirements for payment models? How do you design a payment model? And how do you create incentives for beneficiaries to experience better health care and lower costs? The answers to these questions are all the subject of today's webinar.

Before we begin, we want to remind everyone of the upcoming key dates associated with this funding opportunity. We've received a tremendous interest, and we look forward to the opportunity to reviewing your applications and learning about your ideas. Please note that applications are due by August 15 at 3:00 PM Eastern Daylight Time. We anticipate announcing the awards in early 2014.

Lastly, I want to thank the entire Health Care Innovation Awards team for their outstanding work on producing today's webinar. And now I will turn it over to Jim Gerber.

JIM GERBER: Thanks, Rahul. A basic requirement of HCIA round two is that an applicant must propose a new service delivery model and a corresponding payment model. This webinar will focus, of course, on payment models. So we will start with the definition of service delivery models, since they drive the design of payment models.

We define a service delivery model as the manner in which providers organize and deliver care to patients. The examples on the slide illustrate two service delivery models. The first is a medical home model care delivery for oncology patients. Through comprehensive outpatient oncology care, including patient education, team care, medication management, and 24/7 practice access and inpatient care coordination, this medical home model aims to improve the timeliness and appropriateness of care, reduce unnecessary testing, and reduce avoidable emergency room visits and hospitalizations.

A second example of a service delivery model is an alternate pathway for individuals to access, via telephone, health care services for non-emergency conditions. In this example, patients with a lower acuity problem can talk to a nurse experienced in emergency medical triage and response. A medic will then respond to those patients with minor medical problems on scene and refer or transport them to an appropriate medical facility at a lower cost than the emergency department. In more complicated circumstances, community paramedics will engage with the communities' medical facilities and other resources.

We define a payment model as the manner in which the payer reimburses providers. The examples here illustrate two different types of payment models. The first refers to the bundling of episodes of care. These could include services provided by providers across different settings of care, such as the bundling of in-patient and post-acute care. Bundling encourages the coordination of care, as well as the provision of care in the most appropriate and cost-effective setting in the bundle.

The second example refers to capitated payments, which are payments on a per-person basis for a defined period of time. Capitated payments may apply to the total provision of care for beneficiaries-- that's global capitation-- or to specific types of care-- contact capitation. Capitation discourages unnecessary utilization and optimizes care within a capitated setting.

As we've noted, CMS is specifically seeking new payment models to support the service delivery models funded by the HCIA round two initiative. Consequently, it is a requirement that the applicant must submit in the application either the design of a corresponding payment model or a detailed and fully developed payment model. If the application does not contain a detailed and fully developed payment model, then a successful applicant who becomes an awardee must submit a detailed and fully developed payment model at some time during or by the end of the three-year cooperative agreement period. And now my colleague, Andrew Keenan, will discuss multi-payer participation.

ANDREW KEENAN: Thanks, Jim, for that description of a payment model. One of the key components of the second round of Innovation Awards is multi-payer participation. Every application payment model has to include one or more of the CMS beneficiary programs, Medicare, Medicaid, or CHIP. Additionally, however, we are interested in your ability to secure participation of other non-CMS payers.

A non-CMS payer is a payer other than Medicare, Medicaid, and CHIP, and can include individuals, state and local governments, private insurers, self-insurers, employers and sponsors that contribute to group health plans. And groups with investments in the community may also serve to be payer partners.

While the requirement is that a list of non-CMS payers needs to be submitted by the end of the three-year agreement window, when reviewing applications, we will give preference to those that can demonstrate non-CMS payer buy-in from the onset of the new model. This can be shown by firm, demonstrable commitments from current payer partners, current contracts, letters of support or commitment from private insurers, state governments, or local governments. Please note, if you do not submit a list of non-CMS payers at the time of your application, you must submit with the application a feasible approach for securing participation from multiple payers.

Now I'd like to run through a couple of examples from other Innovation Center's programs. Keep in mind these are examples, and the award is not premised on any predetermined number of payer partners or dollar threshold for funding from these payer partners.

In the Comprehensive Primary Care Initiative, CMS collaborates with private payers in local markets who commit to similar efforts, including, but not limited, commercial insurers, MA plans, states, Medicaid, CHIP, managed care, and others. In fact, approximately 60% of a CPCI practice’s revenue is generated by CMS and other collaborating payers.

In another example, CMS requires Pioneer ACOs to enter into contracts with other payers based on financial performance and accountability, such that more than 50% of revenues will be derived from

such arrangements. In some markets, participants have had existing arrangements prior to partnering with CMS as accountable care organizations, providing for more than that 50% threshold. Now let's turn to the presentation back over Jim.

JIM GERBER: Thank you, Andrew. Applicants must demonstrate the sustainability of a payment model. To be sustainable, a payment model must be scalable and financially sustainable on an ongoing basis after cooperative agreement funding has been completed. A payment model is scalable if it can be replicated in different or more extensive Medicare, Medicaid, and/or CHIP populations. It can be made available to other providers beyond those in the model test. And it has the potential to be the basis for a subsequent solicitation by CMS.

A payment model is financially sustainable if it generates a positive financial return for CMS. And if CMS were to put the payment model in place, providers would have the incentive, without additional federal spending, to fully implement the service delivery model following the end of the three-year cooperative agreement period. Please note that preference will be given to applicants who can demonstrate the potential for financial sustainability sooner than three years by creating a payment model that could be used during the term of the cooperative agreement if adopted by CMS and in a broad solicitation of other providers.

CMS is seeking in HCIA round two and will give preference to payment models that propose new alternative approaches, rather than simply expanding or supplement fee for service payments. In order to provide and put into context a few examples of alternative approaches, we have placed the examples in a two-by-two array based on two dimensions that could be used to categorize the provider component of payment models. Please note that this framework is an illustration only and is not intended to convey a preference or a preferred approach. Let's look at this framework in the next slide.

Let me start by describing how the chart is set up. On the vertical axis, we show the degree to which providers accept accountability. On the horizontal axis, we show the degree to which payment models require changes in the existing provider payment system. Using this structure, we show in the upper left-hand quadrant of the matrix examples of models with lower provider accountability and lower changes required to the current payment system. These examples include care management fees and new fee for service payments within the existing payment system.

In the upper right-hand quadrant, we show an example of a model with lower provider accountability and greater changes required to the current system. In the lower left-hand quadrant, there are several examples of models with higher provider accountability and lower required change in the payment system. These examples include large-magnitude value-based payment adjustments and retrospective bundled payments. Finally, in the lower right-hand quadrant, we see examples of models with higher provider accountability and requiring greater change in the payment system. These include prospective bundled payments and capitation.

Wrapping up, I'd like to emphasize that these are illustrations of provider payment approaches only, and that we would like you to consider other new approaches as well, including models that incorporate new beneficiary incentives and that include other non-provider types of applicants. And now I'll turn it over to Aparna.

APARNA SAHA: Thank you, Jim. As you know, we've been receiving a few questions in through our previous webinars and in our mailbox related to this. So for example, a question that's come in is: how do you define a corresponding payment model? Would you like to answer that?

JIM GERBER: Sure, Aparna. A corresponding payment model is a payment model that supports providers in employing a specific service delivery model and incentivizes them to do so.

APARNA SAHA: Thank you. Another question that has come in: what is difference between the design of a payment model and a detailed and fully developed payment model?

JIM GERBER: The design of a payment model is described in the FOA. And it includes the elements described in slide 16 of this webinar, which Jeff will address in a moment. A detailed and fully developed payment model builds on the payment model design and contains more of the essential components and details needed by CMS to implement the payment model with minimal additional developmental effort.

APARNA SAHA: Thank you, Jim. We'll have more time at the end of this presentation to answer the questions that are coming in through the questions box. So we'll come back to you with other questions. Now let me turn it over to Dr. Jeffrey Clough to review in-depth the elements of a payment model. Jeff?

DR. JEFFREY CLOUGH: Thank you, Aparna. During the next section of the presentation, we will review several key elements of the design of a payment model. We will highlight issues that may be addressed for each of these elements. And we will use a variety of existing payment models to highlight ways in which these elements have been addressed.

Please note that this presentation is not intended to include an exhaustive set of elements and issues that need to be addressed in payment models. The examples are not meant to represent the level of detail that may be necessary when describing a payment model. Specific elements we will describe are payment details, which is how funds will flow under the payment model, payment principles, or how the payment model will create specific provider or beneficiary incentives, description of risk parameters, how the payment model will adjust, shift, ensure, and/or limit risk, return on investment, how the payment model will deliver a positive return on investment for CMS, and progression, how the parameters of the payment model will progress over time.

During this presentation, we will refer to the three payment models listed on this slide. These payment models represent a wide range of possible payment models and are chosen to highlight how design elements apply to different types of payment models. These payment models could all support, to some degree, similar service delivery models targeting reductions in hospital readmissions. While these examples apply primarily to Medicare, the issues and examples are applicable to payment models for all payers.

The transitional care management codes are illustrative of models that transfer minimal accountability, which could include new fee-for-service codes or care management fees. I'm going to pause this for a second. If we can go back to the previous slide.

The Hospital Readmissions Reduction Program is illustrative of a value-based payment adjustment. The two selected models from the Bundled Payments for Care Improvement Initiative represent payment

models with a greater transfer of accountability to providers. Those models include a bundled payment for an episode of care that is defined by an admission to an acute care hospital for a specific clinical condition.

A key difference between the two models is that in model two, providers are paid under the fee for service system and a retrospective reconciliation occurs outside of the usual payment system, while model four replaces the current payment system with a single prospective payment. This provides an illustration of how models with a similar transfer of accountability may differ in the change imposed on the payment system.

We've selected these models because they could correspond to similar service delivery models, but differ significantly in the design of the payment model. These examples illustrate trade-offs in different approaches to payment models. Note that these models are illustrative of payment models and not intended to convey a preference or preferred approach.

As stated earlier, preference will be given to alternative payment models over those that simply expand the fee for service payment system. However, models that expand the fee for service payment system, such as transitional care management codes, will still be considered as standalone payment models or as a part of a payment model with multiple components. Also note, models that focused primarily on acute hospital inpatient care are excluded from consideration in round two.

The first element to discuss is payment details, which describes how funds would flow under a proposed payment model. Some issues to consider for this element are, whom does the payer pay? Whom does the payee pay? And will new business relationships be required? Are there specific legal and operational issues related to these relationships? And how will beneficiary choice be maintained under these relationships? And will a payment model operate within the existing billing and payment system framework, or will it require a new payment mechanism? And how is quality integrated into the payment?

Some examples of how this element is addressed through the example payment models are, for the transitional care management codes, the physician fee schedule is maintained with the addition of the new codes. For the Hospital Readmissions Reduction Program, the inpatient prospective payment system is maintained with an adjustment to the amounts that are normally paid.

For the Bundled Payments for Care Improvement, model two, the current payment system remains in place. However, a new payment mechanism involving the reconciliation is made between CMS and the awardee. And then the awardee may have additional financial arrangements to share that payment with its partners. And this is similar to the payment model used in many shared savings programs.

In model four of the Bundled Payments for Care Improvement, a single bundled payment will be made by CMS to the hospital in place of the current payment system. And that hospital will then have to disburse payments to other providers of services in the episode. And legal and operational issues for disbursing those payments among providers are critically important in this model. Some of those issues involving business relationships between providers for model four would also be applicable to model two for the reconciliation payments, but may not be as extensive.

The next element describes the specific provider or beneficiary incentives the payment model would create. Some representative issues to consider in designing a payment model are, how does the payment model incentivize the service delivery model? All payment models must correspond to the service delivery model being proposed. Does the payment model adequately ensure key elements of the service delivery model are provided?

For models that do not transfer risk, it is of particular importance to ensure that the payment model ensures provision of the desired services. Does the payment model provide flexibility for improvement of the service delivery model and adaptation to different circumstances? Alternative models that transfer risk will typically offer greater flexibility.

Does the payment model incentivize unintended and undesirable behaviors, such as declines in the provision of necessary services? And how are these addressed? Does the payment model directly incentivize beneficiary behavior?

Moving on to the examples for element number two. For the Transitional Care Management Codes, they incentivize care management services by providers, but narrowly define the timing and provision of those services. For the Hospital Readmissions Reduction Program, the focus is on high readmissions rate, which is an outcome measure allowing flexibility for a provider to select a service delivery model that achieves the outcome. For the Bundled Payment for Care Improvement, the payment of a fixed discounted rate supports a variety of service delivery models with monitoring by CMS for any unintended consequences.

Moving onto element number three, risk parameters. This addresses how the model adjusts shifts, ensures, and/or limits risk. Some issues related to this element are, does the payment model shift risk to providers? If so, what is the appropriate amount of risk for targeted providers? And what steps should be taken to limit risk for providers? Some examples may be outlier policies, risk adjustment, or a shared savings mechanism.

Do providers typically provide sufficiently high volumes of services to take on risk for the proposed payment model? And do providers have sufficient risk management capabilities to take on risk for the proposed payment model? And is the risk modeling sufficiently robust? While applicants may not have the capabilities or data to perform comprehensive risk modeling to answer these questions, at a minimum, relevant issues should be described along with an approach to answering these questions, including the data sources.

So looking at some examples, using our example payment models. For the Transitional Care Management Codes, there is minimal change and risk. In the hospital Readmissions Reduction Program, some risk is shifted to hospitals for high readmission rates, but much of the risk for readmission payments is retained by Medicare. For the Bundled Payments for Care Improvement, a large percentage of financial risk is shifted to providers, with some modifications, such as risk adjustment, based on the presenting clinical condition. And there will be outlier policies.

Moving onto element number four, which is return on investment. This describes how the payment model will deliver a positive return on investment for CMS. The model should result in net savings to CMS relative to existing payment systems. So some representative issues are, how is the price determined? What factors would jeopardize achievement of forecasted results when the payment

model is implemented? What are the types of unintended behaviors that may occur due to incentives created by the payment model, and how may they jeopardize anticipated savings? And what steps can be taken to prevent such behaviors? And how will results achieved during the model test be replicated?

So looking at our three examples. For Transitional Care Management Codes, savings to CMS only occur if care transition services result in reduced readmission or other effects. It is necessary for these codes to specify requirements for provision of services to increase the likelihood that the desired outcomes will be achieved. For the Hospital Readmissions Reduction Program, similarly, the savings to CMS will largely occur if providers are successful in reducing readmissions.

For the Bundled Payments for Care Improvement, savings to CMS on a per-episode basis are applied up-front, with providers bearing risk for  further savings. However, CMS must monitor for unintended behaviors, such as cost shifting, an increase in the volume of episodes and changes in patient case mix that are not accounted for with the risk assessment methodology or other components of the payment mechanism.

The fifth element addresses how parameters of the payment model will progress over time. Some representative issues to consider are, will the structure of the payment model change over time, and along which dimensions? For example, the risk payment mechanism. Will there be a phased-in approach? How will the payment model promote continuous improvement of the service delivery model and adapt accordingly? And what key factors, including other delivery and payment reforms, may affect this progression?

So some examples of model progression could include a change in the magnitude of the payment model, such as an increase in the proportion of payment at risk in a pay for performance or shared savings model, a change in the mechanism of payment, such the progression from retrospective to prospective payments, or an incremental addition of components of a hybrid payment model, such as a progression from care management fees to care management fees with shared savings.

This concludes the overview of basic elements of a payment model. As a reminder, fully developed payment models may address additional elements or issues and should reflect the interdependency of these elements. The examples presented here are not intended to represent the level of detail that may need to be provided for each element. I will now turn the presentation over to Jim, who will present an additional example payment model with a brief overview of all of these elements described together.

JIM GERBER: Thanks, Jeff. As Jeff mentioned, we'll close our discussion of the elements of payment models with an example which illustrates all five design elements. The Comprehensive Primary Care Initiative. CPCI is testing in about 500 primary care practices in seven geographic markets whether increased investment in primary care improves care and lowers costs for Medicare patients. CPCI also will provide selected practices serving Medicaid beneficiaries in selected markets, with additional support to allow them to participate.

Let's move to the chart on the next slide showing the key elements of the CPCI payment model design. Starting with the flow of payments, a care management fee will be paid to supplement Medicare fee for service payments. And in addition, practices will have the opportunity to share in savings.

With respect to the payment principles, these payments are intended to encourage increased primary care practice investment in access and coordination. In addition, shared savings are calculated at the regional level in order to encourage practices to work together to share best practices. The key risk parameters of CPCI include risk adjusting care management fees and sharing savings, but not increasing costs, with the participating practices.

Moving on to return on investment, CMS expects to achieve a positive ROI by increasing the provision of comprehensive primary care and by further aligning providers with CMS through shared savings opportunities. Finally, regarding the progression of the parameters of the payment model, care management fees, which are intended to support investment in primary care, will decrease in years three and four, as practices will continue to have the opportunity for shared savings. And now I'll turn the presentation back to Aparna.

APARNA SAHA: Thank you, Jeff and Jim. We have also been receiving a few questions in the Innovation Awards mailbox related to payment model elements. For example, what are some of the tools that can be used to avoid unintended consequences? Jeff, can I refer this to you?

DR. JEFFREY CLOUGH: Sure, Aparna. There are many possible strategies to address unintended consequences, including those that are incorporated directly into the payment mechanisms, such as risk adjustment, and as well as monitoring for anticipated unintended consequences using various metrics of quality utilization and patient satisfaction.

APARNA SAHA: Thank you. Another question that was asked, can we clarify a comment we made on the Total Cost of Care webinar on June 20? Participants were confused by the explanation that CMS provided for the return on investment requirements for applicants. Jeff, I know we worked on this. Could you respond to this?

DR. JEFF CLOUGH: Sure, Aparna. 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 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 as specified in the FOA.

APARNA SAHA: Thank you, Jeff, and thank you to all of our speakers today. We'll come back to you at the end of the presentation to answer all of these questions that are coming in from today's participants.

So in terms of next steps, we have two webinars in this webinar series. The next webinar will be on the overall application package, where we will provide a road map to the different components required for the application. And the final webinar will be focused on the technical aspects of submitting the application through the grants.gov website. We will post materials from each of the webinars within a week of the event, barring any technical issues. And as always, dates, times, and registration information will be provided through our listserv and on our website.

We are excited about the enthusiastic responses we have received through the LOI process. Please remember that you'll be able to make changes from what you submitted in the LOI to your application.

This includes changes in partners, PIs, the intervention, beneficiaries, and funding amounts. We use the LOI for planning purposes, but we recognize that you're still working through many of the details for your application. Please make sure you keep the LOI number that you have received so that you can include in your application.

And please continue to check back on our website for resources and additional information at innovation.cms.gov. If there are any questions that we have not been able to answer on these webinars or through our frequently asked questions posted on our website, please email us at innovationawards@cms.hhs.gov.

We will now transition to the question and answer section of this webinar. As a friendly reminder, please enter your questions in the box titled Submit Your Questions that is located on the lower left of the webinar portal appearing on your screen. Before we get to our first question, we want to remind everyone that the CMS Innovation Center staff is unable to provide you or your organization with any feedback regarding proposals or ideas during this procurement sensitive time period.

We are also unable to meet with any applicants during this time period. This is to ensure the integrity and equity of this competitive funding opportunity. If you do meet with CMS Innovation Center staff during this time period, you may be deemed ineligible for funding in the Health Care Innovation Awards round two. Now, we are ready to begin with the first question.

QUESTION AND ANSWER SESSION:

So it reads, are proposals that look to test current service delivery models but new payment models eligible to apply, or is it considered duplicative? How about existing service delivery models tested on new types of beneficiary? Are those eligible to apply? I'm going to turn it over to Christy.

CHRISTY MEYER: Payment models that are new and that apply to different populations of Medicare, Medicaid, and/or CHIP beneficiaries in support of an existing service delivery model are eligible to apply if they meet the criteria specified in the funding opportunity announcement. CMS will not fund proposals that duplicate models that CMS or other HHS entities are currently testing in other initiatives. Payment models that propose new alternative approaches rather than simply expanding or supplementing fee for service payments will be preferred.

APARNA SAHA: Great. Thank you, Christy. I see another one that I might try to have you answer as well. How does one find out whether a proposal would be duplicative of projects already announced or awarded by CMS or another federal agency?

CHRISTY MEYER: There are several resources. Applicants can review information found on the official websites for the Center for Medicare and Medicaid Services, which is cms.gov, or the Center for Medicare and Medicaid Innovation, as well as the US Department of Health and Human Services. The website for federal grants, grants.gov, is also a great resource. We really recommend for more information that people visit the Innovation Center at innovation.cms.gov, and its partner agencies

APARNA SAHA: Great. Thank you, Christy. Should we do a clarification in the FAQ that people do not need a go-ahead to submit the full application?

CHRISTY MEYER: Yes, so one of the common questions that we've been getting in our inbox is whether or not a letter of intent will be given the go-ahead to submit a full application. And we just want to let everyone know that you can proceed with the application. There won't be a formal notice regarding a go-ahead to submit a full application. All you need is your LOI number.

APARNA SAHA: Great, and so we'll go ahead and do an FAQ on that as well. Thanks. So the next question, do you have to have a commitment from a payer to submit an application? Or can you submit an application and then develop a relationship with a payer over the course of the demonstration? I think I'm going to hand this over to Andrew. Andrew?

ANDREW KEENAN: Applications must include a feasible approach for securing participation of multiple payers. That can include demonstrable commitments from current payer partners, current contracts, letters of support, commitment from private insurers, from state governments, or local governments. Preference will be given to applications that include participation by non-CMS players at the onset of the model's implementation.

APARNA SAHA: Thank you, Andrew. And if you stay on, here's another question for you. Please define a non-CMS payer.

ANDREW KEENAN: A non-CMS payer is an entity that pays for health care services on behalf of a group of patients. A non-CMS payer could include, but is not limited to, private insurers, including MA plans and managed Medicaid organizations, employers, governments, and unions.

APARNA SAHA: And Andrew, what do you mean when you say participation of a non-CMS payer?

ANDREW KEENAN: Participation means the implementation of the service delivery and payment model test in non-CMS patient populations served by the providers participating in the model test for CMS beneficiaries. As noted, CMS recognizes that in order for providers to have meaningful incentives to change their service delivery models, they must engage multiple payers.

APARNA SAHA: Great. Thank you, Andrew. So the next question. If Medicare, Medicaid, and CHIP serve specific populations that are unlike those covered by private insurers, could you please clarify the expected involvement of other payers? How would a payment model tested by a private payer be assumed to demonstrate cost savings for the population served by Medicare, Medicaid, or CHIP? Jim, would you like to answer this one?

JIM GERBER: Sure, Aparna. CMS is not specifically seeking cost savings from payment models tested by private payers. Rather, CMS recognizes that in order for providers to have meaningful incentives to change their service delivery models, they must engage multiple payers.

APARNA SAHA: Thank you, Jim. So the next question. Can the proposed new payment model address only Medicare as a payer and not address other payers? Jeff?

DR. JEFFREY CLOUGH: Sure. The payment model's design must include Medicare, Medicaid, and/or CHIP, any one or more of these programs, though it should ideally include other payers as well. As noted previously, applications must include a feasible approach for securing the participation of multiple payers.

APARNA SAHA: Great. Thank you, Jeff. The next question. How important is three-year ROI versus long-term care costs? Will a project with no ROI in the three-year period be approved if it meets all of the other requirement and shows long-term significant savings? Jim, I think I'm going to ask you to answer this.

JIM GERBER: OK, Aparna. We recognize that some models by their nature will require a longer time to achieve a positive ROI and sustainable cost savings estimates.

APARNA SAHA: Great, thank you. So the next question reads, when should the proposed payment model be implemented? Jeff, I think I'm going to turn this over to you.

DR. JEFFREY CLOUGH: Sure. Detailed and fully developed payment models must be submitted by the end of the three-year cooperative agreement period. Only CMS may implement payment policy changes in the Medicare, Medicaid, and/or CHIP programs, and CMS is under no obligation to do so. CMS does not anticipate making payment policy changes during the performance period. However, CMS may consider on a case-by-case basis the implementation of alternate payment arrangements using award funds during the performance period.

APARNA SAHA: Thank you, Jeff. And while you're here, may an applicant test payment model directly with Medicare, Medicaid, or CHIP populations and programs, rather than with other payers? Would an applicant be permitted to alter payment policies and possibly eligibility requirements for one of these public insurance programs?

DR. JEFFREY CLOUGH: Thanks, Aparna. As noted previously, only CMS may implement payment policy changes. Waivers may be issued at the sole discretion of the Secretary of Health and Human Services in compliance with applicable laws and regulations.

APARNA SAHA: Great, that's very helpful, Jeff. Thank you. So the next question. May a state Medicaid agency apply to test a new payment model? And may managed Medicaid providers apply? What are the applicable restrictions? Christy, I'm going to you hand this over to you.

CHRISTY MEYER: Yes, states and their components may apply, as may managed Medicaid parties that meet to eligibility requirements of the funding opportunity announcement. Restrictions contained in the FOA do apply. Note particularly that funding from the Innovation Center may not supplant funding for services that are currently authorized to the Medicaid state plan. This also applies to funding provided through waivers and other grants, including federal grants.

APARNA SAHA: So then, Christy, regarding managed Medicaid, can community services not on the managed health care side be paid for?

CHRISTY MEYER: Yes, community services may be supported subject to the restrictions in the funding opportunity announcement.

APARNA SAHA: Great, thank you, Christy. So the next question. Can you specifically define payer? Sheila, I'm going to queue this up for you.

SHEILA HANLEY: Sure. A payer is an entity other than a patient that finances or reimburses the cost of health services. This includes insurance carriers, health plans, sponsors, employers or unions, and other third-party payers.

APARNA SAHA: Great. Now would a self-insured employer that is hoping to sell its insurance services externally constitute as a payer?

SHEILA HANLEY: Yes, it would.

APARNA SAHA: Thanks, SHEILA. There's a few more that I might send your way. Would a third-party administrator constitute a payer?

SHEILA HANLEY: Yes.

APARNA SAHA: Would a payer be someone who by definition is at risk?

SHEILA HANLEY: The entity must have the authority to enter into a payment model arrangement. Typically, this means that the entity bears the risk. A payer could also be a third party administrator with authorization from the risk bearing entity to enter into payment arrangements. The applicant or payer would be responsible for obtaining these authorizations. (This response has been edited).

APARNA SAHA: Thank you, Sheila. Would we have to work with multiple payers, or is it enough to work with one, as long as applicants have the commitment from others that they have interest in applying the model as part of their service line, given that it proves successful?

SHEILA HANLEY: Sure. We believe that in order to successfully transform their business models, providers need to work with multiple payers. This is to ensure that a majority of their revenue is tied to incentives for better health care and lower cost.

APARNA SAHA: Great, Thank you, SHEILA. Next question. Since applicants will be testing, or at least developing, a payment model in the private sector that is supposed to be applicable for the public sector, should the application or proposed evaluation address the feasibility of replicating the payment model in the public sector? I think I'm going to turn that over to Jeff.

DR. JEFFREY CLOUGH: Sure. Payment model feasibility is addressed in two ways, as described in the FOA. The payer model must be operationally feasible for CMS. And applications must include a feasible approach for securing participation of multiple payers.

APARNA SAHA: Great. Thank you, Jeff. For the next question, can a payment model be proposed without a service delivery model? For example, a new payment model for services provided under a fee for service. Sheila, I think I'm going to turn this over to you.

SHEILA HANLEY: Sure. Although applicants must propose new payment and service delivery models, it is acceptable to propose a new payment model supporting and corresponding to an existing service delivery model. It will be important to emphasize how the new payment model differs from current payment models, furthers the goal, and meets the criteria of the FOA, including how it will change

incentives, how grant funds will be used, and how it will provide net programmatic savings for CMS. (This response has been edited)

APARNA SAHA: Great. Thank you. Would a new delivery and payment model that combines two existing models, for example, the medical home and bundled payment, also qualify for this grant? Sheila?

SHEILA HANLEY: Yes. And the Comprehensive Primary Care Initiative that Jim referenced earlier is one such example. As always, we would need to examine the application to ensure that the model will produce net programmatic savings for CMS and meet all other applicable requirements.

APARNA SAHA: Great. Thank you, Sheila. So the next question. If there is no other payer interested in testing a payment model now, but this requirement for a willing payer is likely to be met by the end of the grant period, how should an applicant demonstrate this? What evidence do you need that another payer might be willing three years from now to test the new payment model? Jim, I think I'm going to turn this over to you.

JIM GERBER: Applications are required to include a feasible approach for securing participation of multiple payers for their proposed models. This could include, as indicated in the FOA, demonstrable commitments from current payer partners, current contracts, letters of support, or commitment from private insurers, state governments, or local governments.

APARNA SAHA: Great. Thank you, Jim. The next question. For states that are currently involved in a demonstration for dual eligible patients, will those have to be systematically excluded from any programs proposed for the Innovation Challenge program? Sheila?

SHEILA HANLEY: Sure. We will be reviewing applications with unique circumstances on a case-by-case basis and working with other CMS components to resolve issues related to overlap. Importantly, we will not be paying twice for the same services, and we'll need to ensure that a sound model test and evaluation can be conducted.

APARNA SAHA: Great. Thank you. Now, another applicant has asked, we are currently applying for the MSSP program. Are there any restrictions to the same beneficiaries being part of this grant and being assigned to our ACO? Sheila, I think I'm going to ask you to answer this as well.

SHEILA HANLEY: Sure. Again, we'll be reviewing applications with unique circumstances on a case-by-case basis. Importantly, we will not be paying twice for the same services, and we'll need to ensure that a sound model test and that an evaluation can be conducted for the proposal.

APARNA SAHA: Great. Thank you. So the next question reads, if a service delivery or payment model requires a change in current law in order for it to be implemented on a wide scale-- for example, reimbursing some service that Medicare does not currently reimburse right now-- would such an idea be a viable candidate for an award? Christy, I think I'm going to hand this one over to you.

CHRISTY MEYER: Yes, such a proposal will not be excluded from consideration.

APARNA SAHA: Great. Thank you, Christy. The next question reads, when submitting a proposed payment model, does that apply to all payees? Can alternative designs be pursued with the population

outside of Medicare and Medicaid? Sorry, let me read that one again. Can alternative designs be pursued with the population outside for Medicare and Medicaid beneficiaries? Does CMS suggest that we propose a single suggestion for payment model or are multiple payments structures preferred. I think I'm going to hand this over to Jim. Jim?

JIM GERBER: Sure, Aparna. Payment models can be relatively simple or based on more complicated designs, as shown by the various examples described in this webinar. CMS seeks your most innovative ideas and has no specific preferences other than those stated in the FOA.

APARNA SAHA: Great. Thank you, Jim. So let me see if we can go through some more of these questions. So the next one reads, if we check the wrong box for model number on our LOI, can that be clarified in the application? Christy, I think I'm going to turn this one over to you.

CHRISTY MEYER: Sure. I think this refers to the model category that was checked in the Letter of Intent. And that can be changed in the application if you feel you need to make a modification.

APARNA SAHA: Great. Thanks for that clarification. Actually, while I have you here, I think I'm going to ask you the next question as well. Does the description of risk parameters need to be defined in a quantitative manner, or just a general description of how they will be implemented]? Christy?

CHRISTY MEYER: The more precise the proposal, the better, but we understand the complexity of designing risk parameters in a payment model, and in many cases it will be appropriate to describe them in a qualitative manner. (This response has been edited)

APARNA SAHA: Great. Thank you. So the next question. Is it acceptable to test two payment models under a single demonstration? Shared savings with one payer and a partial cap with another payer? Sheila, can I hand this over to you?

Sheila Hanley: Sure. In this instance, yes. However, it's noted in the FOA, during the selection process, CMS may wish to discuss and propose possible adjustments to the proposal to ensure a sound test.

APARNA SAHA: Great. Next question. Can the proposed new payment model address only Medicare as a payer and not address other payers? Jeff, can I ask you to answer this?

DR. JEFFREY CLOUGH: Sure. While the payment model design must include Medicare, Medicaid, or CHIP, or any one or more of these programs, it should ideally include other payers as well. As noted previously, applications must include a feasible approach for securing the participation of multiple payers.

APARNA SAHA: Thank you. The next question reads, Medicare, Medicaid, and CHIP serve specific populations that are unlike those covered by private insurers. Could you please clarify the expected involvement of other payers? How do models tested by a private payer be assumed to demonstrate cost savings for the populations served by Medicare, Medicaid, or CHIP? Jim, I think I'm going to hand this to you.

JIM GERBER: CMS is not specifically seeking cost savings from payment models tested by private payers. Rather, CMS recognizes that in order for providers to have meaningful incentives to change their service delivery models, they must engage multiple payers.

APARNA SAHA: Great. Thank you, Jim. So the next question. Does detailed and fully developed payment models mean that the payment model is operational? Sheila, can I send this to you?

SHEILA HANLEY: Sure. The answer is no. Detailed and fully developed means that the payment model has more of the elements that are needed to sufficiently develop the model. The design of a payment model is described in the FOA. And it includes the elements described in slide 16 of this webinar, which Jeff has addressed. A detailed and fully developed payment model builds on the payment model design and contains more of the essential components and details needed by CMS to implement the payment model with minimal additional developmental effort. (This response has been edited)

APARNA SAHA: Great. Thank you, Sheila. As I'm checking the time, I'm noticing that we are running out of time. Let me see if we can get to the last question. This is a good one. Why is it important to include payment models in this round of the Health Care Innovation Awards and not the first round? Sheila, I'm going to hand this back to you.

SHEILA HANLEY: Sure. Well, in round two, we were interested in addressing gaps in our health care portfolio, and particularly high opportunity areas for better care and lower cost. As expansion in Medicaid and CHIP populations occur, we also wanted to encourage very strong focus in these areas. We're also very interested in improving care delivery and quality for high risk beneficiaries and specific populations while at the same time reducing the cost of their care and developing new sustainable models in prevention.

We wanted to address these areas by taking full advantage of the wide range of innovative ideas being generated by the health care industry and the community at large. We believe that in order to sustain these service delivery innovations beyond the cooperative award period, we need viable payment models that could potentially result in changes to the way Medicare, Medicaid, and CHIP pay for services.

As you know, one of the biggest challenges in health care delivery and financing is aligning financial incentives to support the kind of care that we would all like to receive as patients or to provide as health care professionals. And the challenge is to design payment models so that providers and other entities and stakeholders have sufficient incentives to continue delivery system innovations well beyond the award period. We believe that the provider and community organizations that are closest to the challenges of delivering care cost effectively are in a very unique position to help and to lead the redesign of payment systems that will reward the kind of care and services that they want to deliver.

We also know, as Rahul mentioned in the opening of this webinar, that there is momentum building among providers and many other stakeholders across the country to move more rapidly to a payment system that rewards value. Round two of the Health Care Innovation Awards was designed to encourage the very best ideas from the field in both service and payment reform to meet these challenges.

So last and most importantly, we want to thank everyone for their engagement today on this webinar and for all of your engagement in our previous webinars. And most importantly, we want to thank you

all for the work that you're doing every day to make care better and more and more affordable. Over the past years, we've made great strides in delivering care that is smarter and more affordable by partnering with innovators in the field. And we're very much looking forward to continuing to do so in round two of the Innovation Awards.

We want to thank you for the innovative and important work that you do each day to make care better and more affordable and for joining us this afternoon. We look forward to your joining us next Thursday for our next webinar. Thanks, everyone, and have a great afternoon.

APARNA SAHA: Great. Thank you so much, Sheila. That concludes the question and answer section of this webinar. We ask that attendees please fill out the participant survey appearing on your screen. We value participant feedback throughout this webinar series. And thank you again for joining us today. Goodbye.