Transcript of Innovation Center Update Webinar – November 10, 2014

FRAN GRIFFIN: Welcome to the CMS Innovation Center Update. My name is Fran Griffin and I'll be facilitating the webinar. Please note that it is being recorded including the audio, slides and chat. The recording and materials will be available on the Innovation Center website shortly after the webinar conclusion. All lines are currently in listen-only mode and shall remain so throughout the session. There will be an opportunity for questions following the presentation.

We have been thrilled with the overwhelming response to the webinar and amount of interest in the work of the Innovation Center and the many organizations and providers working in our models. We hope to continue connecting with all of you listening both live today and later via the recording as we strive to transform the US healthcare system towards better health, better care and access at lower costs.

Now it is my pleasure to introduce Dr. Patrick Conway who serves as the Chief Medical Officer and Deputy Administrator for Innovation and Quality for CMS, Director of the Center for Medicare and Medicaid Innovation, and the Director for the Center for Clinical Standards and Quality. So with that, Patrick, I will turn it over to you for the webinar.

PATRICK CONWAY: Great, thank you, Fran, and thank you to all of you for being here. I look forward to giving this update today and I also know many of you are participating in various Innovation Center models or other non-CMS sponsored healthcare transformation models so I want to thank you for that work on behalf of the patients that you serve. On the next slide, you'll see I'm going to talk a bit today about some of our goals and early results, talk about the Innovation Center and give an update on the models and then end with a short discussion about looking forward.

So, if you think about our delivery system and payment transformation agenda, we have an historical state that was traditionally producer- centered, volume driven, unsustainable, fragmented care and built on a fee-for-service system. And we are really trying to work with both the public and the private sector to make sure we're achieving a future state that is people-centered, outcomes driven, sustainable and delivering coordinate care for patients. We're using a number of payment and policy levels to get there. The bottom right of the slide certainly does not list them all but lists a subset – things like value-based purchasing, accountable care organizations and shared savings we'll talk about today, episode based or bundled payment systems, medical homes and care management, advanced primary care medical homes and also data transparency, both on quality and cost of care. So, we are really trying to get the incentives in place to help drive care delivery, transform care delivery to achieve that better healthcare outcomes, better quality and lower cost; and then lastly, get the right information in place to drive health system transformation.

On this next slide, this is from a paper in JAMA that Marilyn Tavenner, the Administrator, myself and Rahul Rajkumar wrote. It talks about four categories of payment to clinicians and organizations. Importantly this is payment TO clinicians and organizations – the providers in the health system. Category one is fee-for-service with no link to quality. Category number two is fee-for-service with a link to quality and efficiency, so an example would be hospital value-based purchasing or physician value-based value modifier. Category three is alternative payment models built on a fee-for-service architecture, so things like accountable care organizations or bundled payments; and category number four, population-based payment.

A couple of examples: one, our Pioneer ACO program where a number of ACOs are moving to population-based payments. Another example, in Maryland, we worked with the state of Maryland and their hospitals on an Innovation Center model statewide that moves hospitals to population-based payments, so over the course of five years, over 80% of payments at hospitals will be from population-based payments, not fee-for-service. I can tell you, when we talk to hospital CEOs, CMOs or others in Maryland, it has really turned the financial model on its head, if you will, where they are heavily investing in community-based interventions to keep people healthy and out of the hospital.

Historically, if you look back three years ago, CMS and Medicare had almost no payments in categories three and four. We now have a substantial percentage in category three and four, and category two has grown over time. We actually have less than 10% of Medicare payments in category one, so, approximately 7% less than category one. So, we are really shifting the payment models to have more payments in category three and four, and then in category two, linking the payments to quality and value.

The next slide actually talks about category two, so CMS is increasingly linking fee-for-service payments to value. This just shows hospitals and physicians. If you look at the performance period 2015 and the rules – there were various statutes and rules that were just finalized – if you add up hospital value-based purchasing, inpatient quality reporting, meaningful use and hospital acquired conditions program for hospitals, there is 8% tied to quality and value. I practice in the hospital setting; as many of you know who come from the hospital setting, 8% is a substantial portion of payment. And then, on the physician- clinician side, we, for the larger groups, have 9%, if you add up the various programs, tied to quality and value. It is still important to work on getting the right metrics in place, really having outcomes-oriented metrics that drive maximal improvement, aligning programs so you can support one to receive credit for all programs (which we have done), and really focusing on those measures that matter. An iterative learning system but the point being that tying substantial parts of payment to quality and value.

Now I'm going to shift gears a bit and talk about some of our early results.

This shows Medicare per capita cost growth. As you all probably know, the last four years is the lowest cost growth in over 50 years. So, there is certainly a portion of this that is change in the delivery system. One example - I'm going to show readmissions in a bit- but also, overall Medicare hospitalizations, and you can look at it. Inpatient hospitalizations are also even combined with inpatient observation care. Over all, if you look at a population level per 1000 Medicare beneficiaries, there has been a substantial decrease in hospital utilization, keeping people healthy and out of the hospital. And that's really a credit to hospitals and communities working together to do that work.

This shows hospitals readmissions for Medicare - 30 day readmissions. As many of you know, we were 19% to 20% readmission rate within 30 days for years. This control chart, you can actually go back a very long period of time. We put a couple of things in place. One, we did have payment incentives but I think equally and potentially even more importantly, we, CMS, and also hospitals, communities, providers across the country, made major investments in decreasing readmissions, quality improvement efforts. We have seen readmission rates drop substantially. This represents over 150,000 Medicare beneficiaries staying home and healthy instead of being in the hospital so a great example of the combination of incentives plus support to drive improvement.

The next slide just shows our patient harm results nationally. The first bullet point is actually from the national scorecard that we worked with the Agency for Healthcare Research and Quality on. It is chart review data, so “gold standard” method of measuring harm. If you look at 2010 to 2012, there was a 9% reduction in healthcare acquired conditions nationally. That translates to an estimated 15,000 lives saved, over 500,000 injuries, infections and adverse events avoided and over $4 billion in cost savings. We are working on releasing the 2013 results soon and we’re trending in the right direction. We can't give you the details today but we are working on releasing the 2013 results soon.

The bottom part of the chart is some specific areas of harm from our leading indicators, from our Partnership for Patients, Hospital Engagement Networks. I'll just call out a couple. Early elective deliveries, over 50% reduction. I practice clinically in the hospital setting, taking care of children generally with multiple chronic conditions. As we know, preterm birth is a major risk factor for complications and morbidity long-term, so, decreasing early elective delivery nationally by more than 50% - great news. Line infections aren't in this chart but we are down almost 50% nationally. I still remember as a resident having an infant who passed away from a central line infection and at the time saying, “these things happen” and “they are not preventable”, which is what we thought at the time. We now know that they are preventable, based on research that was done, then we have now scaled that research nationally, decreasing the central line infections, so a great example of driving national results.

I will now shift gears to the meat of the presentation on CMMI – the Center for Medicare and Medicaid Innovation. I have been in CMS heading towards four years. Originally in my CMO role and director of the Center for Clinical Standards and Quality, I have been leading the Innovation Center for about a year and a half. Just Friday, I was with a group of providers in our Bundles model and it is so exciting to see chief medical officers and chief nursing officers from across the country, very engaged in how they are going to redesign care for patients, for example, those admitted for a total hip replacement. Those are the kind of tangible interactions that make the work so exciting. So, just to orient people to the statutes: the CMS Innovation Center, the purpose of the Center is to test innovative payments and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. So essentially, to be able to extend these models, they have to meet at least one of three criteria. One, quality goes up and costs are at least neutral. Two, cost goes down and quality is neutral. Our best case scenario and what we are always striving for is that quality has improved and costs are decreased.

So the next slide just shows our portfolio. We've got more than 20 models that are currently 3021, meaning Center for Medicare Medicaid Innovation Center funded. We've also got a set of demos that predated the Innovation Center, and/or were funded from other statutory programs, but this shows a picture of our whole portfolio, if you will. I'm going to talk about a number of these areas. There are two areas that I won't talk about today but are critically important. One, the Health Care Innovation Awards; we have made major investments literally in every state across the country to fund the best ideas of innovation to improve quality and lower cost. We just brought in round one for a conference here in Baltimore and the excitement in the room and seeing the results from all of these innovation awards was truly amazing. Also, we've got our Medicare-Medicaid dual eligible focused demonstrations. I won't talk about those today but they are really critical parts of the portfolio as well.

So this just shows, and you can go on our website and drill down into your state, but this just shows, we've got innovation everywhere across the US, every single state; so, very exciting, the amount of innovation ongoing. We've got millions of beneficiaries engaged in these models

and tens of thousands providers directly. And if you think about our state innovation models and models that touch people across the US, those models interact with populations that are over 50% of the US population - so a really broad reach and taking the best ideas from everywhere.

Now I will shift to some specific models of discussion. One, accountable care organizations. As you know, the goal is to incentivize providers to take care of populations of patients and to improve the quality of care while lowering costs. It does promote shared accountability across providers. It really focuses on increasing coordination of care, investing in the infrastructure and redesigning care services. We have interacted with a number of our ACOs and it's really shifting the way they think about their care delivery system and population health management and the goal to achieve better health and better care at lower cost. And as you know, Medicaid and private payers are increasingly launching both accountable care organizations and other alternative type contracts.

So the next slide just shows the first year results, of our ACO programs, and then I'll show you the second year results. There are over 350 ACOs serving over 5 million Medicare beneficiaries - approximately 10% of the Medicare population. So, if you think about the overall Medicare population, we've got approximately 30% in Medicare Advantage which has been growing over time. The ACO portion is growing substantially. We've got other alternative payment models, so in the not too distant future, we likely will have a minority of Medicare beneficiaries in the traditional fee-for-service models, and in those traditional models, a significant portion tied to quality and value.

Then on the bottom part of this page, over $380 million in savings combined for Medicare Shared Savings ACO Programs and Pioneer ACO. Pioneer ACOs outperformed benchmarks on 15 out of 15 clinical quality measures and 4 out of 4 patient experience measures. I should say here that the Pioneer ACO program was designed based on a policy principle that we allow people to migrate risk tracks. So, there were Pioneer ACOs that migrated to lower risk tracks, for example, into the Medicare Shared Savings plan. That was expected. Actually, we expected more to migrate to lower risk tracks than have. We have noticed whenever one migrates, it sort of funds, or describes as a bad event. It is actually not a negative event. We designed with the policy principle that providers are able to migrate risk tracks. We said in our recent RFI that we're thinking about whether we need ways to migrate up the risk continuum as well, in the Pioneer ACO programs and the ACO at high-risk tracks. We're still contemplating that.

The year two results on this slide, once again, savings year two over $370 million net savings. The majority of ACOs in both programs generated savings, so the majority generated savings. This never gets as much pickup as I would like as a quality oriented person but I think some of the best news was the quality and patient experience results. So, the Pioneer ACOs improved 28 out of 33 quality measures, moving from 70% to an overall average of 84% performance. Patient experience improved in 6 out of 7 measures. Medicare Shared Savings likewise also improved for almost all measures of quality and patient experience. And we did publish these results earlier this year. So overall on the ACO program, I think really strong, early, promising results. We are working on releasing the multivariable evaluation report for Pioneer ACOs for the second year soon. We are working to get those results - early results showing improving quality and lowering cost.

So I'll shift and talk about the State Innovation Models. This is a model that we are incredibly excited about. Potentially, we are partnering with states to develop broad-based state

healthcare innovation plans. In round one, we have six implementation states and 19 design or pre-testing states. Let me give you a few examples of the implementation states. One is Arkansas and I was just on a panel with Joe Thompson from Arkansas last week, implementing advanced primary care, medical homes, implementing episode-based bundled payments, working with higher payers in their markets. I believe over the vast majority - over 80% of covered lives are in the model, and it allows the state the flexibility as well to design the programs in ways that meet the needs of that state. So I think a tangible example in Arkansas. In Oregon, coordinating care organizations and other changes being implemented. Vermont - looking at all-payer ACOs and other ways to drive transformation. So states are really focused on driving better healthcare quality, better health outcomes and lower costs for their entire state's population.

We did announce a round two and we had over 30 states apply. We do a plan to announce both implementation and design states later this year. Robust response. We have not made selections yet but, given that response, you can add up the numbers. It is likely that we will have over half the states in the US testing or designing implementation plans for their whole state on what payment models and care delivery models are they going to use to improve quality and lower cost so, very exciting work at the state level.

We did also announce this Medicaid Innovator Accelerator Program with our Center for Medicaid colleagues over the summer. It is a partnership between Medicaid and the Innovation Center. I should say all models now are designed in a partnership across CMS. We are offering states technical assistance in data analytics, quality measures, model development, disseminating best practices and rapid-cycle evaluation. We're also in process and we did a number of listening sessions about other mechanisms to try to understand what are states' needs and how can we best support Medicaid programs to drive delivery system transformation. Initial work may include changes in care delivery such as substance abuse, behavioral health oriented work, long term services and supports and community integration, potentially work on super-utilizers such as perinatal. So we're really focusing on what are the major issues driving gaps in care and lower quality in the Medicaid population, and higher costs, and how would we work with states to help them address those areas through health system transformation.

The next slide just talks about our Bundled Payments projects. We're testing three types of bundles in four models; acute care, acute and post-acute and post- acute alone. Essentially these models take conditions and say we're going to pay, for example, take acute and post-acute care for a 90 day episode. They all have quality measures and we lead with quality in all of our programs. You have to meet a certain level of quality in terms for all our various bundles. I mentioned this. You have hospitals, physician groups, post-acute care providers looking at: how do they redesign care for that episode of care? So how do they measure quality for that episode of care and how would they lower cost and remove waste out of the episode?

We've got thousands of participants in the model in phase 1 and we've got hundreds in phase 2, which is the higher risk-bearing phase. Certainly a challenging program, I think an incredibly robust interest from physician groups, from hospitals and from post-acute providers across this country saying that we can redesign care to achieve higher quality and lower costs for episodes of care. This next slide just shows some of the Partnership for Patients results, so this is the model where we set new, bold goals to reduce harm and reduce readmissions. This shows the harm portion. We've got hospitals that represent 80% of total admissions in the US in this model - the top blue line. The next gray line is "improving on five or more areas of

harm", and I should say improving significantly, defined as a 30% improvement from baseline. We've got now two thirds of hospitals improving significantly in five or more areas of harm, great results across the network. The bottom line that I actually learned from quality improvement collaboratives that I used to work with when I was at Cincinnati Children's Hospital is essentially saying that you define in a network what is "best in class" performance, which we defined as approximately the best 2% performance in early 2013. So this could be almost no line infections for a given year as an example. We now have over one third of hospitals achieving what we thought was "best in class" performance - five or more areas of harm - so really dramatic results across the network.

So I'm going to shift gears and talk a bit about our patient centered medical home models work. For many of you who have worked on practice transformation at the ground level, you know that transforming practice does take time. So, for a few examples, working with the practices that often took 12 to 18 months to fully integrate an electronic health record in a small practice - physicians and staff need time to adjust to new priorities and workflows and sometimes, there is a short-term difficulty in reducing cost because at the beginning, here is the model. You are looking at those practice-level structural and process changes that you need to implement. We have seen this in other programs but I'm also going to share some early promising results with some of these models.

So, we have three major models. Our multiplayer advance primary care practice demonstration - that model is working directly with states and was largely state driven. We've got our Federally Qualified Health Center Medicare demonstration which was focused on moving FQHC's to level 3 NCQA status and then the Comprehensive Primary Care Initiative. I'm going to talk today about the Comprehensive Primary Care Initiative in detail.

So I think one of the key lessons in the Comprehensive Primary Care Initiative is we convened Medicaid and commercial payers in these geographic areas, so states or other geographic areas. And, we aligned on a number of parameters for the model, so a great example of private payer and CMS alignment, including on things such as, we have one aligned set of quality measures - the same set of quality measures for every practice. When I was at Cincinnati Children's, I had to report quality measures to the various payers that wanted quality measures so I can't tell you the importance of this measure alignment issue. So, we've got seven states and regions, 500 practices serving approximately 2.6 million patients. We did define some standardized interventions, working with the other payers; risk stratified care management, so understanding risk stratification and delivery of care management services based on risk; access and continuities, like extended hours, et cetera; planned care for chronic conditions. So, for any of you that have driven health system transformation, you know that much of that improvement happens outside of the office settings - so, how you connect with people at home and in other settings to drive improvement. Coordination of care across the medical neighborhood: so these are things like social determinants of health, really thinking about the broader health context and how you drive improvement; patient and caregiver engagement, shared decision-making, et cetera. So, just a few things from the Comprehensive Primary Care Initiative findings from year one: practices actually added over 1000 care managers who are providing intensive care management to patients at higher risk; 97% plus Meaningful Use; patient shared decision making tools to address a number of areas; and then the early results indicate that expenditures are trending downward, even in just year one of the model. We are working on posting those results soon. All of our evaluations go through a rigorous independent evaluation and in transparency we post the results to our website.

A few things just to think about in terms of primary care results. As we said, primary care practice transformation does take time to implement. The benefits can often, you will have when successfully implementing the process measures, there is a lag time before you see those outcome measures of better quality and lower costs - better health outcomes and lower cost. But, we are seeing some early promising results, seeing steady improvement in the primary medical home capabilities and we're spreading these across CMMI models and into core payment programs. This is actually a critical point. People often focus just on the Innovation Center and the statutory criteria around the model. We are learning from all of these models, and there's, data, feedback that can be monthly to quarterly, both to us and to providers in the model. And, we do a few things. We make adjustments to the model when necessary. We also feed learnings from the models into our core payment programs: what can we learn that we can put into some of our core payment programs? And also across models. We learn key components of care management and risk stratification in our comprehensive primary care model. How do we spread that to our ACOs, to the various ACOs and that payment model? So, we have a learning system, if you will, working with all of these models and we continue to improve on it over time.

So, the next slide just shows a brief slide on Independence at Home, very exciting model, testing the effectiveness of providing chronically ill beneficiaries with home-based primary care. So, these medical practices provide chronically ill beneficiaries with care in their homes. Practices must serve 200 beneficiaries to be eligible and incentive payments are based on meeting quality standards, once again, and reducing total expenditures. And you can see that we've got 14 independent practices and one consortium and the early results are promising. This population has, you know, it is a very ill population, so, we are still working through some of the complexity of risk adjustment issues, but early promising results in Independence at Home.

So now I'm going to shift gears to looking forward and we will end certainly with some extra time. One, you know, when I started in the Innovation Center about a year and a half ago, the process of looking at the portfolio and thinking about what new models need to be launched, and that is really an iterative process that we keep doing. And, I'm going to talk a bit about some of those that are in process, and we have put requests out for information to help shape the models. We are very focused on implementation of models. So you know, we make changes as we identify them. So with the Bundles model, participants identified a number of adjustments that needed to be made which we actually made last week. So, we have a rigorous learning model, and adjustment of models, based on feedback from participants and data as it comes in. We are trying to monitor and optimize results. We are at the phase now where we've got models tests with several years of positive results. So it starts to ask the question of: should these models be expanded? We have a statutory process, we have a regulatory process, but we work through there. But, starting to ask those questions on a number of these models with promising results. I mentioned this - we are really integrating innovation across CMS. The models we are working on now are jointly developed with others across CMS.

The possible model concepts: one of these was actually announced so I updated this slide. Transforming Clinical Practice was just announced last month, at the end of last month. This is a major investment by, from CMMI, to help clinicians and physicians in practice, support them in practice transformation - so, improving quality and lowering costs. We've got a construct of Practice Transformation Networks that we fund, and Support and Alignment Networks. This is also leveraging learning from other programs, and utilizing other programs like the Quality Improvement Organization program, we think we needed to make a major

investment supporting practice transformation, and announced that last month. We've got very positive results and are looking forward to a great array of applications.

Another model and I don't have a slide, just to mention, but we have launched our Care Choice model, which enables palliative and hospice care services to be delivered at the same time as curative care services. So as a clinician and as a family member, I have been through the process of what often seems as a false choice between curative or palliative care services. This will enable clinicians and physicians working with patients and families, if they choose to deliver both palliative and hospice care services at the same time as curative care services. We think this model has high potential to improve quality and lower costs.

Working on outpatient specialty models and oncology, which we hope to release soon. We put out an RFI on health plan innovation, a request for information to say, if we have a model on health plans, whether it is Part C or Part D or Medicaid, what would be a way that we could enable innovation in the health plan space? We also put out a request for information about consumer incentives. So we have more models directly focused directly on both consumer engagement strategies, like shared decision making and incentives, and things like financial incentives and other mechanisms to improve quality and lower cost. We did propose a home health value based purchase model in last year's rule, so we have a number of new models in development to round out the portfolio.

My last slide here, I always say: what can we do together? Here's just a few thoughts. I do think that we need to focus on eliminating patient harm, I'm working in the hospital this weekend, and I think that a number of these bullets actually are encompassed. We always have the opportunity to make sure that we have a highly reliable, as highly reliable healthcare setting as possible that eliminates patient harm, and also, coordinates care for people with multiple chronic conditions. So, I would challenge us all to focus on better care, better health and lower cost for the patient populations that we serve, engage accountable care and other contracts based on achieving better outcomes at lower cost. I know that there is this classic analogy of [*background noise*] and fee-for-service system, palliative care, alternative payment system. For all of the providers and others on the phone looking at how does this move forward, I would really highly encourage you, whether it is CMMI models or private payer models, engage in accountable care and other alternative contracts. This is the direction the health system is moving in and so I think there is the potential here for a first mover advantage and if you engage and learn in the model and improve , being much more successful in the long-term. The most important reason is better care for the patients, to participate as I said in CMMI and other innovative models. I do think that this issue of testing models to better coordinate care for people with multiple conditions is critical. And, we are constantly looking at this, do our current models completely cover this arena or do we need anything else in addition? We do have to invest in the quality and engage in collaborative quality improvement at the learning networks. You know, if there's one thing I learned in the delivery system when I was working on quality improvement from the delivery system, that infrastructure and the data and feedback and the learning collaboratives are critical to improvement. And lastly, just relentless pursuit of improving health outcomes. So, you know, I want to thank all of you for being on today. I want to thank you for the work that you do. I can tell you in the Innovation Center we've got a team of people both in the innovation center and across CMS and HHS that we come to work every day wanting to catalyze a system that achieves those better health outcomes , higher quality and lower cost for all Americans. So, I thank you for the work that you do, and, we do want to be a collaborative partner, and look forward to. I think that we have, I will turn it back over to Fran, but I think I'm going to answer a few questions as well in our time remaining. Thanks a lot.

FRAN GRIFFIN: Great, thanks so much, Patrick. And I'm going to just move over to our question slide, since we do have some time for questions today. So at this time, we'll take some questions from the audience. There are two options for asking a question. If you would like to ask a verbal question, use the “raise hand” icon, and you must have a synchronized audio connection for us to open your line. And you can determine that by looking for a small telephone or a headset icon next to your name. If you see that, you are synchronized and if you raise your hand, we can unmute your line. Or you may type your question into the chat area. I've noticed a few people have posted some questions to the Q&A area, so I will pull a few of those up already. I ask that people please use the chat area, it makes it a little bit easier looking at one place for questions, rather than two.

A few people did ask and I posted it in the chat, the materials from today will be posted on the Innovation Center website. So, Patrick, if it's okay with you, I will read off a couple of questions that have already started to show up because we've got a number already.

So, this question comes from Neal Kaufman: Will CMMI provide increased support for scalable innovations to support individuals with chronic diseases so they can better self-manage their risk factors and conditions?

PATRICK CONWAY: Yes. So, we are doing a number of - that's a great question - we are doing a number of models that touch on this area and I probably should have highlighted even more and I think we are open to, is there even more that we should do in this arena? So a few tangible examples on self-management. One, certainly it’s a part of our Independence at Home model. Two, our advanced primary care models like Comprehensive Primary Care, self-management and engaging patients with self-management, especially individuals with chronic diseases is a critical component of that model. Our ACOs, we have actually focused our ACOs on engaging patients and self-management with chronic diseases. A number of our innovation awards addressed this area of self-management. The last thing I will mention, it's labeled on the slide “consumer incentives” and I should probably update it, it really could be more broad. But you know, the questions that we put out in the request for information on the consumer oriented models, a number of them touched on, do we need models that are around what I will call not just consumer engagement, but, consumer, caregiver and family engagement? So, how do you effectively engage the support structure around a person that would drive better healthcare quality and lower cost? So, those are a few thoughts.

FRAN GRIFFIN: Okay, next question comes from Pam Bloom, asking if you could say anything more about ACO version 2.

PATRICK CONWAY: Yeah. So, we did put out a request for information about that. Let me tell you some of the things that we’ve heard and then we’re working on developing a model, based on that feedback. We heard a lot about moving to more population based payments, that there were providers that, traditionally our finance models in the shared savings models, you are competing against historical benchmark with an opportunity for shared savings. We had a number of providers saying that they wanted more population based payments, so either fully capitated payments or, partially capitated but moving to more of a population-based payment model. We certainly heard about the desire to think about bringing in Medicare, potentially Medicare part D. We heard from some folks on Medicaid as well which we are thinking about. So, could you have an integrated ACO model that is both Medicare and Medicaid, if you had a willing state and willing providers in the state? We certainly heard about the cost-sharing issues, and could we enable a model, which also gets to some of the prospective attribution issues, could you enable a model where beneficiaries are prospectively attributed, or even are

able to, and we're doing this in Pioneers right now, but they are voluntary assignments. They are saying, “this is my ACO”. Things like, could you have lower cost-sharing or no cost sharing for primary care visits and other aspects? So we are looking at all of those issues as we think about ACOs version 2.0. If you think about it, we've got the MSSP and Pioneer ACO program, certainly Medicare Advantage which is capitated payment. We think there is a space between a Pioneer ACO and Medicare Advantage that really allows providers to be more innovative and deliver population management services to a more known population that they serve. Those are a few things we heard regarding ACOs version 2.0.

FRAN GRIFFIN: Thanks, Patrick. Our next question comes from Diana Linder. In the new TCP initiative, can clinicians already involved in transformative activities, such as Medicare Shared Savings Plans and ACOs, also participate in this new initiative?

PATRICK CONWAY: This one I have to be a little careful because it is an open participation. So please send in your questions. We have a very standardized process for answering all of the frequently asked questions. This one has come up, I don't want to verbally give you an answer that is not 100% correct but I think our goal here is to engage as broad of a group as clinicians as possible. So sorry to not answer it as directly, but I want to be sure that you get your question answered in this sort of standard contracting way and also that way everybody gets the exact same answer from our team leading this one.

FRAN GRIFFIN: Okay. So, a couple of similar questions so I will scroll down. From Anny Arana: What are the long term goals or plans for all these innovation models?

PATRICK CONWAY: Yes, so, a few thoughts. So I think, we think that some of them will meet the statutory criteria, for example, improving quality, lowering costs, and therefore could be expanded. So, that is certainly one pathway for a number of these models. I think that you will have other models that you learn from, and you take those learnings you know, into the core programs, or into future Innovation Center models. We also are allowed to modify a model which I alluded to. And then, and we have done this with, parts of models that are not being successful. So you know, there is the potential, we learned from this model but we are going to terminate the model because we have learned from it and we realize it is probably not going to meet the statutory criteria but we need to take the learnings from this model and apply them to either other Innovation Center models in the future or our core payment programs. So at a high level, those are the three possibilities. I will say if you think about an innovation portfolio, our investments to date have been generating very early promising results which I think is a positive. We always need to also be asking ourselves, are we investing in the leading edge of innovation? So we do a lot of interaction and engagement with the private sector, with providers, with other entities that have suggestions of areas that we should be considering. So I think at a high level, these models, some of them will be expanded, some will be modified over time, and others, we will learn from the model and we will apply them to future Innovation Center models or our core payment program.

FRAN GRIFFIN: Thanks, Patrick. We have one hand up from someone with a synchronized phone line so we will test doing a verbal question here. So, this is from Margarita Khosh, your line is unmuted, Margarita, go ahead with your question.

MARGARITA KHOSH: Hi, so the three types of payments, for both acute, the acute and post-acute care and some post-acute alone, how exactly will these work in this reference? How

exactly is all of this going to work? How is the information pulled from these going to work to provider payments?

PATRICK CONWAY: Yes, thank you for the question and I'll try to give a little more information also, we do have more data and detailed off-line. Model 2 in that model, models two and three both have 48 conditions in the model. Model two is acute through post-acute, so it's from admission to either 30, 60, 90 days post-acute and actually providers have flexibility, I should say this, in terms of choosing what conditions they want to work on and also choosing time frames. So we set a high level construct with some flexibility for providers. Model 3 is post-acute only, so it starts once the patient hits the post-acute setting, so that is the starting point for the episode. Model 4 is prospective payment. While the first, two and three are retrospective reconciliations, model number four is a prospective payment system. I should the vast majority of people are in models two and three. And then Model 1 was built from our ACE demo and then added readmissions. We have a relatively small number of hospitals in model 1, the majority in New Jersey, but it is really just focused on the acute care episode. So, those are sort of the four models at a high level.

FRAN GRIFFIN: Thanks, Patrick. We have a number of questions related to whether there will be additional rounds of healthcare innovation awards or SIM awards, if you'd like to speak to that.

PATRICK CONWAY: So on the State Innovation Models, we are in the midst of round two now so we are looking mainly to complete round two. We did say in the solicitation that we are funding some design awards, and essentially we said the future of these design awards could be CMMI funding or state-based support, or other methods to move implementation, other funding methods. So, we sort of left the door open, if you will. And on the Health Care Innovation Awards, we just went through the Health Care Innovation Awards round two, so I think likewise we need to look at results from round one which we are starting to get in, just now starting round two. So we'll have to look at the results of round one to figure out do we need a third-round, and if so, you know, what that would look like.

FRAN GRIFFIN: Okay, thank you. So the next question comes from Marian Stuckey, asking: How can Local Health Departments be more involved with these quality improvement efforts on the population level?

PATRICK CONWAY: That is a great question, so let me give the direct answer then the broader answer. So the direct answer is we would like local public health departments to be much more involved and I have done some meetings with the associations and others on this issue, and have talked to our ACOs and various people in the models. So I mean, we would very much like to make that connection because I think it is critically important. Now let me give the broader context which I did not talk to which would probably be good. I have written about this and we have had a number of sort of discussions, soliciting input on issues around what I will term accountable health communities, but essentially asking the question, should we make an investment that is more at the community level that could, for example, bring together the public health and the social determinants of health infrastructure with the clinical care delivery system? A lot of complexity about how could CMMI make a catalytic investment that would drive that connection and would improve quality and lower cost. As the questioner may know, and number of communities have started programs sort of in this direction. So, not that surprisingly as a pediatrician, I think in the broader health context and I think about health system transformation, primarily. So, the point being, how do you connect, community services, social determinants of health services, and the public health infrastructure with the

care delivery system. As we know, major, a major portion of health outcomes is not driven by care delivery, it is driven by other factors that drive either poor or positive health outcomes. So, we think that this arena is critical and we're actually thinking in addition, so some states in our State Innovation Model are actually focusing on accountable health communities. We have also been asked, should CMMI have a model that directly focuses on accountable communities?

FRAN GRIFFIN: Okay, thank you, Patrick. I do see a number of additional questions related to TCPI and who can participate so we will just direct everyone as mentioned earlier to the Innovation Center website where you'll find answers to some of those questions already posted as well as information about how to contact for more specific questions. So we'll direct folks down that pathway.

Here's an interesting one, Patrick. This comes from Richard Bookman and he says: Where do innovations in genomic medicine fit in? In other words how do innovations driven by the science of medicine get parlayed by CMMI towards the Triple Aim?

PATRICK CONWAY: Yeah that's a great question. So I think in a few mechanisms and we would be open if there's other things that we should be thinking about. So one, I'd say, in a number of our models, we are seeing participants, especially leading age participants, or leading edge participants, sorry, thinking about how they would use genomics , or I will say other advanced diagnostics, for example, to really parse patient populations in a much more exact way, and, that enables them to improve quality and lower costs. So, on the pro side, in a number of our models we are trying to think about how we work with participants on this issue. We also, and this goes to unintended consequences, we have been, and I won't go into details here and I'd be happy to talk off-line, we have had sort of what I will call advanced technologies identified and a number of programs, for example Bundles, and when that happens, similar to our core payment programs, we have done this a few times and are thinking about how we standardize a process around what technologies and cost should be, in an episode for example, versus not within an episode. So I think there's both the pro side of the equation, how do we use the Innovation Center authority to enable genomic and more decision oriented medicine, and there's also the unintended consequence side, of the medicine side, how do you minimize any unintended consequences from any of these models. The goal would not be to limit it to patient and technology, it's the opposite - trying to encourage innovation in all of its forms including genomics .

FRAN GRIFFIN: OK, thanks. We've got time for a couple more questions here; we've got quite a few. So here's a question from John Troidl asking if the budget for the Innovation Center has gone up, down, or stayed the same for fiscal year 2015 and what is anticipated, budget wise, going forward?

PATRICK CONWAY: Yes, so we were appropriated $10 billion over 10 years. So, it was FY10, and the Innovation Center actually started during FY10, through FY19. It is an interesting appropriation that way. It is not an annual appropriation, it is 10 billion over 10 years. At the end of 10 years, the language would appropriate an additional 10 billion over 10 years. So, we are at the stage now, we are sort of halfway through the 10 year period, if you will. Actively, as I sort of alluded to, I have a portfolio management process where we try to determine, what dollars are being spent now, what are the gaps in the portfolio that we need to fill, et cetera. So, we have modeled out that 10 billion dollars throughout that 10 year period and continue to update that based on the various models and progress.

FRAN GRIFFIN: Okay, Patrick, we have a question related to the Million Hearts initiative from George Coutros asking if you can speak to a recent comment you made about the potential for a Million Hearts direct payment model on the ABCs of the Million Hearts initiative?

PATRICK CONWAY: This is a good lesson for me. So, Million Hearts I did not speak much about, but this gives me a great opportunity because it is an exciting model. So, really focus on preventing Million Hearts and strokes, which the questioner sounds like they know. I apologize for the background noise. And then, specifically we are looking at, do we need a payment model to support the Million Hearts in addition? So, you could imagine for example a payment model directly focused on paying for outcomes related to the ABCs. So I would say we are actively looking at that now. Do we need a payment model that would support the Million Hearts initiative?

FRAN GRIFFIN: Okay, great. Thank you, Patrick. So I see we're approaching the bottom of the hour, so a few reminders for everyone. First, thank you for attending today and participating either live or via recording. The recording and the materials from today's session will be posted to the Innovation Center website and I put that into the chat area as well. We encourage all of you to subscribe, if you have not already, to our Innovation Center e-mail list, which a link to that, can be found right on the Innovation Center website, and that way you can receive e-mails about important announcements from the Center, as well as notifications of future events. So, thank you, Patrick, for a very informative update and taking time out of your schedule to be with us today. Thank you, everyone, for attending. This concludes today's webinar. Have a great day.

[Event concluded]