Center for Medicare & Medicaid Innovation
Health Care Innovation Challenge: Measuring Success
December 19, 2011
2:00 p.m. EST

Andrew Shin: Thank you, Jennifer, and good afternoon and morning to some of you who are on the phone. Thank you so much for joining us. I just want to start off today by clarifying that there is a—we know that there is a broken link on part of our website on the Innovations website in the upcoming events section. If you click on the webinar 4 link there, it's not going to take you to the right place. Therefore, if you go to our home page, http://innovations.cms.gov, for those listening on the phone this will be pertinent. You can go ahead and click on the home page will be a twitter feed which has produced the correct link, and also the correct link is embedded in the Innovation Challenge launch page which you'll find in the What We're Doing section, then click on the Healthcare Innovation Challenge link and then near the bottom there'll be a correct working link to webinar 4 which is the webinar running right now.

A final point of administrative updates. We are updating—we understand that the webinar 3 audio as well as the slides are not up on the website. We are trying to produce those as soon as possible. They are running. We're just trying to get them up on the web for you, and we apologize about the delay. We understand that a lot of people have been asking for them, and we do apologize once again. You know, we want to get that stuff up for you as soon as possible to get your applications so we can work on the applications. So with that, I am going to go ahead and start today's presentation by reviewing just where we are.

And on November 17th, we had our first webinar which was an overview of the Innovation Challenge where we described some of the goals and objectives as well as other pertinent information that can be found in the Funding Opportunity announcement. The week after that on December 6th, we discussed the effective project design. We featured Dorothy Teeter and Mark Winn from the Healthcare Innovation Challenge team. We described the application narrative and the awardee selection processing criteria as well as some project oversight and support. Those two webinars are both posted on our website with some slides and audio or transcript information.

Webinar 3 was last week where we described achieving lower cost and improvement where we had Dr. William Shrank as well as Jay Desai helping to discuss the total cost of care and how applicants can demonstrate this on their applications. Finally today, we're here to discuss measuring success, specifically how we demonstrate measurable impact on better health and better care which are the first two parts of the three-part aim. And finally, we'll be discussing operational planning.

And as everybody probably knows, today is the day that letters of intent are due. They will be due at 11:59pm Eastern Standard Time, and that is an automated process. There will not be someone here closing the process down at 11:59; it will be automated. Therefore, I highly suggest that if you intend on submitting a letter of intent today, please do so without enough time to take into account technical glitches, you know, overloading the system and servers. We are trying to prepare as best as we can for a surge of activity at 11:59 and 59 seconds. With that being said, you know, we really cannot go back into the system once the automated processes

occur in shutting off at 11:59 p.m. Eastern Standard Time. So please get in your LOIs as soon as possible today.

I want to just go over a couple of letter of intent housekeeping frequently asked questions before we turn it over to Dorothy Teeter. And the first one is that, as I said, they are due today. For those who are submitting an LOI, the Innovation Center or CMS will not be reviewing your letter of intent for eligibility or other criteria. We will not be reviewing them or providing feedback. However, they will be used for planning purposes. Further, something else I wanted to clarify was that letters of intent are not binding; however, they are required to submit an application. For organizations who are not fully developed or have not fully developed their applications and have not yet identified potential partners yet on their letter of intent, that's fine so long as actual application can reference a letter of intent with, you know, obviously, we would expect some sort of similarity and synergy with the original letter of intent to the application. However, if you are still developing your partnerships or fully composing your proposed project, have no fear. As long as you can reference the unique identifying number that we produced for you when you received your letter of intent, that will be fine. If you don't receive a number, a receipt when you submit your letter of intent, please be patient. We will try to ensure—we do have mechanisms to go back and make sure whether or not you were sent a unique identifier. If not, please wait about 24 hours. And if you still haven't received one, then you can go ahead and send us an e-mail to our resource inbox, and we'll go ahead and investigate that for you.

Finally, the last clarification I just wanted to make was regarding the letter of intent whether or not letter of intents can come from or how many can come from a particular organization. An organization is not bound or limited in any way submitting as many letter of intents as possible or just one. Those will not have any bearing on any processes of how we make awards. That goes for the application as well. An organization can submit a thousand applications or submit just one. They will all be judged individually depending on the criteria stated in the funding opportunity announcement. So that's it for housekeeping on letter of intent. We really look forward to receiving your letters of intent today and helping you along the way as we approach the application process later on in January.

So with that, the Innovation Center as we have mentioned in the past three webinars, has the mission statement to be constructed in connection with the partner identifying testing and spreading new models of care and payment that uniquely improve health and heath care for all Americans. Since we really are focusing on that second tenant of testing today, we are going to have Dorothy Teeter and Dr. Shrank really talk about measurements and how we plan to measure your results in our endeavor to test new models of care to improve quality.

So today's agenda, Dorothy Teeter will be leading off with an introduction and quick overview as well as Dr. Shrank, Director, the—and just for those who were not here last week, Dr. William Shrank was with us last week from the Rapid Cycle Evaluation Group describing the lower cost portion of the three-part aim, and now he's going to discuss another of the better care portion of the three-part aim. And then Alefiyah—Ms. Mesiwala—is going to describe the better health portion of that section. We're going to have Dorothy Teeter with the Operational Performance Section, and then we'll wrap it up with the summary and question and answer session. So with that, I'm going to turn it over to Dorothy Teeter, Senior Adviser for Policy and Programs.

Dorothy Frost Teeter: Thanks, Andy, and hello, everyone out there. It's good to be here for this fourth webinar and continuing our goal of trying to provide as much assistance as possible to those of you who are interested in applying for this innovation challenge. This is again going to be a familiar slide to all of you. This is again the—there are three kind of key aims that we have for this Innovation Challenge. Again, it's a broad solicitation to those out in the community that we know that there are strategies and ideas throughout the country that originate from the experience and expertise of those providing services out there that can be tested again and scaled and spread in a wider dissemination approach.

So since we have said before, we'll say it again. We really do not have time to waste in our health care system. So we therefore are looking for models that accelerate system transformation towards that three-part aim of better care, better health and lower costs through improvement. We're going to talk a little bit more about what we're thinking of when we say system transformation in a follow up slide. Again, repeating once again, we're looking for models that can be rapidly deployed and on their way to improving care within six months of funding. And we also know that rapid and effective system transformation requires infrastructure and future basing work force models which can more effectively carry out the three-part aim.

So this, as I mentioned in the slide previously, this is an attempt to depict what we are meaning when we talk about system transformation. And I want to acknowledge the work of Leo Helsin(?) from UCLA who put together a slide from which we got inspired and especially with his version 1.0, 2.0 and 3.0 of the health system transformation. So there are many points along this continuum, and I want to really emphasize again that we are imagining that we will get applications that relate to as many points along this continuing spectrum. And let me just highlight a few key concepts of what we're thinking about as we think about this transformation.

We know that the health system right now does a really nice job of providing high quality acute care services, and that there's been growing recognition that that by itself is really not enough to achieve the three-part aim. So you see the whole the system across the country—health care systems across the country becoming more cognizant of the fact that we need more seamless health systems to manage the populations of patients that we see. So in addition to that high quality care, you see the advent of accountable care systems. You see that you need to increase the functionality and capability of managing financial risk and payment incentives to get to the three-part aim. You see more attempts to really effectively customize case management and care management services and those that provide preventive services to patients within their population.

As we become more able to identify the populations of patients that we see in addition to those individual patients that arrive on our doorstep from the hospital or clinic each day, as we're better able to then measure what we're talking about today, quality and health performance along with cost performance for those populations. So that it's important as you move forward that as we increase that capability to manage populations in that more seamless way, we can also then do more with measurements along the way and we're going to hear more about that in just a minute.

And then our system transformation continues. We know that many health systems are now seeking community-based organizations to be partners with what they have their community assets to help support the patient populations that health systems are accountable for or clinics or

whoever the providers might be. And so as you see in that last version 3.0, you see more efforts to integrate the care delivery system with community health resources and to begin to understand a little more clearly how those health outcomes that relate to populations can begin to emerge and again have our line of sight work not only the work that public health measure population health on a routine basis but also that partnership with health systems as they're trying to figure how they can contribute to that as well.

So again I want to emphasize this is just a visual depiction of what we see at the Innovation Center going forward. We anticipate we will have proposals all along this continuum and the measurements that relate to that procuring better health.

And again in this webinar here is our usual three-part aim slide which we will be focusing today on better care and better health. And at the end, we'll be trying to put it all together with some comments on successful operational planning that is absolutely foundational in order to achieve the three-part aim.

So as with our other slides, we have decided again that we would use an example throughout the rest of this webinar to depict what it is that so when we come to our comments if you can imagine an example that we're going to describe right now. This is again an illustrative example, and again we're just using it as such. It's not meant to be anything more than illustrative. So in today's example, we've chosen kids with asthma as our target population for which we're planning to improve and measure better care and better health. And again, we are for this we're coming up with two goals for this population. The first is to reduce the number and rate of asthma-related emergency room visits and avoidable hospitalizations for our children with asthma population and, second, to improve the quality of life for these same children.

The strategies we've identified are threefold, and as we go to the middle box there. One is to individualize the case management and care coordination services that any one child within the population needs so that they can experience as few trips to the emergency room with exacerbations and error as possible. A second strategy to meet these goals is to provide the home visits and appropriate home environmental interventions that are needed in order to again partner with the primary care clinicians in the hospital to make sure these kids get the best care possible.

And the third because we know it's important for this particular population, we want to both educate providers and parents together with their kids on the most up to date evidence based approaches for managing asthma. And then finally in concert with those who better improve access to efficient and necessary primary care services. So these things again are the strategies and examples that we're going to use for better care and better health.

And at this point, I'm going to turn over the webinar to Dr. William Shrank who's going to talk more about what we mean by measurement, measurement readiness and his other words of wisdom as the expert that he is in rapid cycle evaluation of measurements.

Dr. William Shank: Thank you, Dorothy. Thank you, thank you. So we believe it is extremely important that applicants can pay an active role in evaluating their own performance. Many applicants will likely not be able to just flip a switch and see where we implement the proposed program. Rather, applicants must carefully assess their own performance and develop data-

driven measurement processes for continuous quality improvement. Such an approach is essential to maximize the efficiency of your program and to increase the likelihood of success.

In the application itself, we ask that applicants include their experience with self-evaluation and quality improvements in the narrative. We ask that applicants are expected to demonstrate data collection and analysis capabilities, and applicants should describe relevant data currently collected, measured and analyzed for quality improvement and, if applicable, new data collection requirements should also be described. At the same time the Innovation Center will sponsor an evaluation of all awardees, we will aim to work with our awardees carefully. We'll ask an awardee to provide some data to us to strengthen our evaluation, and we'll provide data and interim results to awardees when available to support their quality improvement process. The Innovation Center evaluation will serve as the impact analysis that will be needed to scale a successful program.

For awardees whose programs are similar, we'll aim to develop affinity groups to help them share lessons learned. But just to clarify, awardees are expected to evaluate themselves and the Innovation Center will be conducting a simultaneous evaluation. Our goal is for these efforts to be complementary and not duplicative and that by cooperating we'll promote better data availability and greater opportunities to develop and improve innovation once implemented.

So what is better care? One of the three-part aims, as you know, in the better care aim we're trying to assess the quality and efficiency of care delivered to patients and the patient's experience with that care. We're measuring whether a given patient receives the right care at the rate place at the right time. There are a number of different domains within the better care aim. The goal of this slide is to offer a broad measure of domains to consider when measuring the care provided. We expect that some awardees will propose narrower innovations. For example, one focus on a patient population with a specific condition, and those awardees may not reasonably expect to measure care in multiple domains. Applicants should think about a way to measure care provided but certainly are not expected to measure care in every domain listed here. We want to know if patients received the correct processes of care, if the care that was provided evidence based, is there a good rationale for the care provided, was it provided in a coordinated way, was it provided safely, were evidence-based guidelines followed to promote safe care, was care provided efficiently for the patient, was care appropriate. You have a patient with a specific diagnosis like a heart attack receive appropriate medication in the hospital or a discharge.

We also want to know about patients' experience with care. Were they engaged in the decision making process? Are they satisfied with the communication or education about the illness and treatment? Are they satisfied with care? We want to know if patients have access to appropriate services and to information about their condition and treatment and is provided in a culturally sensitive and understandable way. All in all, there is a broad range of domains of better care, and we do not expect applicants to address all or even most. We do expect that applicants will include some measure of better care, and we expect their proposed models will include a clear vision about how performance on those measures will improve as a result of the intervention.

With regard to measures, we have a couple of suggestions. Applicants should identify and define the target population in order to objectively evaluate the impact of their proposal. This could be very narrow. Patients who experienced a hip fracture and were admitted to a specific hospital during a defined time frame would be one example. It could be patients managed by specific

providers. It could even be defined geographically. Applicants should select the care measure required to evaluate continuous performance improvement of their strategy. The measurements must be applicable and appropriate for the intervention that is implemented and should measure the quality of care delivered and the patient's experience with that care.

Data should be analyzed and measured on a continuous basis enabled where appropriate by health IT. When available, applicants should use validated measures that are in the public domain, preferably CMS and HHS measures. There are some interventions that might aim to improve care in ways that have no validated measures. Those applicants may have to develop measures themselves. We expect most can rely on well accepted measures, and a resource slide at the end of this presentation lists a selection of these.

I now would like to introduce Alefiyah Mesiwala who's going to take it over from here.

Dr. Alefiyah Mesiwala: Thank you, Dr. Shrank. Well, at this point, I want to switch gears and expand our understanding of what we mean by better health. So on this slide, we want to illustrate that health has many dimensions, and that the outcomes one measures as a result of your care interventions are very much influenced by a variety of health factors. What are your patient population's health behaviors, the cultural, the physical and social environment in which they live in? All of these indirectly affect the success of your intervention and the measurable impact you demonstrate on the health of your target population.

So if we go back to the earlier example that we presented, in that example if you were a primary care provider serving a pediatric population with asthma exploring probably the factors that affect your patient population of health and simultaneously examining the community resources and assets that you have available, that might actually allow you to better design an effective intervention and ultimately lead you to measurable improvement in health outcomes for your target population.

So on this slide, we want to walk you through one way of thinking about better health. When we say better health, we translate that to mean improved health outcomes for your target population. Now population health outcomes can be defined across four domains, and these domains altogether contribute to an overall understanding of a population's health and well being. So if you look at your slide starting from the left side, you can see that in our population there is a reduction in disease and injury, i.e., morbidity and more individuals from the population engaged in less unhealthy behaviors. Ideally, that should lead to improved health and functional status and an increase in life expectancy. Hence, all of these outcomes together contribute to the overall well being of the population.

The distinction between better care measures and better health measures really relates—really all come back down to your intervention. For better care measures, these measures relate back to the clinical intervention and often give us information about the process while your better health measures are really outcomes that relate to your intervention and give us information about the quality of life and length of life of your population. Now let's take a look at some of these domains a little bit more closely. If we have information about disease prevalence or incidence or perhaps rates of preventable hospitalizations or average outcomes, these can be measured to help us understand the burden of disease or injury in your population, and we'll take some of these domains and explore them a little bit more concretely in our examples in the following slides.

Now for instance let's say you can identify some of these outcomes in your population. The question is how do you get data for these outcomes. We know that available data for these outcomes can be difficult to find. So we encourage you to explore a variety of resources including registry, electronic medical records, claims data --

Shin: Dr. Mesiwala, I'm sorry to interrupt. Apparently, there's been an outage of the audio. And so nobody's going to hear me saying this, but if you can just if you don't mind waiting for one minute, we see the—Jennifer, if you're able to help remedy this situation. But we are getting quite a few dozen questions through the question chat box that cannot hear the audio any more. Operator?

OP: Yes, I'm here, okay. Bear with me just a moment.

Shin: Okay.

[Pause]

Operator: Okay. Can you ask if they can hear now. I don't see any reason.

Shin: Okay, so Jennifer, are you able to send a quick message via the chat box perhaps to everyone to make sure that they can hear? Or Courtney?

[Pause]

Shin: Okay. It looks like we just got a message saying that we are now being heard. Okay, so with that, Dr. Mesa Walla is going to repeat very quickly the slide that we're one which is labeled better health care, better health outcomes. I really want to apologize to everyone. I don't know what happened there, but it looks like we are working now. So Dr. Mesiwala, if you don't mind.

AW: Sure. So again, I'm going to go through again what we mean by better health and I'm at slide 14. So when we think about better health, we usually translate that to mean improved health outcomes for your population. And population health outcomes, we can think about those across four domains, and the sum of these four domains all should lead to an overall understanding of population and health care. So if you look at this slide a little bit more closely, we'll see, for example, and in our population there was a decrease in injury and disease, i.e., morbidity, and more individuals from the population engaged in less unhealthy behaviors. Ideally, that should lead to improved health and functional status and an increase in life expectancy. Hence, all of these outcomes together contribute to the well being of our population.

Now the distinction between better care measures and better health measures are all again—again all relate back to our population and to our strategies. So for better care measures, more specifically these measures give us an understanding about process and the implementation of your intervention. Your better health measures again directly relate to your strategies but are related to the health and functional status of your population. Overall, your better health outcomes give us an understanding of quality of life and length of life.

If you look at some of these domains a little bit more closely, let's say if we had information about disease prevalence or incidence or perhaps information about rates of preventable

hospitalizations or average outcomes. All of this would inform our understanding of disease burden and injury in our population. And as we walk through some of the slides that are coming up with our asthma population, some of these examples will become a little bit more concrete.

So now let's say we identified outcomes that we're interested in. How would we actually go about getting data for these outcomes? Well, we know that available data for these outcomes can be difficult to find. So we encourage you to explore a variety of resources including registry, electronic medical records, claims data and surveys. And this is also where your partners can be very helpful. You may want to reach out to your local health system or your public health department. They may have the data available for you and also be able to direct you to local resources.

Now in terms of unhealthy behaviors, again you can explore all of the resources that we just mentioned. And then there's other ways of getting information about unhealthy behavior. For example, you can administer health questionnaires like health risk assessments, HRAs, which many of these are available commercially to get information about health behaviors for your population. There's also other sources such as survey data. For example, the CDC's Behavioral Risk Factor Surveillance System and many other resources. Again, I want to emphasize that at the end of this webinar we've got a list of resources available for you to take a look at and help you in terms of formulating your measurement plans for population health outcomes.

Another domain that's key to our understanding of population health is health and functional status of your population. Now this is a self-reporting health outcome. In some ways it's a service also included in administering surveys. There are many that are available. You can use, for example, the CDC's Health Related Quality of Life Survey or use something that's commercially available such as SS-12 or SS-36.

And then finally at the bottom right, you'll see one of the fourth domains is life expectancy. Now we include—we realize that life expectancy is a high level outcome. It's a high level outcome, and that it's unlikely that your intervention can demonstrate any sort of measurable difference in life expectancy over the three-year period of this award. But we include it in the discussion of population health outcomes for the sake of completeness and to spur your thinking about the work that you do and how this ultimately impacts not only the quality but the length of life of your population.

So then moving on to this next slide, you know, in the previous slide we just outlined a way of thinking about health outcomes in our population across the four domains. I want to emphasize that we really don't expect applicants to provide measures in all the four domains—only those measures that are applicable and feasible to your project. We also know that progress in care improvement can be demonstrated relatively quickly, but that improvements in population health are likely going to take much longer. And so it really becomes important for applicants to provide a rationale for which population health outcomes that they're targeting and also a rationale for the measurement of population health outcomes in their defined population.

So at this point—on this slide, we're going to return back to the example that we started with at the beginning of our webinar. We at this point discussed what we mean by better care and better health. So let's see how this applies with our pediatric population. So at this point, we've defined a population and we've also identified some of the immediate goals. And in talking about goals,

we also have some key strategies that we want to implement for our population and some of these strategies include individualized case management and care coordination, providing home visits for an environmental intervention, educating providers and patients and their families and also improving access to high quality primary care and clinical preventive services. So after you've identified your goals and your strategies, how do you actually choose measures to demonstrate success in care and in improvement of health.

So on this slide, we're going to explore some of these measures and we're going to walk through how these measures directly relate back to our strategies and also inform our understanding of what we mean by better care and better health. Now the measures of better care are by no means exhaustive. They're just meant to provide some guidance to help you systematically think about how you would come up with strategies, come up with measures that are aligned with those strategies and how those strategies inform your understanding of better health and better care in your population. So earlier we discussed that better care could be described along four domains: improved care quality, improved care experience, appropriate utilization of care and improved access. Now let's look at some of these examples that we have here.

So for example, if you look at the first measure listed here in the better care section for preventive children with asthma action plan now this measure directly relates to one of the strategies that we listed in the previous slides. This measure helps inform our understanding of how successful we were in implementing an improved shared decision making and care coordination strategy in our population and monitoring this measure over the course of three years. An increase would give us some information about (1) not only how successful we were in implementing our intervention but (2) ultimately give us an understanding in terms of how we were able to improve care quality in our population.

If we look at another measure, for example, this measure of percentage children with mold inside of their home in the past 30 days, now monitoring this measure over the course of three years would give us information about how successful we were in intervening with our home visitation program and give us an understanding of how appropriateness of care is impacted by our intervention.

Now similarly if you look at the bottom of the slide and you look at better health, we've also identified outcomes that directly relate back to our immediate goal and give us an understanding of health in our population. We ultimately want to improve the quality of life of asthmatic children in our population and we want to keep them out of the ER of a hospital. So measuring rates of preventable hospitalization gives us an indirect measure of the burden of uncontrolled disease, and looking at the rate of school days missed and the rate of days of limited physical activity gives us an understanding of health and functional status in our population.

So now after you've actually identified your measures and you're able to classify with making your improvement plan, how can you organize all this information? So one way of doing this is creating a score card for both your better care and your better health measures. In the left column, as you can see, you can identify your measures and list them in the left column. And in the right column, you can give us your predictions as to how these measures—how you will impact these measures over the course of the award. We expect you to also cite information about any regional benchmarks that's available for any of the measures that you use. Similarly, give us an estimate of the baseline. Perhaps you have data within your own health system that

can inform this baseline, or you might have to access research and come up with bold estimates for baselines. We want to be very clear by saying that applicants that develop good, thoughtful data-driven estimates will be viewed as favorably as those applicants who have access to actual data. We know that in some cases, especially for the better health measures, information for baselines will be totally unavailable. And so at that point, what we want to see in your applications is a rationale as to how you'll go about measuring baselines if you're selected or the award.

In the column with the heading years one through three, what we expect to see here are your estimates. We want you to create realistic targets for yourself in terms of how you're going to impact the measures that you've selected for yourself. We know that you're not always going to be able to reach these targets. However, your measurement and evaluation plans should be for continuous and rapid measurement and evaluation, and hence close monitoring of your progress should keep you on track to achieve your goal.

In this scorecard for better health, again it's very much similar to the scorecard that we just saw for better care. For better health, we encourage you to systematically think through how you can identify population health outcomes that you would like to impact and how outcomes that are applicable and feasible to your intervention can be measured and monitored over the course of your award.

So at this point before I hand over the webinar to Dorothy, I just want to say that all the information that you provide to us in your plans for measurement and evaluation for both better care and better health will be taken in the context of their plans for lowering costs. And we expect that these plans together will provide for your pathway to achievement of the three-part aim in your calculation. And also I want to reiterate that at the end of the project, we have some slides that list some suggested resources to help you in terms of your measurement and evaluation plans. At this point, I'm going to hand it over to Dorothy.

Teeter: Okay, thanks so much. I know we're giving you all a lot of information here and again the intention is just to give you examples and ideas so you can have as much support as possible for putting together your own application. This last section might seem a little, you know, mundane relative to everything else we've heard during these webinars. But I think I'd like to say that without really effective operational performance, it's going to be pretty tough to achieve those goals.

So while we really know that it's very important to measure better care, better health and the total cost of care, equally important in terms of good execution of whatever your strategies are is going to be a strategy for measuring how you're doing with project operations itself and being able to then come up with ways to monitor that in an ongoing way and some measures to monitor that in an ongoing way and to be able to then design mitigation strategies if things aren't going quite the way you thought they were. And in addition, I want to remind people that you will have a program monitor or project officer from the Innovation Center that will help you with this. So if you are running into a struggle with what your successful awardee with their plan that we will be able to help you with that.

So, again, this is the performance, operational planning and discipline to carry out what you're doing along with a match to the resources needed to do it. This is an example only again we're

just putting this in here because in case it helps somebody with an operational plan schedule that we might expect to see with this application, the kinds of ability to lay out not only the strategic project initiative but what those priorities are within it, what's the short term access is required to make it happen, who the lead responsible party is and the timeframe or milestones in which to get it done. Again, this is just an example of how to tell a clear story of what you're planning to do to achieve that three-part aim, your approach to it, your organizational strategies, your measurement and improvement strategies, et cetera. And again just as a reminder, the budget form that we know and technically is SS-24A is the way that you'll be reflecting the resources required to pull off your initiative or to fund it will be included. So this story of your operational plan should link nicely with and tell a feasible, coherent story of what you want to do, when you want to do it, how you're going to do it and then the resources needed to do it. Okay, Andy.

Shin: Thank you very much, Dorothy. Before I get to the questions and answers, I'm just going to—we've gotten quite a few, and we'll try to answer as many of them as possible. I know that we're coming up near the top of the hour. If you look at this slide right now and this will be posted online very shortly, this is just a summary of the envisioned challenges that we've discussed prior to now. We are going to show you a few resources—resource slides as well to help you with your application development. And Dr. Mesiwala?

IW: I just wanted to say that we'll also be posting online an inventory of resources that you can use and that if you have any sort of suggestions for resources, please e-mail us and let us know at InnovationChallenge@cms.hhs.gov. We've love to see what your suggestions are, and we'll try to update the inventory on a continual basis.

Shin: Right. Thank you very much. So I just wanted to quickly close. As you all know, today is the letter of intent date. On January 27th all applications are due, and we're expecting on March 30th at the end of March for awards to be granted to the selected awardees. We further have these resources for you: http://www.grants.gov is where you get your application. As a reminder, you need a Dunn & Bradstreet Data Universal Number which can be found at the website here as well as the CPR in order to fill out the application. Again, we encourage you to do this as soon as possible. You need it for the application, not necessary for the LOI.

So I'm going to take a few questions and answers. And while I'm doing so, I'm just going to be posting a few slides randomly while we're talking that will provide you—and again, these will be posted online just for a few websites and resources many of which Dr. Mesiwala used in her illustrated example of childhood asthma. So you can find these useful. Again, if you don't find them useful and you have other sources, please use them and send them to us. We'll go ahead and post them and provide them to everyone.

So with that, I'm going to start taking some questions. The first question we had is around construction of building and whether or not the Innovation Challenge award money funds can be used for capital expansion. And the answer to that is that, you know, we're not expecting applicants to budget significant funding for new buildings under construction. CMS might find that new buildings or construction would be awarded if applicants are able to demonstrate detailed rationale explaining why new buildings or construction are required to accomplish their project aims. This is as opposed to other arrangements that do not require capital expenditures. I think that here at CMS we would encourage applicants to look for alternatives to building purchases or construction when forming operational plans and budgets because all these funds

budgeted for capital expenditures will require prior authorization, and there are some Office of Budget and Management circulars that are pertinent to this information. I'll go ahead and post that online shortly—a link perhaps to some of the circular information. But just to let you know that that is the—we'll put that up on the FAQ shortly.

So then another question regarding whether or not the Indian Health Facilities may be partners on a program through the Health Care Innovation Challenge. The answer is yes, they can. Another question regarding whether or not the third webinar will be available on the website. Yes, it will be. We will put that up very shortly. We anticipate that that will be up in the next 48 hours or less. For this webinar, we will try to get this turned around as soon as possible as well.

So a couple of—it looks like we have a batch of letter of intent questions. I'm just going to go through some of those, and then I know that we have a few questions for Dorothy Teeter and some for Dr. Shrank and Dr. Mesiwala. And so please send just, you know, if you have questions for them while they're here, please go ahead and send that to us. It is a rare but great opportunity when we get them here. So I'm sure they'll be chomping at the bit to answer your questions. But I just want to go over some of these letter of intent questions we've gotten.

The questioner asks if the LOI forgot to state the expected number of CMS beneficiaries for the project, will this information need to be sent in some other way. So, you know, we need to submit new LOI. I'm sorry. If the LOI forgot to state the expected number of CMS beneficiaries for the project, will this information need to be sent in some other way. Oh, no, no, it's not. As I mentioned before, the letter of intent generally we'd like them to give us an idea. We really want them for explanation purposes only. You're not bound by any means whether it be the partners or the scope of the project.

The next question is whether or not are there any ways in which the state can participate as a team partner of groups submitting a response. Sure. If you look at the FAQs currently online, we have kind of detailed the different ways that conveners may participate. States, while they cannot be direct recipients of funds, can serve as convener—conveners as a facilitator convener in particular. So they can help forge partnerships, you know, create some sort of data exchange agreements, or anything that a state might provide Medicaid data or do many things that perhaps a state might be uniquely situated to do. They just can't be the prime awardee in this case. I'm going to do a couple more LOIs, then we're going to take a break.

So will there be a confirmation when we submit our letter of intent. Well, so the answer to that is you must have a confirmation number. However, the confirmation email is not necessary so long as you retain your submission number. You should be getting a submission number automatically generated. And if you're not, then you can go ahead and shoot us an e-mail. You probably should wait 24 hours, but you should all have a submission number and that will serve you just fine. Okay, next question. I submitted my letter of intent and received a number for my application. However, I never received a confirmation e-mail. How can I verify that my LOI went through. Again, the submission number is all you need. That will suffice. So with that, I'm going to take a quick break and start reviewing more questions. And I'll let Dorothy Teeter who has the answer to a few questions.

Teeter: Okay, thanks, Andy. Let me see. One of the questions is whether direct conveners can be paid under this project. There is a frequently asked question about that that should clarify your

answer to that. There are two different kinds of conveners that we've identified, and look online at our website. You'll see there is a frequently asked question in response to that.

A second question relates to whether there'll be another letter of intent processor for another round of funding. Yes, there will be should be there funds available after the first round. Again, right now the plan would be for that second round to be awarded in August of 2012. We have not identified yet the date for the letter of intent process at this point. Look for that later on in 2012.

Let me see, here another question. Andy may have answered this. Can we change the lease for the grant application after submitting the letter of intent. Yes, you may. Again, we're just trying to get a sense of what are there in terms of people's ideas. Let's see, Will, there's a question her for you. It says do you want us to estimate—or Alefiyah, either one, do you want us to estimate what percent increase, 5 percent, 10 percent, 30 percent we might hypothesize that we can expect to see as a measure of success or otherwise increase or decrease sufficient as you said in the example.

Mesiwala: So this is Dr. Alefiyah Mesiwala. So, yes, we actually do want you to estimate your percent increase, and we also know that these are just estimates. We know that you may not actually be able to reach those targets. But the continuous measurement and evaluation that you're going to do during the course of the award, that will help you monitor your progress and will help inform kind of where you are. But again we do want you to give us a percent estimate.

Shank: And just to build on that, to the extent that you have evidence available either personal experience or evidence from the literature that suggests that what you're proposing does lead to these meaningful improvements in quality or performance for improved outcomes, it would be great if you could base your estimates in some sort of evidence.

Teeter: Right, thank you. And here's another question. Can an organization which is a limited liability corporation submit an application. The answer to that is yes. Here's a question again that's come up before, but I'll take it again here. Do our participants need to be Medicaid or CHIP patients only, or can some of our patients be self-pay or privately insured. Again, because we're CMS, we focus on Medicare, Medicaid and CHIP as our core accountability and we need to see those populations included in that challenge. However, that does not preclude the admission of under populations as part of your base population.

Shin: Dorothy, I'm just going to interrupt you real quick because we—there's a follow up question for that which is whether or not or the questioners are all kind of asking, well, how many Medicare, Medicaid or CHIP beneficiaries should these models propose to charge it if the proposed project directly or indirectly improves the quality of care or lowers the cost for an additional population, and the answer to that as we stated that's fine. Projects can go beyond in terms of scope the Medicare, Medicaid and CHIP population. However, you know, we're not asking for some percentage of Medicare, Medicaid or CHIP beneficiaries to be included. There's no percentage, we don't have a benchmark number. I think what applicants should keep in mind is that as projects are developed, they should be designed so that lower cost through group quality result in net savings for CMS programs—Medicare, Medicaid and CHIP after taking the investment that CMS is putting in these projects into account. So again, there is no prescriptive, you know—okay, apparently no one can hear me. Anthony, Courtney or Jennifer, we would appreciate your assistance. I think our sound is off again.

Operator: Okay, I can hear you through the audio.

Shin: It's folks on the computer is what the questioners saying that the telephone's up, but the audio's down on the web.

Operator: Okay, so we're good on this side. So okay.

Shin: Okay, now we're back. So just to recap that last answer, there's no specific benchmark of Medicare, Medicaid or CHIP beneficiaries required for proposed projects that have a more expanded scope for uninsured or privately insured or self-insured populations. We just want for applicants to keep in mind that the project should be designed so that lower cost through improved quality result in net savings for CMS programs. It is, you know, specifically designed for that population. So Dorothy Teeter has a question.

Teeter: There's one more, and then I think, Andy, we could wrap up because it looks like we're running out of time. But one other question is can we budget for local evaluation expenses such as a local evaluator in our application. Again, as Dr. Shrank said and he may want to add to this, we will be funding a formal evaluation independent of each individual project. But to the extent you feel within your application you need to and want to hire someone to help you with your self-evaluation and ongoing quality improvement, that's absolutely acceptable.

Shin: Okay, and I'm just going to do a couple quick other questions. Again, I apologize for the technical difficulties. We wanted to get to all of them. We are going to put up FAQs very shortly. Keep the questions coming into our inbox, and we'll try to answer them there if we can't get to them right now. So a quick answer is asking how are the award funds disbursed meaning all at once or even over three years. So the answer to that is that we're asking applicants to propose an operational budget and based on your operational plan and expectations. So I think that in most cases the first year funding would be somewhat lower since part of it would be for start-up activities. Another quick question is regarding whether or not the District of Columbia is eligible to apply. So for the purpose of this initiative, the District of Columbia is considered a state. Neither the DC government nor DC government agencies is eligible to apply as a prime awardee. And them the final question is whether federal agencies can act as conveners. The answer is no, federal agencies cannot act as conveners for applicants. And so we are over time. We really appreciate everyone's participation. And we will go ahead and get these slides and FAQs the answers to these and many other questions posted next week. Okay, and as I said before, the slides and audio for webinar we did last week will be posted very shortly as well, I would say in the next 48 hours or less. With that, on behalf of the CMS Innovation Center and the Health Care Innovation Challenge team, we want to really appreciate everyone's participation. We've gotten so many wonderful letters of intent already. Please keep them coming in, and we really look forward to working with you in the future in the next coming weeks ahead and we start to get towards application day. Thank you very much.

[END TRANSCRIPT]