CENTERS FOR MEDICARE & MEDICAID SERVICES
Accountable Care Organizations Conference Call for Provider Groups
April 6, 2011
1:00 p.m. ET

Moderator: Barbara Cebuhar

Operator: Good afternoon my name is (Sean) and I'll be your conference operator today. At this time I'd like to welcome everyone to the Accountable Care Organization conference call. All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then number one on your telephone keypad. If you would like to withdraw that question please press the pound key. Thank you (Barbara Cebuhar) you may begin.

(Barbara Cebuhar): Thank you very much (Sean). The U.S. Department of Health and Human Services released on Thursday March the 31st proposed new rules to help doctors, hospitals and other healthcare providers better coordinate care for the Medicare patients through accountable care organizations. The proposed new rules will help doctors, hospitals and other providers form ACOs and are now available for public comment. HHS also announced it will host a series of conference calls and listening sessions during the comment period to help the public understand what the Centers for Medicare and Medicaid Services, the agency administering the ACO program, is proposing to do and to ensure that the public understands how to participate in the formal comments process.

This is one of those conference calls where we will inform you of the contents of the notice of proposed rules and respond to questions that you may have about the proposed rule. We want to be clear that this is not a forum for submitting formal comments on the noticed of proposed rules. We will however accept questions during the Q&A portion of today's meeting and

transcripts and recordings of these open door forums and listening sessions will be available at http://www.cms.gov/sharedsavingsprogram along with fact sheets and other relevant information about this proposed rule. If you'd like to hear a recording of this call you should dial 1-800-642-1687 and ask for recording number 56 40 75 63. The call will be available four hours after the completion of this call and it will be available for seven days.

In submitting formal comments to www.regulations.gov please refer to file code CMS-1345P. Because of staff and resource limitation we cannot accept comments by facsimile or fax transmission. You may submit comments in one of four ways that are outlined in NPRM. Electronically at www.regulations.gov, by regular mail, by express or overnight mail, by hand or courier. Please refer to the e-mail invitations for this event for detailed information regarding the ways you may submit your invaluable comments to us. The proposed rule along with the joint CMS, OIG notice are posted at www.ofr.gov/inspection.aspx. For information you can read the fact sheets at www.healthcare.gov/news/factsheets/accountablecare03312011a.html. Formal comments of the proposed rule will be accepted for 60 days and will end on Monday June 6th, 2011 close of business. CMS will respond to all comments in a final rule to be issued later this year.

Additionally the CMS Center for Innovation will be convening healthcare providers and other stakeholders to explore different options for achieving a more integrated system of care delivery. If providers, health plans, state policy leaders and or community based organizations are interested in understanding more about the different ways they can integrate care delivery to improve patient care and population health while reducing costs, they can participate in the regional meetings on seamless care in San Francisco or Philadelphia in May.

More information about these meetings will be available on the CMS Innovation Center's website at http://innovations.cms.gov in the next two to three weeks. I just want to make sure that folks know that there may be members of the press on the call. This is a call for provider groups only. If members of the press have questions please call the CMS press office at 202-

690-6545. I'd like to introduce our first speaker Jonathan Blum who is the Deputy Administrator of CMS and Director of the Center for Medicare, Jon.

Jon Blum: Thank you (Barb) and thank you for everybody who's joined us on the phone call today. I just want to talk a little bit about the process that CMS took and developing the proposed rule but they turned it over to our experts (Terry Postma) or (John Pilotte) and (Tricia Rodgers) who are on the phone to walk folks through CMS's proposal but also to answer any questions you may have.

But on seeing through the process, prior to the issuance of the proposed rule CMS undertook a very extensive outreach. We held public meetings, we solicited pre-comments from the public just to understand from the provider beneficiary and other stakeholder perspective what is going on, what are the major issues of concern. We still (inaudible) what's happening throughout the private market, but we're here today in that same spirit. We intend to have an extensive outreach process, public meetings, public forums like this phone call we're on today. I want to help folks understand the proposal, but also to take questions, take feedback. CMS can only respond formally to comments provided in writing but at the same time we really want to help explain, understand and answer any questions that folks may have.

Before we get into the actual of the proposed rule, I wanted to kind of stop for a few seconds just to talk about the overarching principles that CMS have with developing arch proposals. First is we wanted to issue a proposed rule that provided different kinds of organizations to participate, not just hospitals, not just physicians, your kind of basis on ACOs but really to encourage different kinds of organizations to participate.

We also wanted to create different tracks for organizations to come in. Some who are more sophisticated that can take on more risk and some that are new that need some time to be comfortable to take on two sides of risk arrangements. We had the principle that we wanted the ACO program to be first and foremost to improve quality and reduce cost and so we have proposed what we believe is to be probably the most far sweeping quality framework that CMS has considered to date.

We wanted to have a strong beneficiary notification to ensure that beneficiaries understand what his or her position is participating within an ACO. We also wanted to have strong antitrust protection so CMS worked very closely with our colleagues at the FTC, DoJ and to think about the ACO program, helps within the (peaker) service Medicare context but in the larger healthcare economy.

We wanted to get some flexibility regarding gain sharing and staff rules, and so they have proposed some thoughts about how to consider those waivers. But again we're here in the context to take feedback; to take questions. CMS will continue to do these kinds of outreach meetings over the next several weeks and we'll also be working closely with our colleagues at the Innovation Center to think about other ways that folks could participate in the ACO program, both the base program we're talking about today but also future tracks that are currently in development.

So with that I'll stop and turn it over to my colleagues, they have done a fantastic job they have listened to all the comments CMS had received in advance and I think they have done a wonderful job putting together this proposed rule but again CMS needs feedback and thoughts and this is the first forum to capture that. So Terri do you want to start?

(Barbara Cebuhar): Right. You know what, before I turn it over to Terri I wanted to introduce her and let you know that Dr. Terri Postma is a neurologist and currently serves as a medical officer and advisor in the Center for Medicare at the Centers for Medicare and Medicaid services. Before joining CMS she completed a public policy fellowship with the senate finance committee during the healthcare reform debate. Following the fellowship Dr. Postma took over posts that were issued by her senior leadership on policy issues related to Medicare's payment systems and quality initiative particularly value based purchasing initiatives such as the Medicare Shared Savings program resulting from the passage of the Affordable Care Act. Dr. Postma, if you could go ahead and give people some background that would be helpful.

Terri Postma: Sure I'd be happy to. Thanks so much for joining us today. As (Barbara) said I originally trained as a neurologist but I have been working on issues related

to healthcare reform for the past couple of years and it's been an absolute pleasure to work on the Medicare Shared saving program for the past year which we have issued our proposal for this program last week and I've been asked to take a couple of minutes today to walk through the proposal with you. The Medicare Shared Saving program was mandated last year as part of the Affordable Care Act and it establishes a voluntary program that incentivizes Medicare providers and suppliers to form ACOs to improve the quality and efficiency of care delivered to Medicare fee for service beneficiaries. The proposed rule as we said was public last week and as Jon said we're really looking forward to receiving your comments on it.

Those comments can be submitted in a variety of ways as detailed in the proposed rule but one of the ways is via e-mail to www.regulations.gov. Additional information including a link to the proposal and fact sheets can be found at the website that (Barb) mentioned before www.cms.gov/sharedsavingsprogram/. The Medicare Shared Savings Program is a new approach to delivery of healthcare aimed at reducing fragmentation, improving population health and lowering growth in overall healthcare expenditures by promoting accountability for the care of Medicare fee for service beneficiaries requiring coordinated care for all services provided under Medicare Parts A and B and encouraging investment in infrastructure and redesigned Tier processes.

Our administrator Dr. Don Berwick has articulated a vision for the ACO program and the mission of the Shared Savings Programs. We believe ACOs should embrace several goals. One is putting the beneficiary and family at the center of care. This is done by honoring the individual preferences and values through shared decision making for example. Two is remembering patients over time and place, ensuring that beneficiaries no longer bear the burden of making sure all their healthcare providers have the information about them that they need to provide care.

Three is attending carefully to care transitions. As we all know care transitions are – we could probably do a lot better as providers in making sure that the transition goes smoothly and that everybody has the information that they need to care for the beneficiaries. Four is managing resources carefully

and respectfully. ACOs should ensure that waste is reduced and other step in care adds value to the beneficiary including proactively preventing illness and promoting population health.

ACOs should also proactively manage the beneficiaries care through, for example reminders of preventive care that needs to be given them. ACOs should also evaluate data to improve care in patient outcomes by collecting and evaluating and using data to improve care delivery and patient outcomes.

ACOs should be innovative and enhance the quality of healthcare, improve patient satisfaction and control of healthcare expenditures by continually re-inventing care in the modern age. ACOs would invest in a workforce to build skills, knowledge and teamwork. In the proposal for the Medicare Shared Savings program, existing and newly formed organizations are eligible to participate in the program and must also meet all the other eligibility criteria. An ACO's entity could include ACO professionals defined as MDs, DOs, MPs, PAs and clinical nurse specialists in combination with each other or with hospitals defined as acute care hospitals.

CMS had also proposed to use secretarial discussions or expand a list of eligible entities to include other Medicare enrolled providers and suppliers who joined the statutorily defined group. FQHCs and RHCs cannot independently form an ACO however ACOs would be incentivized to include them as participants through a higher potential sharing rate.

As Jon mentioned earlier, as part of a coordinated inter-agency effort CMS worked closely with FTC and DoJ to ensure newly formed ACOs can participate in the program without being concerned they will run afoul of antitrust laws. The antitrust policy statement displayed on the same day as the proposed rule outlines and solicits comments on proposed safe harbors related to the creation and operation of ACOs and applies to collaborations formed after March 23, 2010. A key component to the antitrust policy statement is the primary service area or PSA which is a calculation for percent share for common services. ACOs must calculate PSAs as part of the application process. PSA calculations indicate whether ACO applicants must undergo expedited antitrust review as part of the application process. ACOs

undergoing antitrust review must have a letter of approval from antitrust agency before entering into an agreement with CMS to participate in the Shared Savings Program.

In the Medicare Shared Savings Program, CMS has proposed that ACOs be provider-centric and driven. An ACO participant is defined as a Medicare enrolled group of providers and suppliers. These ACO participants must create a legal entity recognized under state law and must have a form of shared governance. The governing body must give the ACO participant proportionate and appropriate control over decision making. While ACO participants may join with entities such as entrepreneurs or health plans, the ACO participants must retain 75 percent control over the governing body and the governing body must also include beneficiary presence.

The ACO must demonstrate an organizational commitment, leadership and resources necessary to achieve the Three Part Aim of better care for individuals, better health for their population, and lower growth in expenditures.

Clinical integration is also an important part of the ACO. Clinical integration is demonstrated by having an experienced executive team whose focus is quality improvement, clinical management by a senior level medical director, a financial or human investment in the performance and success of the ACO. The ACO must be working towards building a health IT infrastructure that enables collection and evaluation of data and provides feedback to practitioners at the point of care. 50 percent of the primary care providers according to the proposal must be meaningful users by the end of the first performance year.

One of the visions or missions of the ACO that Don articulated was proactive care delivery. So the proposed rule encourages proactive and person centric care. Eligible organizations will have mechanisms to retain self assessment, internal monitoring and reporting for continuous improvement around promotion of evidence based medicine beneficiary engagements coordinated care population health and addressing health disparities and internal reporting and quality and cost measures.

Additionally the ACO will have a person centered multi strategy focus and continuous improvement around person centered activities including integrating care involving community resources that their beneficiaries need.

In our request for information last fall we heard from stakeholders how important patient data can be for ACOs. While ACOs should be working toward developing health IT that will allow them to share information between providers, CMS recognizes that groups of providers may not have complete data on care delivered to their fee for service beneficiaries outside of their organization. In order to promote ACO success we propose to make available beneficiary identifiable data for patients seen by ACO primary care providers who have been notified and not declined to have their CMS data shared.

Sharing data that contains information about alcohol or substance abuse is prohibited except with beneficiary consent. CMS is also proposing to create aggregate data reports to provide quarterly feedback to ACOs on expenditures and utilization in addition to annual feedback on financial and quality performance.

In order to participate, The ACO must be willing to become accountable for the Medicare Fee For Service population assigned to it. Beneficiary assignment is the basis for establishing and updating a financial benchmark, quality measurement and performance, and can help focus the ACO's efforts to achieve the Three Part Aim. Beneficiaries are assigned to ACOs based on the plurality of assigned charges that primary care services from primary care physicians defined as internal medicine, general practice, family practice and geriatric medicine.

CMS is proposing a hybrid of retrospective assignment with prospective data sharing. This creates an incentive for ACOs to standardize care processes and treat all Medicare patients by associating the same while also aiding ACOs and understanding their patient population.

Beneficiaries should be involved in the ACO. The beneficiary is a fee for service Medicare beneficiary who continues to be able to see any provider they choose even if that provider is not a member of the ACO. Beneficiaries are informed at the point of care that their provider is participating in ACO and told what it means for their care and also provided an opportunity to decline to have their claims data shared with the ACO. Beneficiaries may request to work with their physician to craft an individualized care plan. Through experience of care survey and participation and shared governance the beneficiary contributes to continuous improvement, quality performance evaluation providers.

As Jon mentioned earlier, CMS is proposing a two track approach for ACOs participating in the Shared Savings Program. ACOs may choose to participate in one or two tracks. Each track is a three year agreement. In the first track the initial three year agreement is comprised of two years of one-sided shared savings with automatic transition to two-sided shared savings and losses in the final year.

The second track is a three year agreement comprised totally of two-sided shared savings and losses. All ACOs who would like to continue on the program after the first agreement period must continue in the two-sided model. This approach provides an on ramp for organizations to gain experience and transition to performance-based risk arrangements.

ACOs may share in savingsif the actual assigned patient population expenditures are below the established benchmark. As savings exceed the minimum savings rate and they meet the quality performance standards ACOs are eligible to share in savings of up to 52 percent under the one-sided model and up to 65 percent under the two-sided model, depending on their quality performance.

These plus other differences in the models in calculating financial performance give greater rewards to ACOs choosing greater performance base risk through the two-sided model. ACOs providers continue to be paid under regular Medicare Fee For Service payment systems. For each ACO an annual

risk adjusted expenditure target is calculated based on its assigned patient population and updated by national Medicare expenditures.

Quality performance is an important part of the ACO and the – whether or not the ACO qualifies to receive a share in savings is dependent on their quality performance. Measures make up the quality performance standards to support the Three Part Aim focused on better care and better health for population and lower growth in expenditures. Measures reinforce five domains; preventive health, at-risk and frail elderly populations, patient or care giver experiences, care coordination and patient safety. Process outcomes and patient surveys are the basis for these measures. Quality performance standards established at the domain level to reinforce the Three Part Aim focus. There is some measures that are all or nothing scoring and this raises the bar for chronic diseases.

Shared Savings payments are linked to quality performance based on a sliding scale that rewards those attainment and improvements. High performing ACOs, therefore, in each domain receive a higher sharing rate. The quality performance measures align closely with the national quality strategy of the Department of Health and Human Services with private sector initiatives and with the EHR incentive programs. Further we're proposing in the NPRM that providers participating in the ACO reporting fully and completely on measures that those providers would automatically qualify for the PQRS incentive. And with that I'll conclude. Thank you for giving me the opportunity and (Barbara) I'll turn it back to you.

(Barbara Cebuhar): Great, thank you very much Dr. Postma. And now we'll take your questions. (Sean) if you could tell people how to queue up. Once again if you are a member of the media you need to direct your question to the media affairs office here at CMS. Thank you very much (Sean).

Operator: At this time I will remind participants in order to ask a question please press star then the number one on your telephone keypad. I'll pause for a brief moment to compile the Q&A roster. Again that's star one on your telephone keypad. Your first question comes from a participant whose name is not yet

gathered. Please state your first and last name and your affiliation, your line is now open.

(Barbara Cebuhar): Hi your first name please.

Operator: If your line is on mute please unmute.

Roberta Shapiro: Hello.

(Barbara Cebuhar): Hello we can hear you now.

Roberta Shapiro: This is Roberta.

(Barbara Cebuhar): (Roberta) and your last name and your organization please.

Roberta Shapiro: Shapiro with the University of Alabama at Birmingham Health Systems. I have a question about the shared savings rate. It seems that there was a deviation in the discussion between the percentages and the regs and the percentages just stated. Is that because it's QRA addition? I believe the reg states 50 and 60 percent for the one sided and two sided models.

Terri Postma: Yes, this is Terri. Thank you for that question and for the opportunity to clarify that. For the quality performance measures, the ACOs depending on whether they're on the sided or two sided can get up to 50 or 60 percent. Each domain is worth either 12 or 10 percent depending on which model. But in addition we're also proposing to give opportunities to ACOs to get a little extra shared savings for activities involving including FQHCs and RHCs in their organization. So for the one sided model ACOs can get up to an additional 2.5 percent for including FQHCs and RHCs in their organization. And for the two sided model they can get up to five percent for including FQHCs in that model so that brings you to a total possible of 52.5 percent shared savings in the one sided and a total possible of 55 percent in the two sided.

Roberta Shapiro: Thank you.

(Barbara Cebuhar): Go to our next question please.

Operator: Your next question also comes from a participant whose name is not yet gathered. Please state your first and last name as well as your organization for the presenters.

Matthew Narrett: Dr. Matthew Narrett from the Erickson Health Medical Group.

(Barbara Cebuhar): Your question?

Matthew Narrett: My question is, thank you, my impression is that after the initial two percent savings that there will be the sharing as you just described. Are there other additional fees that Medicare takes out prior to the sharing and also how is – what is the lost mix in terms of the sharing of the losses if your costs exceed the benchmark?

Terri Postma: Yes thanks for that question. There are – depending on what model you're in. Let's talk about the one sided model first. So in a one sided model what we've proposed there is a minimum savings rate, or called an MSR, which is talked about in the provision that congress sets forth which gives us a little cushion around the benchmark to account for normal variation and expenditures. And so what we've proposed to do is that the ACO must pass over that percentage on – and it varies depending on how many assigned beneficiaries there are to the ACO. But it's a range of, I think, from 3.9 percent down to 2 percent.

So that barrier has to be crossed but once it's crossed we're proposing to share back on savings from 2 percent unless you need an exception which would be on the ACO would have less than 10,000 beneficiaries and need a couple of other requirements like they only – they have only ACO professionals in their ACO, have a critical access hospital, be in a rural area and some other things. If that's the case, if the exception is met, then the share back is on first dollar coverage.

Now in the two sided model the normal variation works both ways, that an ACO is at risk above 0 percent and can share below 0 percent. So as long as they pass the 2 percent MSR quarter everybody shares back to 0 percent because normal variation sort of works in both directions for them.

(Barbara Cebuhar): Thank you Terri.

Matthew Narrett: So to try to clarify that, so the first 2 percent in either direction in the two sided model is held by Medicare or not? And then is your percentage of loss risk a function of your quality performance?

Terri Postma: Yes to the second part. The first part about the quarter, so for two sided you have – the ACO would have to cross that 2 percent MSR in either direction whether on the saving side or on the loss side. So before anything is counted – but then it's counted back to first dollar coverage. And as with the one sided where the quality performance is on a sliding scale for the shared savings the better the ACO does on quality, the more they share on savings. Conversely in the two sided model if there are expenditures in excess of the benchmark, that amount – that total amount of losses is mitigated by the ACOs quality score such that the better an ACO does on quality, the less they owe back.

Matthew Narrett: Is that all delineated in the ACO documents currently or is that yet to come out?

Terri Postma: No. Yes, sir that's all in the proposal and we'd appreciate the comments that you have on that.

(Barbara Cebuhar): Thank you very much Dr. Narrett. Dr. Postma. Our next question (Sean) please.

Operator: Your next question comes from the line of (Jennifer Cobalt) please state your affiliation, your line is now open.

(Jennifer Cobalt): I'm sorry my question has just been answered.

(Barbara Cebuhar): Thank you (Sean), our next question please.

Operator: Next question comes from Jan Towers, please state your affiliation.

Jan Towers: American Academy of Nurse Practitioners. Do I understand you to say – I mean looking at page I guess it's 140 on the proposal, that nurse practitioner practices will not be able to be part of ACOs?

Terri Postma: Thanks for the question and a chance to clarify, no it's actually the opposite. We've used the secretarial discretion afforded to us by Section 3022 to expand eligibility to all Medicare and (role) providers and suppliers. Now the statute also gives us pretty strict guidance on how to calculate assignments. So although we encourage participation of all Medicare enrolled providers and suppliers, some of them may not be able to form ACOs independently because they have to be that core at least 5,000 Medicare beneficiaries assigned.

Jan Towers: The 5,000 core is not the issue, the issue is that they have to be part of a physician practice and you're saying no that will not be the case.

Terri Postma: No, that's not the case. We've expanded the secretarial discretion to allow any Medicare enrolled providers and suppliers to be an ACO participant.

Jan Towers: And if they have 5,000 patients they can do that?

Terri Postma: Well the assignment rules are such – are delineated in the proposal, they're based on our statutory requirement to assign on the basis of MDs and DOs on the basis of primary care services received.

Jan Towers: But what you're saying is they could be part of an ACO member group as long as there are no other physician practices to cover that 5,000.

Terri Postma: Yes, that's right.

Jan Towers: But if they wanted to form one of their own and collect 5,000 that would not be possible?

Terri Postma: Correct.

(Barbara Cebuhar): Thank you for your comments Jen. Our next question (Sean).

Operator: Your next question comes from Cynthia Haney, American Nurses Association. Your line is now open.

Cynthia Haney: Thank you, I appreciate the opportunity. This is to actually follow up on Jan Tower's question regarding the assignment of Medicare fee for service beneficiaries to ACOs. We appreciate the expansion of the eligibility to all Medicare providers. But our understanding is that if an individual has a Nurse Practitioner, a PA or a clinical nurse specialist as their primary care provider, that individual could not be assigned to an ACO based on their primary care relationship. Is that true?

Terri Postma: Yes that is true. If you read the proposal we followed what Congress put forth before us as best we could. And in the provision itself – in the law it gives us pretty clear rules on how to make the assignment. And then there's –

Cynthia Haney: Just wanted to –

Terri Postma: Pardon?

Cynthia Haney: Yes, go ahead.

Terri Postma: And the assignment rules according to statutes is that the assignment is based on ACO professionals defined as MDs and DOs based on the primary care services received from them.

Cynthia Haney: Doesn't that, and I do see that. But doesn't that fly in the face of the repeated provisions in both the statute and the proposed regulation that there should be no limit on the choice of provider? Don't you have an inherent conflict there?

Terri Postma: Well this is a fee for service program so there is no limit on the choice of provider Medicare fee for service beneficiaries. And I can't speak to what Congress had in mind.

(Barbara Cebuhar): Thank you for your comment Cynthia we look forward to getting your comments at regulations.gov. Our next question please (Sean).

Operator: Your next question comes from (Sean Martin) from the American (Hostiatic) Association, your line is now open.

(Sean Martin): Hi I think my question – this is (Sean Martin) of the American (Hostiatic) Association. Can you talk a little bit more about this assignment of beneficiaries and exactly who outside the primary care can participate without the beneficiary assignment. So the direct assignment is related to MDs and DOs who – or any one of the three designated primary care practices and the beneficiary receives the (Polaris) services from set positions, correct?

Terri Postma: Yes, you got it.

(Sean Martin): OK, thank you.

Terri Postma: You're welcome.

(Barbara Cebuhar): Our next question please (Sean).

Operator: Your next question comes from (Jennifer Delado) from Health (Pole Sea Source), your line is now open.

(Jennifer Delado): Oh yes, thank you. Could you please explain how quality scores tie in to the payments mechanism?

Terri Postma: Sure. This is (John Pilotte) he's our acting director of our group and he's worked really – he's been very involved in the quality scoring so he'll explain it.

(John Pilotte): Thanks for the question. The ACO as we've laid out will be measured across 5 domains that encompass approximately 65 different measures. And on each individual measure, a benchmark will be set based on for the sliding scale performance. So the better the ACO does on each measure, the more points to earn for that measure and then all the points will be summed up at one of the 5 domain levels for patient experience, care coordination, patient safety, preventive health or frail elderly. So there will be a total maximum points available for each one of those domains, we'll sum up the number of points that the ACO earns based on the sliding scale of performance that is laid out in the NPRM for each measure which rewards organizations that do better on individual measures.

And then at those domains those scores will be averaged out across all the 5 domains and then that percentage will then apply to either the one sided model of 50 percent or the two sided model of 60 percent and then that – those two numbers will in essence be multiplied together and that's the percent of saving that the ACO would receive. And as Terri mentioned earlier, those sharing rates can be at times 52.5 percent under the one sided or at 65 percent under the two sided.

So in essence ACO to receive the maximum sharing rate available, they would have to be a higher performer on quality and include FQHCs and RHCs in their organizations.

(Barbara Cebuhar): Thank you (John), (Jennifer) I appreciate your question. Our next question please (Sean).

(Operator): Your next question comes from Jesse Bushman (Genetec), your line is open.

Jesse Bushman: Thank you for taking the call. I have a question for you about the way that the benchmarks will be established under a second 3 year period. The rule explains – the proposal rather explains that the benchmark will be established based on the utilization or rather the cost associated with individuals that would be assigned through ACO under the algorithm of CMS users.

And then in the 3 year performance period of course the ACO is going to try to reduce the cost associated with those particular individuals. I must say that the ACO will soon continue to have and they want to engage in a second 3 year performance period, it would seem to me that the benchmark for that second 3 year performance period is again going to be based on the – on beneficiaries that would be assigned to them as ACOs.

And some of those beneficiaries probably a large portion of them will have been treated by the ACO when the ACO was attempting to reduce cost. And so the benchmark for the second 3 year period is going to reflect the fact that the ACO engaged in activities that did reduce cost assuming that that happened. And so when they're trying to create savings in the second 3 year period they're essentially going to be competing against their performance in

the first 3 year period. And the line between the benchmark and what they're able to do in terms of savings in the second 3 year periods is – that those two lines are going to get closer together presumably, it'll be harder to generate savings.

So I'm wondering if the CMS has given consideration to how those benchmarks might be established in the second 3 year period.

Terri Postma: Thanks for that comment. We'd really appreciate it if you could send that in in writing. That's something that we're going to have to be addressing as we proceed in the program and in future rule making.

Jesse Bushman: OK, thank you.

(Barbara Cebuhar): (Sean) our next question please.

Operator: Your last question in queue comes from a participant whose name has not been gathered. Please state your first and last name as well as your affiliation for the presenters.

Colleen Matthews: Colleen Matthews from Horizon Healthcare Innovations.

(Barbara Cebuhar): Go ahead with your question.

Colleen Matthews: OK, thanks. Regarding the eligible ACO participants, for hospitals to be eligible it says that they have to employ ACO professionals. I have a 2 part question. If they do employ what is termed ACO professional, is their participation limited to only those professionals who are employed? And secondly if the State in which this ACO was operating does have regulations or laws that identify a structure a organized delivery system that doesn't require employment of the professionals, how will that conflict play with these regulations?

Terri Postma: Thanks for the question. The proposal follows along the lines of the provision and statute which talks about hospital employees ACO professionals as you noted but also partnerships are doing venture arrangements between hospitals and ACO professionals. So what we've tried to do in the proposals is make

this as flexible as possible for different ACO professionals and – on hospitals and ACO participants – other Medicare enrolled providers and suppliers to get together in a way that makes sense to them and is allowable under their State laws.

So why don't you go back and read through that section and see if that makes sense to you and send us in your comments. We'd appreciate that.

(Barbara Cebuhar): Thank you Colleen. (Sean) do we have any other people in the queue?

Operator: Yes ma'am. Your next participant, their information was not gathered. Please state your first and last name as well as your affiliation, your line is open.

Roger Schwartz: I'm Roger Schwartz with the National Association of Community Health Centers.

(Barbara Cebuhar): Go ahead Roger.

Roger Schwartz: The question I have regard to the FQHCs. In the preamble to the rule, you said that you currently lack the requisite data on the service code physician, physician specialty and specific attribution of services to the rendering healthcare professional in the claims and payment systems to enable you to determine beneficiary assignments and basically health in the participation in the ACO at least that's the way it seems to read.

But the health centers do have to submit a UBO form or (04 form) which is submitted for each FQHC – Medicare FQHC encounter and it contains the patient information, the service code and the attending physician's information. What isn't clear to us or to me what data that you're not able to get from the forms we submit that would allow for us to participate as ACO participants and to allow for the determination of a benchmark.

Terri Postma: Thanks for the question and the opportunity to clarify that. We worked really close with folks advocating for FQHCs and RHCs and to make sure that we understood – and the folks here (it seems) to make sure we understood the

payment mechanism. And whether or not those payments or services could be counted for the assignment of beneficiaries.

And I just have to press one thing FQHCs and RHCs can because they're Medicare rules be ACO participants. But what you've identified is that FQHCs and RHCs would not be able to participate independently of other ACOs professionals of whom assignment can be based. And the reason for that as you stated was what we put on the proposal was that we don't currently have the mechanisms to ensure a pairing up of the service with the providers – the providers of service. The primary care service is provided by primary care professionals.

The only thing is that the benchmark – the law requires us to calculate a benchmark based on 3 years' previous experience. Our understanding is that FQHCs have just began to send us some data starting in January 1st of this year. So we will need 3 prior years of data and experience in order to calculate that benchmark. But this is something that we've looked into very closely which is why (Don) our administrator was interested in providing an additional incentive to ACOs that include FQHCs and RHCs as participants.

So we'd appreciate your comments on that. And as we stated in the proposal we would be watching for ways that FQHCs and RHCs, those primary care services providers of those entities, could be included in the future assignments.

Roger Schwartz: Thank you.

(Barbara Cebuhar): Thank you Roger. Our next question please (Sean).

Operator: Your next question comes from (Barbara Tamara) from the American College of Emergency Physicians, your line is open.

(Barbara Tamara): Hi Dr. Postma, I was wondering if you could comment on the issue of recouping investment on the part of various ACO applicants, particularly on the physician side. I know there has been a lot of discussion before the rule even came out about the upfront cost and looking back at the physician group practice where you had really large physician groups and health systems

committing tremendous resources for the start up probably with less complexity in that demo than we are going to see in ACOs. I wonder how people are going to be able to generate shared savings within a three year time frame.

(John Pilotte): This is (John Pilotte) and thank you for your question. As you pointed out there under the PGP demonstration six of those organization shares in savings at some point during the initial three year period and there has been a lot of discussion around private investment in ACO. The GAO did a report on that demonstration that identified a number of start up costs and annual operating costs for the ten PGP sites and if you look at the report then you will see that the startup cost is spread widely among organizations and I think if you point out it will vary based on where the organization is, how advanced they are, what resources they need to put in place, how much they have in place and how much they bring to the table.

It is in all that and along with sort of what their future investment plan is as well in these areas and it is an area that we're cognizant about we have done a number of things in the design for the program to recognize the potential burden on smaller organizations in terms of savings requirements at a lower confidence rate on providing exemptions around the net sharing under the one sided model as well to recognize the potential steeper climb from smaller organizations. They may not be bringing extensive resources to the table but it is an area we recognize and an issue that we've tried to address it the best we can and the rule and we definitely welcome your comments as part of the proposed rule making process.

(Barbara Cebuhar): Thank you for your question Barbara. Our next question please

Operator: Your next question comes from (Elaine Elbature) from AANC

Karen Fisher: Hi actually it's Karen Fisher from the Association of American Medical Colleges the AAMC. Thanks you for taking my call. Can you talk a bit about board representation? The proposed rule talks about board control being 75 percent ACO participants. Could you just talk a little bit about what that means for an ACO participant in terms of if you have a large multi specialty

practice. Do you have to have a proportional amount of physicians on there and if you have a hundred individual physicians, do they each have to be on the board? Could you just talk a little bit about your thinking, about the board representation. Thank you.

Terri Postma: Sure. Thanks for the question. One of the things that we tried to do with the proposal was to maintain much flexibility for ACOs to organize themselves in a way that makes sense to the participants but what we have laid out is sort of a structure, loose structure for them in terms of a few requirements which is that these ACO participants, again defined as a Medicare enrolled taxpayer identification number. So that could be a clinic, it could be a hospital or it could be an individual practitioner.

Those are the ACO participants. They would get together statutorily. They must have a mechanism for shared governance which we are calling a governing body. And we're also requiring that each of those ACO participants have representation on the governing body and that of the governing body structures those participants will hold 75 five percent control over the governing body.

So that way we have some flexibility of getting together with non Medicare enrolled providers such as health plans or entrepreneurs or other groups that it make sense for the ACO participants to contract with to help them be successful in the Shared Savings program. We also propose a requirement that there be beneficiary's involvement on the governing body and this governing body would demonstrate an organizational commitment leadership in resources necessary to achieve the Three Part Aim for better care for individuals, better health for populations and lower growth in healthcare expenditures.

But really we try to maintain as much possibility as possible understanding that the ACO participants themselves probably know best how they can organize in a way to achieve those goals. We really appreciate any comment you have on that point and look forward to them.

(Barbara Cebuhar): Thank you Karen. We have time for one more question.

Operator: Your final question comes from the line of Joel Brill. Please state your affiliation. Joel Brill your line is open.

(Barbara Cebuhar): I think he might be on mute.

Joe Brill: Can you hear me now? How about now, can you hear me now?

(Barbara Cebuhar): Yes we can thank you.

Joe Brill: Marvelous. I am Joe Brill Dr. Joe Brill American Gastroenterological Association. I have two quick questions. Number one is that in the proposed regulations it describes the need for the ACO to have a medical director who is full time to the ACO. And so does the agency have any thoughts as to what the qualifications of that medical director should be? And the corollary to that is that in the proposed regulation sixty five initial quality measures, most of those measures were focused primarily on efforts that would be made at a primary care level. Does the agency anticipate the quality measures to expand in future years to include specialists?

(Barbara Cebuhar): Thanks Dr. Brill.

Terri Postma: Thanks Dr. Brill. As far as senior medical director, the only proposal that we have made around qualifications in terms of that is that they will be board certified and that they be licensed in the state in which the ACO operates.

Beyond that if you think that there are other regulations that we shouldn't make around that then we'd be happy to take those suggestions. But again our goal was to maintain flexibility to allow the ACO to structure itself in a way that makes sense to the ACO participants. As far as the measures are concerned, our statutory guidance on that point is to seek to improve the quality of care provided by ACOs over time by specifying higher standards, new measures or both for the purposes of assessing such quality of care.

One of the intentions that we had in developing proposed measures set was thinking about what kind of ACO participants would get together to form an ACO. Since primary care is the core of the ACO we have initially proposed

primary care measures but during future rule making there may be opportunities to expand that in the future to include measures that are directed at specialists or hospitals. But not knowing at this point who the ACO participants are and what kind of structure they might form we talked about that quite a lot to form the standards that everyone could be held to. We would appreciate any thoughts and comments and if you could send them in writing that would be terrific.

(Barbara Cebuhar): Thank you all very much.

Joe Brill: Thank you very much.

(Barbara Cebuhar): Thank you and we are very grateful for everybody's help on this call and I just want to make sure that folks remember that there is an on call of this call a recording available by dialing 1800-642-1687 and ask for recoding 56407563 that will be available four hours after the completion of this call so 6:00 tonight. And it'll be available for seven days so I want folks to remember that and also know that we are looking for formal comments on the proposed rule by Monday 6th June, 2011. People can go to regulations.gov, www.regulation.gov and refer to the file code CMS 1345P. So thank you again for your help and we really do appreciate your time. If folks could – the speakers could please stay on the line that would be helpful.

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