

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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MSSP ACO NOTICE OF PROPOSED RULEMAKING

REGION VI OPEN DOOR FORUM

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TELECONFERENCE

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TUESDAY
MAY 17, 2011

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The Open Door Forum convened via teleconference at 12:00 noon Eastern Daylight Time, Renard Murray, Regional Administrator, presiding.

PRESENT:

RENARD MURRAY, PhD, Regional Administrator
MARJORIE McCOLL PETTY, JD, MS, Regional
Director, Region VI
JOHN PILOTTE, Acting Director, Performance-
based Payment Policy Staff

P-R-O-C-E-E-D-I-N-G-S

(12:03 p.m.)

OPERATOR: Welcome, and thank you for standing by. At this time, all participants are in listen-only mode. After the presentation, we will conduct a question-and-answer session. Now I'd like to introduce your host for today's conference, Renard Murray. You may begin.

DR. MURRAY: Thank you very much, Jeff. Good morning. I'd like to thank all of you for joining us today on this call to talk about the proposed new rules to help doctors, hospitals, and other healthcare providers better coordinate care for Medicare patients through accountable care organizations, as we affectionately call them, ACOs.

As Jeff mentioned, my name is Renard Murray, and I am the Regional Administrator for the Centers for Medicare and Medicaid Services, which we call CMS. I'd like to begin today's call by introducing our co-host that we're so honored to have on the call

with us today, and that's Ms. Marjorie Petty.

She is the Regional Director for the U.S. Department of Health and Human Services. She serves five states in the region, and those states are Arkansas, Louisiana, Oklahoma, New Mexico, and Texas. So, Marge...

MS. PETTY: I would like to welcome all those who are in attendance this morning. This is a great opportunity. It's a part of the Affordable Care Act, and it's a wonderful opportunity to shift the payment system and provide innovation in the delivery of healthcare.

Those who are in attendance today I'm assuming have seen the new rules that are out. It's an opportunity for us to visit and provide -- for you all to give feedback on those rules.

So we're looking forward to hearing from the CMS Administrator with an update and having a conversation, so thank you again for providing this, Renard, giving us

this opportunity, and thank those of you again for being in attendance.

DR. MURRAY: Okay. Thank you so much for being on the call, Marjorie, and thank you so much for your remarks. Again, as Marjorie said, I want to also add my thank you to everyone here for taking time out of your very busy schedules to attend this listening session this morning on the proposed new rules that will help doctors, hospitals, and other healthcare providers better coordinate care for Medicare patients through ACOs.

We welcome consumers, clinicians, employers, hospitals, health systems, state representatives, healthcare experts, and a host of others. We welcome you today on this call, and we hope to get really good feedback and questions from you at the end of the call.

The United States Department of Health and Human Services, HHS, released on Thursday, March 31, the proposed new rules to help doctors, hospitals, and other healthcare providers better coordinate care for Medicare

patients through accountable care organizations.

ACOs create incentives for healthcare providers to work together to treat an individual patient across care settings. That includes doctors' offices, hospitals, and long-term care facilities.

The Medicare Shared Savings Program will reward ACOs that improve or deliver high quality care and lower growth in healthcare costs while putting patients first.

Patient and provider participation in an ACO is purely voluntary. The ACO new rules will help doctors, hospitals, and other providers form ACOs and are now available, as Marge said, for public comment.

HHS also announced it will hold a series of open-door forums and listening sessions during the comment period to help the public understand what CMS, the agency administering the ACO program, is proposing to do and to ensure that the public understands how to participate in that formal comment

process.

Today is one of those listening sessions where we will inform you of the contents of the Notice of Proposed Rule and respond to questions that you may have on the proposed rule.

I want to be clear today that this is not a forum for submitting formal comments on the Notice of Proposed Rule, we're not accepting formal comments today.

We will, however, accept questions during the Q&A portion of today's call, and transcripts of these open-door forums and listening sessions are posted on our website.

That website is [CMS.gov/sharedsavingsprogram](https://www.cms.gov/sharedsavingsprogram) all one word. Again, [Cms.gov/sharedsavingsprogram](https://www.Cms.gov/sharedsavingsprogram) and also on that website are fact sheets and other relevant information about this proposed rule.

In submitting your formal comments to our regulations.gov website, please refer to the file code CMS-1345-P. Again, on regulations.gov website you would refer to

code CMS-1345-P.

Now, because our staff -- we have staff and resource limitations. We are not able to accept any comments by fax transmission, so you may submit comments in one of four ways that are outlined in the NPRM. That's electronically, as I mentioned, at www.regulations.gov, by regular mail, by express or overnight mail, or by hand courier.

Please refer to the email invitation that you received for this call that has detailed information regarding the ways that you may submit your invaluable comments to us.

The proposed rule, along with the joint CMS-Office of Inspector General Notices are also posted at our website. That's www.ofr.gov which is also on the invitation, and also on our healthcare.gov website there's a tremendous amount of fact sheets and other information about the affordable care organizations.

As I mentioned earlier, formal

comments on the proposed rule will be accepted up until Monday, June 6, 2011, so we have just under a month to receive your comments. CMS will respond to all comments in the final rule to be issued later this year.

So now it gives me great pleasure and an honor to introduce to you our featured speaker for today, and that's Mr. John Pilotte, who is the Director of the Performance-Based Payment Policy staff and the Center for Medicare at the Centers for Medicare and Medicaid Services.

John manages a team of analysts responsible for designing and implementing the Medicare Shared Savings Program for accountable care organizations, as well as other value-based purchasing programs for hospitals, physicians, and other providers.

Previously, John was the Director of the Division of Payment Policy Demonstration in CMS's Office of Research Development and Information. Prior to joining CMS, he was a senior consultant with

PriceWaterhouseCoopers Healthcare Practice and an associate on the Government Relations of the National Association of Children's Hospitals and Related Institutions.

John holds a master's in health policy and management from Johns Hopkins University and a Bachelor of Science degree from Indiana University. So, without further ado, I'll turn it over to John. John?

MR. PILOTTE: Thank you, Renard, and thank you all for taking the time out of your busy day to join us for this open-door forum to go over the Notice of Proposed Rulemaking for the new Medicare Shared Savings Program but also, more importantly, to hear from you all, to answer questions, to hear your questions and answer your questions, as well, on that notice.

The purpose of these open-door forums is really to hear from you all, both on today's call, as well as through the formal comment process that Renard talked about, and I would also strongly encourage you to submit

your comments to us formally on that, on the notice.

We're very interested in hearing them. We're very interested in knowing your thoughts on opportunities for improving the proposed rule. That's why we have a comment process.

We do take those comments very seriously, and it's a way for your voice to be heard in the rulemaking process and help ultimately improve and shape the final -- the final rule and the final product offering for the Medicare Shared Savings Program, as well, so thank you. Thank you in advance for those comments.

What I thought I'd do today is provide just sort of general background of the Shared Savings Program, talk about sort of the goals of the program, the organizations that we propose to be eligible for that, talk about our coordination with other federal agencies as part of this program, and then provide sort of a brief overview of our proposal for really

measuring the quality and efficiency of care for a population of Medicare fee-for-service patients, which is ultimately what ACOs are about, and then open it up for questions and comments from you all. I would add that those comments are due to us June 6, and we very much look forward to getting them.

A little bit of background on the Shared Savings Program, as you know, it was authorized under the Affordable Care Act and is really an enhancement or an addition to the Medicare fee-for-service program.

It uses the existing fee-for-service program for its platform and creates an opportunity for Medicare to engage with providers in a new way under an accountable care organization on which we would assign a patient population to them annually for purposes of measuring their quality performance and how well they care for that population over time and how well they coordinate services.

What the goal here is really

achieving the three-part aim of improving -- providing better care for individuals, better health for populations, and slowing the growth in healthcare expenditures, Medicare expenditures for the program, and ultimately the taxpayers they serve, that we all serve.

ACOs would be eligible for shared savings as a result of better coordination of Part A and Part B services. Those savings would be dependent on their performance. Their earnings savings would be dependent on their performance on quality standards that we set forth and that I'll talk about a little later.

The idea here is to reward providers for improving the quality and efficiency of care while at the same time encouraging them to invest in the infrastructure and care processes necessary for redesigning care and improving coordination of Part A and Part B services.

The program is required to be established January 1, 2012, and we are

working expeditiously to meet that goal. We issued the proposed rule on March 31 of this year. It was published in the *Federal Register* on April 7, and, as I mentioned and as Renard had mentioned, the comment period closes June 6.

The rule also represents sort of unprecedented coordination with a number of federal agencies that also provided guidance on the same day that we announced the rule on March 31. The antitrust agencies put out a policy statement on antitrust considerations for accountable care organizations.

The IRS issued a statement providing guidance for tax-exempt entities who participate in ACOs, and CMS, working with our colleagues in the Office of Inspector General, issued guidance on potential waivers for Stark kickback referral issues around the distribution of shared savings, as well as seeking guidance or seeking comments on potential other areas where waivers might be needed.

That guidance was also published on the same day in the *Federal Register* as our notice, and I would encourage you all to look at that and to submit comments back on that notice, as well.

The Medicare Shared Savings Program represents a new approach to care delivery that builds on the existing Medicare fee-for-service program and provides a new avenue for providers to work with Medicare, as I mentioned, provide better care for individuals, better health for populations, and lower growth in healthcare, Medicare spending.

It promotes accountability for a patient population, moving the program to more of a retroactive claims payment program and encourages providers to be more proactive in gauging the patients they see and coordinating both Part A and Part B services and then linking those incentives to quality performance with the idea here to provide incentives for providers to be more proactive,

to coordinate services better, and rewarding them for delivering high quality and efficient care.

So who is eligible to participate in an accountable care organization, and what do they have to -- what do they have to do in order to participate? The proposed rule lays out a number of criteria that we've proposed and are seeking comment on for ACOs and also proposes specific organizations that are eligible to participate per what's outlined in statute.

So specifically organizations that are eligible to participate in the program include physicians and professionals in group practice arrangements, networks of individual physician practices and other professionals, hospitals employing physicians and other healthcare professionals, and joint ventures or partnerships between hospitals and physicians and healthcare professionals.

Those are the existing organizations that are eligible or newly

formed organizations that are eligible to participate in the ACO program. In addition, the statute provides the Secretary discretion to designate other providers that could participate, and we propose that critical access hospitals, specifically Method II critical access hospitals that bill on behalf of their physicians, would also be eligible to participate independently as ACOs.

So those, in essence, are the five types of organizations or structures that could participate directly as ACOs. However, as I mentioned earlier, ACOs at their hub are encouraged and incented and it'll be critical to their overall success if they coordinate both Part A and Part B services.

So all Medicare providers and suppliers will be critical to the overall success of the ACO, and the ACO will -- and are certainly to be part of an ACO and will be critical for ACOs to work effectively with those providers both inside their organizations and outside their organizations

in order to achieve the goals and objectives of the program.

So what is an ACO, and how have we proposed to define it, and what criteria do those organizations have to meet? We have proposed that an ACO is a legal entity authorized under state law.

It's comprised -- as I mentioned earlier, it's a group of healthcare providers and suppliers that establish a mechanism for shared governance. These are provider-based organizations, and we've proposed a number of criteria around provider participation in the governance structure, including a proposal that ACO participants hold at least 75 percent control of the governing body.

We've also proposed that the ACOs have a designated medical director and they have an established executive team experienced in redesigning care and improving the quality and overall efficiency of care. This, along with strong governing body support, will be critical for ACOs to succeed in achieving the

three-part aim goal as I've laid out.

In addition, ACOs must agree to be held accountable for the quality and cost and overall care of fee-for-service beneficiaries that are assigned to them for purposes of measuring their quality and performance.

ACOs will also be encouraged to invest in the infrastructure and resources necessary to coordinate care and redesign care processes and really propose and lay out a plan for working together with providers inside their organizations, as well as outside their organizations, to better coordinate care for the Medicare fee-for-service patients they serve.

We have proposed a number of criteria for ACOs to demonstrate that they are either financially integrated or, for those that aren't, clinically integrated, including that they have an experienced executive team that directs or influences clinical practice to improve quality and effectiveness.

They have an onsite senior level

medical director that oversees clinical management. The ACO participating providers have a significant financial or human investment in the organization's performance and success. The ACO providers agree to be bound by medical practice or clinical practice guidelines and processes developed and put in place by the ACO.

The ACO has an infrastructure that includes information technology that enables the collection and evaluation of data and the feedback of that data to physicians and other practitioners at the point of care in order to influence patient care at the point of care, and we've also proposed that 50 percent of primary care physicians be meaningful users in the high tech program by the beginning of the second year.

These criteria track clinical integration criteria proposed by the antitrust agencies, as well. It is part of addressing potential antitrust issues in the formation of new organizations.

We've also proposed patient-centeredness criteria, as well, around four key areas that involve promoting the delivery of evidence-based medicine, the reporting on quality and cost measures for ACOs, as I mentioned, in order to redesign care and feed back that information to physicians and practitioners at the point of care, and coordinating Part A and Part B services, as well.

In addition, we've proposed that patients and community stakeholders be actively involved in ACOs, as well, recognizing the ACO is not only responsible for medical care of those patients but also in working with community stakeholders to better coordinate social and other mental health services, as well, necessary, and that will play a critical role in ACOs achieving their overall success.

As I mentioned earlier, we've coordinated extensively with the antitrust agencies around potential antitrust

considerations for ACOs, and the Department of Justice and Federal Trade Commission also proposed a policy statement on the day we released the *Federal Register* notice addressing those issues.

This guidance would be subject to newly formed organizations, those organizations that were formed after the enactment of the Affordable Care Act, and it basically lays out a criteria and a process for ACOs to calculate their provider service area or market share and then determine whether there could be potential antitrust issues for which they would have to seek additional guidance from one of the antitrust agencies.

Basically, if their market share is below 30 percent or their provider service area share, then that's a safety zone where ACOs could operate knowing that there is no issue of concern by the antitrust agencies. There is also a rural exception to those organizations in rural areas, as well, that

would fit into that safety zone.

For those organizations that have a 50 percent or greater market share or provider service area, there would be a required expedited review under an expedited process that's laid out in there that would be conducted by the antitrust agencies.

For those organizations between 30 and 50 percent, there would be a number of options that they could consider. They could elect to go through an expedited antitrust review process.

They could agree to comply with good conduct market restrictions, or they could proceed on their own without any antitrust assurances, recognizing they could be potentially challenged down the road if the antitrust agencies receive a complaint.

Basically, for those ACOs that have to undergo the expedited review process, CMS would be looking for a letter of approval from those antitrust agencies as part of the application process for ACOs before CMS would

enter into an agreement with that ACO.

Now I want to talk a little bit about the patient population and how we establish that from which the ACO would be accountable for and how we would measure quality and financial performance for each ACO.

As I mentioned earlier, ACOs have to agree to accept the responsibility for an assigned patient population. The assigned patient population would be the basis for establishing and updating each ACO's financial benchmark from which we calculate any shareable savings or shared losses under certain circumstances.

It's the population from which we draw the samples for measuring quality across five domains and the ACO's performance in those areas that I'll talk about in a little bit, and it's also the focus of the ACO's efforts to, as I mentioned earlier, deliver evidence-based medicine, improve care coordination, and really achieve the three-

part aim of better care for individuals, better health in populations, and lower growth in cost for the program.

We're proposing that patients be assigned to the ACO based on whether the ACO provides the plurality of allowed charges for primary care services from primary care physicians within the ACO.

We propose that primary care physicians include internal medicine, general practice, family practice, and geriatric medicine per the statute and that each ACO would have to have a minimum of 5,000 assigned patients. Again, those are statutory -- that's a statutory requirement.

While patients assigned to each ACO at the end of each performance year, and, as I mentioned, this would be the basis for measuring the ACO's financial performance and quality performance.

This patient assignment does not affect beneficiaries' Medicare benefits or choice of physician or any other provider

during the course of the year, so beneficiaries would continue to maintain their freedom of choice to see any provider that they choose.

We have proposed to use this retrospective assignment process. It's a process that we've used under a number of physician demonstrations, including our Physician Group Practice demonstration that rewards large physician groups for improving the quality and efficiency of care and was one of the models we looked at in developing and designing the Shared Savings Program.

It's a process we used under a number of smaller physician practice demonstrations, pay-for-performance demonstrations, and it's also a methodology that we use under the Physician Quality Reporting System, group practice reporting option now, that has 35 large medical groups reporting their PQRS quality measures for an assigned patient population, as well.

It's what we've proposed for the

program. We're interested in your comments on that, and we've also proposed a second approach for assigning patients that would involve specialists, so I would encourage you to take a look at that and submit us comments on your thoughts on that.

Under the ACO program, we've proposed a two-track payment approach to allow ACOs to participate in the program under two methods with the idea here that those ACOs that take on greater risk, greater performance-based risk, under the program would be allowed to share in a greater amount of savings under the program.

So we've proposed a two-track approach here, and I'll talk about the second one first. Under the second track, ACOs could enter the program for an initial -- for a three-year agreement under a two-sided shared savings, shared loss approach.

Under that model, ACOs could earn up to 65 percent of the savings they generate based on their quality performance and based

on their inclusion of federally qualified health centers and rural health clinics in their organization.

But also, ACOs would be at risk for potential -- for performance-based risk under that model for potential losses to the program, as well, so there would be both shared savings and shared losses under that model.

Alternatively, for those organizations that aren't ready to engage with Medicare under a two-sided shared savings/shared loss approach and want to get some initial experience under this model could elect an initial three-year agreement that would be comprised of two years of just a shared savings model only, shared savings approach, but then they would be automatically transitioned to the shared savings/shared loss model in the third year of that agreement.

Under the shared savings only model approach, for the first two years ACOs could share up to 52.5 percent of the savings

they generate, again, depending on their quality performance and their involvement and their involvement in federally qualified health centers and rural health clinics in their organization.

They would not be at risk for any losses during those first two years. That would happen only after they had been transitioned the third year and would be measured under the shared savings/shared loss model I discussed earlier.

All ACOs that elect to continue in the program after the first agreement period must continue under the two-sided shared savings/shared loss model.

We have proposed this approach in response to comments we received from the Request for Information that we published late last year that encouraged us to adopt models that had more performance-based risk and provided the opportunity for higher reward for those organizations but also recognize that all organizations aren't ready to go that

route and to provide an on-ramp for those organizations to gain experience with population management and then transition to a shared savings/shared loss model down the road.

So that's the rationale behind our approach and what we have proposed. We're interested in your comments and thoughts on that, as well.

A little bit about the quality measurement framework and then I'm going to talk a little bit about our beneficiary notification and protection provisions, and then I'll open it up for or turn it back to Renard for Q&A.

We have proposed to measure clinical quality for ACOs in five domains. They include patient and caregiver experience, care coordination and care transition, patient safety on the inpatient side, preventive health, and measuring chronic disease for at-risk populations, as well as frail elderly healthcare measures, as well.

The basic mechanism here is that we would use a number of mechanisms to measure ACO quality. They include a number of measures that we can calculate from Medicare claims data and administrative systems.

ACOs would be required to submit to us a modified version of the group practice reporting option tool to capture clinical information that's required for the preventive health and chronic disease and frail elderly measures, as well as a couple of the care coordination measures, as well, and that would use a sampling methodology, as well, to reduce administrative burden on those organizations.

Then we would also propose to use the clinician and caregiver CAHPS survey as an instrument to gain knowledge and an understanding of how well ACOs involve the patient and their families in decisions and to gain their perspective in how well the ACO is performing and delivering care.

The idea here is that you would capture a more complete picture of the health

and well being of the population the ACO is serving, and we would also leverage sort of the existing CMS measurement efforts, as well as incentive programs, to align measures and align reporting methods, again with the goal here of being sensitive in reducing administrative burden but also aligning incentives for those under those programs, as well.

So, ACOs, for example, could earn their PQRS incentive payments by virtue of reporting the ACO quality measures. That would qualify them for those PQRS incentive payments that we've proposed, as well.

We've also proposed that ACOs submit a pay-for reporting approach in the first year of the program so they would meet the quality of performance standards and could earn the maximum amount of savings available for doing that the first year by virtue of completely and accurately reporting those measures.

Then in the second and third year

we propose a scoring mechanism that would reward ACOs that improve or deliver high quality care during the second and third year of their agreement with the idea that the better and the higher performance the ACOs do on the individual quality measures, the greater share of savings they would get to keep.

Finally, before I open it up for questions, I want to touch on the importance of beneficiary notification and beneficiary protection under the program and what we have proposed there.

We've proposed that all ACO professionals would be required to notify the patients that they are participating in an ACO program and that this notification includes general notification about the program and what it means for the patient's care.

It would also indicate that and make clear that the beneficiary continues to have the freedom of provider choice to see any provider they elect, and they are not subject

to any utilization management prior authorization program that's not authorized under the existing Medicare fee-for-service program.

We have also proposed that we would share Medicare claims data with ACOs. Before the reg. we heard a lot from stakeholders about the importance of that ACOs have an understanding of the total healthcare that their patients are receiving and that many ACOs have a good understanding of what's happening to patients within their organization, but they don't always know what's happening to patients outside their organization.

So, in order to meet this need, we've proposed that we would share Medicare Part A and Part B and Part D claims data with ACOs on a monthly basis, and we would allow ACOs to request that information for patients that have a primary care visit at the ACO and who have been notified elected to decline to have their data shared with the ACO.

That basically is an overview of what we've proposed. Again, a couple points. This is a program that builds off of the Medicare fee-for-service program.

It's a new way for providers to engage with Medicare fee-for-service and provides incentives for them to invest in infrastructure and resources required to redesign care, provides an opportunity for them to share in the savings that they generate for the program based on the quality of performance.

It's a voluntary program. It's not required, and so those organizations could elect to come together or to come as existing organizations to participate in those programs, participate as an ACO.

Finally, the comment period closes June 6. I know you all don't need encouragement, but I would encourage you to submit those comments to us through the process that Renard indicated, and we welcome and look forward to those comments. With

that, I'll turn it back to Renard for questions.

DR. MURRAY: Thank you very much, John. That was a great introduction and overview of the new proposed rule. I know that our audience, our callers are on the line with us, have lots of questions that they want to ask, so at this time, Jeff, I'm going to ask if you would open it up to questions, please.

OPERATOR: If you would like to ask a question, please press *1. Please press *2 to withdraw your question. Again, if you would like to ask a question, please press *1.

DR. MURRAY: Okay, and while our comments are queuing up and our questions are queuing up, just a couple reminders. Just, I had mentioned this, but I just want to reemphasize again to get your comments in before Monday, June 6, and the website for that is www.regulations.gov.

Again, www.regulations.gov, and the file number, again, and the file code is

CMS-1345-P, again, CMS-1345-P. You're also able to send comments in via regular mail, overnight mail, express, or hand courier, and that information is included in the invitation that was sent out for this call.

So, Jeff, are there any questions, please?

OPERATOR: Yes, the first question is from David Cockrell. Your line is open.

DR. COCKRELL: Yes, I really appreciate the presentation. I think it was very clear and very succinct. I have a question more as a provider than as an ACO and more as a provider that's really not a primary care physician.

I'm an optometrist, and my concern is really how we can be of help and how we can actually participate in these ACOs for the patients that we care for. I've really not seen that drilled-down detail on that participation.

MR. PILOTTE: Thank you. Thank you for the question. I think there's two

ways that you could participate in this.

One is, since ACOs will be accountable for all of Part A and Part B expenditures for the patient, as well as the quality, it'll be important for ACOs to work with all of the patient providers that are involved in caring for those individuals, including those with chronic disease, as well, and interacting in a proactive way with those providers, whether they're inside or outside an ACO.

Even though patients are assigned to the ACO based on primary care as proposed, the ACO is responsible or accountable for, in essence, the quality and the financial aspects of all the care the patient may receive, so it'll be really important and incumbent on those ACOs to coordinate with all of the providers that their patients are seeing, including those that are involved in caring for patients with chronic disease, as well.

I think the other avenue that we've proposed on this is in how we assign

patients to the ACO. We've proposed a primary care methodology as part of the NPRM, but we're also seeking comment on a modified approach to that, as well, that would assign ACOs on the first swipe based on primary care.

For those patients that don't have a visit with the primary care physician, we would assign patients to the ACO based on the plurality, all of the, in essence, the E&M services they receive.

Both those mechanisms provide an avenue and underscore the importance of ACOs coordinating with all providers that are seeing their patients. The second would provide a broader and more expansive assignment algorithm that would assign patients to ACOs not just on primary care but also on broader services.

So we're in an area that we've had a lot of conversations about. We'll have a lot more. We're really interested in your comments and thoughts on that, and I would encourage you to submit comments formally to

us on that issue, as well, so thank you for the question.

DR. COCKRELL: I would just ask my one follow-up. That sounds great, and my one follow-up would be that are you envisioning, then, that -- we're obviously not part of a large group practice like you've described -- that an individual participating provider, whatever profession they happen to be in, are you envisioning that they would then still --

They would actually be -- that ACO would then, in essence, refer this patient back to them that they've already been seeing or encapsulate them inside the ACO? I'm just trying to wrap my head around where you're really seeing a role for us.

MR. PILOTTE: Yes. No, I think there's a couple ways for, I guess, smaller practices to participate in this. I mean, one is through a broader physician network, and we have examples of that under the demonstration programs where we have, in essence, physician networks made up of small and individual

practices that span sort of specialties because of the care that's required for caring for patients and sort of how they've organized themselves.

So I think that could be a potential avenue. I think there's also potential other organizations that can form.

They could be combinations of the proposed organizations as I've outlined that could be eligible to participate in the program, joint ventures between physicians and hospitals and so forth that could be created and participate in accountable care organizations, as well.

There are avenues for primary care specialists to participate in ACOs either directly as part of a more formal organization that I've outlined, but regardless of that, the ACO is accountable for all A and B services.

It'll be important for those ACOs to be not only working with providers who make up their organizations but also if their

patients are seeing and getting services from providers outside those organizations and coordinating with them, as well.

We haven't proposed the one sort of organizational structure, but there's probably a number of different avenues for providers to come together and to participate in ACOs.

DR. COCKRELL: Thank you.

DR. MURRAY: Many thanks, Dr. Cockrell, for being on the call, and thank you so much for your great question. Jeff, are there other questions, please?

OPERATOR: Yes, the next question is from Carol Ray. Your line is open.

DR. RAY: Thank you. How will the ACOs proactively track the care of the patient if they are getting care outside the ACO?

MR. PILOTTE: That's an excellent question. Thank you for it. We haven't proposed the specific approach to this. I mean, I think as interoperability standards and so forth evolve, I think that's one

mechanism that could be for ACO providers to use to better track patients.

There's a number of information exchanges that are being set up, as well, that could be potentially helpful there, but I think there's probably a number of other sort of innovative or creative ways for ACOs to target specific patient populations or sub-populations that they're serving for tighter and better care coordination as they move, as their patients move along the continuum and see providers initially outside their organization, as well.

I think that will be a challenge for some organizations, really depending on their level of infrastructure and sophistication, if you will, and how integrated they are.

The quality measurement we've proposed focused on a number of areas around care coordination, ambulatory care, sensitive conditions, readmissions, care transitions and so forth, and I think in order, as ACOs

develop mechanisms to track that, monitor that, and redesign care around those areas, I think probably a number of creative models will emerge at the local level as a result of that. That's why we haven't been prescriptive on that, and I think another key part of this, as we've announced today, as well, is providing learning avenues, as well, for ACOs to share and learn from others. I think as those models get developed, I think sort of sharing those findings with other organizations will be important, as well.

DR. RAY: Thank you.

DR. MURRAY: Ms. Ray, thank you so much for your question and for being on the call today. Jeff, are there other questions, please?

OPERATOR: Yes, the next question is from Mike Sanborn. Your line is open.

MR. SANBORN: Thank you and I certainly appreciate the presentation today. On Friday, the AHA released a study that they had done suggesting that the costs for ACO

startup could be significantly greater than the \$1.8 million HHS estimate.

As part of the comment period, do you think information like that might be considered in perhaps adjusting the 65 percent and 52.5 percent shared savings options that folks will have adjusting it upward to perhaps offset some of the costs if they truly are greater?

MR. PILOTTE: Thank you for the question. That's an excellent question. You know, as part of our impact analysis we estimated the \$1.8 million for startup and operation, first-year operations for an ACO.

Those numbers were derived in part from a review of the Physician Group Practice demonstration by the General Accountability Office, as well, and these numbers were available in that report in terms of what it cost GPs for startup and first-year implementation costs.

I think there are a couple things about the resource issue. It will vary by

organization, as we witnessed in the PGP demo.

I think it will be incumbent on a number of things, I think, in terms of what infrastructure is already available and can be brought to the table how much of this is already in the works or plans, and then sort of what additional resources will be required to invest in this, as well.

It's an issue that we're hearing a lot about. There have been a number of studies on this, as well. There's one in *JAMA* and in the *New England Journal* earlier. It's talked about this, as well, and it's an issue we're hearing about. It's something we're sensitive to. It's why we've proposed to align on the quality front to the extent we can with the PQRS program.

So we're not only reducing administrative burden, but we're providing some cash flow after the shared savings on that, like on the HITECH front with aligning with the information technology program to provide a revenue stream, funding stream, if

you will, for critical infrastructure.

It's also why we announced today a request for information around assistance for ACOs, up-front assistance, and should we be considering that as part of the final program.

We're interested in thoughts and comments on that, and I'd encourage you to make comments.

It's also an area that was outlined in the OIG and CMS waiver around the distribution of shared savings. One of the areas we're interested in and thoughts and comments is should that waiver be expanded to include some of this investment and up-front startup costs, as well, in that area.

So it is an issue that we've heard a lot about. It's something that we're concerned about. We're interested in folks' thoughts and comments on that and approaches to address those issues. I would strongly encourage you to submit that, submit those comments to us as part of the comment period, and we'll take it into account for the final.

DR. MURRAY: Thank you for being

on the call today, Mr. Sanborn, and thank you so much for your question. Jeff, there's another question, please.

OPERATOR: At this time, there are no more questions.

DR. MURRAY: Okay. Well, while we're waiting for questions to queue up, and I'm sure that there was probably one burning question out there that needs to be asked, and so we'll wait for it. Then, while we're waiting for that; just some more information to share with you.

As I mentioned earlier, and as John had mentioned as well, we have a website available that has fact sheets and other relevant information about the proposed rule, so if you're looking for information after the call that can be accessed online.

You can get that at www.cms.gov/sharedsavingsprogram all one word, again, www.cms.gov/sharedsavingsprogram and so we encourage you to visit our website to get more information.

Jeff, is there another question, please?

OPERATOR: Once again, to ask a question, please press *1.

DR. MURRAY: Okay. So, since there are no more questions waiting, we're going to end today's call, and I would like to thank all of you all for taking time out of your very busy schedules to partnership with us and to participate in today's call to talk about the reg.

Please note that for those of you that may be on the call that might have missed some of it, or if you have colleagues or friends that were unable to join us today, I encourage you to ask them to visit us at our website, again, [cms.gov/sharedsavingsprogram](https://www.cms.gov/sharedsavingsprogram) where we have information posted there, as well as transcripts from previous calls that have taken place.

Thank you so much for your time and attention on this call. We look forward to getting your comments before Monday, June

6, and enjoy the rest of your day. Thank you.

OPERATOR: This concludes today's conference call. You may now disconnect.

(Whereupon. the foregoing matter was adjourned at 12:56 p.m.)