

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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MEDICARE SHARED SAVINGS PROGRAM/
ACCOUNTABLE CARE ORGANIZATION

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LISTENING SESSION

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THURSDAY
MAY 12, 2011

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The Listening Session convened in
The Hub at United Plaza, 30 South 17th Street,
Philadelphia, Pennsylvania at 10:00 a.m.,
Nancy O'Connor, Regional Administrator,
presiding.

SPEAKERS PRESENT:

NANCY O'CONNOR, Regional Administrator, CMS
JOHN PILOTTE, CMS
BRUCE BITTENBENDER, CMS
ROSEANNE EGAN, CMS
DEBBIE FEIERMAN, CMS

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

10:05 a.m.

MS. O'CONNOR: Good morning, everyone, and welcome to our listening session on Accountable Care Organizations.

I'm Nancy O'Connor, and I am the Regional Administrator for Region III of the Centers for Medicare and Medicaid Services or CMS.

First off, I just want to thank you for taking time to come here today to join us onsite. I know you have very busy schedules. So I appreciate your taking time to come to this very important listening session on the proposed rule for the new Medicare Shared Savings Program.

As you may know, the rule was released on March 31st by the Department of Health and Human Services. It is intended to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations or ACOs.

ACOs create incentives for health care providers to work together to treat a patient across care settings. So doctors, hospitals, long-term care facilities, the whole continuum of care.

The Medicare Shared Savings Program will reward ACOs that improve or deliver high quality care and lower growth in health care costs while putting patients and families first. However, patient and provider participation in an ACO is voluntary.

The proposed rule is open for comment until June 6th, 2011. At the time the proposed rule was released, the Department also announced that it would hold a series of open-door forums and listening sessions throughout the whole country during this comment period. Now the goal of these listening sessions is to try to help the public understand what the Centers for Medicare and Medicaid Services, which is the agency that will be administering the ACO program, is proposing to do and to ensure that

the public understands how to participate in the formal comment process.

So the meeting today is one of these listening sessions that we are holding where we are going to inform you of the contents of the Notice of Proposed Rule and then take questions and respond to questions you may have on the proposed rule, and I really want to stress that this is an opportunity to ask whatever is on your mind to try to understand the proposed rule and get clarification. So we really, really welcome questions.

This forum, however, is not a forum for submitting the formal comments on the Notice of Proposed Rule. We'll accept questions and answers.

A transcript will be provided of this forum and listening session. That transcript will be posted on our website, and I'll announce the website at the end of the session.

There are fact sheets and other

information about the proposed rule in the packet that you received when you came in today.

Now if you want to submit a formal comment on the proposed rule, there are several ways that you can do that, and specific information with mailing addresses is included in your folder.

You can submit comments electronically at www.regulations.gov. You can submit comments by mail, by regular mail. Of course, you can send them via express mail or overnight mail. You can bring them to CMS personally or have a courier bring them.

When submitting formal comments, please refer to a file code. The file code is CMS-1345-P as in Paul, and because we have some limitations at CMS with resources, we will not be able to accept comments by fax transmission.

Now the proposed rule along with the joint CMS/Office of Inspector General notice is posted on a website at

ofr.gov/inspection.aspx, and there is also a fact sheet available on the healthcare.gov website.

As I said earlier, the comment period for the proposed rule will end on Monday, June 6th, 2011, and CMS will respond to all the comments that are received in a final rule that will be issued later this year.

So today we are going to share some information with you about the regulations to try to set the stage for you about ACOs. Then we're going to go into a listening mode to hear from you. We ask that you raise your hand if you do have a question. So that people on the phones can hear your question, we'll get a mike to you so that you can ask your question.

And, again, we want to hear your input, your ideas, but, again, this is not a session where your comment or your question will be considered a formal comment regarding the new regulation. You still need to

formally submit the comments, if you have them, in writing through the mechanisms I mentioned.

We'll begin comments in the room or questions in the room and then we will go to folks on the phone.

Okay. So now it gives me great pleasure to introduce John Pilotte, Director of the Medicare Performance Based Payment Policy Staff at our Baltimore Headquarters of CMS.

Jon Blum was going to join us today, but unfortunately, he had to stay back in Washington, D.C., but he has left us in very good hands.

John manages the staff that is designing and implementing Medicare Value Based Purchasing Programs including the Medicare Shared Savings Program. So he's actually writing this regulation.

He manages the development of value based purchasing plans for ambulatory surgical centers, skilled nursing facilities, and home

health agencies.

He has extensive experience. Formerly, he was the Director of the Division of Payment Policy Demonstrations in CMS's Office of Research Development and Information, and before he joined CMS, John was a senior consultant with Price Waterhouse Cooper's health care practice, and he was an associate on the government relations staff of the National Association of Children's Hospitals and Related Institutions.

He has a Master's Degree in Health Policy and Management from Johns Hopkins University and a Bachelor's of Science from Indiana University.

So it gives me great pleasure to welcome John this morning to talk about the proposed rule.

MR. PILOTTE: Yes, can everyone hear me? On the phone, I know we had some problems yesterday in New York, and we didn't know about it until sort of halfway through, but --

MS. O'CONNOR: So can folks hear John on the phone? Operator, is it coming --

TELEPHONE OPERATOR: Hello. This is the operator. John, you must speak a little bit louder -

MR. PILOTTE: Okay.

TELEPHONE OPERATOR: -- or come closer to the mike.

MR. PILOTTE: All right. Is that better?

TELEPHONE OPERATOR: That's much better. Thank you.

MR. PILOTTE: All right. Well, I want to thank you, Nancy, and the staff in the Philadelphia Regional Office for hosting us today, and I want to thank you all for taking the time out of your day to come and hear about the Medicare Shared Savings Program and the ACO rule.

I thought I'd spend a little bit of time going over what we've proposed in the NPRM and touching on the key points on this and then more importantly, allow sufficient

time to hear from you all about your questions, your thoughts and comments on it because that's, as Nancy said, the main purpose of doing this. It's good to hear directly from folks in the field that are considering this and looking at the challenges and the opportunities that the rule presents.

A little bit of background on the Shared Savings Program. As you all know, this was authorized under the Affordable Care Act. It sets up a new program within the Medicare Fee-for-Service, the traditional Fee-for-Service Program at CMS in Medicare. It builds off of the Fee-for-Service Program and creates an avenue for providers to come in and participate in the program on a voluntary basis as Accountable Care Organizations under a new approach where they would take responsibility and accountability for a population of patients that then through various proposed measurement framework for measuring quality and financial performance and depending on how well they do on that and

the savings that they generate for the program would be eligible to share in savings under the program.

The Shared Savings Program's required to be stood up and operational by January 1, 2012, and we plan on meeting that goal.

We issued the proposed rule at the end of March. It was published in The Federal Register on April 7th, and, as Nancy said, and I would encourage you all, not that you probably need encouraging, but to submit formal comments on that. We do look at all of those comments. They do shape our thinking around what we're proposing and what we'll put in the final. We did a similar process late last year through a request for information on about eight to ten key areas. That input is welcomed. It's valued, and your comments are reviewed. Each comment is reviewed and responded to individually. So I would encourage you to take advantage of that.

The Shared Savings Program also

represents something somewhat unprecedented. It's a coordination with multiple federal agencies that put out guidance on the same day. The Department of Justice and the Federal Trade Commission put out a policy statement around competition and antitrust issues around the creation of ACOs. The IRS put out guidance as well regarding the participation of tax exempt entities in ACOs and how the treatment of shared savings applies to tax-exempt policy as well as the Office of Inspector General working with the CMS folks put out guidance about the treatment on the distribution of shared savings within organizations and proposed a waiver as well as seeking comment on other areas as well.

So the goals of the Shared Savings Program in Accountable Care Organizations, as I mentioned, it's a new approach to delivering care in the Fee-for-Service Program with the goals of achieving better care for individuals, better health for populations, and lower growth in health care costs for the

Medicare program and ultimately the taxpayers who finance Medicare Part A and Part B services.

It promotes accountability for a patient population moving the Fee-for-Service Program from more of a reactive care program to providing incentives to providers to be more proactive in coordinating and delivering care to Medicare Fee-for-Service patients.

It promotes the coordination of both Part A and Part B services for the first time and provides opportunities for organizations that are effective in meeting the program goals to share in savings that are generated both on Part A and Part B services regardless of whether they're a Part A or a Part B provider under the program.

It encourages providers to make investment in the infrastructure and resources required to redesign care at the point of care with the goal here again of improving the overall quality, efficiency and effectiveness of care delivered not only to Medicare Fee-

for-Service patients, but a lot of stakeholders have told us that they redesign care for all of their patients. So there's certainly some spill-over opportunities here as well.

And then finally it provides a new incentive stream for Accountable Care Organizations that are successful in meeting the financial objectives that we've proposed in the NPRM to share in part of that savings depending on their overall quality performance. So, again, it's linking payment to quality performance as well on a broader scale basis than what we've traditionally done in a number of our value based purchasing initiatives around pay for reporting and now going forward on hospital value based purchasing for pay for performance.

So who's eligible to be an ACO and what do they have to do to participate? The statute lays out four key provider organizations that could be eligible for ACO and we've defined in our Notice of Proposed

Rulemaking. These include physician groups, physician networks, hospitals employing physicians, and joint ventures between hospitals and physician groups. Again, these are provider based entities, and these organizations can come together or come as existing organizations and apply to the Shared Savings Program to be Accountable Care Organizations.

In addition, the statute provides the Secretary discretionary authority to designate other providers to participate in this, and we've proposed to allow Method 2 Critical Access Hospitals, those critical access hospitals that bill for their physician services to participate as well independently as Accountable Care Organizations.

These, in essence, five organization structures are organizations that can come in and participate independently as Accountable Care Organizations, but since the ACO is accountable for all the Part A and Part B services, we expect that it'll bring with it

the full continuum. So all providers are important to ACOs since they're on the hook, if you will, for all the A and B services whether they provide it directly or not and so, in essence, all providers can participate as part of an Accountable Care Organizations. But the five that I've previously described are the organizations that would, in essence, hold the agreement with CMS and who would have patients assigned directly to them.

So what are some of the criteria that we've proposed the ACOs would have to meet? We've indicated that they have to be a legal entity recognized under state law and that these are really provider based organizations. So we expect that not only will providers be delivering the care under the ACO, but we expect providers to be actively participating in the governance of the organization as well, and we've proposed that ACOs have to demonstrate and describe what their mechanism is for involving providers in their governance structure and

how that governance and organizational structure would work, and, particularly, we proposed that ACOs have representation of at least 75 percent on their organizational governing body of Medicare participating providers that are participating in the ACOs.

As I mentioned earlier, ACOs have to agree to be held accountable for a population of care that we would assign to them at the end of each performance year for purposes of measuring quality and financial performance.

We expect ACOs to make investments in infrastructure and care processes to better coordinate care both for purposes of delivering care more efficiently and effectively for generating savings, but also in reporting quality on a number of areas that I'll talk about later as well, and we've indicated in our rule as well what we think the potential start-up costs for ACOs are recognizing that this will vary depending on sort of the organizational level of readiness

and sophistication that they bring to the table, and again here the overall goal here is for Part A and Part B providers to work more effectively together to coordinate services for Fee-for-Service beneficiaries.

We've laid out a number of criteria to encourage ACOs to demonstrate how they are clinically integrated which are consistent with the clinical integration criteria put forth by the antitrust agencies as well that require providers to have a vested interest in the overall success and performance of the organization. We've laid out a number of patient centered criteria as well that we're proposing that ask ACOs to demonstrate to us how they can deliver evidence based medicine, how they can deliver more individualized tailored care that's patient centered that involves the patient and their caregivers in their decision making around services, that they have a mechanism in place for capturing clinical and cost information and feeding that back to their providers on a more real-time

basis so they have the opportunity to change care and influence care at the point of care when they're interacting with Medicare Fee-for-Service patients.

We've also proposed criteria as well for ACOs to demonstrate and tell us how they are involving community stakeholders in their organizations as well. So that it's not only about the health of the population of the health care, but also the overall social well being of our Medicare Fee-for-Service patients.

As I mentioned, the antitrust agencies as well as the OIG and IRS put out sort of parallel guidance on the same day, and I wanted to touch a little bit about on what the antitrust agencies have proposed and how that interacts with the Shared Savings Program in CMS.

These criteria in this process apply to newly formed ACOs. Those organizations that have formed after the enactment of the Affordable Care Act. They

don't apply to existing organizations that are already operating in market areas today or prior to enactment of the Affordable Care Act.

The antitrust agencies have basically proposed a process for ACOs to calculate their market share, and if they find that they're below 30 percent under a provider service area definition that, again, is all spelled out in the antitrust agency policy statement, that creates a safety zone. They can go on doing their business. They don't need to worry about potential challenges from the antitrust agencies.

There's also a rural exception that applies to that as well for providers in rural areas.

For those ACOs that find their market share over 50 percent, the antitrust agencies are proposing an expedited review process and basically, what we are saying at CMS is we would want to see a letter from the antitrust agencies indicating they don't have antitrust concerns and they wouldn't challenge

an ACO going forward. So that they have that green light letter, if you will, from the antitrust agencies and submit it as part of their application before CMS would enter into an agreement with an ACO with over 50 percent provider service area control in their area.

And for those ACOs in between 30 and 50 percent, they've proposed a process that they could seek an expedited antitrust review, they could agree to abide by good market conduct criteria, or they could risk going it alone and being subject to a potential challenge down the road.

But, again, all of that guidance is spelled out in the antitrust agency's policy statement including how these provider service area definitions are calculated as well.

As I mentioned, ACOs are accountable for a population of patients that we would measure their financial and quality performance annually on. This population would be Fee-for-Service patients, and they would be assigned to the ACO based on the

amount of primary care that the ACO provides to them. So an ACO's population would be defined for them at the end of each performance year for measurement purposes. At the end of each performance year based on whether the ACO provides the plurality of primary care services by its primary care providers.

This is an attribution model that we actually have quite a bit of experience with in the program. We've used it for all five years of our physician group practice demonstration which the folks at Geisinger Health System in Danville participated in. We used this similar assignment rule for some small physician practice pay for performance demonstrations that we've run and we use a similar assignment algorithm under the group practice reporting option for large medical groups that participate under the Physician Quality Reporting System now.

So, basically, how this would work is that at the end of each performance year,

we would look back through the claims submitted by the ACO and look to see if their primary care providers are providing the plurality of primary care services. That would create the patient population from which we would measure their financial performance for determining shared savings, and it would also be the population from which we draw our samples for the quality reporting the ACOs would do as well.

This does not affect beneficiaries' choice of providers during the course of the year. They continue to be free to choose any provider they would see, and we hope really with ACOs that one of the key objectives here is really to increase patient provider communication as well and to make, more informed, better choices of how and which services to use during the course of the year, and this assignment algorithm really is for purposes of the program as a look-back mechanism for measuring quality and financial performance.

What we've proposed in the NPRM is a two-track payment approach for ACOs to elect when they enter into the program with the basic premise here that the more performance based risk that you take on, the greater reward potential is for ACOs, and I'll talk a little bit about the first track and the second track and sort of how that would work.

Under the second track, which is a shared savings/shared loss track, ACOs could elect that for the first or subsequent agreement periods, and they would be held accountable for any performance based losses that may occur under the program. But they could also then share up to 65 percent of the savings they generate as well. Again, depending on their quality of performance and depending on their involvement of Federally Qualified Health Centers and Rural Health Clinics in the program.

Under the first track, since we know that a lot of organizations aren't ready or may not be ready to move into performance

based risk contracting with or agreements with CMS, we've proposed that the first two years of that three-year agreement would be a shared savings only proposition. So those organizations that generated shared savings the first two years of that agreement could share up to 52.5 percent of the savings that they generate. Again, contingent on their quality of performance and their involvement in Federally Qualified Health Centers and Rural Health Clinics. But they would not be held accountable for any losses that they generate those first two years.

They would be automatically transitioned to shared savings/shared loss the third year of that agreement, and any subsequent agreements that they participate in the shared savings program, they would be under the two-sided approach as well.

We believe this provides an on ramp for organizations who may not be quite ready to do performance based agreements with CMS to learn about and to get their infrastructure

ready and gain some experience under the program before they move to a performance based risk agreement where they're accountable for both shared savings and shared losses.

On the quality measurement front, as I've indicated, ACOs that do generate shared savings, their final sharing rate with the program, the amount of savings they get to keep, would be dependent on their quality of performance that we've proposed to measure in five domains.

Under the two-sided track for those ACOs that incur losses and would be sharing in losses with the program, their quality performance would impact the amount of losses that ultimately would be payable back to CMS as well. So the better they do on quality, the lower amount of losses they would have to pay back under the two-sided approach. Likewise under the shared savings, the better they do on quality, the more of the savings they get to keep.

We've proposed to measure quality

in five domains: patient and caregiver experience; using the clinician and group CAHPS survey instrument; preventive health and at risk population; frail elderly health -- care measures, this is an area that uses a lot of preventive measures including one I learned this morning developed by the QIO here in Pennsylvania for measuring BMI; as well as a number of areas around chronic disease that are important to the Medicare population: CHF, diabetes, coronary artery disease, hypertension and so forth.

These two domains would really be captured using a process that we've developed in demonstrations. It's part of the program now under the Physician Quality Reporting System. We have 35 large medical groups doing this now in the program using a tool that we've developed where we capture clinical information from providers directly under a sampling methodology that's similar to sort of what's used in the HEDIS Medicare Advantage Program for quality reporting as well.

And then we've also proposed patient safety measures. Again, all of these patient safety measures are hospital based. Regardless of whether the ACO has a hospital in it, ACOs are accountable for the Part A and Part B services that they use, and these measures would be calculated primarily by CMS through claims or administrative systems, and then we've also proposed a number of care coordination measures as well looking at, again, claims based measures around ambulatory care sensitive conditions as well as readmissions.

We've proposed that these measures and we've sought to align them with other quality reporting initiatives in the program now on the physician front and hospital front, and we've also proposed that ACOs would be allowed to earn their PQRS incentive payments for reporting the measures under the ACO program. We've also aligned these with the HITECH program as well for physicians that are participating in that, and we've proposed some

eligibility criteria for requiring 50 percent of primary care physicians to be meaningful users by the beginning of the second year. But, again, the idea here is to align these measures with other physician and hospital and other quality reporting initiatives going on in the program to be sensitive about burden, but also to align those incentive structures as well.

A little bit about beneficiary notifications and then we'll turn it over to you guys to hear from you. We've proposed that ACOs notify their patients that they're participating in an ACO and what the implications of that is for their patients.

We expect that since this is a voluntary program that it would include information that indicates that the beneficiaries are not subject or restricted in any way, shape or form in the services that they would continue to receive and are entitled to under Part A and Part B. They're not subject to utilization review, utilization

management, prior authorization, and so forth. But they continue to have the freedom of choice to see any provider they choose.

We also have proposed to share data with ACOs. Both Part A and Part B and Part D data. We heard a lot from stakeholders during our pre-proposal comments that, while ACOs and providers have a good understanding of what's happening within their practice, they don't always understand what's happening to their patients outside their organization. So we've proposed to provide Part A and Part B and Part D data to them for those patients that they have notified that they may be requesting data and have not declined to have their data shared, and, again, we would do that on a monthly basis.

That sort of concludes my overview of the rule. Again, I would encourage you to submit comments. You have a number of documents in your folders about how to do that, and I encourage you to get those in by June 6th when the comment period closes.

Thank you.

MS. O'CONNOR: Okay. So now we want to into a listening mode here, and we want to hear from folks here in the room first of challenges that the rule presents, opportunities, questions that you may have about the rule, but we really want to get your reaction and hear from you, you know. So, I will open the floor. Please.

MR. BRENNER: Can you clarify how you're handling FQHCs, Federally Qualified Health Centers, in this model? There's some confusion in the FQHC world about how their data's being handled and some of their challenges of being involved in this.

COURT REPORTER: Excuse me. Can I ask that people give their names?

MR. BRENNER: Sure. It's Jeff Brenner, the Executive Director for the Camden Coalition of Health Care Providers.

MR. PILOTTE: No. Thank you. Thank you for the question. We've heard a lot from folks.

MS. O'CONNOR: The question, for those on the phone, dealt with how CMS is dealing with FQHCs and data. So we need some clarification on that.

MR. PILOTTE: Yes. What we've proposed is that ACOs would have higher sharing rates for including FQHCs and RHCs in their organization. So under the two-sided approach I talked about, depending on their utilization of FQHCs and RHCs, they could earn up to an additional 5 percentage points of shared savings and then under the one-sided approach, they could earn up to an additional 2.5 percentage points of shared savings based on their utilizations of FQHCs and RHCs.

Because of the way the assignment algorithms work and because of the way FQHCs and RHCs currently bill the program and are paid under sort of a case rate, a lot of the more detailed information about who's providing the services in the FQHCs and so forth doesn't make it into our claims repository. So each ACO would be measured

from sort of a historical benchmark that would be calculated for each one. The program starts January 1, 2012. So we'd be using '09, '10 and '11 data to historically assign patients to ACOs and then determine what their benchmark is that then would be updated annually based on a national factor and so forth. Because all that relies on claims data, particularly Part B claims data, to create the assignment, that information is not currently in our claims systems because of the way FQHCs and RHCs are paid for the historical period.

So that's why this is an important issue for us. It's an important issue for the Administrator. We've worked a lot with HRSA on this to try to figure out how we can involve them, and so that's partly why we're proposing these higher sharing rates in the interim period.

Now there are billing requirements that are changing starting in 2011. FQHCs are submitting claims with more of this detail on

them. We expect the FQHCs and the RHCs could participate independently as an ACO in future years once we have sufficient three-year benchmark to calculate per the statute. But until that happens, we would have to in essence, impute numbers or something for each FQHC, RHC, ACO, if you would, and we haven't proposed doing that.

So that's why we've ended up with these proposed higher sharing rates for FQHC and RHC participation, but I think they're important to the program.

I've been out and seen a number of FQHCs. I think they actually have a lot of the infrastructure and the ability and have the care models that could be successful that we want in the program. But I think because of some of these technical issues right now, we're kind of limited in what we can do.

But I would encourage you to submit comments on that formally as well so we can consider those and react to them.

MS. O'CONNOR: Okay. Are there

other? Go ahead.

MR. OLMSTEAD: Hi. Dennis Olmstead, Pennsylvania Medical Society.

John, thanks for your presentation. Can you further elaborate how the measures used in the ACOs are aligned with the PQRS and the meaningful use measures?

MR. PILOTTE: Yes. Thank you for the question. In the chart that accompanies the rule, it sort of defines sort of where the measure is coming from and so forth and what I mean by align is the measure numerator and denominator specification would be the same for those measures. So, we've done this for a variety of reasons, but particularly because of administrative burden, we don't want measures out there that conflict and require providers to report it one way for this program and another way for that. What I mean by that is that, you know, the numerator and denominators will be aligned after those measures. We would use similar reporting mechanisms as well for ACOs. We've proposed

to use this group practice reporting option tool that would be enhanced to reflect the ACO spectrum of measures that would be reported. We've proposed to align the incentive structure for PQRS under that. So, all ACO participating providers who submit data or the ACO submits data on their behalf would qualify for this incentive payments regardless.

So, that's where we sought to align is on the incentives side and giving credit for submitting one way for as many programs as possible as well as the details for numerator/denominator level as well to align those specifications to be sensitive to administrative burden and so forth for providers as well. The idea here is you submit to one -- you submit to ACOs. You get credit for those programs or using the same numerator and denominator specifications as well. So, you may submit that data to HITECH. You may submit it to ACOs, GPRO reporting, but it's the same data that's getting submitted.

MS. O'CONNOR: The question over

here please.

MR. WILT: Hi. Daniel Wilt with the Regional Extension Center and also the State HIE for Maryland with CRISP.

So, a question about how are you aligning the problems with the HIE stuff and REC programs with the ONC and also, is there any impact on participating in any of the incentive programs for meaningful use e-prescribing, PQRS? Can you participate in both or are there any limitations on that?

MR. PILOTTE: The answer is yes, you can participate in all of those PQRS, you know, e-prescribing and HITECH. You know, under my understanding of the high tech rules, participating in that also gets you the e-prescribing incentives as well.

So, what we've proposed for ACOs is that 50 percent of primary-care physicians be HITECH meaningful users by the beginning of the second performance year. So, we would expect that ACOs would meet that standard and have their PCPs in those programs by the

beginning of the second year.

You know, as the previous question was about alignment, there is a lot of alignment around the measures that get submitted to both these programs. So, we're sensitive to administrator burden, providers. Only capture the same clinical information. There may be some submission processes where they have to submit it to HITECH and they might have to submit it under the ACO program because they're really reporting on slightly different populations and so forth. But, it would be the same measures.

You know, health information technology from what we've heard from stakeholders is going to be really important as ACOs move to more -- for population management and really, you know, the purpose of all this quality data is not so you have it to submit to us once a year although that's nice and we appreciate it. But the idea here is that providers can use that information and have the systems to be able to slice and dice

it and feed it back to their providers throughout the year. So, they can really use it to improve their performance, use it to influence care at the point of care when they're seeing the patients and that's really where the big value from all of this comes.

So, you know, as the health information exchanges get set up and play a bigger role and providers are participating in that, I think they'll really be important because, you know, ACOs are accountable for all the services that their patients see both Part A and Part B, whether they're providing them directly or not. So, they'll need better mechanisms in place to manage the transitions and to track their patients along the continuum. I think the health information technology within the organization as well as those exchanges that get set up around the country as well in their markets and so forth will be important to them.

MS. O'CONNOR: Question over here.

MS. CLARKE: Good morning. Pam

Clarke from the Hospital and Health System Association of Pennsylvania.

And I have a couple of questions on the quality reporting and in particular, we had some confusion about the 30 percent threshold. Is that per measure or is that by domain?

MR. PILOTTE: Yes. No, that's a great question. What we've proposed for the quality, performance structure is -- the first year, it would be in essence a pay for reporting. So, those ACOs that submit the data and really the data that they're required to submit to us are really mostly in three domains. They have to do the patient and caregiver expense, survey the clinical group CAHP survey and they would have to do the preventive care and the at-risk chronic disease and frail elderly measures through this GPRO tool and so forth. That's sort of the main reporting.

There's a couple of measures, I think, in the care coordination around med

reconciliation and care transitions that they would have to do as well, but those are sort of the main domains that get reported that the ACO would have to report on.

Now, it's pay for reporting the first year. So, they submit that data. They meet the standard. They would get, you know, their 50 or 60 percent sharing rate. Depending on sort of whether they involve FQHCs and RHCs, it could be slightly higher.

For the second and third year, we proposed a sliding scale performance structure that basically allows the ACO to keep more of the savings the higher they do on quality performance. So, for those measures, it starts at 30 and it goes up to 90. So, for each one of those measures, we would calculate a rate.

The ACO would earn a number of points for each one of those rates and then those points would be summed up for each of the five domains independently and then they would get a percentage of points earned versus

points available per domain and we propose basically to equally weight all of those domains. So, we'd average those numbers together and that, in essence, would be their quality score that would get applied to their shared savings.

Now, on the sliding scale for the points that they earn for each domain, you have to get at least -- if we can get a measure, a number of these measures have benchmarks that are -- we could derive from the Medicare Advantage Program, from the HEDIS data that they report. The claims based one. We could calculate from Fee-For-Service claims data. We're still working through how we would do that, but maybe on a 5 percent sample or something. Create a distribution and look at what the 30th percentile of Fee-For-Service claims are or Medicare Advantage HEDIS performances to really create, in essence, the benchmark. So, if the 30th percentile of performance is 50 percent, then as long as they got above 50 percent, they would earn, I

think we're proposing 1.1 points for each measure.

And then for those measures where we don't have claims data or an MA HEDIS benchmark to look at, it would be a straight 30, 40, 50, 60, 70, 80, 90 sliding scale. It would just be a straight percent. So, if they got 30 percent on the measure, they get their 1.1 points.

So, they would have to report on all of the measures. If they didn't, they wouldn't meet the quality of performance standard that we propose. That could be grounds for termination as well if they're not reporting on all the measures.

But, they could, in essence, end up with less than 30 percent at the domain level as well or they could end up with a zero at the domain level as well which would then -- the maximum percentage of shared savings they could keep would be 80 percent because each one of those domains, in essence, is worth 20 percent of the shared savings that they

generate.

So, if they don't report an individual measure, that's a problem. If they report and it's poor performance, they wouldn't earn any points. If they had poor performance across an entire domain, I think that's probably unlikely, but that would be reflected in the amount of shared savings they would get to keep. In essence, they wouldn't get any shared savings for that domain.

MS. CLARKE: So, to kind of break it down, the 30 percent threshold does apply both to the individual measures and also to the overall domain? Because, you know, some of our members were questioning if they didn't meet a 30 percent threshold on an individual measure, does that automatically mean they're not eligible for shared savings?

MR. PILOTTE: No, if they flunked the measure, in essence, they got below a 30 percent, they just wouldn't get any points for that measure.

That would get averaged out at the

domain level. So, conceivably, they could be poor performing on several measures and still end up with a domain score because of the point scoring mechanism and so forth.

So, if you got 20 percent at the domain level, that would just get averaged out with your other four domains. Where you would see it is in the amount of shared savings that you would get. You would get a reduced amount of shared savings based on that lower quality performance for that domain.

MS. CLARKE: And my other question which it sounds like you sort of answered which is we were confused about how the Medicare Advantage data would be incorporated since you don't have claims data for Medicare Advantage.

MR. PILOTTE: Yes.

MS. CLARKE: So, it's the HEDIS data you're going to be incorporating in the evaluation of the performance measures?

MR. PILOTTE: Yes, and that's similar to what we've done in our PGP

demonstration and some of our small physician practice demonstration where we've set up benchmarks based on a flat percentage or a similar HEDIS metric or an identical HEDIS metric that's available. So, it would be the HEDIS data we would be looking at that the MA plans submit to create the distribution for each measure.

MS. CLARKE: And my final question, I thank you for your answers, is that the measures -- there's three different mechanisms. One's the GPRO tool. The second is the CAHP survey and the third is claims. Is there another survey that's supposed to be conducted in addition to those three mechanisms?

MR. PILOTTE: Yes. Yes.

MS. CLARKE: There is?

MR. PILOTTE: We have proposed a care transition survey as well as part of that proposed rule as well that looks at the three variables around do you understand your discharge orders, med reconciliation and I'm

blinking on the third one. But, yes.

MS. CLARKE: Okay. And the patient safety measures which are hospital measures only, if you have an ACO that's physician only, are they still responsible for that domain?

MR. PILOTTE: Yes, because even though you're physician only, you know, probably 20/25 percent of your patients are still utilizing inpatient services. You know, there's probably a narrow distribution of hospitals that they're using as well, but the idea here is since the ACO is accountable for the dollars for those patients, they're also accountable for the quality that they're getting as well in those facilities. The idea is to encourage physicians and hospitals to work more closely together particularly around -- there's a number of care transition type metric as well that they're going to be measured on as well and so, the idea is to drive better communications and drive integration and improve those measures the ACO

patient population's receiving regardless of whether they're provided directly or by other providers that the ACOs patient see.

MS. CLARKE: Thank you.

MR. WILSON: Hi. Don Wilson. I'm Medical Director for the Quality Improvement Organization for Pennsylvania and also for the two Regional Extension Centers here in Pennsylvania.

My question actually is in relation another program in the HITECH, the 3026 funded program, the care transitions programs and how do you see these two programs? If a community decides that they want to participate in that, does that automatically nullify their ability to participate in this or can they do both because they really could complement each other kind of nicely and they kind of look at some of the same things really.

MR. PILOTTE: Yes. No, it's a great question and no, it doesn't nullify. Participation in the care transitions program doesn't nullify participation in the shared

savings program for an ACO or ACO-like entity.

What is precluded is an ACO can only be in one Medicare shared savings initiative. So, you know, we don't want to be paying twice for the same similar services and so, per the statute, we're requiring -- that would preclude an ACO from participating in multiple shared savings programs with Medicare.

I think it's a good point. There are a number of initiatives out there already that can complement this. There's probably a number of -- the care transitions is one area. I know the AOA sites and the **ships** and so forth have a number of care transition-type services they provide along with, you know, the QIOs under the scope of work and so forth.

So, I think there are a number of resources available in communities that look at this sort of broader coordination of A and B services. You know, that's one example. I'm sure there are others that are going on that could be complementary and could be

potentially leverage for ACOs as well. So, I think there's probably depending on sort of who the organization is and their sort of level of sophistication and sort of the resources available to them and I think that there are other community stakeholders that are doing things like this and the idea here is to encourage better integration with those resources as well since they're all really focused on Medicare Fee-For-Service patients.

MR. TEDESCHI: John Tedeschi, CEO of Advocare.

You might have hinted at the answer to the question I was just going to ask you.

I was a little bit confused by the language of a provider only being able to be part of ACO. What would the thought process be towards that? It's very confusing.

MR. PILOTTE: Yes. No, that's a great question and I think it's covered probably in a number of different areas in the NPRM as well.

What we've proposed is that -- and

this also has antitrust -- antitrust agencies have a lot of views on this as well that they've outlined in their policy statement.

What we've proposed for those providers on which assignment of patients to the ACOs is based, so, what we've proposed is primary care providers --

MR. TEDESCHI: Right.

MR. PILOTTE: -- internal medicine, family practice, geriatrics and general medicine would have to be exclusive to an ACO. So, we can make sure we're assigning patients to only one ACO for purposes of measure quality and financial performance.

Other providers could participate in multiple ACOs since assignment is not based the provision of their services and antitrust agencies also have concerns about specialists being exclusive to a single ACO as well.

So, that's what we've sort of laid out and proposed. That it's really only those primary care providers that have to be linked to one ACO.

MR. TEDESCHI: What would be the thought process though if you had a large integrated group with a wide population in various geographic areas? You had that integrated group. You have providers that really don't belong in one ACO practically.

MR. PILOTTE: You mean primary care providers?

MR. TEDESCHI: Yes.

MR. PILOTTE: Well, I mean I don't know. I would encourage you to submit some comments on what explicitly you have in mind, but, you know, we'd have to take a look at that. But, I mean, this issue of --

MR. TEDESCHI: Well, you're looking at large -- one of the factions that you mentioned during this presentation is one of the cooperative people in an ACO strategy would be large integrated groups. Large integrated groups could have a wide geographic distribution that it doesn't make sense to be limited to an ACO which may have to have a relationship with a hospital system or various

other components of delivery of care and measurement of the data.

MR. PILOTTE: Yes, and they do. I mean these big integrated systems I mean span multi-county areas.

MR. TEDESCHI: Well, why would they be just one ACO?

MR. PILOTTE: Well, I think how they form and how they elect to participate in the program leave that to them, but I think what we're saying is in order to be able to hold them accountable for a patient population based on what we've proposed in the rule of assigning patients based on primary care services in order to have that happen and so we aren't assigning patients to multiple ACOs in the same area, the ACOs primary care providers would have to be exclusive to that organization recognizing that all the specialists in the hospital itself could participate and would have to participate in multiple ACOs.

MR. TEDESCHI: You're defining it

as one hospital. It could be ten hospitals.

MR. PILOTTE: Right. Well --

MR. TEDESCHI: It -- you know, I think it leads to -- you know, a large enough clinically integrated group that has the ability to collect data, you know, certainly can break down that data in multiple arenas of ACO categories and give you the same bang for the buck.

MR. PILOTTE: Yes.

MR. TEDESCHI: I didn't get the point of it. It just -- to me, it just didn't make any practical sense.

The other question I had is what is -- you know, the primary care world also includes children. What is the thought process or are you going to just totally avoid the thought of pediatrics?

MR. PILOTTE: Yes. No, I mean kids are important. I have two of my own. No, we haven't. You know, we do, but it is Medicare Fee-For-Service to the extent that, you know, it is aged and disabled and ESRD. We do pick

up some kids in the Medicare program in the ESRD world. So, you know, essentially those patients could be applied although they're very few and far between thankfully.

There is a pediatric ACO demonstration that was authorized under the Affordable Care Act as well that's being developed currently as well in the program, but it's a demonstration and the demonstration folks are working on that and, you know, I know -- I've heard rumblings with Medicaid and so forth in different arenas as well. The states look at this as well. Which would -- really where you'd be picking up the lion's share of kids and pregnant women and so forth as well. So.

MR. TEDESCHI: The largest long-term bang for the buck starts with children and preventive care.

MR. PILOTTE: Yes, well, I agree.

MS. RYAN: We have a question over here.

MR. CARSON: Good morning. Steve

Carson from Temple University Health System.

I want to be able to stay on the same thing we've been discussing this morning and my question really has to do with as a hospital provider, if I participate as a provider as part of the ACO, would that preclude that provider from going down the trail working within the Innovation area for community-based transitions of care?

MR. PILOTTE: No, because community-based care transitions program is not a shared savings program.

What we have proposed though is, and thank you for bringing this question up again, that, you know, fees that are paid to these organizations under these various demonstration initiatives and so forth and I know there's like, I think, a pre-discharge fee that's proposed as part of the community-based care transitions program from the A and B trust funds, so, all of those payments would be counted into the ACOs, you know, annual performance calculations. If it's in their

benchmark period, it would be included in that as well. But, you would not be precluded from participating in those multiple initiatives as long as they don't involve a shared savings component for the Medicare program. But, any fees that you would get under those would be calculated in the annual reconciliation process for the ACOs.

MS. O'CONNOR: Are there any other questions in the room? Okay. Thank you.

MR. HANNAH: Thank you for comments. Brian Hannah, Medical Director of Information Services at Northeastern Hospital.

Forgive me for my naive comments and questions. I'm looking more as a physician and information technology application. I'm here to learn because I know that IT's part of this.

It seems to me just as an outsider that CMS and the Department of Justice they ought to get their goals aligned. Because on the one hand CMS is asking physicians and hospitals to more closely coordinate care and

they're going to share a business relationship with somebody. That's going to lead into my second question. Who gets the money and who distributes the money?

But, and then obviously information technology, there's going to be investments in that. There's going to be shared information technology. Everybody knows the difficulty of sharing different applications and interface and all that. So, it's more efficient and effective if you have one system.

So, it leads me to conclude that basically to save money that the hospitals, I'm thinking of a hospital in a local community, my brethren, the hospital -- primary care docs if they're going to be coordinating their care so closely in order to save money, that at the same time now the Department of Justice is going to be sniffing around and evaluate the contracts as to whether they're violating antitrust rules.

So, I'd just like you to comment on that.

The second question is -- well, actually, that was a comment and the question is who gets the money? Everybody says the Accountable Care Organization gets the money. So, if you have a hospital and you have a physician that's in a community based, he signs an agreement to join the ACO, who gets that check and who then distributes it from there between the hospital and the provider, the physician?

It seems to me if you're trying to -- CMS' goal is reduce admissions to the hospital. I understand that. Keep them out of the emergency room, but that, in turn, is going to lead to reduced revenue for the hospital. So, are they then going to be tempted to hold back on the money? I'm --

MR. PILOTTE: Yes.

MR. HANNAH: Again, they're naive questions and I apologize.

MR. PILOTTE: Oh, no. No, there's no question that's naive and you know this is helpful. Because we aren't always clear in

our proposed rules and so forth.

But, I mean to your last question about who gets the money, in the shared savings, that would be payable to the ACO entity, the organization that holds the agreement with CMS and what we've asked as part of the application process is that the ACO tell us how it plans to distribute any shared savings they get. We want to know that partly so we don't have any program integrity issues around that and so forth, but it's really up to the ACO and its participating providers and its governing body to figure out sort of how that distribution would be distributed within its organization.

And the ACO would have complete flexibility on that within the existing confines of the waivers and fee for service rules and regulations and so forth.

On the second point -- on your first point about the antitrust agencies and so forth, that is something we've heard a lot about from various stakeholders and so forth.

We have sought to align our clinical integration criteria that we're proposing for ACOs with those clinical integration criteria that are put forth by the antitrust agencies as well to create better alignment, reduce or be sensitive to burden and so forth and to address similar like issues.

I know the antitrust agencies are interested in comments and feedback on their policy statement as well. So, I would encourage you to submit that formally to them as well as to us.

MS. O'CONNOR: Okay. Any other questions here and then we'll go to the phones.

Operator, are their questions from folks who are listening in?

TELEPHONE OPERATOR: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press *1. Thank you. Please record your name clearly when prompted.

First question comes from Sandra

McCuen.

MS. MCCUEN: Hi. My name is Sandy McCuen and I'm with the Pennsylvania Physical Therapy Association.

And my question is about the shared savings and what services would be included. I assume on the outpatient it would be some shared savings on the fee schedule allowed now.

But, with rehab services not being primary either in organizing an ACO or the quality -- necessary to rehab services, if a patient receives rehab services on an outpatient basis and they were determined to be receiving that from an ACO outpatient provider, would the rehab services be part of the calculation for the shared savings?

MR. PILOTTE: Yes. Thank you for the question. Yes, that for those patients that are assigned to the ACO, the ACO would be responsible or held accountable for all of the Part A and Part B expenditures for those patients regardless of what -- for those

services that are paid on a Medicare Fee-For-Service claim. So, the extent that those services are billed for that patient and paid by Medicare, we would have a claim for them. If a patient is assigned to the ACO, the total Part A and Part B cost for that patient would go into the measurement of that ACOs performance.

MS. MCCUEN: And if I could follow up on that. So, it would appear that it would be to the ACOs advantage to try to capture as many services as possible that the Medicare beneficiary might receive and though I know that it is to be voluntary that a patient would be notified of participation in an ACO and could seek care with any provider they choose, it would seem to me that there's a strong incentive for the ACO to influence patients to receive as many services as possible within their provider group or association of providers that are participating in the ACO. Would that be correct?

MR. PILOTTE: Yes, I mean the goal here is to have patients working, you know, closely with their physicians and making the best choices of provider that can meet the needs that that individual patient needs. Really regardless of whether it's inside or outside the ACO, really the goal here is really to drive the integration of care. Ideally, that would probably be more easily within the ACO, but we know that a lot of care is still delivered outside the organizations from various demos and so forth. So, it will be equally important for those organizations to develop new ways to work with those providers as well as better integrated care within their existing organization.

MS. MCCUEN: From the Pennsylvania Physical Therapy Association, one of our concerns would be that when there is shared savings involved, the issue of keeping patients within that umbrella and influencing patients to do that regardless of the quality of care that may be within those

organizations, it would seem to be a real strong incentive to perhaps not consider all providers in the community that might provide high quality care.

So, I guess that would be registering a concern relative to the model.

MR. PILOTTE: Yes. Thank you for that and I would encourage you to submit that in the formal comment process as well.

MS. O'CONNOR: Operator, are there other questions on the line?

TELEPHONE OPERATOR: Yes, we have further questions coming in. Our next question comes from Cindy Wilson. Please go ahead.

MS. WILSON: Hi. Yes. My question has to do with the durable medical equipment provider with this model. Will they have to have a competitive bid contract in order to provide durable medical equipment to the members that fall under the ACO?

MR. PILOTTE: You know, I don't know enough about competitive bidding and DME

to tell you, but I can tell you this. However DME providers are paid under the program, we would be capturing those Part A and Part B claims submitted by those organizations. So, it would go into the calculations of the ACOs' benchmark and their annual performance since the ACO is accountable for the total Part A and Part B cost of those patients.

MS. WILSON: But, my question is if a hospital owns a durable medical equipment company and they're forming an ACO and they want to use their durable medical equipment company, but they don't have a competitive bid contract, you know, would they be able to provide the services to the patients? Because right now, it's not that way. If you didn't get a competitive bid contract, you don't get to provide certain Medicare services to patients.

MR. PILOTTE: Yes, it would be for those services covered and paid for under the program that would go into the calculation. So, if that provider doesn't bill Medicare,

then we would have no record of the cost. It would not go into the calculation of the ACOs' services.

MS. O'CONNOR: And that sounds like we need to clarify things further with how the program would work with DME suppliers. So, we would ask that you would submit that as a concern and need for clarification. Thank you.

MS. WILSON: Okay. Thank you very much.

MS. O'CONNOR: Operator, next question. Are there any other questions, operator?

TELEPHONE OPERATORS: We have a question from I believe it's Arivala Gan Polyaman. Your line if open.

MR. POLYAMAN: Hi. This is Ari from India's LLC. This question is related to the quality measures included for the ACOs.

I heard that the National Quality Forum, the AHRQ heads and the CMS is working on various parameters and I would just like to

know who is the final authority in this subject?

MR. PILOTTE: If I understood the question correctly, it's who is -- how do you go about finding out more information about how CMS is working with NQF?

MR. POLYAMAN: Yes, among the proposals from CMS, AHRQ and National Quality Forum, which one we should consider at the basis, the law of the land?

MR. PILOTTE: The law of the land. What we've proposed for the ACO program is the measures are spelled out in our Notice of Proposed Rulemaking. The source of those measures is identified there and most of those measures if not all of them, I believe, are in NQF reviewed or approved and the corresponding NQF number is listed in that table for each one of those measures as well as more information about the source of those measures.

I know under a lot of CMS Medicare Value Based Purchasing Initiatives, we seek to

align with the industry measures and so forth to the greatest extent that we can and to use those NQF measures.

MS. O'CONNOR: Operator.

MR. POLYAMAN: Thank you.

MS. O'CONNOR: Operator, next question.

TELEPHONE OPERATORS: Our next question comes from Gerry Stover.

MR. STOVER: Good morning. My name's Gerry Stover. I'm with the Kentucky and the West Virginia Academy of Family Physicians.

My question has to deal with the data. I saw in the regs that data will be made available during the period that you form an ACO, but what about prior to that? If a group of physician, hospital organization looking to form an ACO, may they request data and what would be the process of that?

MR. PILOTTE: Yes. Thank you for the question and I would encourage you also to submit formal comments on that as well for us

to consider.

What we proposed is that for each ACO we have to calculate a three-year benchmark based on really the three years prior to the beginning of the agreement period. So, ACOs that start January 1, 2012, it would be, you know, calendar year '09, '10 and '11 data.

We would assign patients historically to those organizations for purposes of calculating the benchmark and what we've proposed is that we would provide them with an aggregate report of cost and utilization information as well as demographic information for those beneficiaries that would be assigned each one of those years as well as with the preliminary benchmark amount recognizing that we don't have complete '11 data prior to the start of the program on January 1st, 2011.

So, we would provide an aggregate data report that would cover utilization expenditures and demographic information for

those years. We've also proposed to provide ACOs with a list of beneficiaries that were assigned to them during those periods so they actually have a better understanding of the characteristics and the types of patients as well as the individual patients that they would likely be held accountable for throughout the performance periods.

MS. O'CONNOR: Operator, next question.

TELEPHONE OPERATORS: No have no further questions coming in.

MS. O'CONNOR: Okay. Are there any other questions in the room? How about on the telephone one more time? Okay.

Well, I just want to thank everyone for coming out today or listening on the phone and participating in this session. I think the comments and the questions were very helpful.

Again, I encourage you to submit a formal comment as I've described.

Also, I know that many folks that

I've talked to have been, you know, developing and implementing some very innovative practices within their communities and CMS is very interested in your sharing those ideas with us.

Our Center for Innovation at CMS is soliciting input and if you go onto the Innovations.CMS.gov website, there is a tab on sharing your ideas and I would encourage you to take a look at that. If you have some innovative practices that can help to improve quality and reduce health care costs, we would definitely be interested in hearing those ideas.

There is information as I said on the proposed rule and information in your packets and if you would like a transcript of this meeting, you can go onto our website at CMS.gov/sharedsavingsprogram and if you missed some of the meeting or if you want to hear any of the Q&A again or the presentation, you can get a transcript from the meeting today on that.

So, again, thank you, John, for coming up to have this session with us today and thank you all for joining us. Have a nice afternoon.

(Whereupon, at 11:26 a.m., the listening session was adjourned.)