

CENTER FOR MEDICARE & MEDICAID SERVICES

+ + + + +

MSSP ACO NOTICE OF PROPOSED RULEMAKING

+ + + + +

PRESENTATION & LISTENING SESSION

+ + + + +

WEDNESDAY

May 18, 2011

+ + + + +

Hilton Grand Rapids Airport Hotel  
4747 28th Street, S.E.  
Grand Rapids, Michigan

+ + + + +

The above-entitled matter commenced at  
4:20 p.m. with John Hammarlund as the  
moderator.

PRESENT:

JOHN T. HAMMARLUND, Regional Administrator,  
DHHS

DR. TERRI POSTMA, Center for Medicare and  
Medicaid

ELIZABETH SURGENER, Center for Medicare and  
Medicaid

FAYE C. STARCEVICH, MHS, Health Insurance  
Specialist, DHHS

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

MR. HAMMARLUND: Let's get started. You're going to hear the name of Ashley a lot here, folks. She's going to be giving instructions to the folks here on the phone.

(Whereupon Ashley proceeds to give instructions to the people participating via telephone.)

MR. HAMMARLUND: Thanks very much, Ashley. And good afternoon, everybody! Thank you to all of our participants on the phone today. We very much appreciate your patience.

I know you have been busily wondering where we might be and we're glad to finally have connected with you. We thank you so much for joining us. And we're also grateful to have everybody joining us here in Grand Rapids where we have a live audience as well.

My name is John Hammarlund; I am the Regional Administrator for the Center for Medicare and Medicaid Services serving Region V. We are based out of Chicago. And it's my

great pleasure to welcome you in this important listening session on the Medicare Shared Savings Program and CMS' recent regulations regarding Accountable Care Organizations.

We have lots of stakeholders and partners with us here in Grand Rapids today, clinicians, consumers, employers, hospitals, health systems, health plans, and many others from the industry, and we likewise have lots of stakeholders on the phone as well. We thank each of you for taking time out of your busy schedules to spend some time with us today.

We are really excited to have with us today the medical officer for the Center for Medicare, Dr. Terri Postma, all the way from Washington, D.C. and Baltimore. But before I introduce Terri, let me tell you a little bit about the purpose and the mechanics of today's listening session on the proposed rule. It is designed to help doctors, hospitals and other healthcare providers to

better coordinate care for Medicare patients through the Accountable Care Organizations or ACOs.

The proposed rule was promulgated by HHS on Thursday, March 31st. It's in the long corollary notice. It's posted on our website and at the Federal Register website. HHS has also announced there's been a whole series of open door forum and listening sessions during the open comment period to help the public understand what CMS is proposing to do and to ensure that the public understands how to participate in the formal comment process. And this is one of those listening sessions.

ACOs are designed to create incentives for healthcare providers to work together to treat an individual patient in positive care settings, including doctor's 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 the patients first. The patient and provider participation in an ACO is purely voluntary.

Now, the comment period for this proposed rule ends on Monday, June 6th, so you have until then to get your comments to us. And you may submit comments in one of four ways; they are outlined in the notice of proposed rulemaking: electronically at [www.regulations.gov](http://www.regulations.gov), by regular mail, by express or overnight mail, or by hand and/or courier and because of staff resource limitations, unfortunately, we do not accept comments by facsimile transmission.

Now, I want to distinguish today's dialogue from the formal comment process. This session today is not a forum for submitting formal comments on the proposed rule. Instead, we want to have a community dialogue with you after we've given you a thumbnail sketch of the proposal, and we'll have a chance to hear and answer your questions as well as hear your comments. But

the comments you offer today cannot and will not substitute for your formal comments which you have to submit to us electronically or by mail.

MR. HAMMARLUND: We'll begin with comments from those of you who are here and then we will go to those who are on the phone, then we will go back and forth until we have exhausted our comments.

And now it gives me great pleasure to welcome here today Dr. Terri Postma, a neurologist who is currently serving as medical officer and adviser at the Center for Medicare, at CMS, headquartered in Baltimore and in Washington, D.C. Before joining CMS, Terri completed a public policy fellowship with the Senate Finance Committee during the healthcare reform debate. Following the fellowship, Dr. Postma took a post at CMS where she advises senior leadership on policy issues related to Medicare's payment systems and quality initiatives, particularly value-based purchasing initiatives such as the

Medicare Shared Savings Program which resulted from the past instructive Affordable Care Act.

It is great to have Terri with us today. In fact, this is her hometown. So, welcome home, Dr. Postma. Please welcome Dr. Postma.

(Applause)

DR. POSTMA: Thank you so much, John. Thanks, everyone, for that welcome. It's always nice to come home. I'm a graduate of Calvin College and moved fairly quickly to the East Coast where I had a number of really interesting opportunities. But born and raised right here, and so I appreciate the opportunity to speak with you today and for your warm welcome.

So, as John said, my purpose today is to go through some of the highlights of the proposals for the Medicare Shared Savings Program. And I intend to give a brief overview of several aspects of how the law directs us to implement the Shared Savings Program. And I'll highlight some of the areas

where we have discussion in what we've proposed. Clearly our time is very limited and I won't be able to go through every single option. Most of you will be involved in discussions later on.

All right... So, these are the topics that we'll cover tonight. So, the Medicare Shared Savings Program was mandated last year, as you know, as part of the Affordable Care Act. It's Section 3022 in that Act and it establishes a voluntary program. It incentivizes many care providers and suppliers to form what are known as the Accountable Care Organizations or ACOs in order to improve the quality and efficiency of care delivered to Medicare Fee-For-Service population.

The provision must be established no later than January 1st, 2012 which is right around the corner. And on March 31st, we displayed a notice of proposed rulemaking containing proposed policies to implement the Shared Savings Program. As John mentioned,

we're looking forward to reviewing your comments on that proposal on how to make it better, either in support of the options that we've proposed or in support of the other options that we did not propose. And as John said, the more specific you can be about what your preference is and why, it will be very, very helpful to us in the final.

We read every single comment. We take everyone very seriously. We want to make this program a success. The comments are due on June 6th.

I want to give you a website that contains a lot of useful information and I'll share it again at the end of this talk. But it is [cms.gov/sharedsavingsprogram/](https://www.cms.gov/sharedsavingsprogram/) all one word. There you'll find a link to the proposed rule. You'll find information on how to submit comments, various fact sheets that distill a lot of the information, and also links to concurrently released notices by FTC, DOJ, OIG and the IRS.

As many of you know, the concept

of ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality, and that tackles the featured ACOs in their June 2009 report to Congress. During the development of this healthcare reform provision, Congress drew from those expert sources as well as from the Physician Group Practice Demonstration Project at CMS. The Physician Group Practice Demonstration (PGP Demo) showed promise as a model for improving the quality of care delivered to Medicare Fee-For-Service population while controlling growth in expenditures. In the first four years of the demonstration, all ten PGP participants demonstrated quality improvement on their measure modules, and six of the ten groups received \$78 million in savings.

And Region V was very well represented in the demonstration. You probably are aware that the University of Michigan Faculty Group Practice was one of the participants and as well as Marshfield Clinic

in Wisconsin and Park Nicollet Health Services in Minnesota. And I encourage you to reach out to those folks if you haven't, if you're interested in participating in a program. There is information on our websites about lessons learned from that demonstration. But I encourage you to reach out to your colleagues who you may know in those health systems and talk to them about their particular challenges and successes.

Anyone who is involved in our healthcare system, whether it's a provider or a patient or the family member of the patient, is well aware that our healthcare system is fragmented. It's developed in pieces. There is a hospital developed over here, a clinic over there, home health over here. And they really developed without any conscious or well-designed connection between those pieces.

Fragmentation of payment, particular fee-for-service payment, reinforces that fragmented care. And the Shared Savings Program, that is a new approach to the

delivery of healthcare aimed at reducing that fragmentation, improving population health and lowering overall healthcare cost by promoting accountability for the care of the Medicare Fee-For-Service beneficiaries, improving coordination for services provided under both Parts A and B, and encouraging investment in infrastructure and redesign of care processes.

Participants would continue to receive fee-for-service payments, but their organization, the way they improve together would be rewarded each year with an incentive payment for demonstrating high quality and efficient care delivery. It should be emphasized that this is not a managed care model. It's an incentive for providers of fee-for-service care to improve the quality and efficiency of care delivered to fee-for-service Medicare beneficiaries.

Our administrator, Dr. Don Berwick, is passionate about healthcare delivery system reform and he talks a lot about the three-part aim. That is, better

care for individuals, better health for populations, and lower growth in expenditures.

He feels that ACOs should have these following goals.

First, the ACO should always put the beneficiary and family at the center of care by honoring individual preferences and values through shared decision making. The ACO should remember beneficiaries over time and place, that is, the ACO should have memory about the patient, ensuring that beneficiaries no longer bear the burden of making sure all their healthcare providers understand their care and have the information about them, that they need to provide high quality coordinated care. ACOs should attend carefully the care transitions as patients move along the care continuum from hospital to clinic, from clinic to specialist, and all along the way.

The ACO should also ensure that waste is reduced at every step and that every step in care adds value to the beneficiary including proactively preventing illness and

promoting population health. The ACO should proactively manage the beneficiaries' care through, for example, preventive care reminders at point of care. The ACO should be continually collecting, evaluating and using data to improve care delivery and patient outcomes. And the ACO should also be continually investing in their workforce to build the skill, knowledge and teamwork within that workforce. And finally, the ACO should continually be innovative to enhance the quality of care, improve patient satisfaction, and control growth over healthcare expenditures by continually reinventing care in the modern age.

Now, the law states that an ACO must be a legal entity. It must be a group of healthcare providers and suppliers that works to manage and coordinate care for Medicare Fee-For-Service beneficiaries. The ACO must agree to be held accountable for the quality, cost and overall care of Medicare beneficiaries who are assigned to it, and must

also encourage investment in infrastructure and redesign coordinated care processes behind quality and efficient care delivery. The law further states that these providers and suppliers must have a mechanism for shared governance. And so, we have made proposals around what that might look like.

So, we'll get into some of those.

Let me talk a little bit about the eligibility criteria. The law lists a number of eligibility criteria that the providers and suppliers must meet in order to be eligible to participate in addition to the ones I just mentioned. So, the proposal explores each one of those, and we've made proposals around how to verify that the ACOs that apply meet those eligibility criteria. We are seeking comments on all of them and it will be very useful to hear from you about them.

So, by law, ACOs must meet the following eligibility criteria:

\*The ACO must have a formal, legal structure that allows it to receive and to

distribute the shared savings payments.

\*The ACO must have a sufficient number of primary care professionals for assignment of at least 5,000 Medicare Fee-For-Service beneficiaries.

\*The ACO must agree to participate in the program for a three-year period.

\*The ACO must have a leadership and management structure that includes clinical and administrative systems.

\*The ACO must define processes to promote evidence-based medicine, report quality and cost measures, and to coordinate care.

\*And the ACO must demonstrate that it meets patients that are in these criteria.

Okay, that's the law. So, how do we at CMS propose to evaluate whether an ACO is doing that to participate? So, we've proposed that the legal entity must be recognized under state law, have a taxpayer ID that can allow the ACO to receive and then to distribute the shared savings payments. We've

proposed that the mechanism for shared governance be in the form of a governing body which is provider based. That is, it would be comprised of at least 75 percent of Medicare enrolled providers and suppliers, and include a beneficiary representative. The governing body is what makes the decisions for the ACOs such as how best to redesign care processes, how best to coordinate care within that group of providers and suppliers, and how those shared savings would be distributed among the participants.

The law says the ACO must have enough primary care physicians sufficient to care for and assign at least 5,000 fee-for-service beneficiaries. This is an important piece. And I'm going to go into a little bit more detail about this later when I talk about beneficiary assignment.

Clinical integration is also a very important part of the ACO. It's something we work closely with FTC and DoJ. Clinical integration is something that

mitigates concerns that the ACO is behaving anti-competitively. And our goal is that participants that come into the program would have the time and be able to make that three-year commitment required by law to really do the work that needs to be done without raising anti-competitive concerns.

So, the law states that the ACO must have clinical and administrative systems in place. And we've proposed that clinical integration is demonstrated by having an experienced executive team whose focus is quality improvement, clinical management by a local senior level medical director, and financial or human investment in the performance and success of the ACO.

Then another one I talked about is that the law states that the ACO must define processes to promote evidence-based medicine and patient engagement, report quality and cost measures, and coordinate care. So, what we've proposed around that is that as part of the application, the ACO will tell us how they

propose to do that.

And finally, the law states that the ACO must meet patient centeredness criteria as defined by the Secretary. This is quite a challenge because the Secretary had never before this defined patient centeredness. So, we drew from experts from the Institute of Medicine, from the National Partnership for Women and Families, to propose a set of patient centeredness criteria emphasizing such things as: provide patient communications and education, engagement between the provider and patient, patient involvement in governance as I mentioned earlier, use of individualized care plans, internal monitoring and reporting for continual improvement, and community stakeholder collaborations. We're seeking comment on all those.

So, we've proposed that both existing and newly formed organizations will be eligible to participate in the program. They must also be able to meet all the other

eligibility criteria. ACO entities could include ACO professionals in combination with each other or with hospitals. And the law defines an ACO professional as an M.D., a D.O., N.P., P.A., or a clinical nurse specialist.

But the law also gave the Secretary discretion to expand that list, and we've proposed to do that to include all other Medicare enrolled providers and suppliers who would join with groups that are capable of meeting all of the eligibility criteria. And the key one, as I mentioned before, is the eligibility criteria that the ACO have a primary care core of physicians sufficient to care for and to assign at least 5,000 fee-for-service beneficiaries. So, therefore, while any Medicare enrolled provider and supplier is invited to join together and seek to participate in the program, whatever groups from must be able to, must have that primary care physician core sufficient to assign at least 5,000 fee-for-service beneficiaries.

We have also proposed that Method 2, Critical Access Hospitals that bill for physician primary care services might be able to comprise that core. And we looked very closely into whether FQHCs, Federally Qualified Health Centers, or rural health centers might be able to participate as the primary care core. However, the law requires us to match primary care services with the rendering primary care physician, and the way that they bill doesn't allow us to do that. However, we do think that those are very important. The safety net provider is an important part of the healthcare system. So, we've proposed to incentivize ACOs to include them as participants. And if they do, that ACO would have access to a higher sharing rate.

We've proposed the ACOs may choose to participate in one of two tracks. Both would be the statutorily mandated three-year agreement period. The first track would be comprised though of two years of one-sided

shared savings with a transition in the third year to performance-based risk where the ACO would share both savings and losses with CMS if there were any. The second track would be three years of performance-based risk where the ACO would share both savings and losses. At the end of the three-year agreement period, the ACO would have the opportunity to continue in the program but could only do so under the second track. And so, the ACOs coming in would have the opportunity to choose either of those two tracks.

We think that this provides an on-ramp or an entry point to organizations to gain experience in track one with the shared savings model before transitioning to performance-based risk. But leaving track two available we think provides the opportunity for groups to take on performance-based risk immediately, those who are maybe more established and have experience at least from this models, to take them on immediately, and that would be in exchange for a higher sharing

rate.

As I previously mentioned, in order to participate, the ACO must be willing to become accountable for the Medicare Fee-For-Service population assigned to it. And again, I want to emphasize that this is not a managed care setting, so it poses a bit of a challenge. Unlike a managed care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see regardless of whether that practitioner is participating in the ACO or not. So, because of this, when we refer to assignment, what we're really talking about is the operational necessary of defining a unique population for the ACO for purposes of determining whether that ACO has met the standards necessary to receive an incentive payment for improving the quality and efficiency of care delivered to that population. Beneficiary assignment is the basis for establishing and updating the financial benchmark for quality measurement

and performance, and the focus of the ACOs' efforts to achieve what Don talks about, the three-part aim.

We've proposed to assign beneficiaries in a similar fashion to the way that the beneficiaries were assigned in the PGP Demonstration. That is, we've proposed to assign beneficiaries retrospectively based on the plurality of allowed charges. Unlike the PGP Demonstration though, we have proposed that beneficiary assignment be based on services rendered by primary care physicians defined as internal medicine, geriatric medicine, general practice and family practice. In the proposed rule, we discuss alternatives such as the two-step process of assignment or on the basis of all types of physicians. So, the two-step method would be that, the first step would be the same as I just said; it would be based on the plurality of allowed charges by those specific primary care physician types. But then there will be a second pass on the basis of all provider

types for beneficiaries who lack a connection to a primary care physician. So, we're seeking your comment on that proposal.

Many stakeholders express a preference for prospective assignment of beneficiaries. They have told us that it's important for them to understand who their patient population is in advance so they can proactively redesign care processes that make sense for improving the quality and efficiency of care delivered to those specific patients.

So, while prospective assignment makes a lot of sense in the managed care world where the beneficiaries choose to be walked in to a set of providers or into a network, the Medicare Shared Savings Program is focused on the fee-for-service population. We have expressed concerns in the proposal that the prospective assignment may unintentionally place limits on fee-for-service care or cause the ACO to create care processes for a select group of individuals rather than standardizing care processes for all fee-for-service patients.

Moreover, when we've talked about this a little further with the stakeholders, they told us that they want to be held accountable for who they actually care for during the course of the year rather than risk being held accountable for beneficiaries that may choose to receive care elsewhere during that year.

So, with those things in mind, what we're proposing is to assign patients retrospectively based on where they choose to receive the plurality of their primary care services. So, if they chose to receive plurality of services by the providers participating in the ACO, they would become part of the population assigned to the ACO for purposes of evaluation. But in response to those concerns that we heard, and in order to assist the ACO to proactively redesign care processes that make sense for their population, we're proposing to provide the ACO with certain data at the start of the agreement period.

Those data would be in the form of

an aggregate data report on beneficiary characteristics and utilization derived from fee-for-service population cared for by the ACO during the three-year benchmark period. Additionally, upon request, the ACO would be able to access the names of the beneficiaries used to derive the benchmark that would be shared with the ACO. So, going forward, they have a pretty good idea of who is likely to be in their assignment at the end of the year.

We've done a lot of modeling with the PGP data and we've found that when we assign on the basis of primary care physicians that I mentioned, about 80 percent of the fee-for-service population is stable over time. Now, that's going to be different from system to system, but that's what our data suggests.

And we believe this hybrid approach creates an incentive for ACOs to standardize care processes and treat all Medicare Fee-For-Service patients the same, while also aiding the ACO in understanding their patient populations and proactively redesigning care

processes for them.

We've proposed that providers participating in the program be required to notify their patients that they are participating similar to the Physician Group Practice Demonstration. And beneficiaries will also receive general information from CMS about the Shared Savings Program. The information will make clear that there are no changes in their benefits or their rights under fee-for-service to choose their providers. We've further proposed that beneficiaries be given the opportunity to decline to have their data shared with the ACO. That's another part of the data sharing that we've proposed is that, on a monthly basis, we would make available patient identifiable claims data to the ACO upon request.

Okay. According to the statute, without meeting both the quality standard and achieving lower growth in expenditures, the ACO would not share in savings. So, the

quality standard is a very important bar to the ACO to pass. The statute also directs us to evaluate the ACO in such measures as patient experience of care, utilization process, and outcomes. We've proposed 65 measures to format a quality performance standard. Measures would be collected in three different ways:

\*Via claims posing no burden to the provider, the ACO;

\*Via the patient experience of care survey, and we propose specifically to use the Clinician & Group CAHPS Survey which is a well-recognized survey; and then finally,

\*With the GPRO tool which was used in the PGP Demonstration, it's also used in PQRS.

We've proposed five domains: patient and care given experience of care, care coordination, patient safety, preventive health, and at risk or frail elderly health. And we've proposed measures that align with other CMS initiatives such as PQRS and EHR or

"meaningful use" incentive program. We've also proposed that regardless of whether the ACO has successfully met the quality standard and regardless of whether the ACO shares in savings, eligible professionals would qualify for the PQRS bonus if they participate in an ACO that fully reports measures through the Shared Savings Program. So, that PQRS would not be deducted from any shared savings. That would be a benefit that the ACO providers and suppliers would be able to take advantage of.

And in this way, they wouldn't have to both be doing PQRS and be doing the ACO. And again, that's something we're seeking comment on.

All right... Early in the fall or as early as last summer, we started hearing a lot from stakeholders about their concerns about their ability to afford previously non-financially integrated groups to get together in a way that wouldn't trigger antitrust concerns. So, in response to that, we worked very closely with FTC and DoJ to develop an

application process that would ensure applicants would be able to meet the required three-year commitment, and that's an addition.

So, there are two pieces, the clinical integration piece that I talked before, and now this piece is another part of FTC-DoJ concerns, and that helps mitigate those.

The antitrust policy statement which was published by FTC and DoJ concurrently with the ACO proposed rule outlines and solicits comments on proposed safe harbors related to the creation and operation of the ACOs, and applies to collaborations formed after the passage of the Affordable Care Act in March 23, 2010. A key component to that antitrust policy statement is the primary service area or PSA calculation for percent share for common services. ACOs must calculate their PSAs as part of the application process, and the PSA calculations would indicate whether the ACO applicant must undergo an expedited antitrust review as part of the application process. ACOs undergoing

antitrust review must have a letter of approval from an antitrust agency before entering an agreement with CMS.

So, this would apply in particular to ACOs with a calculated PSA of greater than 50 percent. ACOs with a PSA share of 30 to 50 percent may also request an expedited review if they have concerns, or they must agree to comply with the market conduct principles, or do neither but run the risk of antitrust scrutiny in the future. ACOs with a PSA share of less than 30 percent meet what the policy statement describes as the antitrust agency's safety zone and no review is necessary. Additionally, as described in the antitrust policy statement, any ACO that meets a rural exception would qualify for that safety zone.

Okay. So, three notices have been issued in concurrence with the NPRM. There is a joint CMS and OIG publication with comment period regarding possible waivers of civil monetary penalties law, anti-kickback statute, and the physician self-referral law. So,

those proposed waivers, I invite you to send in your comments on those as well, whether they are too broad, too narrow. We really want to be able to have providers participate in a way where they can be successful and where they can really focus on the redesign of care processes and not worry about getting hit in the future with these OIG concerns or the antitrust concerns. The second one as I already mentioned is the proposed statement of the antitrust enforcement policy by FTC and DoJ. And the IRS also issued a notice of tax guidance for ACOs that I invite you to review.

So, with that, I will open it up for questions and oh, I guess I'm going to turn it over to you first, John. Thanks.

(Ashley gives out instructions to phone participants who wish to make comments or ask questions.)

MR. HAMMARLUND: Thanks a lot, Ashley. And while you're getting the queue there, why don't I just remind the folks here that if they would like to ask a question or

give us a comment, we have two microphones here. Elizabeth Surgener and Faye Starcevich are holding up microphones. We'd like you to just raise your hand and we will give you the mic, and we would like to ask you also to state your name and the organization that you represent. I also want to draw attention to Faye Starcevich because she is our subject matter expert in the Chicago Regional Office for ACO matters. And so, for those of you in the room here in Grand Rapids, for those of our stakeholders who are on the call from the six states of Region V, you want to get to know Faye Starcevich if you have any additional questions or need some technical assistance.

So, again, for those of you in the room, let us know if you want to chime in. We'd be happy to take in your questions and comments. But I'll first go back to you, Ashley, and see if we have anybody in the queue on the phone. Ashley, do we have any questions yet on the phone?

ASHLEY: There are no questions at this time.

MR. HAMMARLUND: No questions at this time. We'll give folks a little chance to think about them. We've got a question here in the room. Be sure again to state your name and organization. We're going to then repeat the question as best we can, use this one here, so that everybody can hear. Yes, please.

MS. APPEL: Thank you. I'm Laura Appel from the Michigan Health & Hospital Association. We represent all of Michigan's acute care hospitals and a number of the long-term acute care hospitals. So, in Michigan we have about 144, it's a quite a large group of people.

First, just a couple of comments:

Number one, we've had the opportunity to talk to many of our constituency groups, our rural organizations, physician and hospital constituency council that we have, our legislative policy panel. The overall

reaction, which I know you're looking for specific comments, but the overall reaction from the group has been this is simply not something that we feel we can work with. I know that that is very disappointing to the folks that did an immense amount of work to try to pull this off in a very short period of time. But I have to be honest, that's what the membership is saying back to us.

We will prepare comments under the official system and outline various specific pieces. Let me give you just one so that I don't dominate the conversation. But let's just go to the antitrust piece. That is extremely disappointing to us in that it essentially, I do not know of another situation, although I'm no expert on antitrust, I don't know of another situation in healthcare where you have to, other than a merger, an official merger, where you have to go and say, you know, we're going to try and do a better job of providing quality healthcare, please let us know that we're not

in violation of your antitrust laws. We can meet all of the data, we've done all of the studies, we've found all of the evidence about how much we dominate the market share, we've done an immense amount of work and now it's up to you to decide whether or not we can go forward with improving quality of care for patients by clinically integrating which is absolutely the goal we all share.

That just seems to be a backwards approach. I don't see any shortage of the FTC or the Department of Justice being active related to people that are inappropriately dominating their marketplace. So, I don't see that, I mean if folks were to try to attempt a better clinical integration, how that would be treated any differently than what we're doing already rather than doing this pre-screening type approach.

The other thing I would like to say is I think it's fairly readily accepted that healthcare is this odd thing when it comes to the economic models. When you build

more, the competition doesn't really reduce cost, it often increases it. Adding a second hospital doing cardiac bypass procedures doesn't reduce the cost of bypass in that city or region, it sometimes makes it go up. So, it would seem to me that there would actually be, from an economic studies perspective, perhaps some interest in more market concentration. I mean I'm not proposing that, but I think that, again, healthcare is this odd duck that way, and this rule seems to miss that as well.

So, that's just one specific comment. But from the overall group, one attorney that I spoke to that represents a lot of Michigan hospitals said with respect to this rule, we're thinking thanks but no thanks at least for now.

DR. POSTMA: Okay. Thank you for that comment. I just want to make one thing clear about the antitrust proposals. And I'm not a lawyer so don't quote me on this, but I sat around with them for a number of months,

and my understanding from the antitrust agencies is that they have two concerns. They have the concern you mentioned about the clinical integration piece that is sort of the cartel law kind of side of things so that they make sure that folks are getting together for purposes of good clinical integration and not for purposes of negotiating prices together.

The second piece is the monopoly piece. And that's the piece that's focused on in terms of looking at the PSAs and market share as part of the application process. So, there are two distinct antitrust concerns are my understanding.

MR. HAMMARLUND: And for those of you on the phone, I'll just do my best to very quickly summarize this comment that was from somebody who represents the Michigan hospitals who talked to a lot of constituents and they have a lot of concerns, that they really didn't think the rule served the table well enough for them to participate in this. And in particular, there was a concern about the

antitrust provisions.

You know, my response to that is thank you for your comment, and this is your chance to now tell us, as I know you intend to do, what we could do differently in that rule that you think would incentivize folks to play.

We have one more question here, Ashley, and then I'll go back to the phones.

MS. APPEL: I haven't had as much specific input, but I think that there are a number of things that despite what I know are very thoughtful approach, for example, with the retrospective assignment of beneficiaries, I absolutely understand that you were doing a very thoughtful approach in terms of we don't want 30 people in the waiting room, 20 people to be treated one way and 10 people another. We want the quality to be applied to everyone; you know, real quality initiatives, absolutely.

That is just a very difficult thing for folks to wrap their minds around.

There's a lot of resistance to that concept, rightly or wrongly. I think that's a cultural change that is difficult for people to contemplate.

Another thing that I think is disappointing to folks is the decision which I know CMS handled very carefully to include downside risk. There is no requirement for downside risk in the law. Many people anticipated there would be and I think some of us kind of tried to assure them, well, no, there is not a requirement for that. And then of course the rule does include that.

There is a huge, not only investment of money required to become an accountable care organization, but really personal and human capital here. Dr. Postma, you're a physician. This is really asking a lot of physicians to very much change the way they approach the way they do their work, and do it in conjunction with hospital leaders. Just getting together for that group might be a very big commitment and difficult exercise.

In addition, there is definitely investment in infrastructure, the legal work that would go into this, all of those things.

And people will be at risk for their organization and how well this works regardless of whether there is downside risk that gets paid to the Medicare program. I think that the balance of downside risk regardless of what the Medicare Shared Savings Program will do, the downside risk of trying to pull this all together is very large. And the additional dread of this, it just doesn't engage people.

I think people are working towards better clinical integration. We have a lot of things going on here in Michigan that we will be commenting on our letter related to our quality collaborative through the MHA Keystone Center for Patient Safety & Quality. People will continue their work, they're going to continue to integrate here, but whether they're going to elect to be part of the Shared Savings Program is very iffy because of

these difficult pieces of the rule. And now I'll stop talking.

DR. POSTMA: Okay, thank you. I just wanted to touch on a couple of things that you mentioned. Thank you for recognizing how much thought went into the proposal for retrospective assignment. And you're right, I think that a lot of the, maybe not so much confusion but concern around that is driven by the managed care sector that's accustomed to having a very distinct pool of beneficiaries.

But those beneficiaries have chosen to be within that network. And so, here we're talking about, you know, it is a challenge in the fee-for-service population. One thing that we do have experience with is the PGP model where there was retrospective assignment of the fee-for-service population. So, that's just one comment I wanted to make.

The other one about the downside risk, the Affordable Care Act is really two pieces. It's PPACA, the Patient Protection Affordable Care Act, and then a week later was

passed the Reconciliation Act. And the Reconciliation Act amended this provision to give -- discretion to explore other payment models within this Shared Savings Program. And one of the things we heard last fall from stakeholders was that the more that, providers ask for risk to be considered. It was part of our request for information last fall. So, in response to that, we've suggested these two tracks.

We are seeking comment on that. If that's too fast, we want to hear about that. If you think that we should phase it in more slowly or in a different way, those comments will be very useful to us. So, I appreciate you bringing that up.

Also, what you said that, this is hard stuff. It's really tough stuff. But coordination of care, that level of physician-patient interaction, and I'm going to speak for a minute just as a physician, not as a CMS employee, but when I was practicing, that's what I loved about practicing medicine has

been to help my patients in a very individual way, being able to talk with them, and became very frustrated by not having the time to do that because there were so many other demands on my time.

So, this is a tough process. It's change. That type of interaction has been undervalued, devalued for decades. And I think that this provision holds a lot of promise for incentivizing providers who want to do that, who are doing that, who want to get back to that. And one of the things that the PGPs told us was very important was having those clinical champions within the clinics. So, it's clinical champions for quality and for coordination of care who are invested in making that change. So, thanks for bringing that up.

MR. HAMMARLUND: Thank you very much for your comment. And for those of you on the phone, I hope you were able to hear that discussion addressing both patient provisions as well as the downside risk provisions.

Ashley, let's see if we've got anybody on the phone now. Who's got a comment or question for us?

ASHLEY: I actually have a question from Lakita Lavonne. Your line is open.

MS. LAVONNE: My apologies that was a mistake.

ASHLEY: Next question comes from Robert Orvaine, your line is open.

MR. ORVAINE: Thank you for all the hard work that went into this. You mentioned ACOs would have to be recognized by the state. Are you talking about regulatory regulation would require new law or would contractual relationship with the state be adequate for that recognition?

DR. POSTMA: Yes, thanks for that. Okay, so do I have to repeat that question?

MR. HAMMARLUND: I think people heard it well.

DR. POSTMA: Did you guys hear that? It was a question about state

recognition of the ACO and what does that mean. So, the law states that the ACO must be a legal entity. And so, what we've proposed in the interim is that that means that those groups of providers and suppliers must get together and get a taxpayer ID. So, that's state recognition that they're a legal entity.

Usually that involves developing bylaws or something like that, but it's really a way for groups of non-financially integrated providers and suppliers to get together to form this governing body and to have this tax ID where CMS can send a shared savings payment, and then they work together to figure out how that shared savings payment is going to be distributed.

And so, that's our proposal. And of course the governing body, 75 percent at least of providers and suppliers, leaving room for those providers and suppliers to join up with other folks that are non-Medicare enrolled providers and suppliers that might be able to assist with some of the up front

capital that might be needed to form the ACO and get it off the ground. So, we welcome comment on that. We are, our goal in that proposal was to both fulfill the requirement as stated in law and, like I mentioned, we envision these as being provider driven and thought that suggesting the 75 percent number would help maintain the decision making and the control of that governing body, the ACO, in the hands of the providers while also recognizing that there may be room for non-Medicare enrolled providers and suppliers to play a role, and also recognizing that, I don't think we know what the perfect collaboration is in terms of groups of providers and suppliers getting together. So, a big part of our goal is to maintain a lot of that flexibility for the providers and suppliers who know best in their region what way they could form, so that they can form in a way that makes sense to them and for their population.

MR. HAMMARLUND: Let me just do a

sound check here. Sir, were you able to hear that answer?

MR. ORVAINE: Yes, I was. Thank you very much.

MR. HAMMARLUND: Great, thanks. And could you remind us where you're calling from?

MR. ORVAINE: Michigan Medicaid.

MR. HAMMARLUND: Great, thank you very much. Ashley, do we have another caller on the line?

ASHLEY: The next question comes from Josad Kamaradi. Your line is open.

MR. KAMARADI: My question is this. We looked at the 65 criteria, and are they evidence-based? Because this takes a lot of time away from the patients to document. Now we are realizing after so many years of NCQA, that it's getting too cumbersome and we are trying to be, we need to do all these things as the groups that made the \$76 million had only 32 criteria to deal with? Those are my questions.

DR. POSTMA: Great, thank you. The question was about the 65 proposed measures. We've heard a lot from stakeholders that that seems to be a very overwhelming amount. And the caller also noted that the PGPs have 32 measures that they needed to report. So, we're looking at ways to make these measures more user friendly. They are NQF endorsed measures, and while the Patient Experience of Care Survey of course is an AHRQ survey that's well known, that takes care about I think seven or so measures that we've proposed. So, that's the survey piece.

So, when you subtract that out, when you subtract out the claims base measures that we've proposed which would be calculated by CMS, they wouldn't need to be reported by the providers and suppliers, then I think we're left with probably about 45 or so measures which still, maybe for some folks, seems like a lot. Those measures are largely measures of process and outcomes that we can't get through claims. They're largely in folks'

medical records. And so, we propose to use this tool that's populated with the measures and with the patient population that, where it's going to be a sample population. And this tool is sent to the ACO, the ACO would collect those measures and send the tool back, and then the tool has a way of calculating the performance on the measures.

So, it's a tool that we've used with PGP. We've used it with PQRS. We did choose measures that were aligned with PQRS, with the EHR incentive program. But we are seeking comment, and again specific comments especially here will be very helpful to us, to see if we've missed the mark in terms of things that the ACO should be looking at that are really important. What measures should we be considering that we didn't propose? What measures specifically, maybe there is overlap or redundancy, some places that we can pare those down. Let us know that; be very specific.

MR. HAMMARLUND: Thank you very

much for your comment. I believe we have a comment here in the room now.

MR. NEWMAN: Steven Newman, President of Michigan State Medical Society. One of our concerns has been also by solo practitioners, and the question is, how does this affect, how does solo practitioners develop the infrastructure to participate in this? How does an independent group establish contracts with large systems that are participating in ACO's? And what quality data will a specialist segment of the medical community need to have to record to meet accountable care?

DR. POSTMA: Can you, before you pass that back can you repeat the second and third question. I got how does the solo practitioner participate, and then what was the second one? Is it group practice?

MR. NEWMAN: How does the independent, how does the independent group establish contracts with large systems that are participating in ACO's?

DR. POSTMA: Okay. Okay, great. So the first question about the solo practitioner. First I think it would be very hard for a solo practitioner to participate in this program for a number of reasons. First they have to have at least 5,000 Medicare B for service beneficiaries that would be assigned to them. So I think that would be a tough hurdle for a solo practitioner to overcome. So that means that that solo practitioner would have to reach out and group together with a local hospital, with a local larger group practice to be able to participate. So that's one thing.

In the contracting between providers, those are going to have to be contract developed, negotiations are going to have to go on between non-financially integrated groups of providers and suppliers that want to join together to form an ACO. And so once they have those, once they've made the decision to do that, they apply together and they've made, you know, they've gotten

their taxpayer I.D., right, so they're a legal entity. And again, it probably involved developing bylaws and that kind of thing, making sure that everybody is represented, all the participants are represented. And then, so that taxpayer I.D. becomes the ACO for purposes of contracting or making the agreement with CMS. So I hope that makes sense to you.

MR. NEWMAN: The third issue is, what quality data would specialists need to report in order to participate?

DR. POSTMA: The question was what quality data would specialists need to report in order to participate? One of the things that when we sat down to, you know, to develop this quality standard, one of the first things we did was to sit down and say, okay, who's going to be participating in an ACO, and what quality standard does there need to be for an ACO.

So, one of the interesting things about the way that quality measures are

developed is sort of in high low care. Quality measures are developed for hospitals, developed for primary care providers, developed for specialists and you know; you can run with that into any number of different buckets.

So the challenge was to find measures that could cut across those settings and follow the beneficiary. So, we've proposed measures that are largely focused on measures that follow the beneficiary regardless of where they receive care, so whether we can get that by claims or through a medical record, that are largely focused on primary care. But that means that when the ACO goes into their medical record to fill out that GPRO tool, that they'll have to talk to their providers and find out maybe the cardiologist gave the pneumococcal vaccination, you know, maybe that wasn't done by the primary care provider, but that counts because it was done.

And so, it's really a question of

the ACO providers and suppliers talking to each other to make sure that the patients have gotten what they need in terms of their primary care, whether it's preventive services or whether they're getting the beta blocker or the anti-platelet, those kinds of things. So, there aren't any real specific, I mean we really didn't propose any measures that couldn't be gathered outside of those silos. So, really it is trying to integrate the whole care for the beneficiary.

MR. HAMMARLUND: Do we have another question or comment in the room? Yes.

MR. WALTERS: Thank you for all the hard work you have put into this. I am Tom Walters from the DMC PHO located in Detroit. And I have a number of kinds of questions and thoughts.

First off, as everybody has said, there is going to be a tremendous investment on the part of new organizations to pull the information together. Data warehouse; very expensive to build to accept this kind of

information, and the staff infrastructure that's going to be needed to get to all of these offices to put these kinds of processes in place. And as I understand it, the return in the first two years is really quite limited. If you are fortunate enough to have a gain, it seems to me that the Federal Government keeps the majority of that, and then what's left over is withheld to offset losses in future periods.

So, you're going to have probably at least three years of expenses, a lot of expenses coming in with virtually no aid. In the third year, as I understand it, you have unlimited loss potential that the groups are going to have to face up which could be really quite -- And what I'm trying to understand is how do you keep the group together if things are going south in year two? How are you going to keep a group together? Are you going to go back individually against all the physicians and hospital? And the other thing, if I could ask, too, and this is a

little bit more detailed, but I understand that the risk sharing, if the ACO includes a hospital is different and is less than if it's just a physician organization. Somehow I think there was some provision in there that either the standards are more stringent or the risk sharing was different if your ACO included a hospital.

And last, I'm sorry, I'm creating questions like crazy, but there is a difference in prices between hospitals depending on if you're teaching disproportionate share of critical care. Are those costs standardized out or would an ACO be better off to partner up with a low-cost, non-teaching, non-DSH hospital? Thank you for hearing me ramble on.

MR. HAMMARLUND: No, thank you for those great questions.

DR. POSTMA: No, those are excellent details and meaty questions. And so, you've clearly done your research and I appreciate that. And I'll try to get to each

one of them, let me know if I miss one.

So, the first question was really a comment about the staff infrastructure that would be necessary and pulling all this data together. And that's one area that I'd suggest, if you're interested in participating, you talk with the PGPs, see how they did it because they had different ways of doing that. But you're right; it will take some staff to gather the data and to put that together.

And the second comment was that the return appears to be rather limited. We've proposed that in track one the ACO could receive up to 50 percent in shared savings for very high quality reporting. And then in track two under the two-sided model which has, as you noted, more risk involved in that, it would be up 60 percent. I think what you might have been referring to about the risk sharing including a hospital might have been our proposal to increase the risk sharing if there is an FQHC or RHC involved. Is that

possible?

MR. WALTERS: I don't think so, but --

DR. POSTMA: Okay. Well, that's what I can think of, because we've proposed to increase the sharing for ACOs that have FQHCs or RHCs as participants. So, in track one, the one-sided, they could get up to an additional 2.5 percent, so a total possible 52.5 percent sharing. And then for two-sided or that second track, it would be an additional possible 5 percent, so there's a total possible 65 percent.

Now, as far as the return being limited, as you mentioned, we have proposed a 25 percent withhold of any shared savings that's generated in the first couple of years in order to help offset if there are any losses in the third year. If there aren't, that 25 percent withhold would be returned to the ACO, it's been earned, it's theirs. But that is something that we're seeking comment on, so I encourage you to do that.

Additionally, I don't know if you saw this but Innovation Center came out with several notices yesterday about some of the activity going on there. One of the things they're seeking your comment on is a proposal to give what are called advanced payments to certain ACOs that may need help getting started in the Shared Savings Program. So, I encourage you to look at that and to comment on that. That is one thing that we're considering. You can think of it as kind of a scholarship if you will for certain groups of providers and suppliers that would meet certain criteria to qualify for this advanced payment which would then be deducted from any shared savings in the future to help them get started.

And the final thing was about the cost standardization adjustments for DSH or IME. This was something we really struggled with, primarily because the way the law is written it says that we can adjust for beneficiary characteristics and, oh, I don't

have my statute in front of me, but such other things as the Secretary determines appropriate for the benchmark years. But it didn't give us that discretion during the performance years. So, if you strip away IME and DSH for the benchmark, it essentially raises the benchmark and makes it harder for ACOs to overcome that per capita benchmark in the performance years.

So, we proposed not to do that but we are seeking comment on whether there is a benefit to doing that. Since the benchmark is an ACO-specific benchmark, it shouldn't pose a barrier or it shouldn't make the choice of providers different or hospitals different because it's your own population, your own benchmark compared to your own performance. So, it's individualized. It's not a national benchmark, it's not a regional benchmark, and it's an ACO-specific benchmark.

So, I hope that helps answer some of those questions.

MR. WALTERS: And I'll ask a

couple of questions later.

MR. HAMMARLUND: Okay. Ashley, can you let us know if you have any other callers on the line? And what we're going to do to improve so that those on the telephone lines will be able to hear is we'll have you probably speak into that speaker a little bit, too.

DR. POSTMA: Okay.

MR. HAMMARLUND: But Ashley, do we have any other calls or comments?

ASHLEY: I am showing no further questions at this time.

MR. HAMMARLUND: All right, thank you. Let's see anybody else in the room. Oh, we've got one over in the back. Thank you.

MS. NIHYST: Sherry Nihyst from the Physicians' Organization of Western Michigan. I have a question on the provider participants in the ACO. If an ACO completes the application to be a participant in the ACO project, can the PCPs participating in the ACO change in terms of coming, leaving, adding?

Or does that need to remain static? And then I'd ask the same question about other non-primary care providers in the ACO. Does that need to remain static or can changes occur during the three-year period?

DR. POSTMA: Great, that's an excellent question, and one that we really looked at. It's a much more complex question than one would think on the surface, primarily because of the antitrust issues. So, the ACO, the groups of providers and suppliers that come in at the beginning will have had to go through that PSA calculation and all of that.

If they needed a review by an antitrust agency, they will have gone through that.

So, what we're proposing is that the taxpayer IDs of the individual practices, so like the clinics, it's basically the tax ID through which the billings are sent. So, if you're in a group practice, for example, that group practice has its own tax ID. And then the providers in the group generally have, they might have their own tax ID but they have

their own NPIs, and they bill through that tax ID. So, what we've proposed is that those tax IDs that get together that make up the ACO that have gone through the application process, have calculated the PSA shares, we've proposed that they can't be added to during the course of the three-year agreement primarily because if there is an addition, there would have to potentially be another antitrust review halfway through the agreement period. And we don't want to risk, because there is risk of loss of that 25 percent withhold for breaking the agreement before the three years is up, we didn't want to put ACOs in the position where they might have repercussions for breaking the three-year agreement.

So, what we've proposed is that those tax IDs, they can't be added to but they could be subtracted from. And moreover, the providers that are in the practice can come and go, so they're not stuck in that group practice for three years. If they're moving,

or starting a new practice or something, they're welcome to do that. We really try to maintain as much flexibility as possible while also ensuring that there is some stability over the course of the three years.

So, I encourage you to look at that. And moreover, in terms of exclusivity to a single ACO, what we have proposed is those tax IDs on which assignment is based must be exclusive to a single ACO, so operationally we can ensure that there is a unique beneficiary assignment to each ACO. But those tax IDs of those clinics upon which assignment is not based, and what we've proposed is that they not be based on specialists for example. So, if there is a cardiology practice that wants to participate, they would not have to be exclusive to a single ACO. Additionally, the hospital wouldn't have to be exclusive to a single ACO because they are not generating primary care services upon which assignment would be based.

So, I know that's very complex

but, a complex answer to a seemingly simple question. But I encourage you to comment on that, how we can maintain the stability necessary to assess the ACO and to avoid some of those antitrust concerns while also maintaining the flexibility that is necessary for the providers participating.

MR. HAMMARLUND: Ashley, we're going to take one more question here in the room and then I'll come back to you to see if we have somebody in the queue.

MR. MESSING: Hello, my name is Tom Messing from Michigan Pain Consultants in Grand Rapids. So, what I hear you saying is that the antitrust measures so to speak as far as market share will be based primarily on primary care market share?

DR. POSTMA: My understanding is that, see, I'm not an antitrust lawyer.

MR. MESSING: Well, the docs that are assigned, based on the docs that are -- sorry. Based on the docs that are assigned to the ACO. So, what I hear you saying is

specialists may negotiate their services with ACOs but the docs themselves won't have to be exclusive to ACO, they could create contracts with many ACOs?

DR. POSTMA: Certain providers would be able to do that, the ones upon whom assignment, the TINs, the billing TINs upon whom assignment is not based, would not have to be exclusive to a single ACO. However, the ACO needs to, when they apply, they need to calculate their PSAs which look at a variety of different types of services, not just primary care services. But I really don't have enough in-depth knowledge of that personally to be able to tell you what those are. But they are in the antitrust policy statement put out by FTC and DoJ and they are seeking comment on that.

MR. HAMMARLUND: Ashley, let's go back to the phone queue. Do you have any other questions or comments in line?

ASHLEY: No, I'm sorry, no further questions here.

MR. HAMMARLUND: Thank you. Let's see here in the room in Grand Rapids if we have any final questions or comments.

One more time Ashley, anybody in the queue?

ASHLEY: I'm still showing no further questions.

MR. HAMMARLUND: All right. Well, I think that means we can bring this session to a close. I want to thank everybody for coming here today to Grand Rapids to join us.

Thank you all for those who are on the phone listening in. Your comments and your questions helped our thinking very much and we appreciate your input.

Reminder for those of you in the room here, we have some handouts outside if you would like to take a look at them. Also, for those of you on the phone, be sure to get on to the resource link that Dr. Postma gave you earlier, [www.cms.gov/sharedsavingsprogram](http://www.cms.gov/sharedsavingsprogram) all one word. You'll find lots of resources there.

Again, please, please, please give us your comments. We look forward to your formal comments by June 6th. Let's once again give a big hand to Dr. Terri Postma for joining us today.

(Applause)

MR. HAMMARLUND: And thank you all again for coming. We really appreciate it. Ashley, we'll close out the call. Can you let us know how many we had on the phone today?

ASHLEY: Thank you for participating in this conference call --

DR. POSTMA: I don't think she heard you.

MR. HAMMARLUND: How many folks did we have on the line today, Ashley?

ASHLEY: John, I'll hold your line from the conference. I was just speaking over to everybody.

MR. HAMMARLUND: Okay.

ASHLEY: Let me get a fresh line now, one moment.

MR. HAMMARLUND: Thanks. While

she's doing that, let's give a big hand to the Michigan State Medical Society. They were very kind to let us hijack their meeting at the very end. Hello!

(Applause)

MR. HAMMARLUND: We really appreciate all of your help. So, thank you for your partnership today.

ASHLEY: We had 120, John.

MR. HAMMARLUND: 120. Ashley thanks so much for your help today. We really appreciate all that you did.

ASHLEY: You're welcome. No problem. Have a good day.

MR. HAMMARLUND: Take care.

(Whereupon, the session was concluded at 5:45 p.m.)

