

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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MSSP ACO NOTICE OF PROPOSED RULEMAKING

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OPEN DOOR FORUM

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MONDAY,
MAY 9, 2011

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The Open Door Forum convened via teleconference at 3:00 p.m. Eastern Daylight Time, Brenda Hudson, presiding.

CMS STAFF PRESENT:

JEFF HINSON, Region VIII Regional
Administrator

JOHN PILOTTE, Director, Performance Based
Payment Policy Staff

BRENDA HUDSON, Health Insurance Specialist

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

3:01 p.m.

MS. HUDSON: Thank you, Danielle.

Good afternoon. I would like to thank all of you for attending today's call on the new proposed rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations.

My name is Brenda Hudson, and I am with the Centers for Medicare and Medicaid Services Regional External Affairs Team in the Denver Regional Office.

I would like to begin today's call by introducing Denver's Regional Administrator Jeff Hinson.

Jeff began serving as the Regional Administrator in January 2010. In his role he is responsible for CMS's external affairs operations and for the ten states of both the Kansas City and Denver regions which include Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah,

1 and Wyoming.

2 Jeff, thank you for joining us
3 today.

4 MR. HINSON: Thank you, Brenda.
5 Good afternoon. I would like to thank you for
6 attending today's call on the proposed new
7 rule to help doctors, hospitals, and other
8 health care providers better coordinate care
9 for Medicare patients through Accountable Care
10 Organizations.

11 Welcome, consumers, clinicians,
12 employers, hospitals, health systems, state
13 representatives, health care experts, all,
14 welcome.

15 U.S. Department of Health and
16 Human Services released on Thursday, March
17 31st, proposed new rules to help doctors,
18 hospitals, and other health care providers
19 better coordinate care for Medicare patients
20 through Accountable Care Organizations, ACOs.

21 ACOs create incentives for health
22 care providers to work together to treat an
23 individual patient across care settings

1 including doctors' offices, hospitals, and
2 long-term care facilities.

3 The Medicare Shared Savings
4 Program will reward ACOs that improve or
5 deliver high-quality care and lower growth in
6 health care costs while putting the patients
7 first.

8 Patient and provider participation
9 in an ACO is purely voluntary. The proposed
10 rules will help doctors, hospitals, and other
11 providers form ACOs and are now available for
12 public comment.

13 HHS also announced it will hold a
14 series of open-door forums and listening
15 sessions during the comment period to help the
16 public understand what the Centers for
17 Medicare and Medicaid Services, CMS, the
18 agency administering the ACO program, is
19 proposing to do and to ensure the public
20 understands how to participate in the formal
21 comment process.

22 This is one of the listening
23 sessions where we will inform you of the

1 contents of the notice of the proposed rule
2 and respond to questions you may have on the
3 proposed rule.

4 We want to be clear that this not
5 a forum for submitting formal comments on the
6 notice of proposed rule. We will, however,
7 accept questions during the Q and A portion of
8 today's meeting, and a transcript of these
9 open door forums and listening sessions will
10 be posted at
11 <http://www.cms.gov/sharedsavingsprogram/> along
12 with fact sheets and other relative
13 information about this proposed rule.

14 With respect to submitting formal
15 comments, I'm going to have to have Brenda go
16 over that process right now for you.

17 Thank you, Brenda.

18 MS. HUDSON: Sure, thanks, Jeff, so
19 in submitting formal comments to the
20 www.regulations.gov website, please refer to
21 the file code CMS-1345-P.

22 Because of staff and resource
23 limitations we cannot accept comments by fax

1 transmission. You may submit comments in one
2 of four ways that are outlined in the proposed
3 rule including either electronically through
4 www.regulations.gov; by regular mail; by
5 Express or overnight mail; or by hand courier.

6 Please refer to the e-mail
7 invitation for this event for a detailed
8 description of how you may submit your public
9 comments to us.

10 The proposed rule along with the
11 joint CMS and OIG notice are posted at
12 www.ofr.gov/inspections.aspx. For more
13 information you may also review the fact
14 sheets that are available at
15 [www.healthcare.gov/news/factsheets/accountable
16 care03312011a.html](http://www.healthcare.gov/news/factsheets/accountable-care03312011a.html).

17 Formal comments on the proposed
18 rule will be accepted up until Monday, June 6,
19 2011. CMS will respond to all comments in a
20 final rule that will be issued later this
21 year.

22 MR. HINSON: Thank you, Brenda.
23 Now I'd like to introduce our guest speaker

1 for today's call, John Pilotte, CMS's Director
2 of Performance-Based Payment Policy in the
3 Center for Medicare.

4 John manages a team of analysts
5 responsible for designing and implementing the
6 Medicare Shared Savings Program for
7 Accountable Care Organizations as well as
8 other value-based purchasing programs for
9 hospitals, physicians, and other providers.

10 Previously John was the Director
11 of the Division of Payment Policy
12 Demonstration in CMS's Office of Research and
13 Development Information.

14 Prior to joining CMS, John was a
15 Senior Consultant with Price Waterhouse Cooper
16 Healthcare Practice and an associate on the
17 government-relations staff on the National
18 Association of Children's Hospitals and
19 related institutions.

20
21 He has a Master's in Health Policy
22 in Management from Johns Hopkins University
23 and a Bachelors of Science from Indiana

1 University.

2 Thank you, John, for joining us
3 today. I'm going to turn this over to you.

4 MR. PILOTTE: Thank you, Jeff, and
5 thank you all for taking time out of your day
6 to join in this open-door forum on the
7 proposed Rule for the new Medicare Shared
8 Savings Program, and as Brenda laid out there,
9 the process for commenting, I would like to
10 encourage you all to comment on the rule.

11 We have put out a proposal for
12 what we think the program should look like,
13 but we're very, very interested in getting
14 your comments, reaction, and feedback to that,
15 and we welcome all comments we receive.

16 We do take the comment process
17 very seriously. Each and every comment that's
18 received will be reviewed and it's your
19 opportunity to shape the final rule for the
20 Shared Savings Program, so again, I would
21 encourage you to comment on that, and we look
22 forward to getting those comments.

23 Today I thought I would, before we

1 turn it over to an opportunity to take your
2 questions and so forth, sort of go over the
3 proposed rule and then we can open it up and
4 take questions.

5 As you all know, the Medicare
6 Shared Savings Program was mandated by the
7 Affordable Care Act and established as the
8 Shared Savings Program for Accountable Care
9 Organizations. The statute requires that the
10 program be established by January 1, 2012. We
11 published the Notice of Proposed Rulemaking on
12 April 7th, and final comments are due back to
13 us on June 6, and again I would encourage you
14 to comment.

15 The Shared Savings Program is a new
16 approach to the delivery of health care aimed
17 at reducing fragmentation, improving
18 population health, and lowering overall growth
19 in Medicare expenditures by promoting
20 accountability for the care of Medicare fee-
21 for-service beneficiaries for the care
22 delivered to them by their providers requiring
23 coordination of both Part A and Part B

1 services to really drive integration between
2 those two components and encouraging providers
3 to invest in the infrastructure and care
4 processes and other resources required to
5 redesign care to achieve better and higher
6 quality and more effective and efficient care.

7 Dr. Berwick has spoken very
8 eloquently about his vision for Accountable
9 Care Organizations as a new way to promote the
10 delivery of seamless coordinated care that
11 promotes better care, better health, and lower
12 growth in Medicare program expenditures by
13 putting the beneficiary and their caregivers
14 at the center of care, remembering patients
15 over time and place, particularly through the
16 use of health information technology and other
17 mechanisms that don't require the patient to
18 constantly repeat their story as they move
19 through the continuum to result in better care
20 for them.

21 Attending - ACOs will attend
22 carefully to care transition as patients move
23 along the continuum to better manage the hand-

1 off in care. The ACOs would proactively
2 manage the beneficiary's care moving from
3 reactive care to more proactive population
4 health especially in the areas of preventive
5 care as well as with a special emphasis on
6 beneficiaries with chronic disease. They're
7 so highly prevalent in the Medicare program.

8 The ACOs would also evaluate data
9 continuously to improve their care, learn
10 about their organizations, learn new ways to
11 improve care and improve patient outcomes and
12 continuing to invest in team-based care as
13 well as their broader work force.

14 The statute lays out who is
15 eligible to participate in the Medicare Shared
16 Savings Program, who is eligible to form an
17 ACO, and those include ACO professionals
18 defined as physicians and practitioners in
19 group practices, physician networks made up of
20 physicians and practitioners, hospitals
21 employing physicians and practitioners as well
22 as joint ventures and partnerships between
23 hospitals and ACO professionals.

1 In addition, the Secretary has been
2 provided the discretion to identify other
3 providers and suppliers who may form ACOs
4 independently, and we've also proposed to use
5 that discretion to propose that method II
6 critical access hospitals, and bills for
7 physician services provided at the critical
8 hospitals, may also independently form
9 Accountable Care Organizations.

10 We've also laid out proposals to
11 encourage the active participation of FQHCs,
12 Federally Qualified Health Centers, and rural
13 health clinics in ACOs, but because of some
14 technical issues they are not allowed to
15 participate independently as an ACO at this
16 time.

17 As part of the eligibility and
18 application process, we've worked very closely
19 with our colleagues in the anti-trust
20 agencies, the Department of Justice and the
21 Federal Trade Commission who also published a
22 joint statement when we released the reg that
23 talks about market share issues and so forth

1 with ACOs and lays out clinical integration
2 criteria and a process for ACOs who may have
3 concerns or basically lays out a process for
4 helping ACOs determine when they may have to
5 go through anti-trust review.

6 It provides a safe harbor for ACOs
7 with the provider service area or market share
8 below 30 percent or that have a rural
9 exception that asks them to provide the safety
10 zone. For ACOs over 50 percent market share
11 and so forth, they would be required to go
12 through a mandatory expedited review, and they
13 would be eligible to participate in that
14 Medicare Shared Savings Program once they have
15 received a letter from the anti-trust agencies
16 indicating that they do not have any anti-
17 trust concerns.

18 For ACOs in between 30 and 50
19 percent, they can apply for a process for
20 expedited review by one of the anti-trust
21 agencies or agree to comply with the list of
22 conduct restrictions or even potentially go
23 forth without any assurances from the anti-

1 trust agencies, recognizing that they could be
2 challenged at some point down the road, and
3 that information and material is provided in
4 the anti-trust agencies, the Department of
5 Justice, Federal Trade Commission's anti-trust
6 statement that was also released on the same
7 day as the regulation, and it is talked about
8 in the NPRM as well.

9 With respect to the notice of
10 proposed rulemaking and the other provisions
11 that it lays out for requirements for those
12 organizations eligible to participate in the
13 ACO, we've proposed a number of criteria for
14 ACOs to meet to demonstrate that they are
15 committed to this program, that they have the
16 ability to be successful under it, again to
17 improve the quality and efficiency of care
18 that's delivered to Medicare fee-for-service
19 patients, and that they are sufficiently
20 integrated to be able to achieve those program
21 goals as well.

22 The ACOs are provider-based
23 organizations. We expect providers to be

1 active participants not only in the delivery
2 structure but also in the governance and
3 leadership of ACOs. We've proposed that they
4 be actively involved in the governing body and
5 organizational structure, along with other
6 community stakeholders and Medicare patients,
7 and that they also have an experienced
8 leadership team and an on-site medical
9 director as well as a physician-directed
10 quality assurance and process and improvement
11 committee.

12 Many of these criteria are
13 consistent with the clinical integration
14 criteria set forth by the anti-trust agencies
15 that require ACOs to demonstrate that the
16 providers have significant financial or human
17 investment in the organization's performance
18 and overall success.

19 This is reinforced in other areas
20 in the NPRM as well, around our criteria for
21 patient-centeredness and provisions to promote
22 the use of health information technology to
23 link providers together and to have them

1 better coordinate care for Medicare patients.

2 ACOs would be responsible for an
3 assigned patient population, as it's laid out
4 in the statute, and the ACO must agree to
5 accept responsibility for an assigned patient
6 population. This population is really the
7 basis for establishing and updating the
8 benchmark for which ACO's financial
9 performance is measured. It also provides the
10 population for which they would report on
11 quality measures for determining their quality
12 performance during the agreement period.

13 Patients would be assigned to the
14 ACOs based on the plurality of their allowed
15 charges for primary care services delivered by
16 primary care physicians, and we propose to use
17 a retrospective assignment process with
18 prospective data sharing.

19 We would work with each ACO at the
20 beginning of their three-year agreement period
21 to prospectively identify the patients that
22 would be historically assigned to them, and
23 they would likely be held accountable for

1 during the three-year agreement period. At the
2 end of each performance year for quality
3 measurement, financial performance
4 measurement, we would retrospectively assign a
5 patient to each ACO based on whether they
6 received the plurality of their primary care
7 services from a primary care physician, so
8 this would actually hold and then measure the
9 ACO's performance based on actual patients
10 that they saw during the performance year.

11 We think this approach creates
12 incentives for ACOs to really standardize care
13 for all their patients, and is also consistent
14 with something we heard from a lot of
15 stakeholders during the request for
16 information we issued prior to the proposal
17 going out that ACOs have a better
18 understanding of the populations they could be
19 held accountable for but also would be
20 reconciled for financial and quality reporting
21 purposes based on patients they saw during the
22 year.

23 We also propose the ACOs would have

1 a mechanism for proactive care delivery, they
2 would have processes and procedures in place
3 for routine self-assessments, internal
4 monitoring or reporting for continuous
5 improvement, promotion of evidence-based
6 medicine, and mechanisms to promote
7 beneficiary engagement, population health and
8 care coordination including provisions that
9 would address disparities in health care and
10 demonstrate that they have the ability to
11 report internally on quality and cost
12 measures.

13 ACOs would also be required to
14 demonstrate that they have a multi-strategy
15 patient-centered focus and have mechanisms in
16 place for involving community-based resources
17 in meeting the health as well as the social
18 needs of the patients that they serve.

19 Under the Medicare Shared Savings
20 Program beneficiaries would continue to be
21 able to see any provider they choose even if
22 that provider is not a member of the ACO.
23 There is no enrollment here. Patients would

1 be, as I mentioned earlier, retrospectively
2 assigned to each ACO for financial and quality
3 measurement purposes.

4 We are proposing that beneficiaries
5 be informed at the point of care that their
6 providers are participating in the ACO and
7 what the implications of that relationship are
8 for their care. We also propose that we would
9 share data with an ACO for patients that they
10 see in their primary care practices, by
11 primary care physicians, so that the ACOs
12 would have a better understanding of the care
13 their patients are receiving outside their
14 organization, and to be able to use that
15 information to better coordinate services.
16 We've laid out a process to share data on a
17 monthly basis with ACOs on patients whom have
18 been notified and not declined to have their
19 data shared with the ACO.

20 We've proposed a two-track approach
21 for financial reconciliation purposes for ACOs
22 to choose at the time of application and prior
23 to signing their three-year agreements with

1 CMS. This approach provides an on-ramp for
2 organizations to gain experience with
3 population and health management as well as
4 transition to performance-based risk
5 arrangements over time.

6 The idea here is that for those
7 organizations that are ready to take on
8 performance-based risks, there would be a
9 mechanism in place for them to do so. It
10 would provide them higher sharing rates in
11 return for accepting that accountability,
12 under the sort of premise that if there's
13 higher risks, there's higher reward.

14 However, for those organizations
15 that aren't ready to do that we've proposed a
16 separate track that would basically be two
17 years under a shared savings only arrangement
18 and then transition them to a third year of
19 risk, performance-based risk, in year three
20 whereas the other track I mentioned previously
21 would be a shared savings/shared loss model
22 for all three years.

23 Any ACOs that elect to continue in

1 the program beyond the first three-year
2 agreement would be under the shared savings
3 and shared loss agreement for those subsequent
4 agreement periods. ACOs would also only be
5 able to be in one Medicare shared savings
6 initiative in order for us to avoid duplicate
7 payments and not paying for the same, or
8 similar, services twice.

9 Basically the way we would measure
10 financial performance for each ACO is that
11 ACOs would continue to be paid under regular
12 Medicare fee-for-service payment for patient
13 care that they deliver throughout the year,
14 and then for each ACO, an annual risk adjusted
15 expenditure target would be calculated based
16 on its historically-assigned patient
17 population. It then would be updated each
18 year of the three-year agreement by a national
19 Medicare expenditure amount that would reflect
20 the national growth in Medicare expenditures.

21 So we would take each ACO's
22 specific benchmark expenditure amount and then
23 update that by the flat dollar equivalent of

1 national growth in Medicare expenditures for
2 each year of the three-year agreement.

3 The benchmark would be risk
4 adjusted based on the three-year historically
5 aligned patient benchmark and we propose not
6 to take into account changes in health status
7 between the performance year and the benchmark
8 period in order to guard against changes that
9 may be a result of more complete and accurate
10 coding.

11 ACOs may share in savings if their
12 actual assigned patient population
13 expenditures are below their established
14 benchmark, if the savings exceed the minimum
15 savings rate and they meet the quality
16 performance standard.

17 ACOs in essence would be eligible
18 to share up to 52 1/2 percent of savings under
19 the one-sided model based on their quality
20 performance and involvement in FQHCs and RHCs
21 and up to 65 percent in the two-sided models.

22 ACOs would be measured across five
23 domains that are consistent with areas that

1 are of priority importance for the Medicare
2 program and the national quality strategy.
3 They would be assessed on preventive health
4 measures, at-risk, chronic disease and frail
5 elderly measures, patient and caregiver
6 experience, care coordination and patient
7 safety.

8 The measures involve a mix of
9 process outcome and survey-based measures. In
10 addition there are other measures that can be
11 calculated for Medicare claims data and
12 Medicare administrative assistance that we
13 would calculate annually for each ACO.
14 Likewise, ACOs would have to report on the
15 survey-based measures and the other measures
16 that require clinical information on an annual
17 basis as well.

18 The quality performance standard
19 would be established in each of the five
20 domains to reinforce the importance of all of
21 those domains and basically we propose to set
22 the quality performance standard at the
23 reporting level for the first year. In

1 subsequent years of the agreement period, any
2 shared savings the ACO would earn would be
3 distributed to them based on their quality
4 performance, under a methodology that's laid
5 out in the NPRM. In essence, higher performing
6 ACOs would receive a higher sharing rate,
7 higher performing on the quality side would
8 result in a higher sharing rate whereas lower
9 performing ACOs in each domain would receive a
10 lower sharing rate of any savings they
11 generate.

12 In addition, we propose to align
13 the quality reporting methodology and approach
14 with those processes that are currently used
15 in the Medicare program to the extent we can
16 through PQRS, HITECH and the Hospital Value
17 Based Purchasing program as well to be
18 sensitive around administrative burden on
19 providers.

20 We've also proposed, for
21 physicians, to allow them to earn their PQRS
22 incentive payments by virtue of reporting the
23 quality measures under the ACO program, and

1 basically all ACO participating providers and
2 suppliers that are PQRS incentive payment
3 eligible would be able to earn those payments
4 for the first year of the Medicare Shared
5 Savings Program by publicly reporting those
6 measures, or I should say reporting those
7 measures under the ACO program.

8 In addition, we've proposed,
9 because of the importance of health
10 information technology and coordinating
11 services, providing point-of-care reminders
12 and alerts to practitioners at the point of
13 care and to align ACOs with better information
14 sharing. We're proposing that 50 percent of
15 the primary care physicians that make up the
16 ACO be meaningful users under the HITECH
17 program by the beginning of the second year.

18 With respect to beneficiary
19 notification, I talked a little bit about what
20 ACOs are required to do around notifying
21 patients at the point of care that they're
22 participating in an ACO and as well as to
23 provide notification to the patients that they

1 may request data, as well as provide an
2 opportunity for patients to not have their
3 data shared with the ACO, if they decline to
4 have that happen.

5 We would use and leverage existing
6 CMS communication mechanisms and partner
7 organizations for educating Medicare
8 beneficiaries about the Shared Savings
9 Program. We've also proposed to provide
10 standardized communication and marketing
11 materials to ACOs as well as to provide a file
12 and use process for non-standardized marketing
13 materials.

14 Data sharing that I talked about,
15 we've proposed to share with ACOs for patients
16 that have not declined to have their data
17 shared with the ACO and whom the ACO has seen
18 during the performance year.

19 Parts A and B and Part D drug data,
20 we've proposed a minimum data set that we
21 would provide each ACO on a monthly basis and
22 we're seeking comment on that. We welcome
23 your thoughts and comments around what are the

1 important and appropriate data elements to
2 help ACOs better coordinate services for the
3 Medicare fee-for-service patients, and again
4 the NPRM sort of lays out a process for that.

5 With respect to monitoring and
6 review, the statute indicates that we must
7 monitor ACOs for the avoidance of at-risk
8 beneficiaries, and this can result in
9 termination from the Shared Savings Program
10 for those ACOs that are found to be engaged in
11 the practice of avoiding at-risk
12 beneficiaries.

13 We proposed a definition of what we
14 mean by at-risk beneficiaries in the NPRM to
15 include the patients with multiple or chronic
16 conditions, high cost, frequent
17 hospitalizations, and so forth.

18 We plan on leveraging existing, and
19 establish new mechanisms, for monitoring ACOs
20 and to also use the data that we have
21 available under the ACO program to incorporate
22 that into our monitoring program along with
23 site visits and other mechanisms.

1 As I mentioned earlier, ACOs'
2 agreements can be terminated for avoidance of
3 at-risk patients, failure to meet the quality
4 performance standard, beneficiary notification
5 or public reporting on compliance, program
6 integrity issues or significant changes in the
7 ACO structure eligibility requirements.
8 Again, more detail is provided in the NPRM.

9 Again, the goal - one of the
10 primary motivations here, particularly with
11 respect to changes in ACO structure - is to
12 ensure continued compliance with our
13 eligibility requirements but also to provide
14 stability in our measurement systems as we
15 look to measure the ACOs' financial
16 performance over a period of time. We want
17 to make sure that the organization we're
18 measuring in year three of their agreement is
19 consistent with the organizations that we've
20 calculated their historical benchmark on as
21 well.

22 We've also laid out a review
23 process and appeals process as well.

1 I think that kind of provides sort
2 of a broad overview of the NPRM. I think with
3 that I'll turn it back to you, Jeff, and we
4 can take questions.

5 MS. HUDSON: This is Brenda Hudson,
6 and, Danielle, I think we can go ahead and
7 queue it up for the Q and A session.

8 MODERATOR: Thank you. At this
9 time we would like to begin the question and
10 answer session. To ask a question, please
11 press star one. You will be prompted to
12 record your name. You may withdraw your
13 question by pressing star two. Once again, to
14 ask a question press star one. One moment
15 please.

16 Once again, to ask a question,
17 press star one, and there are no questions.

18 MS. HUDSON: Okay. Well, John, I
19 guess that was a very clear and succinct
20 explanation, and people are probably
21 pondering.

22 Well, I guess if we don't have any
23 further questions, we can go ahead and just

1 kind of recap how people would go about
2 sending their comments in, so again, we just
3 wanted to reiterate that today's call is not a
4 forum for submitting your formal comments,
5 that to do so formally we would like for you
6 to follow the instructions that are laid out
7 in the invitation to this event and also in
8 the proposed rule.

9 If you or any of your colleagues
10 may have missed some or part of this
11 presentation, it will be available through the
12 Encore feature in about two hours after the
13 completion of the event, and the transcript
14 for the call today will also be posted at
15 <http://www.cms.gov/sharedsavingsprogram/> along
16 with fact sheets and other relevant
17 information about the proposed rule.

18 Danielle, I think I'll just try one
19 more time and see if there are any questions
20 that may have popped up as kind of last minute
21 here, and if not, we'll go ahead and conclude.

22 MODERATOR: There are no questions.

23 MS. HUDSON: Okay, well in that

1 case, thank you everyone for joining us today,
2 and we look forward to receiving your
3 comments.

4 MODERATOR: Thank you for
5 participating in today's conference. You may
6 disconnect at this time.

7 (Whereupon, the above-entitled
8 matter was concluded at 3:36 p.m.)