

CENTERS FOR MEDICARE & MEDICAID SERVICES
Accountable Care Organizations Conference Call for Hospitals
April 7, 2011
1:00 p.m. ET

Moderator: Barb Cebuhar

Operator: Good afternoon. My name is (Beth) and I will be your conference operator today.

At this time I would like to welcome everyone to the Accountable Care Organization for Hospitals.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Barb Cebuhar, you may begin your conference.

Barbara Cebuhar: Good morning and afternoon to everyone. My name is Barbara Cebuhar and I work in the Centers for Medicare and Medicaid Services, Office of External Affairs.

The U.S. Department of Health and Human Services released on Thursday, March 31st, proposed new rules to help doctors, hospitals and other healthcare providers better coordinate care for Medicare patients through Accountable Care Organizations. The proposed new rules will help doctors, hospitals and other providers form ACOs and are now available for public comments.

HHS also announced it will hold a series of conference calls and listening sessions during the comment period to help the public understand what the

Centers for Medicare and Medicaid Services, the agency administering the ACO program, is proposing to do and to ensure that the public understands how to participate in the formal comment process. This is one of those conference calls where we will inform you of the contents of the notice of proposed rule and respond to questions you may have on the proposed rule. We want to be very clear that this is not a forum for submitting formal comments on the notice of proposed rule. We will, however, accept questions during the Q&A portion of today's meeting and there will be transcripts and recordings of these open-door forums and listening sessions that will be posted at the following e-mail address – I'm sorry, the following Web sites: <http://www.cms.gov/sharesavingsprogram/>. That will be available along with fact sheets and other relevant information about this proposed rule. If you'd like to hear an encore of this call, you should dial 1-800-642-1687 and ask for recording number 56412810. The encore performance will be available four hours after the completion of this call and they will be available for seven days.

In submitting formal comments, you need to go to www.regulations.gov. Please refer to file code number CMS-1345-P, as in Paul. Because of staff and resource limitations, we cannot accept comments by fax transmission. You may submit comments in one of four ways that are outlined in the NPRM: electronically at www.regulations.gov, by regular mail, by express or overnight mail, by hand or courier. Please refer to the e-mail invitation for this event for detailed information regarding the ways you may submit your invaluable comments to us.

The proposed rule along with the joint CMS OIG notice are posted at www.ofr.gov/inspection.aspx. For more information, you can read the fact sheet available at <http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html>. Formal comments on this proposed rule will be accepted for 60 days and will end on Monday, June 6, 2011. CMS will respond to all comments and a final rule to be issued later this year.

Now I just want to make sure that folks know that this is being recorded and there will be a transcript of this available later at the Web site that I

mentioned. There also are maybe members of the press on this call. This is a call for hospitals only. If members of the press have questions, please call the CMS press office.

Now I'd like to introduce our first speaker, Jonathan Blum, who's the Deputy Administrator of CMS and Director of the Center for Medicare. Jon, would you go ahead?

Jonathan Blum: Great. Thanks, Barbara. And I want to thank everybody for taking the time this afternoon and this morning, depending on your time zone, to join us for this call. And in developing the proposed rule, CMS and our partner agencies spent a lot of time listening to pre-comments to best understand the issues and to understand what's happening throughout all communities regarding building more accountable care throughout all healthcare delivery.

We are here today in the same spirit, wanting to listen, wanting to help to answer questions, to help clarify, within the proposed rule. And as folks know that have gone through the rule, in certain places CMS has put down its best proposal, in other places we discussed different options, and really want to solicit feedback from the public. And so we know there is a lot of interest and a lot of concern, a lot of questions, but also a lot of suggestions for how CMS should best finalize this rule. As Barb said, all comments that CMS must – can respond to has to be received in writing, but here today we are here to listen, to help clarify, and to help folks understand the proposed rule. I want to emphasize the word "proposed," and CMS has a very strong commitment to listen and to take seriously every comment that is received.

I want to turn the content session over to our two experts. We have with us today Tricia Rodgers. She and our team has spent a tremendous amount of time developing this rule, a lot of thanks – I want to compliment them, but Tricia will walk you through the contents, then help to clarify, help to answer any questions that folks on the phone may have.

So again, thank you for taking the time. We are really in the spirit to listen, to explain, to help clarify. We look forward to today's discussion. So, Tricia?

Tricia Rodgers: Thanks, Jon.

The Medicare Shared Savings Program was mandated last year as part of the Affordable Care Act. It establishes a voluntary program that incentivizes Medicare providers and suppliers to form ACOs to improve the quality and efficiency of care delivered to Medicare beneficiaries. The proposed rule was put on display last week and we're looking forward to receiving comments on it. As Barb pointed out, additional information including a link to the proposal and fact sheet can be found at the www.cms.gov/sharedsavingsprogram Web site.

The Medicare Shared Savings Program is a new approach to the delivery of healthcare aimed at reducing fragmentation, improving population health and lowering growth in overall healthcare expenditures by promoting accountability for the care of Medicare fee-for-service beneficiaries, requiring coordinated care for all services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesigned care processes.

To meet the mission of the Shared Savings Program, an ACO should embrace the following goals: putting the beneficiary and family at the center of care by honoring individual preferences and values through shared decision-making; ensuring beneficiaries no longer bear the burden of making sure all their healthcare providers have the information about them that they need to provide care; attending carefully to care transitions; ensuring that waste is reduced and every step in care adds value to the beneficiary, including proactively preventing illness and promoting population health; proactively managing the beneficiary's care through reminders and advice; collecting, evaluating and using data to improve care delivery and patient outcomes; being innovative to enhance the quality of healthcare, improve patient satisfaction and control the growth of healthcare costs by continually reinventing care in the modern age; and investing in workforce to build skill, knowledge and teamwork.

Existing and newly-formed organizations are eligible to participate in the program and must also meet all other eligibility criteria. ACO entities include ACO professionals, defined as MDs, DOs, nurse practitioners, physician

assistants and clinical nurse specialists, in combination with each other or with hospitals, and those would be defined as acute care hospitals. CMS has proposed to use secretarial discretion to expand the list of eligible entities to include other Medicare-enrolled providers and suppliers who join the statutorily defined groups. FQHCs and RHCs cannot independently form an ACO, however, ACOs will be incentivized to include them as participants through a higher potential sharing rate.

As part of a coordinated interagency effort, CMS worked with the Federal Trade Commission and the Department of Justice to ensure newly-formed ACOs can participate in the program without being concerned they will run afoul of antitrust laws. The antitrust policy statement displayed on the same date as our proposed rule outlines and solicits comments on the proposed safe harbors related to the creation and operation of ACOs and it applies to collaborations formed after March 23, 2010.

A key component to the antitrust policy statement is the primary service area or PSA calculation for the percent share of common services. ACOs must calculate PSAs as part of the application process. PSA calculations indicate whether ACO applicants 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.

In the Medicare Shared Savings Program, CMS has proposed that ACOs be provider-centric and driven. An ACO participant is defined as a Medicare-enrolled group of providers or suppliers. These ACO participants must create a legal entity recognized under state law and must have a form of shared governance. This governing body must give the ACO participant proportionate and appropriate control over decision-making while ACO participants may join with entities such as entrepreneurs or health plans, the ACO participants must retain 75% control over the governing body. The governing body must also include a beneficiary presence. The ACO must demonstrate an organizational commitment, leadership and resources necessary to achieve the three-part aim of better care for individuals, better health for population and lower growth in expenditures.

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

The proposed rule encourages proactive and person-centered care. Eligible organizations will also have mechanisms for routine self-assessment, internal monitoring and reporting for continuous improvement around promotion of evidence-based medicine, beneficiary engagement, coordinated care, population health, and addressing health disparity and internal reporting on quality and cost measures. Additionally, the ACO will have a person-centered multi-strategy focus and continuous improvement around person-centered activities including integrated care involving community resources, beneficiary's needs.

We heard from stakeholders from our request for information last fall how important patient data can be for ACOs. While ACOs should be working toward developing health IT that will allow them to share information between providers, CMS recognizes that groups of providers may not have complete data on care delivered to their fee-for-service beneficiaries outside their organizations. In order to promote ACO's success, we proposed to make available beneficiary identifiable data for patients seen by ACO primary care providers who have been notified and not declined to have CMS share their data. CMS is also proposing to create aggregate data reports to provide quarterly feedback to ACOs on expenditures and utilization in addition to annual feedback on financial and quality performance.

In order to participate, the ACO must be willing to become accountable for Medicare fee-for-service population assigned to it. Beneficiary assignment is a basis for establishing and updating the financial benchmark, quality measurement and performance and focus of ACO's efforts to achieve the three-part aim. Beneficiaries are assigned to ACOs based on the plurality of

assigned charges for primary care services from primary care physicians, and that would be the internal medicine, general practice, family practice and geriatric medicine.

CMS is proposing retrospective assignment with a prospective data sharing aspect. This creates an incentive for ACOs to standardize care processes and treat all Medicare patients the same while aiding ACOs in understanding their patient populations.

Beneficiaries continue to be able to see any provider they choose even if that provider is not part of an ACO. Beneficiaries will be informed that their provider is participating in an ACO and provided the opportunity to decline to have their claims data shared with the ACO.

CMS has proposed a two-track approach for ACOs participating in the Shared Savings Program. ACOs may choose to participate in one of two tracks: an initial three-year agreement comprised of two years of one-sided shared savings and an automatic transition to two-sided shared savings or losses in the final year of the agreement, or a three-year agreement of two-sided shared savings or losses. All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model. This approach provides an on-ramp for organizations to gain experience and transition to risk arrangements.

The measures making up the quality performance standards support the three-part aim, focusing on better care and better health dimensions. Measures reinforce the following five domains: preventive health, at-risk and frail elderly populations, patient and caregiver experience, care coordination, and patient safety.

Shared Savings payments will be linked to quality performance based on a sliding scale that rewards both attainment and improvement. High-performing ACOs in each domain could receive a higher sharing rate. This aligns with the Medicare quality and EHR incentive programs as well as national quality strategy and private sector initiatives.

ACOs may share in savings if the actual assigned patient population expenditures are below the established benchmark. If savings exceed the minimum savings rate and they meet the quality performance standard, they may share in savings. ACOs are eligible to share savings up to 52.5 percent under the one-sided model and up to 65 percent under the two-sided model, depending on quality performance.

ACO providers will continue to be paid under the regular fee-for-service payment system. And for each ACO, we proposed an annual risk-adjusted expenditure target would be calculated based on its assigned patient population updated by national Medicare expenditures.

No adjustment for changes in the health status between the performance years and the benchmark period will occur to guard against changes due to more complete and accurate coding rather than changes in the population health status.

And with that Barb, do we want to turn it over for questions.

Barbara Cebuhar: Yes, I would. And thank you very much, Tricia. Now we'll take your questions. (Beth), if you could tell people how to queue up again, I would be grateful. Thank you.

Operator: At this time I would like remind everyone, in order to ask a question, press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (Margaret Reagan), Premier Healthcare. Your line is open.

(Margaret Reagan): Hi. Thank you very much for having the call, really appreciate it.

There's one question we're getting an awful lot, revolves around, how is the ACO regulation going to interact with the Innovation Center? And I know that hasn't been completely rolled out, but we have some folks trying to figure out, you know, how they can participate in both, or can they, and if you could shed some light on that, that'd be fantastic.

Tricia Rodgers: Sure. Thanks so much for your question.

There will be more information about the Innovation Center's demonstration projects rolling out in the near future. The statute does say that we are not able to duplicate payments for Shared Savings Program, so depending on what the initiatives that come out of the Innovation Center, if they're Shared Savings Program, then it will impact participation in both the Medicare Shared Savings Program and any demonstrations that are coming forth as a Shared Savings Program.

(Margaret Reagan): Yeah, that's very helpful. Just one last piece there, so you really don't know what types of things are there for folks that are "ACO light," that might not be able to jump in to the coup for ACOs, how many things you would be having at that particular area.

Tricia Rodgers: Just that more information will be coming hopefully shortly.

(Margaret Reagan): OK, thank you.

Barbara Cebuhar: Thanks, (Margaret). Our next question please, (Beth).

Operator: Your next question comes from the line of (Suzanne Edwards) with (Virtua). Your line is open.

Megan Webster: Hi, this is actually Megan Webster and I'm with the Assisted Living Federation of America. And if I understand it, we're interested in the new requirement that would penalize hospitals if the discharged patient is readmitted within 30 days. My question is, our providers are thinking if they could possibly have hospitals discharge people to assisted living centers versus their own home, so that we could make sure they're basically healthy for 30 days. My question is, would an assisted living provider fit the description of an ACO participant?

Tricia Rodgers: Thank you for your question. The definition of an ACO participant that we have, we have used our secretarial discretion to allow participation in the program of any Medicare-enrolled provider or supplier regardless of what

Medicare-enrolled providers or suppliers who join together, they must also meet all the other eligibility requirements. But we have proposed to use our secretarial discretion to form ACOs under the program of any Medicare-enrolled provider or supplier.

Megan Webster: OK. So I mean, it's under the secretarial discretion, so that's kind of what we would – we'd be in that category?

Tricia Rodgers: As long as – well, sorry, as long as you are a Medicare-enrolled provider or supplier, you would be eligible to participate in an ACO.

Megan Webster: OK.

Tricia Rodgers: Under the proposed – that are currently proposed.

Megan Webster: OK, great. Thank you.

Tricia Rodgers: You're welcome.

Barbara Cebuhar: Thanks for your comment, Megan. Our next question please.

Operator: Your next question comes from (Mike Bereck). Please state the name of your organization. Your line is open.

(Mike Bereck): Hi. I represent Summit Medical Group.

The only question we have is the, at this time, is the application of the risk score and what diagnosis codes for what dates of service apply to what base year?

Tricia Rodgers: Thanks for your question. Can you – I'm sorry, can you repeat it one more time please?

(Mike Bereck): The dates of service, for which date of service years apply to which base years for calculating the benchmark? Would date of service base year three applied to the data risk score for base year three?

Tricia Rodgers: So I think I'm understanding – well, I don't know if I'm understanding your question. So for calculating the benchmark and performance year expenditures, we're proposing to utilize the CMS HDP model for risk adjustment and we will calculate the ACO's risk score by applying the model to the assigned beneficiary population attributed in each year of the three years of the benchmark. And then we propose to not account for changes in the risk score during the performance years.

(Mike Bereck): I will submit my question in a more detailed, in a written form.

Barbara Cebuhar: Thank you, (Mike). Our next question please?

Operator: Your next question comes from the line of Dr. Charles Kelly, Henry Ford Health. Your line is open.

Charles Kelly: This is really an extension of the first question regarding participation in the Innovation Center. With the release of this recent ACO rule on shared savings, we identified two different processes. Number one, what the elements were in terms of administrative operational quality performance of a federally recognized ACO. Am I correct in assuming that if we submit a project to the CMMI Center, under an innovation format, that those same requirements would apply?

Tricia Rodgers: Not necessarily. I mean we work closely with the Centers for Medicare and Medicaid Innovations, but depending on what type of programs and demonstrations are going to put forward will determine what the application process and other processes are for applicants.

Barbara Cebuhar: Thank you for your question, Dr. Kelly. Our next question please.

Operator: Your next question comes from the line of (Tim Walters). Please state the name of your organization. Your line is open.

(Tim Walters): Yes, I'm with Citizens Memorial Hospital in Bolivar, Missouri. We operate a number of rural health clinics, and I read some of the discussion about rural health clinics' participation in ACOs in the rule. And I guess I wanted to clarify, most of our patients, I would say, well over half, would be receiving

their primary care through our rural health clinics. So, if we were to participate in an ACO, am I correct that essentially, we wouldn't form one on our own, we would link up with a metropolitan system, but if we did that, am I correct that essentially most of our patients will not really be part of the ACO then as CMS is currently planning to implement the system? And if so – or would they be in the ACO if they see any other primary care doctor during the attribution period?

Tricia Rodgers: Well, yes. Yes. The beneficiaries will be assigned based on the plurality of care received; based on the primary care services that they received.

(Tim Walters): But if a plurality was in a rural health clinic setting, are you saying they would be – essentially not made part of the ACO then? Or would rural health clinics even be involved in that calculation of the plurality?

Tricia Rodgers: That's right. The RHCs would not be involved in the calculation of that plurality.

(Tim Walters): Just be 1,500 billings essentially ...

Tricia Rodgers: Based on the primary care, yes.

(Tim Walters): OK. If I could ask one follow-up, in the document you mentioned that you're hesitant to impose or – one reason you're not including rural health clinics is because you're not gathering the HCPCS and some other data that would be necessary. And you say you're hesitant to impose regulatory change here without support from the RHC community, and I appreciate that. Is there some way you could maybe express what type of additional information would be needed where for most payors that we'd bill on 1,500 we do have to gather this information anyway, and I don't believe it would be a major change, but I guess without knowing what all you would be wanting, it may be a little bit hard to assess that.

Tricia Rodgers: Well, we currently lack the data elements, things like service codes, physicians, physician specialty, specific attribution of services to the rendering professional, healthcare professional in the claims and payment systems, that would enable us to determine beneficiary assignment.

(Tim Walters): Primarily we're talking about the difference between what goes on a 1,500 and what goes on the (UB), is that the type of data that you ...

Tricia Rodgers: That's the type of data, yes.

(Tim Walters): OK. All right. Thank you.

Barbara Cebuhar: Thank you, (Mr. Walters). Our next question please, (Beth).

Operator: Next we have (Daniel Thompson), (Children's Health). Your line is open.

(Daniel Thompson): Hi, thank you. Would someone please repeat the recording number for the encore of the conference call?

Barbara Cebuhar: Surely. It is 800-642-1687. And the code for today's call which will be available for seven days is 56412810. And that will be available for seven days.

(Daniel Thompson): Thanks.

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

Operator: Next we have Michael Miller, HealthCare.com. Your line is open.

Michael Miller, your line is open?

Michael Miller: Hi. Sorry about that, I had the phone muted. It's actually HealthPalCom, one word.

I have a simple question about recognizing what kind of organizations (would be participating as an ACO) and whether it'd be exclusive or non-exclusive. And as I was reading the proposed rule, it seems that hospitals that are not rural or central access hospitals would not be eligible to participate in ACO in an exclusive basis. Is that correct? Or could you elucidate it more on that?

Barbara Cebuhar: Mr. Miller, are you a member of the media?

Michael Miller: I am not.

Barbara Cebuhar: OK, thank you.

Tricia Rodgers: Sure. So your question is about the FQHCs and RHCs specifically, or?

Michael Miller: No. About hospitals.

Tricia Rodgers: I'm sorry. OK.

Michael Miller: Yes.

Tricia Rodgers: So the definition in the statute says – specifies that it is for – let me see if I can pull that up fairly quickly – basically it's a – it describes the Subsection D, hospitals. And we have also proposed that Method 2 critical access hospitals would also be eligible.

Michael Miller: The question is really about whether hospitals will be prohibited from participating in ACO on an exclusive basis.

Tricia Rodgers: As long as you have enough primary care professionals that could care for 5,000 beneficiaries and be assigned, then that's not a problem.

Michael Miller: OK. Thank you.

Tricia Rodgers: You're welcome.

Barbara Cebuhar: Thank you, Mr. Miller. Our next question please.

Operator: John Haughton, please state the name of your organization, your line is open.

John Haughton: Hi, this is John Haughton, I'm the Medical Information Officer for Covisint, a health exchange provider.

My question relates to the owner of the two-tailed gain share risk which presumably includes the primary care physician associated with 5,000 patients, and whether they have the latitude to then make payments to other organizations, and to use an example of your earlier caller, about discharging somebody to assisted living. Is there any mechanism to, within the ACO

statute, that would allow payment for those services that may be harvestable on the gain share? So let's say the skilled nursing bed costs however many thousands of dollars or \$1000 a day, let's say an assisted living costs \$200 a day, it still could be advantageous to a group to discharge to assisted living even if they're only getting a 50 percent gain share. So the specific question is, is there any mechanism in the ACO for, spend from the ACO responsible group?

Tricia Rodgers: I think it's probably going to be best for you to submit that comment in writing so that our antitrust colleagues can respond to that question please.

John Haughton: OK. Thank you very much.

Barbara Cebuhar: Thank you, Mr. Haughton. And our next question please, (Beth).

Operator: Your next question, Daniel Fass from WESTMED. Your line is open.

Daniel Fass: Yeah, thank you for this informative phone call and for laying the ground-works which will hopefully be the transformation of medical care, and I speak for multispecialty groups. And a majority of the physicians are concerned that as we're probably on the cutting-edge of cost-effective delivery of healthcare, will we be penalized by comparing ourselves to ourselves? And moving forward, will there be an expectation of continuing cost savings with an aging population and increasing medical innovation?

Tricia Rodgers: Thank you for that question. I think the expectation is that we will be looking for continued increases in quality and reductions in costs. However, all of that will be addressed in future rule-making, once we get this up and running.
Thank you.

Barbara Cebuhar: Thank you, Mr. (West). Our next question please, (Beth).

Operator: (Joe DeMiller), please state the name of your organization, your line is open.

(Joe DeMiller): Yes. I'm with Premier. And my question relates to critical access hospitals. Are critical access hospitals going to be affected from their perspective of Medicare reimbursement if they participate in an ACO?

Tricia Rodgers: No. This is – the program is being run under the fee-for-service program, and so all payments will continue under the traditional fee-for-service payment system.

Barbara Cebuhar: Thank you, (Mr. DeMiller). Our next question please.

Operator: Your next question comes from the line of Jonathan Feit, Beyond Lucid Technology. Your line is open.

Jonathan Feit: Good morning. Thanks very much for, again, for doing this call.

So I'm actually a technology provider, of the kind that you addressed earlier as needing to – well, essentially as ACOs and whatnot need to begin looking at technologies designed to connect patients, connect various healthcare providers within the organization, and make the patient information available. And I guess my question simply comes down to, as technologies like ours and presumably others in the market become available, is there some way of working either with CMS or with the group overseeing ACOs or Centers for Medicare/Medicaid Innovation to let folks in the marketplace know that we are out there and we are addressing, in particular, the cost question? I've heard that brought up for instance many times in the conferences recently, i.e. who and how are the costs associated with technology going to be addressed in terms of getting ACOs onboard with technology. I'm wondering if there's a channel that you guys are setting up through the Innovation Center or some other center to let people out there looking for technologies essentially find those who are providing technologies in a cost-effective manner. I appreciate it very much. Thanks.

Tricia Rodgers: Thank you for that. It's an interesting comment and question. I hope that you submit it formally into the www.regulations.gov Web site. I will also talk – let my colleagues know in the Innovation Center of the interest in this specific field. Thank you.

Barbara Cebuhar: Thank you very much, Mr. Feit. Next question please, (Beth).

Operator: Your next question comes from the line of Mr. Lalime. Please state the name of your organization. Your line is open.

Mr. Lalime, your line is open.

Barbara Cebuhar: You may still be on mute.

Operator: I will go on to the next question.

Barbara Cebuhar: Great. Thanks.

Operator: Emily Brower, please state the name of your organization, your line is open.

Emily Brower: Hi, this is Emily Brower from Harvard Vanguard Medical Associates and Atrius Health.

My question regards what kind of notification – the notification for beneficiaries around the fact that there are providers participating in an ACO, and what will be some of the positive messages that will be given to patients along with their opportunity to opt out, so that they can see that there's benefit from participating in the ACO and that their provider group, you know, is stepping up to the plate to manage care for them in this program.

Tricia Rodgers: Thank you for bringing that up for clarification. We intend, CMS will work with the ACOs in the program to come up with marketing materials that explain the ACO program very clearly to beneficiaries so that they understand all of the benefits of what can come of this program, while at the same time letting them know of their opportunity to opt out of the data sharing aspect. Thank you.

Barbara Cebuhar: Thanks for your question, Emily. Our next question please, (Beth).

Operator: Rob Bates, Avera Health, your line is open.

Rob Bates: Yes. Thanks for this very informative opportunity here. Our question would be, if you missed the opportunity to be an ACO on 1/1 of 2012, what is your next opportunity to apply? Is there a three-year cohort that begins in January of '13 or does that really slide back until 2015?

Tricia Rodgers: Thank you for that. Our application process will become – we will put more information out about our application process after the final rule is out. However, as you stated, there is a three-year agreement period as proposed, but CMS expects that we will have some sort of annual application process. Thank you.

Barbara Cebuhar: Thank you very much, Mr. Bates. Our next question please, (Beth).

Operator: We'll try the line of Mr. Lalime again. Your line is open. Please state the name of your organization.

Ken Lalime: Hi, this is Ken Lalime. Can you hear me?

Barbara Cebuhar: Yes, we can. Thank you.

Ken Lalime: Thank you. Yes, I'm Executive Director of the Connecticut State Medical Society-IPA.

My question relates to, there's a section of the proposed rule that talks about having experience or it would be helpful if the organization had experience with non-Medicare payor initiatives. Would that include relationships with Medicare Advantage payors?

Tricia Rodgers: I think that could be one of the – one example, yes.

Ken Lalime: Great. Thank you.

Barbara Cebuhar: Thank you, Mr. Lalime. Our next question please, (Beth).

Operator: Again if you would like to ask a question, press star then the number 1 on your telephone keypad.

Mr. Lalime would like to ask a follow-up question. His line is open.

Ken Lalime: Yes, thank you. In another section, it talks about the obligations of the organization, says that there needs to be a medical director. Does that need to

be a full-time employed medical director, even if that was going to be for a fairly small membership ACO?

Tricia Rodgers: I need to look specifically at the proposed text, but I believe it states physically present or something along those lines. If you would give me your information, I'm happy to look that up and reply back to you.

Ken Lalime: Sure. What information do you need?

Tricia Rodgers: E-mail would be fine.

Ken Lalime: OK. It's klalime@csms-ipa.com.

Tricia Rodgers: OK, thank you.

Ken Lalime: I did see that it had to be board-certified, et cetera, et cetera, I just didn't know if that would be a full-time physician.

Tricia Rodgers: OK, thank you.

Ken Lalime: Thank you.

Barbara Cebuhar: Our next question please.

Operator: From the line of (John Lorgan). Please state the name of your organization. Your line is open.

(John Lorgan): I'm with Carilion Clinic. And the question is, during the presentation, I thought I heard you say that an applicant would have to have a letter from the FTC or some antitrust agency. Did I understand that correctly?

Tricia Rodgers: That would only be if the PSA calculations indicated that they needed to undergo an expedited antitrust review.

(John Lorgan): So if you're greater than the 50 percent, or whatever the threshold ...

Tricia Rodgers: That's right. Fifty percent is – we are – it is required – the review is required if you are greater than 50 percent, and then the 30 – if you are in the 30

percent to 50 percent range, you would – it would be up to the ACO to decide whether it wanted to go forward with a review or agree to comply with the list of conduct restrictions.

(John Lorgan): And since market share data for things like physician services is not readily available, how is the applicant going to know whether they're at or above 50 percent?

Tricia Rodgers: Data will be made available for the applicant to calculate the PSAs.

(John Lorgan): Thank you.

Tricia Rodgers: You're welcome.

Barbara Cebuhar: Our next question please, (Beth).

Operator: Your next question comes from the line of someone whose last name is Barr. Your line is open. Please state your name and organization.

Lynn Barr: This is Lynn Barr from the California Rural eHealth Information Network. And I had a question about the – two questions of clarification. One of them was, for many of our rural counties where the rural providers are really just sole providers for the entire county, I was curious as to why CMS just didn't use the PSA calculations to assign beneficiaries to those types of counties when there was no competition.

Tricia Rodgers: I think that it's a very interesting question and hope that you would submit it for official comment.

Lynn Barr: OK, great. Thank you. And then the other question I had was, in the current proposed rule, how exactly is it that the – so, you have these rural providers that are participating and you've got the quality measures and also the efficiencies that are being afforded in those communities. How is that actually being accounted for in the parent ACO, since they can't become an ACO themselves? So, are those savings in any way being recognized, or – in those calculations for the larger ACO?

Tricia Rodgers: I think what you're asking is the – will the claims data be used regardless of where the services are performed in calculating the shared savings payments? And if services are performed in rural areas and there are savings there, would it be – would that be included?

Lynn Barr: Right, yes, because you're not really counting those beneficiaries, right? We're not sort of accounting for them financially. So I'm unclear on how that saving works out, right, so we're not – because the larger ACO appears to benefit by partnering with rural, right? But it's not clear to me how the financial savings would trickle back. Or is that measured at all? I was just not clear.

Tricia Rodgers: So the ACO would be accountable for all costs or the Medicare beneficiaries assigned to that ACO regardless of where those services were provided. And as far as what the ACO will do to distribute any shared savings it acquires, that is up to the ACO how they're going to distribute it. We proposed that we would like to know how, but not – we did not determine how it should be distributed, but rather requested to know how in our proposal.

Lynn Barr: OK. So if a rural – if beneficiaries in rural providers in rural counties are actually – their costs are actually included? Because I guess I'm really unclear on that from the proposed rule-making, because it says that we can't count them because we don't have the HCPCS codes. So ...

Tricia Rodgers: That's just for assignment purposes, or ...

Lynn Barr: How do they get assigned to the larger ACO then?

Tricia Rodgers: They could – if they're assigned to the ACO in which a rural facility is a part of it, is participating in that ACO, that ACO needs to be accountable for all Parts A and B services for those assigned beneficiaries.

Lynn Barr: OK. All right.

Barbara Cebuhar: Thank you, Ms. Barr. Our next question please, (Beth).

Operator: From the line of Amanda Tosto. Please state the name of your organization.

Amanda Tosto: Hi, my name is Amanda Tosto, I'm calling from ECG Management Consultants. My question is actually, follows on from the last question, and it's about the methodology for which the ACO will distribute funds to the ACO participant. I did read in the regulations, as you recently stated, that the ACO needs to indicate the criteria that they plan to employ for distributing the shared savings and explain how the methodology fulfills the triple aim. But I do have a – my question is, does Medicare have any recommendations or best practices regarding creating the proper incentives or creating a methodology for distribution of these shared savings?

Tricia Rodgers: Thank you for that. I would hope that you would ask that question formally in the comment – during the comment period. I will say that right now our proposal was just to see how ACOs planned on distributing the funds, but certainly your comment would be welcome during our comment period. Thank you.

Amanda Tosto: OK. Thank you very much for your work, I appreciate this. Thanks. Great.

Barbara Cebuhar: (Beth), our next question please.

Operator: From the line of (Tamara Dupavel Brown Lee). Please state the name of your organization. Your line is open.

(Tamara Dupavel Brown Lee): Thank you. I'm with Lone Star Circle of Care, an FQHC. And I guess my question is probably along the lines of those that asked questions about the rural hospitals, rural access points, and just what might be the feeling of the Office of the Secretary for including beneficiaries that are represented by us in ACO partnerships going on in the future. I'm presuming that they will not be counted in that sense. Am I correct in that?

Tricia Rodgers: Can you repeat your question or restate it? I don't understand what you're asking please.

(Tamara Dupavel Brown Lee): Sure. Earlier someone was asking a question about rural health centers and whether their patients would be involved in the plurality with calculating where beneficiaries are going. And I imagine the same

would be the case with regard to federally-qualified health centers. Is that clear, clearer?

Tricia Rodgers: Yes. So, beneficiaries will be assigned based on primary care services, based on the services performed – sorry, I don't think I'm explaining this very well. We need to assign beneficiaries based on the services they received under primary care. And so if – the question of SQHCs and the rural hospitals is that we do not have the – on our claims right now, we currently lack the data elements to attribute these services to health – to the healthcare professionals. And so we're unable to determine the beneficiary assignment for those particular facilities.

(Tamara Dupavel Brown Lee): OK. Thank you.

Barbara Cebuhar: Thank you, (Ms. Brown Lee). We have time for two more questions. (Beth), could you please queue them up?

Operator: Your next question comes from the line of Maria Hernandez. Please state the name of your organization. Your line is open.

Maria Hernandez: Yes. I am in private practice in Pembroke Pines, Florida. We see regular fee-for-service and we also see risk patients as part of a Medicare Advantage Plan down here.

I have a specific question, in as far as the financial awards will be given, are you taking into account also the medical risk adjustment scores of each of the beneficiaries involved in the ACO? And if you're doing away with the MRA scores, are you willing to repair and how is ICD-10 going to be impacting the scores within the future in actual reimbursement of the ACO?

Tricia Rodgers: Thank you for that question. We are going to calculate the ACO risk score by applying the (HDP) model to the assignment of the beneficiary population attributed in each year of the three years of the benchmark. We're also proposing to not account for changes in risk score during their performance years.

Maria Hernandez: And how is that going to be changing when ICD-10, which is basically within a year's time, approaching?

Tricia Rodgers: Well, that would be discussed in the future rule-making.

Maria Hernandez: OK. Thank you.

Barbara Cebuhar: Thank you, Dr. Hernandez. Our next question please.

Operator: Your next question comes from the line of Ruby Rodriguez from Puerto Rico Hospital. Your line is open.

Ruby Rodriguez: Hi. My question is related to the Medicare Advantage Program. Will that program be competing with the ACO or will they be able to cover patients that have Medicare Advantage?

Tricia Rodgers: Currently proposed, the statute is clear that it's for Medicare fee-for-service Parts A and B services. So right now that, as the statute stands and as we proposed, that's how it goes. As far as your question on the competition with Medicare Advantage plans, I invite you to submit that comment through our formal comment process.

Ruby Rodriguez: OK. Thank you very much.

Tricia Rodgers: Thank you.

Barbara Cebuhar: We have time for one more question.

Operator: Your next question comes from the line of (Fyke Sam), Florida Accountable. Your line is open.

(Vic Stanley): Hi, this is (Vic Stanley), sorry. I had one question. What exactly is CMS's end-gain with the ACO program? The ACO program is basically in existence for three years, but what's the overall aim and what is CMS – what do they hope to achieve as an evolution of this program?

Tricia Rodgers: So the ACO agreement period is for three years, however, this is a Medicare program that is, I mean, we're seeking to have a new approach to the delivery

of healthcare, basically aimed at reducing fragmentation, improving population health and lowering growth in overall healthcare expenditures.

(Vic Stanley): Yeah, but what happens after those three years?

Tricia Rodgers: Well, we will have continued programs. People will be able to – we proposed three years, people can reapply possibly or continue on depending on what future rule-making says about what happens after three years as far if there is a new application process or what-have-you. But it's just a three-year agreement period. But this is a program. And then future rule-making will determine how things will change as we progress.

Barbara Cebuhar: Thank you very much, Mr. (Stanley).

I just want to make sure folks know we are very grateful for everybody's insights and input. I just want to make sure that folks know how to file their formal comments. You need to go to www.regulations.gov, and please refer to File Code CMS-1345P as in Paul, so you can file electronically via www.regulations.gov. You can send regular mail or you can send express or overnight mail, or you can deliver by hand or courier, and the information is in the invitation that you received.

Also I just want folks to know that there is an encore of this call available for the next seven days. It will be available probably at about 6 o'clock tonight. You can dial 800-642-1687 and ask for Recording Number 56412810.

(Beth), I think we are finished with this call. I'm very grateful for everybody's participation, and we look forward to seeing your comments.

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

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