

**Centers for Medicare & Medicaid Services  
Accountable Care Organizations Conference Call for Advocates  
April 8, 2011  
1:00 p.m. CT**

**Moderator: Barb Cebuhar**

Operator: Good afternoon. My name is (Stephanie), and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Accountable Care Organization Conference Call. 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 one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Thank you, (Stephanie). 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 health care 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 comment.

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

Centers for Medicare and Medicaid Services, the agency administering the ACO program is doing 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 content of the Notice of Proposed Rule and respond to questions that you may have or comments on the proposed rules. We want to be clear that this is not a forum for submitting formal comments on the Notice of Proposed Rule.

We will, however, accept questions and comments during the Q&A portion of today's meeting and transcripts and recordings of these conference calls and listening sessions will be posted at the following Web site. It's <http://www.cms.gov/sharesavingsprogram> along with the fact sheets and other relevant information about this proposed rule.

If you know somebody that didn't make the call, if you'd like to pass along an Encore of this call, you should dial 800-642-1687 and ask for recording number 56392847 four hours after the completion of the call. They will be available for about seven days.

In submitting formal comments to [www.regulations.gov](http://www.regulations.gov), please refer to file code CMS1345P as in (Paul). Because of staff and resource limitations, we cannot accept comments by facsimile transmission. You may submit comments in one of four ways that are outlined in the Notice of Proposed Rulemaking. First, electronically, at [www.regulations.gov](http://www.regulations.gov). By regular mail, by express or overnight mail, by hand or courier, please refer to the email 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](http://www.ofr.gov/inspection.aspx). For more information regarding the ACO proposal, you should read the fact sheet at [www.healthcare.gov/news/factsheets](http://www.healthcare.gov/news/factsheets) – plural – [/accountablecare03312011a.html](http://accountablecare03312011a.html).

Formal comments on the proposed rule will be accepted for 60 days and will end Monday, June 6, 2011. CMS will respond to all comments in the final rule to be issued later this year – excuse me.

I just want to make sure folks know that there may be members of the press on this call. This is a call for advocates only. If members of the press have questions, please call the CMS Press Office at 202-690-6145.

I'd like to introduce our first speaker, Jonathan Blum, who is the Deputy Administrator of the Centers for Medicare and Medicaid Services and Director of the Center for Medicare.

Jon?

Jon Blum: Great. Thanks, Barbara. I want to thank everybody who's joined us on the phone this afternoon and this morning, depending on your time zone.

What I'll just offer is a few quick words, but then turn the phone over to our true experts who can walk folks through, on the phone, the provisions that are contained within the Shared Savings rule.

CMS, over the past several months, has done extensive outreach and solicitation of comments – pre-comments – to inform our thinking in developing the proposed rule. We intend to continue that outreach and to continue – one, to help explain the provisions but also to take feedback, to take comments to our proposals.

Throughout the rule, folks will see that sometimes we considered several options, discuss CMS's proposal for those two options. But we understand and we respect the fact that there is a tremendous degree of interest and work already going throughout the country and thinking about how to build more accountable care.

Today's phone call really is in that spirit, to one, to explain our – on our proposal and also to answer any questions that folks may have. CMS will continue to do this throughout the comment period, but as Barb said, for CMS

to respond to comments, we need to have those comments submitted to us in writing.

Again, I want to thank everybody. We are very excited about the proposed rule, but we also understand that there will be lots of comments, lots of interest that CMS will consider very carefully.

With that, I will stop and turn the call over to our true expert, John Pilotte, to walk us through the provisions and then to help answer any questions that you may have. So thank you for taking the time.

CMS will have more of these forums. But we're really here in the spirit to want to explain but then to also take any questions.

So, John, why don't you take it away?

John Pilotte: Great. Thank you, Jon, and thank you, Barb. And thank you all for taking the time out this afternoon to join us for this conference call on the Medicare Shared Savings Program.

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 accountable care organizations to improve the overall quality and efficiency of care delivered to Medicare fee-for-service beneficiaries.

As Barb mentioned, the proposed rule is published last – actually published yesterday in the Federal Register, but went on display last week. And we're looking forward to receiving comments on it. And as Barb indicated, the comment period ends June 6th, and we welcome your thoughts and comments on that, and we take them seriously and will respond to each one we get.

Additional information about the Shared Savings Program, I know Barb provided a number of different sites. There's – I'm going to give you one more as well. And it has links to all the other sites as well, and it's [www.cms.gov/sharesavingsprogram](http://www.cms.gov/sharesavingsprogram), and that's actually a forward slash. You can find the – all the fact sheets and the Federal Register notice and other

– and the other agencies notices are all available off of that document – off of that Web site.

The Medicare Shared Savings Program is a new approach to the delivery of healthcare aimed at reducing fragmentation, providing seamless care to Medicare beneficiaries, improving population health, and improving care processes, and in lowering the overall growth in Medicare expenditures by promoting accountability for the care and Medicare fee-for-service beneficiaries delivered by providers participating in Accountable Care Organizations, improving the coordination of both Part A and Part B services for which the ACO accepts accountability, and encouraging investment in infrastructure and redesigned care processes – necessary and critical to improving the overall quality on the efficiency of care delivered.

Dr. Berwick has spoken very eloquently about his vision for the Medicare Shared Savings Program. Specifically, he has laid out a vision that an ACO should put the beneficiary and family at the center of care by honoring individual preferences and values through shared decision-making, remembering beneficiaries over time and place, ensuring that beneficiaries don't have to repeat their stories as they move along the continuum of care, attending carefully to transitions in care as beneficiaries move along the continuum, ensuring that waste is reduced and that every step in care adds value to the beneficiary, including proactively preventing illness and promoting population health especially for patients with chronic conditions that are so prevalent in the Medicare population, proactively managing the beneficiaries' care through preventive care reminders, alerts at the point of care for physicians to enable them to truly transform care as part of broader care teams as well, collecting and evaluating using data continuously to improve the quality of care the patients receive and the outcomes, investing in team-based care, and their workforce to continually improve and to use a team-based care to provide effective care to Medicare patients.

Existing – who's eligible to be an ACO? ACOs are provider-based organizations. Existing and newly formed organizations are eligible to participate in the program who meet all the other eligibility criteria. ACO entities include ACO professionals and combinations with each other or

hospitals; physician networks, physician groups, and joint ventures between the two.

ACOs must have a patient population of these 5,000 fee-for-service beneficiaries that they accept accountability for and agree to be held accountable for which. And we've – the Secretary has used her discretion to include Method II CAHs, which are critical access hospitals for physicians who bill for physician services for primary care to also be considered independently as ACOs.

Medicare participating providers are eligible to participate in ACOs, but only primary care services delivered by primary care physicians will be used to align patients to ACOs.

As part of a coordinated interagency effort, CMS worked closely with the Federal Trade Commission and Department of Justice to ensure that newly-formed ACOs can participate in the program without being concerned if they run afoul of antitrust laws.

The antitrust policy statement, which was also displayed on the same date of the proposed rule outlines and solicits comments on proposed safe harbors related to the creation and operation of ACOs and applies to collaborations formed after March 23, 2010. And again, more information about this can be found off the Web site. I encourage you to review that and the other documents put out in conjunction with the proposed rule by the Internal Revenue Service and also our colleagues and Inspect General's Office around Stark, antitrust, and civil monetary penalty waiver provisions.

As I mentioned earlier, ACOs are provider-based, and we are made up of providers, and we expect providers to take an active role in their governance and leadership structure. We have proposed the ACOs be provider-driven and that 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.

The governing body must give the ACO participants proportionate and appropriate control over decision-making. While ACO participants may join with entities such as entrepreneurs or health plans, the ACO participants, that is Medicare-enrolled providers and suppliers, must retain 75 percent control over the governing body. The governing body must also include beneficiaries and involve community stakeholders in the governance and leadership of the organization as well.

We have proposed a critical integration criteria as part of the eligibility requirements for ACOs for the program, and these are aligned with criteria for clinical integration that have been put forth by the antitrust agencies as well as part of their policy statement.

And clinical integration is demonstrated by having an experienced executive team who focuses on quality improvement, clinical management by a local senior level of medical director and financial or human investment by providers in the performance and success of the ACO. The ACO must be working toward building a health IT structure as well that enables the collection and evaluation of data, and provides feedback to practitioners at the point of care. And we're proposing a 50 percent of primary care physicians be meaningful users in the EHR HITECH program by the beginning of the second year.

The proposed rule encourages proactive and person-centered care. Eligible organizations will also have mechanisms in place for routine self-assessments, internal monitoring and reporting for continuous improvement around promotion of evidence-based medicine, beneficiary engagement, coordination of care, population health, and addressing health disparities, as well as have mechanisms in place for reporting and monitoring internal quality and efficiency measures, including using those measures to – and the results from those measures to improve care at the point of care.

Additionally, ACOs will have a person-centered multi-strategy focus and continuous improvement around patient-centered activities. We've laid out a number of criteria for person-centered care. ACOs must have a beneficiary experience of care survey in place and use the results to improve over time,

and we'll talk a little bit about that later in the quality reporting the ACOs must do as part of the program.

The ACO must have patient involvement in the governing body as well that we've talked about previously. The ACO also must evaluate and address the needs of their population, including consideration of the diversity to take that into account in the delivery of care to the population they serve. ACOs must identify high-risk individual and offer individualized care plans to targeted populations as well that are, again, purely voluntary and at the request of the beneficiary.

The ACO must have a mechanism in place for coordinating care and have – or be working towards developing a system to electronically exchange information to facilitate beneficiary transitions from one care setting to another. The ACO must communicate clinical knowledge and choices for treatment based on evidence-based medicine in a way that it's understandable to beneficiaries.

The ACO must have written standards for beneficiary access to care, access to their medical records and written standards for beneficiary communications. And the ACO must have internal processes for measuring the clinical quality and performance of their providers and suppliers, and must use that information to improve care and services over time.

ACOs must accept accountability or must be willing to accept accountability for the population of Medicare fee-for-service patients that they see during the course of that three-year agreement with CMS. And it should be emphasized that unlike the managed care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see regardless of whether that practitioner participates in the ACO or not.

Because of this, when we refer to assignment, we are really talking about the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the standards necessary to receive an incentive payment and for improving the quality and efficiency of care delivered.

Beneficiary assignment is the basis for establishing and updating the financial benchmark, quality measurement, and performance, and the focus of the ACOs efforts to achieve the three-part aim – better population health, better care for individuals, and lower growth in Medicare expenditures.

Beneficiaries are assigned to the ACO retrospectively at the end of each of performance year based on the actual utilization of – on their actual utilization of care. Beneficiaries would be assigned to the ACO as the ACO providers delivered the plurality of primary care services to patients by primary care physicians where we are basically using primary care physicians to assign patients to the ACO at the end of each performance year. And we define primary care physicians as those, including internal medicine, general practice, family practice, and geriatric medicine.

As I mentioned, we're proposing retrospective assignment, which creates an incentive for ACOs to standardize their care processes across all their Medicare patients and even across all their patients – period. And also, we're providing – proposing to provide data sharing mechanisms that would help ACOs better understand their patient populations historically, as well as prospectively, and allow them to use that data and information to better redesign care processes.

We have proposed a two-track approach for ACOs. ACOs that are willing and to take on both the opportunity to share on savings as well as the potential to share on losses can choose to do a three-year agreement that would allow them to share both savings and losses, or they can elect another – a separate track that would allow them to share savings the first two years and then be performance-based risk for the third year of that agreement.

This two-track approach for ACOs provides greater rewards for those organizations that are willing to take performance-based risk out of the gate and encourages organizations – the ACOs to do that by providing higher opportunities for – and higher sharing rates for those organizations that elect to do that. It also provides an opportunity for those organizations that aren't ready or who are interested in gaining more experience with population health

to choose a track that might – is more appropriate for them by allowing them to only share on savings that might be generated, not holding them accountable for performance-based risk until the third year of the agreement.

As I mentioned earlier, ACOs would be held accountable for the population of patients that's assigned to them at the end of each performance year. An ACO would be able to share on savings if the actual assigned patient population expenditures are below the benchmark for each ACO, and if the savings exceeded a minimum savings rate and they need the quality performance standards. They would be eligible to share up to 65 percent of savings under the two-sided model and up to 52-1/2 percent under the one-sided model.

In addition, under the two-sided model, the ACOs would be able to share on savings on a first-dollar coverage basis as is under the one-sided model, they were to share on savings net of two percent savings threshold.

We've proposed an aggressive quality measurement and reporting methodology as part of the proposed rule. ACOs will be measured on quality and up to – in five domains that span up to 65 measures. The domains – the quality measurement reporting strategy is consistent with the three-part aim and focusing on better care and better health for populations. The five domains cover areas and measures that are conditions that are highly prevalent in the Medicare population or target measures, target areas for the agency or – and department, or represent areas of high cost as well.

The five domains focus on preventive care, at-risk and frail elderly populations, and this is where you'll find a lot of measures focusing on chronic conditions for patients in the Medicare population – diabetes, heart failure, coronary artery disease, hypertension, COPD.

Patient and caregiver experience. We're proposing to use a clinician in Group CAHPS survey instrument to assess patient experience of care by the ACOs in a number of areas.

Care coordination, including looking at how well ACOs manage, handle, and coordinate transitions in care, and ambulatory – including ambulatory care

sensitive conditions that provide opportunities for ACOs that effectively manage chronic conditions in ambulatory settings to, you know, provide better opportunities for patients and to keep people in an ambulatory setting, and then patient safety measures as well that focus on inpatient settings. These measures encompass a range of process outcome and survey-based measures.

We also propose to align these measures with measures reported under the physician quality reporting system now as well as in the EHR incentive program under HITECH to both be sensitive to provider burden but also to align the program with incentive under those programs. So providers participating in ACO and reporting measures through the ACO would be eligible to earn their PQRS incentive payments as a result of that.

And as I mentioned earlier, we are encouraging providers to participate in EHR incentive program as well by setting the standards that ACOs have to have 50 percent of their primary care physicians participating in the second year. We think that it provides important opportunities for – to reduce administrative burden, and also align incentive structures and provide cash flow and capital for smaller ACOs to put tools necessary in place for a better population health management as well.

Basically, under the program, any shared savings that ACO generates would be dependent on their quality performance so the higher an ACO performs on these quality measures, the more of that savings they could . Conversely under the two-sided track. If in the event that an ACO incurs losses under that and as the share on losses with Medicare, those losses could be reduced depending on how well it performs on quality, so high performance on quality measures is incented under the program in a very strong way.

Beneficiary involvement is an important part of the ACO program, and I'd like to reinforce that beneficiaries continue to be able to see any provider they choose even if that provider is not a member of the ACO. We are proposing that beneficiaries be informed that their provider is participating in an ACO at the point of care, meaning they are told what it means for their care and provided an opportunity to decline to have their claims data shared with the ACO.

We're also proposing that one of the – as a result of stakeholder input that we've heard that, you know, while providers have a good understanding of what's happening to patients within their practice, they don't necessarily know all of the care that they're receiving outside their organization, which can present real challenges and coordinating care and producing good outcomes.

So in order to help fill that gap and to promote proactively the coordination of care by ACOs, we're proposing to share data, but we also wanted to ensure that beneficiaries were made aware that their providers might be receiving from Medicare claims data on their patient – on their experience – their claims experience outside the ACO. And so we're asking the ACOs – to notify them that the providers are participating in an ACO and what it means for their care, but also that they may receive data and provide an opportunity for beneficiaries to decline to have their data shared.

In addition, we propose that part of the NPRM, a process for review of communications and marketing materials, including providing proposals to provide standardized communication materials to ACOs that they can use with their patients as well as a process for reviewing non-standardized materials as well. And again, this is sort of modeled – akin to some of policies and procedures, and so forth that we've used in other parts of this in the Medicare program when communicating with the beneficiaries.

As I mentioned earlier, part of promoting better coordinated care, we're proposing that ACOs could receive upon their request and confirmation that beneficiaries have not declined to have their data share Parts A, B, and – a subset of Parts A, B, and Part D data that they could use it to more proactively monitor and track patients.

In addition, the statute talks about monitoring ACOs for the avoidance of at-risk patients, and this is something that we take very seriously. And we propose a process for monitoring program and aggressive monitoring program for monitoring ACOs to ensure that they aren't avoiding beneficiaries with complex medical conditions or chronic conditions as well.

Patients – ACOs that are found to be avoiding at-risk beneficiaries as a ground for termination, and also ACOs that fail to meet the quality performance standard are also at risk of termination as well.

So with that I'll end and I'll turn it back to you, Barb, for questions.

Barbara Cebuhar: Great. Thanks very much, John. And that was John Pilotte, Acting Director, Performance-Based Payment Policy Staff in the Center for Medicare.

(Stephanie), if you could instruct people how to offer comments or ask questions, I would really appreciate it. Thank you.

Operator: Certainly. At this time, if you would like to make a comment or ask a question, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the question-and-answer and comment offer.

Your first question comes from the line of Trisha Nemore from Center for Medicare Advocacy. Your line is open.

Trish Nemore: Thank you. I was briefly cut off from the call at the beginning. And I know that Barb gave two websites where you're having a lot of information, one ended with shared savings, and I'm not sure what the other one was. I was wondering if you could either give those URLs again or...

Barbara Cebuhar: I'm happy to.

Trish Nemore: ...send them out to us. And also, is there a place that we can go with questions as we are reading the proposed rule and trying to formulate our comments?

Barbara Cebuhar: Trish, the place where you can go and get most of your information is <http://www.cms.gov/sharedsavingsprogram>. And I think that Jon, do you have a preference but I think that you'll take questions through the [www.regulations.gov](http://www.regulations.gov), right?

John Pilotte: Well, if you have formal comments, you need to submit them through [www.regulations.gov](http://www.regulations.gov), as Barb mentioned. If you have questions, you can actually – there's a phone number that's published in the Federal Register.

Trish Nemore: OK, just use – I have the Federal Register thing. So just...

John Pilotte: OK.

Trish Nemore: ...if there's Terri Postma.

John Pilotte: Yes, and it's 410-786-8084. You can leave your message there or you can also submit it to us via the ACO mailbox, which is on that voicemail as well.

Trish Nemore: OK. Thank you.

Barbara Cebuhar: Thank you, Trish.

Our next question please, (Stephanie)?

Operator: Your next question comes from the line of (Michelle Giddy) from Families USA. Your line is open.

(Michelle Giddy): Hi. I have two questions. One – the first one is with respect to the ACOs that come in as the one-sided to the shared savings only who would, after the two years and the three-year contract – as I read it, and I could be misunderstanding would automatically be converted to the two-sided at-risk model. So first, is that correct? And if it is, are you going to build any evaluation to confirm that the ACO is, in fact, ready to go to the two-sided model?

John Pilotte: Yes, thank you for the question. Yes, that is correct. The ACOs would be automatically transitioned to third year by agreement under – to the two-sided model. ACOs would have to demonstrate as part of their application process, which – if they need all of the program eligibility requirements and have all the necessary processes in place before they would be allowed to start either three-year agreement, and that includes, you know, demonstrating that they have the ability to, you know, coordinate care, report quality measures, you

know, the patient-centeredness criteria, report on patient experience of care, and all of the – and the other provisions that are laid out in there. And those would be uniform regardless of what track you elect.

So, you know, all ACOs would have to meet those standards, including – and report on quality regardless of which track they're in. So we think we set a high bar for organizations to meet. We think that that's consistent with the two-sided approach. And, you know, we're basically providing an on-ramp for those organizations that they may not be ready initially, but to quickly ramp up to be able to move to a two-sided track.

(Michelle Giddy): So they need to demonstrate as part of their application that they can actually achieve the ability to be two sided within than two-year period?

John Pilotte: Correct.

(Michelle Giddy): OK. And my second question is with respect to notice, I know that you – you know, it's in the rule and you've said that it would happen at the point of service, and when a patient shows up, we're a little concerned about that and so I wanted to find out what barriers you see to practices providing notices prior to that. So once they know that they're an ACO doing a mailing to their beneficiaries, as opposed to – the patient shows up for their annual physical and they're told at that time.

John Pilotte: Yes, I mean. I think we – you know, we have proposed a number of mechanisms through notification and signage, and so forth. And we would definitely welcome comments on those approaches and so forth, and I would encourage you to submit that proposal that you've outlined as well through the formal counter process for consideration as well.

(Michelle Giddy): OK. Thank you.

Barbara Cebuhar: Thank you, (Michelle).

Our next question please, (Stephanie)?

Operator: Your next question comes from the line of (Gail McGinn) from PHI. Your line is open.

(Gail McGinn): Hi. Thank you so much for providing this information. My question is with regard to potential participation by long-term organizations. I wonder if you could share your thinking on that.

John Pilotte: Yes, thank you for the question. All Medicare-enrolled providers are eligible to participate in an ACO. ACO participants could be any Medicare-enrolled provider – A or B providers. So, you know, long-term care facilities, skilled nursing facilities could participate at an ACO.

However the – per the statute, it talks about aligning patients based on utilization of primary care services. So – and we would only use those primary care providers to align patients to the ACOs for purposes of determining eligibility, measuring quality and financial performance for the organization. But we would expect that ACOs would involve providers along the continuum of care because I think coordination with both Part A and Part B services is one of – and Part A and Part B providers is one of the primary objectives of the program. So I think it will be important to – for ACOs to have those processes and mechanism in place to coordinate with all Medicare providers with their patients – align patients in A, B, and D.

Barbara Cebuhar: Thank you for your question, (Gail).

Our next question please, (Stephanie)?

Operator: Your next question comes from the line of (Diane James) from Prince George's County Area Agency on Aging. Your line is open.

(Diane James): Thank you. My question is with regards to coordination of care. With Medicare beneficiaries who go to the VA for care, how is that going to work smoothly for those individuals if (at all)?

John Pilotte: Yes. Thank you for the question. Yes, I mean, ACOs would be encouraged to coordinate with all providers that are touching their patients for which they're held accountable with.

So if an ACO – if a patient is using primary care, physicians within an ACO but is getting specialty care and so forth from a VA facility, we'd expect the ACO would have incentives to sort of coordinate with those – with those providers regardless.

Barbara Cebuhar: Thank you, Ms. (James).

Could we get our next question please, (Stephanie)?

Operator: Your next question comes from the line of Kevin Lewis from Maine Primary Care Association. Your line is open.

Kevin Lewis: Yes, thanks so much for this opportunity. I wanted to ask you briefly about the fee-for-service component structure of the ACO. One of the things we're aware of is the need for community assets and things that aren't currently paid for under fee-for-service to really move the dial and make the ACO successful.

And yet, the shared savings and the revenues available to invest those types of tools would come later. And so wondering if there's any possibility that upfront investments more – ala managed care or a PMPM approach might be possible.

John Pilotte: And thank you for the question, and that's something that we have heard from various stakeholders.

I think providers would continue to be paid. ACO providers would continue to be paid under normal Medicare fee-for-service payment methodologies and rules and so forth. And, you know, but to the extent that they invest and redesign processes and coordination services and so forth, and that leads to savings for the program, then they could have an opportunity to share on that. There would be no upfront payments for those additional services, however, under the program.

What we have a proposed though for small - recognizing this issue is one of the reasons why we brought in and aligned the quality reporting structure with

Physician Quality Reporting System so providers could earn incentive payments under that program by virtue of reporting quality measures under the Shared Savings Program.

We've also aligned it with EHR meaningful youth program as well to provide some – provide additional incentives and align with those incentives to provide a revenue stream for those ACOs, particularly smaller ACOs.

In addition, there's a number of sort of design features in the program to address smaller ACOs, particularly incenting the minimum savings requirement relative to larger ACOs. Smaller ACOs would have – we utilize a lower confidence interval to set the minimum savings rate so that would bring down the minimum savings level necessary relative to larger organizations to be able to share on savings.

And then we've also allowed our proposed that under the one-sided model the ACOs with less than 10,000 patients that may be – and who are either physician only or rural, or involve safety net providers would be exempt from that savings threshold. But just to sort of repeat, we're not proposing any upfront payments, however, and ACO providers will continue to be paid under normal Medicare fee-for-service payment rules.

Barbara Cebuhar: Thank you, Mr. Lewis.

Our next question please, (Stephanie)?

Operator: Your next question comes from the line of Jenifer Simpson from AAPD. Your line is open.

Jenifer Simpson: Thank you. My question is in regard to the governors' board. We're not quite sure what the vision is here for involvement of the beneficiary and with the (inaudible) or – could you just explain a little bit further what that vision is and the purpose for doing that?

John Pilotte: I'm sorry. If I understood that – if I heard the question, you're cutting out a little bit. But the question was sort of what roles are beneficiaries expected to play in the governance structure of ACOs and sort of why is it there.

We feel that it's very important that ACOs not only reflect the providers that they represent but also bring in patient experience into their governance and leadership structures and so forth. And we proposed, including Medicare patients, beneficiaries on the board, but we also recognize there are some issues around state law and so forth that might preclude that.

And we've – also we've proposed alternative ways as well. The ACOs could meet that and, you know, we certainly welcome comment on this as well. We think it's important that ACOs not only reflect the providers that they represent but they involve the patients that they serve and get their perspectives in it as well as the community that – the broader communities that they serve as well. And that's why we've proposed to incorporate not only a beneficiary experience into the governance and leadership structure but also the community stakeholders as well that they – you know, serve.

So we welcome your thoughts and comments on those areas. It's an area we have provided some – proposed some flexibility around as well, and I would encourage you to submit formal comments on that.

Barbara Cebuhar: Thank you, Ms. Simpson.

Our next comment please.

Operator: Your next comment or question comes from the line of Jonathan Peck from the Institute for Alternative Future. Your line is open.

Jonathan Peck: Thank you. I want to follow up on that last question. Is there any means to assure that the consumer or patient or beneficiary voice is actually heard and we don't have the experience where that voice is marginalized?

John Pilotte: Yes. I mean, we would expect that – you know, that the ACO as part of its application process would tell us how it represents the patients, and beneficiaries, and community stakeholders. It involves them in its governance, and their leadership structure is one of the things that will be evaluated on.

We would also then be looking at also, you know, how they – as one of the patient-centeredness criteria, how they incorporate patient experience of care, not only how they measure but how they incorporate those findings and results into their organizational structure and how they use that to improve their overall quality and effectiveness of care they delivered to patients.

So I think it's – you know, I think there are a number of areas in addition to sort of the beneficiary involvement in the governance and leadership structure that reinforces the importance of ensuring – and ensuring the beneficiaries' experience and voices are taken into account and considered throughout the organization.

Thank you very much for the question.

Barbara Cebuhar: Thank you, Mr. Peck.

Our next question please.

Operator: Again, if you would like to ask a question or make a comment, please press star then the number one on your telephone keypad.

Your next comment or question – Jonathan Peck from the Institute for Alternative Future has a follow-up question. Your line is open.

Jonathan Peck: Thank you again. This is a different matter. What is the expectation CMS has in terms of the timing of reports from these each year and how that might affect the expansion of this payment means beyond the limited Medicare population it's already planning for.

John Pilotte: Yes, thanks for this follow-up question. First, in terms – a little bit about reporting, I mean, it's a good point that we don't really talk much about.

You know, we've proposed a couple of different mechanisms to provide ACOs with feedback during the course of their agreement. One is to provide them with quarterly reports that would encompass, you know, both expenditure utilization data that can be gleaned from claims data for patients that could potentially be aligned to their organizations throughout the

agreement period. So they could, you know, use that information to sort of monitor how they're doing and use it to be more proactive in terms of coordinating services for the patient population that they're serving.

The other is part of the annual reconciliation process is the ACOs would receive a feedback report on both the quality results from data that they both submit to us. A number of the measures we lay out required clinical information. The ACOs would be required to submit to us, and we're looking at leveraging the quality reporting platform and Physician Quality Reporting System that allows us to collect clinical information to provide, you know, more meaningful and sort of intermediate outcome measures on patients and calculate those results for ACOs.

We would incorporate the patient experience. And then there's a number of sort of outcome-based measures that we can calculate from claims that we would have measured them on as well. So they would get feedback from that on an annual basis. And then those results would also then, as I mentioned earlier, be incorporated into how much shared savings that they might earn or be used in offsetting potential shared losses that they might be on the hook for.

So that annual reconciliation process would occur probably if – and the ACO would get feedback probably around nine months after the end of the performance year.

The biggest factor in that is that we proposed a six-month claims run-out in order to provide the fullest amount of actual claims experience that we can get for an ACO in order to reconcile its financial performance. So, you know, that's sort of the methodology and feedback mechanism we're proposing to provide ACO both sort of on a quarterly basis throughout the agreement period but also the reconciliation process.

And I would – you know, we very much see this program as, you know, the beginning and plan on, you know, refining it and addressing a potential expansion as well to the annual rulemaking process that we would be putting forth as well. So I think that we'll sort of wait. You know, that's our

anticipation. We'll sort of wait and sort of see what the future holds, but we very much plan on and see this as a vehicle that we would continually address in the triennial rulemaking.

Barbara Cebuhar: Thank you, Mr. Peck.

Our next question please, (Stephanie)?

Operator: Your next question comes from the line of (Mela Williams) from Patient Advocate Foundation. Your line is open.

(Mela Williams) from Patient Advocate Foundation, your line is open.

Barbara Cebuhar: You might be on mute.

Do we have another question, (Stephanie)?

Operator: Yes, your next question comes from the line of Jenifer Simpson from AAPD. Your line is open.

Jenifer Simpson: Thank you. This is follow-up to the last answer that I heard in regard to the reconciliation and the feedback on an annual basis. Will that information be publicly available? And if so, how so?

John Pilotte: Thanks for the question. We have proposed a number of information variables or sort of a list of information that we would require ACOs to publicly report that would encompass both sort of organization – information about their organizational structure and so forth as well as whether they have shared on savings under the program as well.

Barbara Cebuhar: Thank you, Ms. Simpson.

Do we have another question, (Stephanie)?

Operator: Your next question comes from the line of Trish Nemore from Center for Medicare Advocacy. Your line is open.

Trish Nemore: Hi. Thank you again. In the definition section, I guess, in the rule, there is a term ACO participants and then there is a term ACO providers and suppliers. And I wasn't clear from reading it exactly what the difference is between those two – in those two terms and what you anticipate, you know, why those distinctions have been made.

John Pilotte: You know, that's a good question. Thank you very much.

ACO participants would be, in essence, that sort of – that sort of legal organizations that represents the individual ACO providers and suppliers. So if we think of it as sort of a physician practice, the ACO participants would be the physician practices or the hospital that employs physicians. It would be the – at the organizational level. And then the providers and suppliers would be – the ACO providers and suppliers would be the individual providers and suppliers that make up the organization, so the individual physicians – MDs, PAs, and other providers. That's the distinction.

So when we align patients with the ACO, we're looking at aligning them at the ACO participant level.

Barbara Cebuhar: Thank you, (Trish).

Do we have another question? We have time for one more.

Operator: Your next question comes from the line of (Joe Lyons) from Orion Advisors. Your line is open.

(Joe Lyons): Thank you. Thanks for giving us this opportunity. I'm about a quarter of the way through reading the proposed rule and wondered if they keep going and going to see any financial modeling for this – you know, the basic set of assumptions. Is there anything in the proposed rule, or is there anywhere else we can go to start looking at what the financials look like, particularly given the rather significant outlay that's going to be required for ACOs to get these things up and running.

John Pilotte: You're almost there. If you keep reading, it's in the back. It's in the Regulatory Impact Analysis...

(Joe Lyons): Right. OK.

John Pilotte: ...that lays out the – our projections for the impact on patients, providers in the program. And there's a number of areas that – you know, that are highlighted in there. And again, we welcome your thoughts and comments on those as well through the formal comment submission process.

(Joe Lyons): OK. Thank you. It's helpful.

Barbara Cebuhar: Thank you very much, everyone. We are very grateful for your participation today. I want to make sure that I reiterate the importance of your feedback.

We are – if you know someone that was unable to join the call, let me give you the Encore number that will be available by about six o'clock tonight. It's 1-800-642-1687, and the call – caller ID or the call – the meeting ID is 56392847.

We are accepting comments up until Monday, June the 6th. So if you could, by close the business that day, get your documents up to us electronically via regulations.gov, by regular mail, by express or overnight mail, or by hand or courier, and all that information is in your invitation. We are very grateful for your time today and look forward to your comments. Thank you.

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

END