CENTERS FOR MEDICARE AND MEDICAID SERVICES

Moderator: Natalie Highsmith
Conference Leader: Jim Coan
October 28, 2008
2:00 pm ET

Operator: Good afternoon. My name is (Jessica) 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 Special Open Door Forum, Medicare Medical Home Demonstration.

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.

Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, (Jessica), and good day to everyone and thank you for joining us for this Special Open Door Forum on the Medicare Medical Home Demonstrations.

This Special Open Door is to inform physician practices and physicians about the design of the Medicare Medical Home Demonstration project.

CMS staff will describe the definition of a Medicare medical home, the goals of the demonstration, practice eligibility, and beneficiary eligibility requirements.

This Medicare Medical Home Demonstration is authorized by Section 204 of the Tax Relief and Health Care Act, also known as TRHCA, of 2006.

This is a three-year demonstration, which will begin by soliciting physician practices, (FQHC)s, and CHCs to enroll beginning in January 2009.

Background material has been posted on the demonstration web page if you go to our cms.hhs.gov, the main page, you can do a search for Medicare Medical -- tongue-tied in trying to say that -- Medicare Medical Home Demonstration. And you will be able to locate the slide presentation for today, design reports, along with other information.

I will now turn the call over to Herb Kuhn, who is our Deputy Director.

Herb Kuhn: Thank you very much, Natalie. And I, too, want to extend my warm welcome to everyone who's on the phone for participating in today's Special Open Door Forum on the Medicare Medical Home Demonstration. It goes without saying that CMS is committed to continuing to explore innovative ways to deliver the highest quality care to Medicare beneficiaries in the most cost-effective way. And I think that can also be said for everyone who is on this call with us today.

The Medicare Medical Home Demonstration is one of the more promising coordinated care disease management innovations. And we're pleased to have this opportunity today to provide the physician community information about

the background of the demonstration, design details, and importantly, the projected timetable for this demonstration.

But before we get into that discussion, let me step back and take an opportunity to thank the many associations and societies, as well as the individual practitioners, for their valuable input in helping to inform the development of this demonstration.

The bottom line is here we could not have done this without all of you. And you have all been absolutely terrific in helping us get to the stage where we are today.

And I don't want to leave anybody out, but I do want to kind of highlight a couple of professional organizations that have been so extraordinarily helpful to us. And that includes the American Academy of Family Practitioners, the American College of Physicians, the American Medical Association, and especially the Relative Value Scale Update Committee, the American Board of Internal Medicine, and finally, the American Geriatric Society.

Again, all of you have been absolutely helpful, very helpful to CMS in the development of this particular demonstration.

Also I would say - like to say that we are very pleased that the National Committee for Quality Assurance, NCQA, has agreed to conduct the qualification process for us. NCQA has provided recognition for medical home pilots in the private sector and their involvement in the Medicare demonstration will ensure consistency in Medicare and private sector medical home initiatives.

Again, having that synched up with the private sector is going to be so important for this as we go forward.

So, again, we appreciate everybody joining us today. We got a count before we started on this call. There are many, many individuals on this call, so we thank you for joining us today.

And we look forward to working with all of you throughout the development - the continued development and ultimately the implementation of this very important demonstration.

So with that, Natalie, I'll turn the call back to you.

Natalie Highsmith: Thank you, Herb. And I apologize, I called you our Deputy Director, not our Deputy Administrator.

Now I will turn the call over to James Coan, who is our Project Officer for the Medical Home Demonstration.

James Coan: Thank you, Natalie. And welcome, everyone, again.

We have with us today Dr. Myles Maxfield of Mathematica Policy Research to present the Medicare Medical Home Demonstration design. Over the past year, Mathematica under contract to CMS has assisted in the development of the demonstration design. So I would direct all of you to the slides that we posted on our web site. Hopefully you have downloaded them and are looking at them. And I will gladly turn the presentation over to Dr. Maxfield.

Dr. Maxfield: Okay, good afternoon. First I'd like to thank CMS for the opportunity to share the design of the Medicare Medical Home Demonstration with you.

I'm going to be going through the slides that were available on the demonstration web site. The announcement of this forum contains the link to those slides.

Since most of you are dialing in, I will do my best to call out the slide numbers as I go. And as Natalie said, we'll take questions at the end.

So Slide 2 indicates that the design was the product of a collaboration of many organization and many individuals, chief among them is the Office of Research, Development, and Information at CMS, and its contractors, Mathematica, which I represent, the Center for Studying Health System Change, and NCQA.

The team included as shown on the slide many individuals, and I won't go through each of them. I will note that Jim Coan is the ORDI Project Officer for the entire effort.

On Slide 3, we list the (unintelligible) important motivations for doing this demonstration and an important context here that is that the design is not completely final at this stage and is subject to the review of leadership at CMS, HHS, and OMB. That final review has not happened.

The point here is that the - there's some aspects of the design of the demonstration that may be subject to change.

Slide 4 is what motivated the demonstration. The demonstration is designed to address the triple issues of the currently unsustainable rates of increase in Medicare costs, the recognition that the quality of some healthcare delivered to Medicare beneficiaries is not quite up to par, and third, that the healthcare

of many Medicare beneficiaries is fragmented and delivered in a perhaps inefficient manner.

Slide 5 indicates the statutory basis for the demonstration. It's actually authorized in two statutes, the Tax Relief and Health Care Act of 2006, Section 204, and as well the Medicare Improvements for Patients and Providers Act of 2008, Section 133.

Slide 6 indicates that the goals of the demonstration really mirror the motivations for having it in the first place. We designed the demonstration to improve the way in which healthcare of Medicare beneficiaries is managed, to improve the quality of healthcare received by beneficiaries, to improve the satisfaction of both patients and providers, and last but not least to reduce the cost of that care.

Slide 7 indicates just a little bit of the process that we went through in producing this design. First and importantly, we consulted with several of the key provider societies that were instrumental in developing the medical home model. These included the American College of Physicians, the American Academy of Family Physicians, and the American Geriatric Society.

Second, as required by the authorizing legislation, we asked the Relative Value Sale Update Committee, which I will call RUC, the RUC, to estimate the work relative value units for providing medical home services, the office expenses, and the insurance costs associated with those - providing those services.

Our - let me just mention at this point that our design report may be downloaded from the web site that you have the link to.

In addition to the design report, you can also download the tool that will be used to document the - a practice's capability to provide these services. This tool is a version of NCQA's Physician Practice Connection patient standard medical home instrument, which we specifically tailored to the needs of this demonstration.

Slide 8 gets to the core of the demonstration by answering the question how will you know a medical home when you see one? To design an operational demonstration, which was our mandate, we adopted an operational definition of medical homes, namely a practice is a medical home if it scores on the CMS version of the PPC instruction, has scores that exceed the thresholds set out in the documentation that you can download from the web site.

Each applying practice will be scored in several domains, including continuity of care, clinical information systems, delivery system design, decision support, systems for the support of patient and family engagement, coordination of care across provider settings, and access to care.

Again, the detailed definitions of each of these domains can be downloaded - it can be found in the material you can download.

Moving to Slide 9, in order to make participation in the demonstration feasible for more practices, the demonstration will have two tiers of medical homes, a basic and an advanced tier.

The two tiers will be mirrored by two care management fees. A basic fee goes with the basic tier. A full fee goes with the advanced tier. And, again, the detailed definition of each of these tiers can be seen in Table 2 of the design report.

Slide 10 presents several highlights of the Tier 1 requirements. A basic medical home will discuss - will have the ability and will provide the following services. It will the role of medical homes with their patients. It will establish written standards for patient access to care. It will use data to identify and track patients. It will use an integrated care plan for medical home patients. It will provide education and support to medical home patients. And it will track medical tests and referrals.

Slide 11 summarizes the key requirements to be qualified as a Tier 2 medical home or an advanced medical home.

The requirements begin with all of the requirements for Tier 1. In addition to these, a practice will need to use a certified electronic medical record, have a systematic approach to coordinating the patient's care with hospitals, outpatient facilities, and other facilities, review the medications list of patients discharged from an inpatient stay.

And finally in recognition of the fact that there are multiple ways of becoming a medical home, the practice can select three out of a list of nine capabilities beyond those that I've already mentioned. Examples of these optional capabilities include using an electronic prescribing system, collecting performance data, and using performance metrics.

Slide 12 is just a reminder, a quick reminder of where you can get all of this material.

Moving to Slide 13, we recognize that some practices that quality at the beginning of the demonstration as Tier 1 or a basic medical home may want to become an advanced medical home during the demonstration.

Such practices would submit the material to be qualified as - at the higher level of medical home by - with the following process.

First, they'd retrieve their original PPC that they submitted at the beginning of the demonstration and edit it, edit it by adding whatever additional advanced medical home capabilities they've developed.

Secondly, they'd go through the same process with the documentation that goes along with the completed PPC tool. This documentation, you pull out the documentation that was submitted at the beginning of the demonstration and augment it by the additional documentation required to demonstrate that you've got the advanced capabilities. And then both of these would be submitted to the implementation contractor.

There are two time windows for submitting this material to move from a basic to an advanced medical home. The first window is in October and November of 2010. The second one - the second window is the same two months in the following year, 2011.

Once the practice is qualified as a Tier 2 medical home, it will start receiving Tier 2 care management fees.

Slide 14 outlines the eligibility requirements for physicians to participate in the demonstration.

As specified in the Tax Relief and Health Care Act, to be eligible for a - for the demonstration, a physician must be board certified, a board-certified MD or DO. Having said this, practices of all size are eligible, as are federally qualified health centers.

The other requirement in the Tax Relief and Health Care Act is the physicians must be able to manage a patient's care in a comprehensive way. In terms of specialty, this translates into general internists, family practice physicians, geriatricians, and most other specialists being eligible.

Physicians specializing in radiology, pathology, anesthesiology, dermatology, ophthalmology, emergency medicine, chiropractors, psychiatrists, psychiatry, and surgery are not eligible for the demonstration.

Turning from physicians to practices in Slide 15, to be eligible for the demonstration, a practice has to have the capability of providing medical home services. In a formal sense, this means getting a high score on the required domains in the PPC tool.

In a more qualitative sense, a practice must be able to verse the development and implementation of a comprehensive care plan that cuts across care settings, use evidence-based medicine and decision support tools, use health information technology to monitor and track the health status of patients, and encourage patients to manage their own medical conditions.

Okay, moving to Slide 16, we move to the patient, how does the patient become eligible?

A patient has to be a beneficiary in fee-for-service Medicare, must have one or more chronic conditions -- and I will say as an aside that the list of chronic conditions are also available on the web site -- and must be covered by both Part A and Part B at the time of enrollment.

A patient is not eligible if he or she is in a Medicare Advantage plan, is in hospice, in a long-term nursing home, receiving treatment for end-stage renal disease, or last participating in any other Medicare demonstration.

Turning to Slide 17, the demonstration will operate in eight sites. A site will be - either be an entire state or part of a state. I will say at this point, CMS has not selected the sites, but the - we anticipate that the sites will include urban sites, rural sites, and medically underserved areas.

Roughly speaking, the demonstration will include about 400 practices containing roughly 2000 physicians and roughly 400,000 beneficiaries. These figures, just to be clear, refer to the entire demonstration and not for each site.

Slide 18 gives you the demonstration timeline. We anticipate OMB will approve the - and clear the demonstration in - by December. CMS plans to announce the sites at that time.

Recruitment of practices will begin in January of '09. And applications will be accepted from January through March of that year.

From April through November, the implementation contractor will review the applications and notify practices that they should go ahead and complete the PPC tool and submit the associated documentation.

From May through December, the implementation contractor will notify applicants whether they are qualified and were selected for the demonstration.

Starting in April of 2009, the Lipitz Center for Integrated Health Care at the Johns Hopkins University will technical assistance to practices on how best to implement medical home capabilities.

The bona fide operations of the demonstration will begin in January of 2010 and will end in December of 2012. The evaluation of the demonstration will continue for one year after that.

Slide 19 lists the details of how a practice applies and becomes qualified. The first step is to fill out a very brief application form. The next step is to fill out the CMS version of the PPC tool and assemble the required documentation of the medical home capabilities that the practice has.

This step of filling out the PPC tool and assembling the documentation based on experience may take between 60 and 80 hours of time to complete.

The implementation contractor then reviews the application, the PPC, and the supporting documentation and notifies the practice whether it's qualified as a medical home and selected for the demonstration.

And when I say selected from the demonstration, what I mean is if in - if the - a demonstration is oversubscribed, the implementation contractor will select from among the qualified applicants.

CMS is as you saw from the schedule on the previous slide, CMS is allowing several months for these processes, but encourages practices to submit their materials as soon as they can.

Once a practice is qualified and selected to participate, it can begin enrolling patients as shown on Slide 20.

Patient enrollment can continue through December 2011. We feel that the key to patient enrollment is a written medical home agreement between the patient and the physicians. This agreement serves several purposes.

First, it documents the active, informed consent by the patient to participate in the demonstration. Second, it ensures that both the patient and the physician recognize and understand their responsibilities and obligations under the medical home. Third, it documents the continued enrollment of the patient.

Now this last third point refers to the fact that physicians will need to submit an enrollment renewal form for each patient for each year of the demonstration.

Care management payments will begin for each enrolled patient on January - in January 2010 and patients will continue for -eligible to enroll patients through December 2012.

Okay.

Slide 21 summarizes what we feel the benefits are to practices of participating in the demonstration. These include both financial and non-financial factors.

Financial factors include both the care management fee, as well as a share in savings payment, which I'll talk about in just a second.

The non-financial factors include the professional satisfaction of providing higher quality healthcare, as well as improved day-to-day workflow within the practice.

So let me drill down on the details of the financial factors beginning on Slide 22.

Now as we've mentioned, this process of setting the care management fee began by asking the RUC to estimate the work relative value units, the practice expenses, and the insurance costs associated for - with providing medical home services.

The RUC took great care not - to only include those activities that are not already reimbursed by Medicare.

The next step after that is that CMS converted the RVUs into a fee. They then adjusted the fee to reflect the fact that patients with high disease burden will require more costly medical home services. I call this risk-adjusting the fee.

Disease burden is measured by the patient's hierarchical condition category or HCC score.

Slide 23 actually shows what the fees are. The rows in the table represent the two medical home tiers. The RUC's medical home RVUs translate directly into the figures in the right-hand column labeled "Blended Rate."

CMS then did a - applied a risk-adjustment algorithm, as I just mentioned, to the blended rate to produce rates in the - in columns for patients with low HCC scores and for the column for patients who have high HCC scores. And let me just illustrate how to use the table.

For example, a participating Tier 1 practice would receive $27.12 per month for a patient whose HCC score is lower than 1.6. As a second example, a

participating Tier 2 practice would receive $100.35 per month for a patient whose HCC score is greater than or equal to 1.6.

So let me move on in Slide 24 to the share and savings payment. And let me begin this by defining what we mean by savings.

What we mean is the decrease in total Part A and Part B Medicare costs of enrolled payments over the entire period of the demonstration.

We're going to measure the decrease by comparing enrolled patients to patients in a comparison group. The comparison group patients will not be in medical homes.

It's important to remember that the total cost of the enrolled patient group includes the cumulative care management fees that CMS pays to the practices, participating practices. So that's what we mean by savings.

Now the - let's go through the share and savings part of this. The first 2% of the savings will not be shared. However, 80% of the savings above that floor will be shared with participating practices. These shared savings will be allocated among participating practices in proportion to the number of months, member months of their enrolled patients.

So all of that was pretty technical. Let me move on in Slide 25 to list sources of information on the process and the requirements for becoming qualified for the demonstration.

The source that's available now to the public is the demonstration web site. CMS will continue to update that web site and put more material on there. The

remaining sources listed in Slide 25 will be made available to practices in the demonstration sites.

In Slide 26, continuing on the source - the theme of the sources of help here and recognizing that becoming a medical home for many practices is not an easy thing to do, the - what we listed here are sources, potential sources of technical assistance for achieving that status of medical home.

And I would say the one I'd begin with is that - the John A. Hartford Foundation has funded the Lipitz Center for Integrated Health Care at Hopkins to provide technical assistance specifically to practices applying or participating in the demonstration.

Other organizations to contact include the American Association of Family Physicians, the American College of Physicians, and the American Osteopathy Association, and TransforMed.

Okay, let's move on to Slides 27 and 28, where we acknowledge that patients, even enrolled patients in medical homes, are going to go through many types of transitions during the demonstration period. So we have to figure out what we're going to do when each of these transitions occurs.

Slide 27 lists the types of transitions that would result in the patient becoming ineligible for continued enrollment. These include a patient that - who does not sign the annual enrollment form or otherwise actively disenrolls from the demonstration; secondly, patients who move away from the demonstration; third, lose - patients who lose Part A or Part B coverage; or patients who enroll in an MA plan; fifth, patients who change from on practice to another and where the new practice is not participating in the demonstration; and last, patients who pass away during the demonstration.

And just to be obvious about it, the care management fee will stop at the time the patient becomes ineligible. However, I would mention that it will be possible for patients who become newly eligible again to re-enroll.

So moving on to Slide 28, this lists the rules of - regarding patient transitions that would result in continued eligibility. So this - these transitions can happen without damaging continued enrollment and eligibility.

These include changing from one medical home to another that's participating in the demonstration, patients receiving home healthcare, patients entering a nursing home on the assumption that the medical home physician continues to provide care, and lastly patients that begin receiving hospice care.

Slide 29 reminds us that the demonstration will be evaluated. The evaluation contractor will select a comparison group of non-medical home practices and patients.

The impacts of the demonstration will be measured by comparing demonstration practices and patients to the comparison group. The evaluation contractor will measure the impact of providing medical home services on costs and utilization, quality of care and health outcomes, quality of care and health outcomes, patients' experience of care, practice workflow, costs to the practice, and the satisfaction of the participating physicians.

And the final slide, Slide 30, indicates the - a - an email address to which you can send questions, comments, and statements on the demonstration design and on the materials posted on the web site.

And, again, thanks very much to CMS and I'll turn the microphone back to Natalie.

Natalie Highsmith: Thank you, Dr. Maxfield.

Now we will go ahead and move into our open Q&A portion of the call. (Jessica), if you can just remind everyone on how to get into the queue to ask their question?

And everyone, please remember, when it is your turn, to restate your name, the state you are calling from, and what provider or organization you are representing today.

Operator: At this time I would like to remind everyone if you would like to ask a question, press star and the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Your first question comes from (Zula Fallaman). Your line is open.

(Zula Fallaman): Hi. I'm (Zula Fallaman). I'm calling from (CCTC) and I'm in Colorado.

I wanted to - one of the slides said that you had to have an EMR that was CCHIT-certified. And I just wanted to see if - what if we had practices that weren't certified.

Man: You mean their EHR was not a certified or approved EHR?

(Zula Fallaman): Yes.

Man: That wouldn't qualify. The documentation they would have to send in order to be qualified as a medical home for the demonstration would have to include CCHIT approved electronic health record for Tier 2 only.

(Zula Fallaman): Okay. Thank you.

Operator: Your next question comes from the line of (Bob Parish). Your line is open.

(Bob Parish): Hi. This is (Bob Parish) from West Michigan, the Alliance for Health.

And I was interested in trying to get a little bit more detailed information on how the eight sites are going to be selected by CMS, including what are the criteria that are going to be used, how are those criteria going to be applied state by state or however the process is going to take place?

Man: Okay.

CMS is going to (choose the) sites that are going to provide us with the best geographic distribution across the country so that we can evaluate the demonstration appropriately. It has to apply to a pretty broad area. And primarily geography is going to figure largely and also that the areas that are chosen do not have other CMS demonstrations going on and which we risk contamination of the comparison group.

Sites also have to have a sufficiently large enough Medicare fee-for-service population with both Part A and Part B and are not enrolled MA plans. And the sites must also be able to provide sufficient physician-based practices so that we can recruit up to 400 practices and roughly 2000 physicians.

CMS would prefer sites that have Medicare high costs because there's a greater potential for better care management of chronically ill beneficiaries to produce savings under those circumstances. And we would also prefer sites that have existing private payer medical home pilots occurring. We think that that might help us in recruitment.

Natalie Highsmith: Okay, next question, please, (Jessica).

Operator: Your next question comes from the line of (Corinne Lee). Your line is open.

(Corinne Lee): Hi. This is (Corinne Lee) from Queens Long Island Medical Group.

I do have a question in which once we have the application, who do we send it to?

Man: We have contracted with an entity who will be facilitating our implementation, which is a mighty, mighty big task. One of the first things is to notify practices in selected demonstration sites of their opportunity to participate in the demonstration. All of that information that they're sending will provide you with enough information to know how to fill out the application and where to send it.

We don't have a specific location at this point in time. So that would be coming if your area was chosen. You would be receiving information. And it would describe what process you need to complete the application process.

(Corinne Lee): How would I know if my area is chosen?

Man: Well, we certainly plan on making an announcement as soon as we know, or as soon as we get approval I should say. And following that, we plan on

notifying all practices in demonstration areas that they would be eligible. We'll also post that information on our web site.

(Corinne Lee): Thank you.

Operator: Your next question comes from the line of (Katherine Hill). Your line is open.

(Katherine Hill): Thank you. We're located in Dallas, Texas. I'm (Katherine Hill) with Texas Health Resources.

We are interested in participating with our senior medical clinic. And I'm a little concerned that there is already a Medicare demonstration project in the area, in the Dallas area, but it doesn't really I think affect our ability to participate in this project.

Will there be some discernment exercised there on excluding a city or state just because it has a demonstration project ongoing?

Man: To some extent, but the simple answer to it is probably not. We have to be very careful that we're not causing unforeseen consequences or introducing them into the medical home demonstration. It draws a pretty fine line as to what might impact on a demonstration and what might not. And we have to consider that it's not just the type of demonstration we're operating, but will other demonstrations in the area influence the kind of care that control groups also receive. So we have to be very careful.

(Katherine Hill): I see. All right, thank you.

Operator: Your next question comes from the line of (Brian Bailey). Your line is open.

(Rick Rutherford): Yeah, this is (Rick Rutherford) with the American Neurological Association.

I had a question, first of all, on Slide 23 where the speaker talked about the care management fee. I wasn't sure what was meant by the blended rate. He mentioned the specifics of the HCC score, less than 1.6 and more than 1.6. But what is the blended rate and how is it utilized.

Man: We are required under the Tax Relief and Health Care Act to go to the RUC to develop the values and ultimately the fees that would be paid out in a Medicare medical home demonstration.

The blended rate is actually the calculation using the RUC relative values that were provided to us. Those values pertain to a whole list of what we might call descriptors, the kinds of services that ought to be provided in a Tier 1 or a Tier 2 medical home by the individual practitioner.

And according to what that effort would be through the calculation process, we came up with what we called a blended rate. And it's kind of a - you can look at it as a base. The $40.40 or the $51.70 for the respective tiers is what would be paid for each participant each month if we did not have any risk adjustment.

We went ahead and did some adjusting on the risk because of a recognition of the fact that some patients will require less care, others will require more. And in order to be fair and balanced in it, it made sense that we adjust that rate. So those who require greater - a greater amount of care, those who are sicker, for example, would have a score we think of equal to or greater than 1.6 on the HCC. So therefore, they - it would be justified to pay a higher rate. But each of those rates, higher or lower, are based on the blended rate.

(Rick Rutherford): Okay.

Operator: Your next question comes from the line of (Teresa Ulrich). Your line is open.

(Teresa Ulrich): Yes, my question would rural health clinics be eligible for participation.

Man: We haven't made a decision on that yet. We're looking at it. So I'm going to have to ask you to be patient and keep monitoring our web site. When announcements are made, we'll try and clarify that.

(Teresa Ulrich): Thank you.

Operator: Your next question comes from the line of (Margaret Kuzinski). Your line is open.

Ms. (Kuzinski), your line is open.

(Margaret Kuzinski): Oh, hi, this is (Margaret Kuzinski) from Medical Network One, Rochester, Michigan.

I have a question on the Tier 2 requirements, the EMR. If we - if the provider has an electronic population-based disease registry such as (unintelligible), which is PQRI-approved - an approved vendor, could they use that in lieu of an EMR?

Man: We're conversing on that. It doesn't seem like it would apply. We are restricting it to CCHIT-approved electronic health records. They're really the only ones that we can use for the standardization of those records for the sake of our demonstration. And we don't mean to say that the electronic

population-based method that you're talking about is not a good one. But we can't use - we don't think we can use it in our demonstration.

(Margaret Kuzinski): Hm, didn't you have a question, too.

Woman: We have one other question.

When you look at your enrollment (unintelligible) what is the rationale for eliminating all Medigap and Medicare Advantage patients?

Man: Well, as far as the Medicare Advantage patients are concerned, as a capitated patient, we lose all control of any claims that we would need to establish first of all improvements in care and other health activities and also to determine if there were any savings. We would not be able to calculate or to identify a patient's let's say hospitalization record from a Medicare Advantage plan. It makes it a little bit difficult.

But in demonstrations like this, we often have to do that. We're not - well, it's for the sake of the demonstration. I'll put it that way.

We didn't do anything or eliminate anybody in the Medigap area, though.

Woman: Okay, thanks.

Operator: Your next question comes from the line of (Coleen Michaels). Your line is open.

(Coleen Michaels Walsh): Yes, this is (Coleen Michaels Walsh). I'm from Watertown, Massachusetts.

And my question is from what I read that this is excluded from Medicare Advantage members and plans, but if a member were to join this plan and they were enrolled in the Medicare Advantage, were they be told beforehand, one, when they enroll that they're in a Medicare Advantage that they're not eligible for this and they'd have to disenroll.

And would the Medicare Advantage plan receive notification via its reply tape that the member did join this and is terminated from their program?

Man: If the patient is a Medicare Advantage patient, they would not be eligible to join in the first place.

(Coleen Michaels Walsh): Okay.

But in a case where the member, you know, might have some issues and didn't know, you know, didn't divulge that information, once they enroll the member, would they, you know, cross-match it to the CMS system so that this person if they were enrolled would be notified and subsequently decided to say would be disenrolled and then they - the Medicare Advantage plan would then be notified?

Man: The demonstration applies to physician-based practices, not to Medicare Advantage plans.

(Coleen Michaels Walsh): Oh, okay, so that would be clear to - okay, then that would be the physician's responsibility to inform and not include those members in the demonstration?

Man: Well, the MA plan couldn't enroll them. They wouldn't be eligible...

(Coleen Michaels Walsh): Okay.

Man: ...(for the) medical home practice.

(Coleen Michaels Walsh): Okay, very good. That - you answered my question. I appreciate your help. Thank you very much.

Operator: Your next question comes from the line of (Amy Burke). Your line is open.

Hi, (Amy)?

Natalie Highsmith: Okay, let's move to the next question, please.

Operator: The next question comes from the line of (Roger Prong). Your line is open.

(Roger Prong): Yes, this is (Roger Prong) from Waterford, Michigan.

My question was one of your slides talked about care being fragmented and ineffectual. And then another one talked about tracking referrals. But it didn't seem to be - there isn't a referral system particularly set up for the Medicare recipient.

And, of course, that card is acceptable anywhere. Is it the physician's burden to make sure that the patients are not going to other physicians that - where they haven't been referred by that - by their primary physician?

Man: Okay, I'm going to address two parts of this because I think there's a basic misunderstanding. Medical home is not a gatekeeper system and they do not have to approve a patient going to another practitioner. But medical home really is responsible for the overall management of the patient in that the

primary - the - what we call the personal physician of that patient needs to be aware of the comings and going of that patient through their medical lives.

So it's important that that physician understand where the patient goes for other care and what kind of care they receive so that it can be managed. That avoids things like mis-prescriptions and also tests and test results so that there's a - some kind of a - an accounting for those things so that they're not duplicated unnecessarily or that the tests are at least known to the broader area.

So essentially that is one of the primary functions that monitoring of a medical home personal physician to know what happens to the patient. But let's not confuse it that the medical home personal physician will approve or disapprove or disapprove the patient going to other places.

Operator: Your next question comes from the line of (John Cantelmo). Your line is open.

(John Cantelmo): Hi, this is (John Cantelmo) with Baycare Health Partners in Springfield, Massachusetts. And we are a large PHO in Western Mass.

And I'm wondering what the role might be for a PHO and ICA that provides coordinated capabilities and functionality for multiple practices in an area that might be interested in participating?

Man: I'm honestly not sure. Could you tell me a little bit more about your practice?

(John Cantelmo): Well, again...

Man: Because I'm not following, I'm sorry.

(John Cantelmo): It's a PHO with 200 independent physician groups that offers integrated - clinical integration activities and other services. So we have a lot of practices that access pieces of our service. So we supply services across multiple practices. And we have the capability to provide medical home capability to independent practices.

So a PHO I thought would we apply for the demonstration or would the individual practices that we support have to apply?

Man: Okay, thanks for the clarification.

It sounds to me - first of all, I wouldn't want to discourage you. And if you have the opportunity, you could certainly explore that and even apply to see if you could be eligible.

But by virtue of the statute, this is a - this isn't available to practices - I'm sorry, physician-based practices. It sounds more like it would apply to the practices that use your services as opposed to your particular entity. But I don't want to discourage you right now.

(John Cantelmo): Okay, thank you. We have a second question.

(Tess Jacobson): (Tess Jacobson) with you here.

I have a question on the HCC. (Unintelligible) practice and whether or not (unintelligible) updated every month or every six months or how would you get the larger fee if they had more co-morbidities?

That's it.

Man: Yeah, the HCC scores apply to all Medicare beneficiaries. And they're generally used for Medicare Advantage patients. We're using them in this demonstration in order for us to be able to risk-adjust the patients that would need more or less care depending on their circumstances.

We don't anticipate adjusting the HCC score. We frankly don't think that it's going to be too often that a patient score is going to change during the course of the demonstration.

(Tess Jacobson): Okay.

Man: So initially when a patient is considered eligible and their adjustment is made, that's probably the score that they're going to stick with.

We are considering, however, adjusting the HCC score, perhaps annually. We're going to have to take a look at that a little bit later on, though.

(John Cantelmo): Okay, thank you.

Operator: Your next question comes from the line of (Herman Dennis). Your line is open.

(Denise Herman): My name is (Denise Herman) and I'm from North Carolina with Caldwell Physicians.

Our question concerns eligibility of North Carolina. There is a demonstration project currently going on in our state, but it does not involve our country and there are multiple other counties in the state that are not involved in this

demonstration. Would North Carolina still be eligible as one of the eight states?

Man: At this point, we haven't made any decisions. All we can really talk to you about is the criteria that we would use and in general terms. States that have existing Medicare demonstrations would probably not be good candidates, but we are considering recommending states and parts of states. So that's as far as I can go with it. I can't tell you whether or not that would be an exception in North Carolina or anyplace else.

(Denise Herman): Okay.

Operator: Your next question comes from the line of (Janae Seeley). Your line is open.

Woman: (Unintelligible).

(Joseph Schlack): Yes, this is (Joseph Schlack), Tulsa, Oklahoma.

We're part of a large, integrated group practice and the question is if we have certain physicians that are interested in participating in the medical home project, do we have to have all of our group? Or can we isolate it down to certain beta sites within our practices?

Man: Yes, you can. It's not necessary that all physicians within a practice be associated with the medical home demonstration.

(Joseph Schlack): All right.

And just one other comment if I might, the HCC, I heard the comments earlier. I think it's absolutely imperative that this will have to be adjusted at

least on an annual basis for these types of patients, progressive illnesses is obviously an issue. So I - I'm just making that comment.

Man: Thank you.

(Joseph Schlack): Thank you.

Operator: Your next question comes from the line of (Jessica Schmidt). Your line is open.

(Jessica Schmidt): Hi. This is (Jessica Schmidt) calling from Family Medicine, Geriatrics and Wellness in Pennsylvania.

Our question is if our practice is already a PPC-PCMH-certified, is there going to be some kind of crosswalk for us to get this additional certification? Or are we going to have to go through the application process again?

Man: Technically you're going to have to go through the application process again. But you've done - probably done an awful lot of the documentation already. It would be - most likely it would be an abbreviated process for you.

But you will have to apply because the standards that we're using in our version of the PPC-PCMH tool is just enough different from the NCQA standard tool to make it necessary for you to answer our questions as well.

(Jessica Schmidt): Okay, thank you.

Operator: Your next question comes from the line of (Chad Krillich). Your line is open.

(Chad Krillich): Hi. This is (Chad Krillich) from MultiCare Medical Group in Tacoma, Washington.

And I have two questions. One, how does Joint Commission accreditation for ambulatory care centers play into one's qualification for this project?

Man: That wouldn't have a bearing on the qualification for a medical home.

(Chad Krillich): Two is where can I find a resource such that we can see how our patients score out for HCC?

Man: I don't believe that you can.

(Chad Krillich): So we're not able to see how our population of patients medical complexity would affect the payment from Medicare as we undertake the project. Is that correct?

Man: We are looking at the information that we plan to provide in the demonstration sites, what information we would provide to practices even before they applied. And we - one of the things we're considering providing is the average HCC score.

We would not provide individual HCC scores, but we might consider providing the - what - when we look at the practice from claims data what - who are the Medicare beneficiaries, what are their HCC score and provide the practice that average score.

(Chad Krillich): Well, if I could just make a comment then, it would be helpful if that information obviously could be shared so that we would know as we

undertake the project to consider the costs that are involved with that, knowing how that would affect us financially.

Man: We will consider that.

(Chad Krillich): Thank you.

Operator: Your next question comes from the line of (Deidre Gifford). Your line is open.

(Deidre Gifford): Thank you. (Deidre Gifford) with the Maryland multi-payer medical home demonstration.

I have a couple additional questions about the PPC. The first question is could you -- sorry about that -- could you discuss in general your rationale for changing the scoring from the way the PPC scoring is currently being done?

And then my other question for - are you or NCQA planning to provide a crosswalk between the old scoring and the new tiers so that people who either are in the process of going through the PPC recognition now or have already gone through it can see where the differences lie?

Man: Hm. It's a good question.

What we're using for our demonstration is virtually all of the PPC, the existing NCQA PPC core capabilities. We probably include more of them at our Tier 1 than NCQA does. So they would remain the same, but you might have to qualify with more capabilities at Tier 1 than you would for the entry level or the Tier 1 of NCQA.

We do provide a crosswalk between one of our charts that's listed or that's posted on our web site against the PPC CMS version that was created for the demonstration. And you could look at them actually and see what we're requiring, but you would have to probably crosswalk it yourself with the PPC tool from NCQA.

What you would see is pretty much the same language. It's just that instead of needing two of five elements, you might need four of five for ours.

(Deidre Gifford): And are you able to share a little bit of the thinking about changing the scoring? The reason why I'm asking is because most of the multi-payer demonstrations that are in the planning stages or that have already launched are using the NCQA PPC-PCMH.

So many of the practices in the states where you might be looking will either have recently undergone or might be in the process of undergoing NCQA recognition for their commercial demonstrations. So then if they have to go through another repeat process for recognition with CMS, it might be both costly and a little bit redundant for the practices. It might discourage some of the practices from being able to apply.

Man: You make a good point. I think what we'd like to do is perhaps discuss that more with NCQA.

(Deidre Gifford): Okay. Great, thank you.

Operator: Your next question comes from the line of (Barbara Holleran). Your line is open.

(Barbara Holleran): Hi. My question is - oh, actually (Barbara Holleran) from Minnesota Medicaid.

And my question is whether you have developed procedure codes for reporting the care management services? And will they be identified as Tier 1, Tier 2? Or what other kind of descriptions would you be using for them?

And I see that you are considering it to be a monthly service and is this required to be performed with another service or reported with another service? I guess I'm just looking at the administrative part of it then.

Man: Yes, the fee is not claims-based. The fee would be generated and paid automatically on a monthly basis...

(Barbara Holleran): Okay.

Man: ...as soon as all beneficiaries were verified for eligibility. They will be checked every month.

Adjustments will be made if let's a beneficiary passes on and it's not known in the databases for two or three months. Adjustments would be made for payments made in error to the overall payment.

But there will be no need at the practice level to submit a claim. It's not associated with any services. The patient fee or the management fee would be paid irrespective of the patient being seen in that given month by the patient - by the physician at all. And I think that's all.

(Barbara Holleran): Okay, thank you.

Operator: Your next question comes from the line of (Tom Schaeffer). Your line is open.

(Tom Schaeffer): Hi, this is (Tom Schaeffer) from the University of Maryland. And I realize this is very early in the game, but I'm curious as to whether you have any idea of what the role of Part D enrollment will be in this demo? And, for instance, will it be mandatory or who's responsible of the bene is not currently enrolled, et cetera, et cetera, et cetera?

Man: Part D has no bearing on the demonstration.

(Tom Schaeffer): Okay.

And then just a follow up - a quick follow-up question, in the evaluation, does that also kind of suggest that drug use and utilization will not be part of the first bullet of Medicare costs and utilization?

Man: (Unintelligible) I mean, are you talking about how we're doing the budget neutrality calculation or how we're looking at the overall sort of evaluation...

(Tom Schaeffer): (Unintelligible).

Man: ...of the demonstration.

(Tom Schaeffer): The impact of the demonstration, yes.

Man: I think we will look at - we will probably look at drug costs as part of the evaluation, but we probably will not include it as part of the budget neutrality calculation.

(Tom Schaeffer): Okay, thank you very much.

Operator: Your next question comes from the line of (Josephine Zoyk). Your line is open.

(Josephine Zankowicz): Thank you. This is (Josephine Zankowicz). I'm the education coordinator and director for the Home Care Association of New Jersey.

I just have a couple of questions, one about the coordination with home care and hospice with the demonstration and whether there would be any encouragement with physicians to partner with home care and hospice agencies?

Man: We think that would be pretty much up to the practice. The demonstration is geared for and designed to impact on physician-based practices. How they partner or what resources they utilize throughout, you know, the routine practice patterns is kind of entirely up to them.

(Josephine Zankowicz): It just seems like a logical partnership in terms of trying to keep people out of the hospital and working closely with primary physicians, so I just wanted to pose that (unintelligible) question to the group.

Man: No, it's a thoughtful question. And I see your point. We would hope that medical homes would see the value in things like that as well and utilize it.

(Josephine Zankowicz): Thank you.

Operator: Your next question comes from the line of (Larry O'Day). Your line is open.

(Larry O'Day): Thank you.

My question concerns patients who are excluded from eligibility for this demonstration. I understand that Medicare Advantage patients can not enroll. There are, however, other patients who are enrolled in the old Medicare cost contracts, which are still out there. There are about a dozen of them I think that were grandfathered in many years ago and they still exist and they enrolled tens of thousands of patients.

Part of this may be made moot depending on where you pick your geographic sites, but I'm wondering, are Medicare cost contract enrollees eligible to participate?

Man: I think we're going to have to look at that. I think our initial feeling is probably not because I don't think we can capture - well, that we can capture Part A costs. I don't believe we can capture individual Part B costs for a cost HMO. And we would need that to do our evaluation.

(Larry O'Day): Okay.

Will you put something up on the site or something or otherwise find a way to give us an answer to that question.

Man: Yes, we'll figure that out.

(Larry O'Day): Okay.

Operator: Your next question comes from the line of (Tisha Boston). Your line is open.

(Tisha Boston): Hi. I'm (Tisha Boston) from Senior Primary Care Practice in Columbia, South Carolina.

We are currently using an electronic medical record in our practice. How will we go about finding out if it's CCHIT-approved?

Man: If I'm not mistaken, you can go to a web site for CCHIT if you Googled it. I think that would be the best place to start. I know that they do have a list of approved records, but I'm not - I haven't gone there in quite a while, so I don't want to mislead you.

(Tisha Boston): Okay.

Man: But I think your best bet is probably to try and find the CCHIT web site.

(Tisha Boston): Okay, thank you.

Operator: Your next question comes from the line of (Kara Bailey). Your line is open.

(Kara Bailey): This is (Kara Bailey) with the Minnesota Department of Human Services.

We have two questions. One, we were wondering if you could explain the referral process and responsibility for home and community-based services?

And then we have a completely unrelated question. We had noted that patients may lose eligibility if they move away from the demonstration site. And we were wondering what the indicators are or what the flags are to the clinic to trigger knowledge that that patient is no longer attending that clinic?

Thank you.

Man: Okay, well, home and community-based services are not general - are not Medicare covered services. So I think while we would hope physicians are doing some coordination on those services, I'm not sure. We really haven't thought about the coordination aspects for dual-eligibles and the - what the responsibility might be for the medical home or the Medicaid side of services. So I think we're going to have to think about that a little more.

In terms of the flag, there is no Medicare flag to tell you on a timely basis that a Medicare beneficiary has moved away from the area. And one of the things we plan to do is - as part of the monitoring of the demonstration is to review sort of on an annual basis whether the Medicare beneficiary has continued to see the medical home.

We do get update we believe. We'll review once a year if we're seeing a change in the address on our enrollment side. But there is no automatic process unless the beneficiary informs the physician that they're moving out of area that we know quickly that a beneficiary has moved.

Operator: Your next question comes from the line of (Margaret Halsey). Your line is open.

Natalie Highsmith: Hi (Margaret)?

Okay, let's move to the next question, please.

Operator: Your next question comes from the line of (Malcolm Perry). Your line is open.

(Malcolm Perry): Hi, this is (Malcolm Perry) from Elliot Health Systems in New Hampshire.

And just to follow up on the last question, we have, of course, up in New Hampshire, we have a lot of folks that migrate south for a few months of the winter. And I'm just wondering how that will impact their enrollment status and is there a residency requirement as part of the enrollment requirement?

Man: That's a little bit tricky to answer that one. Certainly there's an enrollment requirement. We expect that patient's primary residence will dictate where they get the bulk of their primary care.

A medical home we don't think necessarily needs to be - doesn't necessarily need to be the only place that a patient can receive care. Hypothetically if somebody were to head south for the winter, their care could still be managed and monitored by a physician in New Hampshire. That would be up to the individual practice.

But as we mentioned earlier, we are going to be periodically monitoring whether or not a patient is - has seen their physician within a given period of time, probably a 12-month period of time. And if a physician hasn't actually seen the patient that they're responsible for managing their care in the course of a year, that would indicate that the patient no longer is seeing that practice and would probably be dropped.

(Malcolm Perry): Thank you.

Operator: Your next question comes from the line of (Palinthia Essari). Your line is open.

(Palantha Essari): Thank you. I'm (Palantha Essari) from Home Care Physicians in East Point, Michigan. And I've got a couple of questions.

Number one, we are a nontraditional practice in that we provide home visits to our patient base and 90% of our patient base is Medicare. Secondly, we also employ the use of midlevel providers in our practice. And so we wanted to know, number one, if we're eligible to participate in the demonstration project, and number two, how midlevel providers are being viewed as a part of the demonstration project?

Man: It - the extent of your practice that provides home visits, are you providing all of the primary care for those - for a beneficiary?

(Palantha Essari): That is correct.

Man: You're doing all of the primary care, including providing home visits?

(Palantha Essari): Yes.

Man: (Unintelligible).

Man: Then you would be potentially eligible.

Man: The requirement in terms of a midlevel practitioner, the monthly care management fee has to go to a board-certified physician.

(Palantha Essari): Oh, okay.

Man: That doesn't mean that the practice itself can't have as part of the individual's providing care management be midlevel practitioners who are providing the care management, but the monthly fee is going to a board-certified physicians.

(Palantha Essari): Thank you.

Operator: Your next question comes from the line of (Tom Reed). Your line is open.

(Depasco): Yeah, this is Dr. (Depasco) for (Tom Reed) and Personalized Physician Care in Florida.

On Page 24, just to clarify a bit, you have 80% of the savings above the first 2% minus fees are shared with the participating practice. My question is do the savings go to the individual participating practice or is it of the group and then divided up? And does it matter how many you have enrolled in the whole tally?

Man: Okay.

I mean, the distribution will be based on the member months of the enrollees, so if a practice has more than - more beneficiaries enrolled, they will get a larger percentage of the shared savings.

(Depasco): The savings goes back to the individual practice.

Man: Yes.

(Depasco): Okay, thank you.

Operator: Your next question comes from the line of (Kyla Keister). Your line is open.

(Kyla Keister): Hi there. My name is (Kyla) and I'm calling from the Iowa Healthcare Collaborative in Des Moines, Iowa. And I have a couple of different questions, but first just a quick clarifying question.

There isn't an application process to come a site, correct?

Man: That's correct.

(Kyla Keister): Okay.

And then I have a question about the practices that are selected to participate. I know there's been a couple of other questions related to this.

But my understanding is that a clinic is defined by someone that has one tax ID number. But we have one practice with one tax ID number, but a couple different sites. And so I'm curious if that group would be counted as one practice even though they have multiple eligible providers?

Man: It's an interesting point that you raise and we are this moment looking at that. It goes to the definition of what is a practice and how could a practice be qualified as a medical home, does it have to be a single geographic location or could it be - could it include satellite locations. And we just don't have the answer right now.

(Kyla Keister): Okay.

And then that care management fee that's paid, it's not all of the - I understand that all of the physicians don't have to necessarily participate, but does that fee go to the practice as a whole or does it go just to the physicians that are participating? Or how does that work?

Man: The way we envision it is the unit of recognition or the unit of qualification is the practice.

(Kyla Keister): Okay.

Man: And the services are provided by personal physicians. We anticipate that the payments will be made to the practice and distributed to the physicians through the practice.

(Kyla Keister): Okay, very good.

And then the last questions here about the risk adjustment and the HCC score, are you going to be stratifying each site or each patient? Or are you just going to use an average of 25% being sicker and 75% less sick? And is that HCC score based on claims?

Man: The HCC score is identified with an individual Medicare beneficiary. And it's based - Medicare calculates the HCC score based on a review of claims that were submitted. I believe it's a year earlier than when the score is actually calculated. So it's based on Medicare claims data.

(Kyla Keister): Okay.

And then will it always be an average of that 25%/75%...

Man: Yeah.

(Kyla Keister): ...distribution that you discussed in your presentation?

Man: (Unintelligible).

(Kyla Keister): Or will it be based on the actual HCC score of the group?

Man: The actual HCC score. So, in fact, if a practice had only people with a score of 1.6, then everyone in that - every beneficiary in that practice would get the hire rate.

(Kyla Keister): Okay. Thank you.

Operator: Your next question comes from the line of (Harry Heeman). Your line is open.

(Harry Hyman): Hi. (Harry Hyman) and I'm a family physician in Atlanta, Georgia.

Two questions -- one, in terms of the evaluation piece of this, is anything being done to deal with selection bias? I mean, clearly practices that are motivated to get involved in this demonstration project are more likely to be doing some of the functionality that's included already.

So that's question one. And question two is if improved quality is one of the key goals of this, I was surprised that none of the reimbursement components is related to quality.

You know, one of the challenges in medicine obviously is that there's misaligned incentives between care and outcomes and what one pays us. And this just seems to reinforce that if the only incentive is based on cost reduction.

Man: Well, I mean, this demonstration is following the requirements in the statute. And, I mean, it is a complicated demonstration as designed now. And at this point, we have decided not to try to add a pay-for-performance component to that demonstration. Now in terms of - or paying for quality.

In terms of the evaluation, you are correct. It is - it's the evaluation, design, and coning up with an appropriate control group will be a significant part of the evaluation design. And they're fully aware of all of the issues that could confound the evaluation.

(Harry Hyman): Thank you.

Operator: Your next question comes from the line of (Margaret Kuzinski). Your line is open.

(Jenny): Hi. This is (Jenny) with - I'm sitting with (Margaret). And I have a question that I'm struggling with.

I was hoping that this demonstration project would help us to enable the elimination of some silos that exist, the NCQA, Medicare, Medicare Advantage, Medicate, and is there a way that this demonstration project could be adapted to move more toward collaboration and articulation of what these other organizations has already approved as being relative so that we stick with a patient-centered model instead of a payer-centered model?

Man: Well, I mean, this - the statute says we are conducting a Medicare demonstration. The statute did not say we are conducting a demonstration that cuts across both Medicare and Medicaid. It's clear to us that this demonstration does not apply as defined in the statute to the Medicare Advantage population because we couldn't really conduct an evaluation.

So I understand your concern about potential silos. But what we are - I guess what we are trying to address is to make sure that there is coordination across the primary care and specialty, which is another form of silos that is occurring in the medical system.

So we're not trying to cut across payment groups, even though we will be looking at whether we can do the demonstration in the same place that there are private sector initiatives.

(Jenny): And how can we link the work that is done toward achieving NCQA's expectations and have yours just be an additive instead of a redo?

Man: Well, I mean, the - we have been, again, establishing our criteria for eligibility for this demonstration and this was a carefully thought-out process. We decided that because of the significant reimbursement that we are providing under this demonstration, because of the specific requirements that are mandated in the legislation, we could not simply use the current NCQA requirements, so we had to increase them in certain areas.

There isn't that much difference between the NCQA requirements and ours because ours are generally tougher.

(Jenny): Any...

Operator: Ma'am, your line is reopened.

Natalie Highsmith: (Jenny)?

(Jenny): Any chance that this project is going to change after November 4?

Man: Until we get complete clearance through the department and (LNB), there is a chance that the design could be changed. We made that clear in the very first slide.

(Jenny): Thank you so much.

Operator: Your next question comes from the line of (Amy Burke). Your line is open.

(Amy Burke): Thank you. Yes, my name is (Amy Burke). I'm calling from Bethesda, Maryland. I'm with (IBM).

I just had a question about the midlevel providers. You might've addressed this. It was difficult to hear. But how (unintelligible) do the midlevel providers have a role within this demo project, such as nurse practitioners and physicians assistants and whether or not they'll be reimbursed for the care they give.

Man: The way the legislation is written, those are not practitioners that would be included in the demonstration directly. How practices use those professionals, particularly nurse practitioners and PAs, is entirely up to the practice. But they would not be entities that would be eligible through - for collecting care management fees directly from CMS.

(Amy Burke): Okay, thank you.

Operator: Your next question comes from the line of (Betty Rider). Your line is open.

(Betty Rider): Hi. I'm a healthcare administrator in North Carolina.

There's been some mention made of what was called the CMS version of the NCQA criteria being available. It's not clear where those can be found. So I really have two questions about that that are related.

What is the CMS expectation of the number of practices that can actually meet the Tier 1 criteria, which has been - as it's been described to us, perhaps a bit more robust than what we know of and many of us are operating under the current Tier 1 criteria of NCQA.

The related follow-up question to that is there - I've heard several different versions of the same question related to eligibility. One is that there will not be a demonstration project in states where there is an existing demonstration project.

Another is that while states with existing demonstrations have an advantage -- I'm sorry, states with an existing demonstration project in their state may not be good candidates, but they could be considered for an application. So back to the same question, if there's an existing CMS demonstration project in your state, is your practice eligible to submit?

Man: What we are planning to do in the site selection is to use states or parts of states. When we consider the parts of states, that might be states that have demonstrations, but not sufficient in numbers to contaminate let's say another part of the state. So I can't go blanket and say if your state has a demonstration, we would not consider you. That may not be the case. It may not be true.

In general, though, we are looking for areas that don't currently have Medicare demonstrations so that we can preserve the integrity of the results that we find.

(Betty Rider): Thank you.

And is that document available somewhere online that we could look at?

Man: I'm sorry, yes, the information in the presentation if you have that in front of you, it's all listed on the CMS web site on the web page for medical home demonstration.

(Betty Rider): Thank you.

Operator: Your next question comes from the line of (Cindy Helstead). Your line is open.

(Cindy Helstead): Good afternoon. (Cindy Helstead) from the Wisconsin Medical Society.

My question is also on eligibility. We've been fortunate in our state to receive the (EHR} demonstration and the Medicare medical group practice demonstration.

But I'm not sure when the timelines of those. I know the (EHR) hasn't started yet for us. But when one demonstration ends and that we might be eligible for parts of our state to apply for this demonstration, will you be posting like the United States or state maps and say where there are active demonstrations and what the time - the windows are that they would be exempt because of demonstrations covering the whole state?

Man: We can consider that. But I think your best bet is to wait until we get approval for the demonstration. And then we can put out a whole lot more information and be more explicit to avoid some of this deep, dark secret that we're holding here.

We apologize for that. But it doesn't make sense for us to disclose any of the locations or what we're considering in the event that those things change. It

would cause a great deal of disappointment among people who believed that the demonstration was coming to their hometown.

So please understand, we're doing this secretively at this point until we're approved so that we can avoid any confusion or disappointment further down the road. That's why I suggested it might be best just to wait till we can legitimately announce demonstration sites and explain further about our criteria and about the selection process.

(Cindy Helstead): Do you mean sites that are eligible to apply or do you mean that they would already have been selected and so - and how you chose them is going to be made transparent?

Man: Well, we're trying to be as -- excuse me. We're trying to be as transparent as we can right now by telling you what our criteria is. We plan on announcing the sites at pretty much all of the same time. Those will be the sites that the demonstration will be conducted in.

The rest of the country will not. It should become very, very clear at that point. And so as not to mislead you, I would suggest that you wait until that point.

(Cindy Helstead): It's too late to apply then, right?

Man: We're not accepting applications for site selection. We never were.

(Cindy Helstead): Oh, okay.

Well, I'm missing a link here. I'll just...

Man: When we talked about the application process, that was for practices in eligible sites, sites that our criteria would help us choose. We're not asking for or soliciting for sites to apply because they want to be included. Once the sites are chosen and approved, practices can then apply to participate in a demonstration, but only from those sites.

(Cindy Helstead): Thank you. That clarifies it.

Man: Thank you.

Operator: Your next question comes from the line of Dr. Gresham Bayne. Your line is open.

Gresham Bayne: Yes, Gresham Bayne in San Diego. I represent the American Academy of Home Care Physicians.

My question is is the statute mandate CCHIT certification of the EMR for the advanced medical home demo?

Man: No, it's not.

Gresham Bayne: The reason I ask is you may have - you may want to look at a perverse consequence of that you're restricting your potential practices to those that don't deliver care in the home, which arguably is where the most high cost patients with the most difficult access to coordinated care lie.

The (ONCHIT) issued National Strategy 1.3.9 in June to identify this sort of technical problem because CCHIT certification standards all are based upon office connection speeds, which is true broadband at, you know, 10 megabytes or better connection speed whereas a mobile wireless WiWAN for mobile

providers to care in the home can't connect any faster than a typical 150-kilobyte-per-second.

So these CCHIT certification charts can't work when you try to deliver the services in the home some of your earlier callers have suggested.

Man: Appreciate the information. Electronic health record would pertain to a Tier 2 practice. It wouldn't be required in a Tier 1 practice, so it probably wouldn't be a problem for folks at that level.

In apply and qualifying at a Tier 2 level, we have to have some kind of a standard so we know that the products that are being used are acceptable or have been reviewed. CCHIT is about the only one that we can go to at this point. And inasmuch as this is a demonstration and not exclusionary criteria for the general medical community, but only as it pertains to this demonstration, we think that that's a pretty fair assessment.

Gresham Bayne: Thank you.

Operator: Your next question comes from the line (Carol Rodman).

(Carol Rodman): Thank you. This is (Carol Rodman) from Uphams Corner Health Center in Dorchester, Massachusetts.

I'm wondering whether community health centers ordinarily of the nonprofit or public sector variety would be eligible.

Man: Well, once again, we're looking at that. So I don't have a definitive answer for you at the moment. Suffice it to say that if community health centers were to be included, they would have to qualify as being physician-based and they

would also have to qualify as a medical home. So other than that, I - there's really nothing more I can say.

(Carol Rodman): Thank you very much..

Operator: Your next question comes from the line of (Andrew Knoughton). Your line is open.

(Andrew Knoughton): Good afternoon. (Andrew Knoughton), Center for Medicare Advocacy, Washington, DC.

Just very quick question, are dual-eligibles who have Part A and Part B coverage eligible to participate in the medical home demo?

Man: Yes, they are.

(Andrew Knoughton): Okay, thank you.

Operator: Your next question comes from the line of (Mindy Alvarez). Your line is open.

(Mindy Alavarez): Well, thank you. This is (Mindy Alaverez) from Priority Health in West Michigan.

My question is more around the enrollment component. For those practices who are able to provide these services and are recognized by CMS, how will they be made aware of the patients who are eligible?

And then secondly, is there a template or a form out there that practices will use to meet your requirements for the patient provider agreement and ongoing renewal?

Man: Okay, at this time, we don't plan on providing a list or attributing patients to any particular practice. We plan on trying to provide an estimate of the number of patients that might be eligible in a given practice. And what the potential revenues generated from the fees might be.

That's strictly for planning purposes. We do not expect to go so far as to attribute actual patients on an individual basis because of the possibilities that we could easily be very wrong about assigning a patient to a given practice. It's an imperfect process.

We would expect that practices that we're applying to participate in the demonstration and indeed could qualify as a Tier 1 or a Tier 2 medical home would be able to identify the patients that would eligible and submit the agreement form.

The agreement form, we plan on providing a template. We won't call this an official form, but in a sense it has to include a certain amount of information that should be standard for all practices in medical home demonstration so that the patients are properly informed of what services they can expect.

To some extent, we think that the practice is going to have to customize it to their individual patient population, so we're leaving that open. But it'll probably come out looking similar to an important information statement such as you get with - when you have a flu shot or something of that nature with a lot more information about medical home that should be given to all patients

and an area for customizing it so that a practice can actually specify what that practice will provide to their patients as well.

(Mindy Alavarez): Thank you.

Operator: Your next question comes from the line of (Alan Lazaroff). Your line is open.

Natalie Highsmith: Hello, (Alan)?

Okay, let's move to the next question, please?

Operator: Your next question comes from the line of (Debbie Huskie). Your line is open.

(Debbie Huskie): Yes, I was just wanting to know if you could provide the definition of the savings again that was presented on Page 24 with respect to the first 2% of savings, they're not shared, then you provided a definition. Could you give that to me again, please?

Man: Well, in its simplest terms, it would be the total cost of the Medicare beneficiaries who are receiving medical home services, the total Medicare cost, plus the care management fees, those costs will be compared to the costs of a comparable control group.

And the difference if the cost of the medical home beneficiaries is lower, then there would be a savings. And it's that difference that would be then shared with the physicians.

(Debbie Huskie): Okay. Thank you very much.

Operator: Your next question comes from the line of (Donna Simon). Your line is open.

(Donna Simon): Yes, my question, I was wondering, does this apply to hospital-owned physician practices as well? I'm assuming it does, but just wanted to clarify?

Man: As long as they're providing primary care services to Medicare beneficiaries.

(Donna Simon): Okay.

Operator: Your next question comes from the line of (Elizabeth Newell). Your line is open.

Natalie Highsmith: Hi (Elizabeth)?

(Elizabeth Newell): Hello?

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(Elizabeth Newell): Hello?

Natalie Highsmith: (Elizabeth)?

(Elizabeth Newell): Hello?

Natalie Highsmith: Yes, we can hear you.

(Elizabeth Newell): Hi, thanks.

I was wondering what information CMS would be providing to providers of pilot enrollees? It's my understanding that the coordination piece is a large role of the medical home between the primary care physician and specialists among other healthcare encounters. And currently one of the barriers, especially with fee-for-service patients, is the PCP may not know what other health services are being received by their patients.

So my question is is CMS going to be providing any information to providers on the enrollees of the pilot project? For instance, monthly reports of Medicare claims submitted or past claim information or any Part D medication and filled scripts?

Thanks.

Man: No, we have no plans of providing that level of detail. We are talking potentially 400,000 beneficiaries. It would be pretty hard to do.

Plus in theory as a medical home, we would expect the practice to be able to identify that kind of information so that they can properly manage the patient.

Operator: Your next question comes from the line of (Joseph Shay). Your line is open.

(Joseph Shay): Hi. This is (Joseph Shay) from the University of Chicago.

I was actually wondering about the budget neutrality clause. I'm looking at it and it looks like you have $100 million extra from the MIPPA in 2008. But suggesting the possibility that there are no medical savings from the medical

home, you can blow through that pretty quick. And if you do, how will you deduct from Part A and Part B reimbursements to cover your losses?

Man: At this time, we have no plans to recover any losses from the participating physicians.

(Joseph Shay): So does that mean that you would - there's no way right now that you have planned to reduce reimbursements to either hospitals or physicians or other services if they do exceed budget neutrality?

Man: That is our current plan.

(Joseph Shay): Okay, thank you.

Operator: Your next question comes from the line of (Elaine Scoche). Your line is open.

(Elaine Scoche): We are wondering what the cost will be for Tier 1 recognition and then if a practice decides to go after the Tier 2 recognition, what the additional cost would be?

Man: The only cost associated with qualification in the medical home demonstration would be costs incurred by the practices for necessary infrastructure to quality. There are no fees associated with the processing of the PPC-PCMH, CMS version of the qualification tool.

(Elaine Scoche): Thank you.

Operator: Your next question comes from the line of (Alan Lazaroff). Your line is open.

(Alan Lazaroff): Yes, as a hospital-owned facility, we currently bill for our professional component and then a facility side component. Will either of those not be available with the acceptance of the care management fee?

Man: We are not changing the regular Medicare reimbursement.

(Alan Lazaroff): Very good.

Man: So the care management fee is over and above whatever the - whatever reimbursement Medicare is currently providing.:

(Alan Lazaroff): Thank you.

Operator: Your next question comes from the line of (Kyla Keister). Your line is open.

(Kyla Keister): Yes, this (Kyla) from Iowa Healthcare Collaborative again.

You gave a general definition of the cost savings, but will the method to determine those cost savings be transparent at some point?

Man: Transparent? I think we will describe the method. I mean, I suspect it will end up being a fairly complicated regression model, so if regression models are transparent to you, then it may be transparent.

(Kyla Keister): Okay, thanks.

Operator: Your next question comes from the line of (Kara Bailey). Your line is open.

(John Selstead): This is (John Selstead) on (Kara Bailey)'s line. And I was wondering if you could say something more about the comparison population, do you anticipate

it in the same geography with the issues of voluntary selection into the demonstration or with different geographies the variation in costs.

Man: Well, I mean, we recognize the complexity of doing a control group. And part of it depends on what the penetration level will be in the demonstration sites that select. For instance, in - you know, if we get a large penetration in - of people signing up, then it's possible, although that would not be our preference because we would have to go to another geographic area.

But our preference will be to identify sites in the same geographic areas that have not applied for medical home recognition and use their beneficiaries as our control.

(John Selstead): Thank you.

Operator: There are no other questions at this time.

Man: We want to thank everyone for calling in. Hope we were able to provide you with some solid information and hopefully adequately answered your questions.

We invite you to forward questions, again, to the mailbox medhomedemo@cms.hhs.gov. We'd be happy to answer your questions from that point of view as well.

So I want to thank Dr. Maxfield and Natalie for coordinating the call for us and we appreciate your interest and your continued support of medical home demonstration.

Natalie Highsmith: (Jessica), can you tell us how many people joined us on the phone lines today?

Operator: Four hundred and eighty.

Natalie Highsmith: Wonderful. Thank you.

END