Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare Shared Savings Program:
Accountable Care Organizations (ACOs)
Thursday, June 24, 2010 2:00-4:00 pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on the Medicare Shared Savings Program. This Special Open Door Forum will focus on the formation and use of accountable care organizations, or ACOs, to enhance the quality and efficiency of physician services. The purpose of this Special Open Door Forum is to solicit comments from physicians, physician associations, hospitals, consumer groups, and all others interested in the implementation of this new program.

Following a brief presentation by CMS staff on the statutory requirements of the Shared Savings Program, we will open the phones to comments. CMS is seeking stakeholder input on a number of topics including:

- Joint accountability among providers in the formation and use of accountable care organizations;
- Cost and quality measures to assess performance;
- Risk adjustment;
- Assignment of Medicare beneficiaries to ACOs;
- Benchmarks for purposes of defining shared savings;
- Coordination with other value-based purchasing initiatives;
- Medicare beneficiary protections.

We look forward to your participation.
Special Open Door Forum Participation Instructions:
Dial: 1-800-837-1935 Conference ID 82156293. Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at, http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around Wednesday, July 7, 2010.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/ .

Thank you for your interest in CMS Open Door Forums.

Audio files for this transcript: http://media.cms.hhs.gov/audio/AccountableCareOrg-Disk1.mp3 & http://media.cms.hhs.gov/audio/AccountableCareOrg-Disk2.mp3

Centers for Medicare & Medicaid Services
Special Open Door Forum: Medicare Shared Savings Program-Accountable Care Organizations
Conference Call Only
Moderator: Barbara Cebuhar
Thursday, June 24, 2010
2:00 p.m.-3:30pm ET

Operator: Good afternoon. My name is Mason, and I'll 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 Special Open-Door Forum. 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 or have any comments 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 now begin.

Barbara Cebuhar: Good afternoon, everyone. We are thrilled that you could join us today for our Special Open-Door Forum, where we're going to focus on the formation and use of accountable care organizations, or ACOs, to enhance the quality and efficiency of physician services. The purpose of this Special Open-Door Forum, first and foremost, is to solicit comments from physicians, physicians associations, hospitals, consumer groups and all others interested in the implementation of this new program.

Following a brief presentation by CMS leadership, our – we on the statutory requirements of the shared savings program, we will open the phones to comments. CMS is seeking stakeholder input on a number of topics, including joint accountability among providers in the formation and use of accountable care organizations, the cost and quality measures to assess performance, risk adjustment, assignment of Medicare beneficiaries to ACOs, benchmarks for purposes of defining share savings, coordination with other value-based purchasing initiatives, and Medicare beneficiary protections.

I'd like to introduce Jon Blum, who's the Deputy Administrator and Director of the Center for Medicare, and he has a few comments for you all.

Jon Blum: Great. Well, thank you – thank you to everyone who's chosen to join us today for this very important call. I think I just want to kind of get a couple of seconds for remarks but then turn it over to my colleague, Terri, to walk us through what current law requires the agency to complete. But I think from our perspective here in CMS, we have a tremendous opportunity to define ACOs that can participate in the shared savings program. This provision is – they implemented, as a result of the Affordable Care Act, and to our minds, one of the key policy initiatives that will help to improve quality to improve value to the overall Medicare program.

We are here to seek your input, to seek your suggestions. Our goal is to have a proposed regulation out sometime this fall. We're here today really to help the agency, one, to identify the issues that CMS' proposed rule will have to address the concerns and here to listen. And so please be frank with your comments. Please tell us what's on your mind, both the opportunities for ACOs, but also some of the challenges that the agency will have to address.

As CMS promulgates its proposed rule or develops its proposed rule, we want to take into account the various learnings from the field. CMS has the process still conducting the group practice demonstration. There are some key learnings from that. There are - there are other models being tested within the private sector. We want to take those learnings too as well, and to my mind, there are a couple of categories that – of questions that we hope the public will really help to inform the agency.

First is, how do we create rules that promote and encourage top clinical – top clinical staff to help lead ACOs, develop ACOs to build the best possible organizations? Secondly, how do we – how do we establish the targets correctly to ensure that we have opportunities for participation, but also ensure that the taxpayers share in the savings? Third is how do we think about beneficiary protections, and do we need to think about beneficiary issues differently than the traditional fee for service program? Fourth, how do we – how do we assess quality? How do we assess good top performance? And fifth, what kinds of tools, data, what have you should the agency put in place to help to monitor, to assess the overall value, the overall performance, the overall beneficiary experience that the ACO program can bring to the – to the program?

But again, please give us your feedback, please give us your ideas. Please challenge the agency. We're here to listen. We're here to take all inputs, and we'll also have more forums for the future, but this is the

first opportunity for the public, for stakeholders, to physicians really to give the agency feedback to help us develop the best possible regulation.

So with that, I'll stop, turn it over to Terri, who will walk us through what the Affordable Care Act requires CMS to do.

So Terri?

Dr. Terri Postma: Thanks. So what I'd like to do is just go over the statutory authority as enacted by the Affordable Care Act. This is on the P-PACA section 3022. It's called the Medicare Shared Savings Program, and it requires CMS to establish a shared savings program that promotes accountability for a patient population and coordinates items and services under parts A and B and encourages investment in infrastructure and redesigned care processes for high quality and efficiency service delivery.

As Jon mentioned, our CMS experience with a model such as this includes the physician group practice demo. This program is to be established no later than January 1, 2012. Some of the statutory requirements are in the categories of ACO eligibility criteria, quality and reporting, assignment of beneficiaries, payments and treatment of services and eligibility for shared savings, and I'll go over those briefly.

Eligibility criteria, according to the statute, the ACO must become willing to become accountable for quality, cost and care of Medicare fee for service beneficiaries. The ACO must agree to participate for not less than three years. The ACO must have a formal legal structure in order to share and distribute savings. It must include primary care providers sufficient for the care of at least 5,000 beneficiaries and have in place a leadership and management structure, including administration. The ACO must define processes to promote evidence-based medicine, reporting, technologies and the like, and demonstrate to the HHS secretary that it meets patient centeredness criteria.

Statutory requirements for quality and reporting include the HHS secretary to determine measures. The ACO shall submit data in the form and matter specified, and the HHS secretary will establish quality performance standards and may incorporate reporting requirements and incentive payments related to other value-based purchasing initiatives such as PQRI, e-prescribing and electronic health records.

The assignment of beneficiaries under the statute is based on their utilization of primary care services and payments and treatments of services. The statute requires that CMS to continue to pay under fee

for service, and there's an option to work through the CMS center for innovation to use other payment models, such as partial capitation.

The ACO meets eligibility for shared savings under the statute if it meets quality standards, and the estimated average per capita expenditures adjusted for beneficiary characteristics is at the least – at least the percent below the benchmark, as specified by the HHS secretary. Savings are then shared with the ACO and with CMS.

With that, I'd like to open the phone lines for – as was stated, we're taking comments and suggestions at this time, since we're very new in the development of the program.

Operator: At this time, I would like to remind everyone, in order to ask a question, or if you have any comments, please press star one on your telephone keypad. Your first question comes from the line of (Elizabeth Basket) from the American Hospital Association. Your line is now open.

Elizabeth Baskett: Hello. Thank you for the opportunity to speak with you today. I just have a few comments I'd like to share. We recognize that the statutory authority restricts the design of ACOs in some ways, but we hope the agency approaches the regulations with flexibility, writing a rule that is not to prescriptive in formulation and structure. Also, you mentioned earlier that you are going to take some learnings from the private sector. We think that's great. There's a lot of efforts that are going on right now, and we really encourage you to look at those efforts that providers are already engaging in, where they are working with large employers, as well as other entities.

Specifically, on the areas that you asked for comments, on the cost and quality measures to assess performance, we strongly encourage the agency to minimize reporting burden for hospitals and physicians. We ask you to focus on quality measures that address outcomes, coordination of care and also patient satisfaction. We also suggest that you start it with claim-based measures in the early stages of the ACO development and then progress more to robust measures, using specific clinical data, such as electronic lab results, registries, et cetera. Also, it's essential that quality measurements under the HIT meaningful use definition be synchronized with other recording programs and supports. Finally, we believe it's absolutely essential that you provide timely data on the program – and I know you addressed that in your opening comments. We think that real time data is extremely important so that we can track the system performance and make sure that we have feedback to providers.

As far as attribution of Medicare beneficiaries to ACOs, we really believe that you need to prospectively assign the beneficiaries based on where they received care in the prior year. This is different than how you ran the PGP program, and we think it's very important that we know who we are treating and ask that you do prospectively assign the beneficiaries.

In regards to benchmarks for shared savings, we encourage you to design a flexible approach towards shared savings, one that clearly articulates what the targets are and articulates that in advance. Also, the shared savings need to reach to the ACOs as soon as possible, not two or three years later. They should avoid taking also savings off the top, as was done in the PGP demonstration. The ACOs really need those shared savings in order to finance the startup costs, which are pretty significant, and costs include infrastructure, HIT analysis and et cetera.

Again, here is where real-time data exchange also comes into play. It will be absolutely essential to have that data so that the shared savings can reach the providers in a timely manner. Also, we encourage you to waive legal barriers that inhibit distribution of shared savings. For example, paying bonuses to a subset of ACO members. In regards to coordination with other value-based purchasing initiatives (inaudible) the VVP program for those participating in the ACO program.

And finally, in regards to joint accountability among providers, we want to note that hospitals are essential components to ACO, and we think you should also look at waiving legal and regulatory barriers that may serve to inhibit the formation and use of ACOs as well as limit accountability among providers.

We really appreciate today's open-door forum. We're happy to hear that you plan to have more forums in the future. We think it's incredibly important that the providers and the agency work together to develop the ACO program. We suggest perhaps holding a day-long listening session in the future before any regulations are released, and we know you've used this approach in other initiatives, including the VVP program and encourage you to do that for the ACO program.

So again, thank you for the opportunity to comment. We look forward to working with you in the future.

Dr. Terri Postma: Thank you very much, and as part of this listening session, we'd also encourage folks if they have experience in this area, to tell us their lessons learned.

Operator: Your next question or comment comes from the line of Leo Cuello from nHelp. Your line is now open.

Leonardo Cuello: Hello. My name is Leonardo Cuello, and I'm representing the Campaign for Better Care, as well as my organization, the National Health Law Program. The Campaign for Better Care is a multiyear effort to improve care, especially for vulnerable older adults with chronic conditions, who are the heaviest users of this system, lead to the highest costs and ultimately receive the poorest outcomes.

We – the Campaign for Better Care really believes that ACOs may be a way to achieve better, more coordinated and patient-centered care, but there are a lot of things that need to be done to make sure that the beneficiaries are at the center of this and truly benefit from it, and I'll just mention two things that are really important. The first one is monitoring the impact on health disparities. ACOs have tremendous potential to start addressing the serious disparities problems we see, and one key element to that is collecting race, ethnicity, language and gender data, and collecting it in a way that you can stratify and compare that information so that CMS can really evaluate the impact on different populations, and what I'm talking about there are the participation rates. As you roll out new models are certain communities being included and other communities being excluded? The services within the model, as you are rolling out a model, are we seeing that certain communities are getting a lot of services and other communities are not getting services? And then, of course, on the outcomes side, are we seeing that, despite the existence of these new models, certain communities continue to get worse outcomes?

The other area that I think is really, really important for – from the point of view of beneficiaries is how does – how does the consumer experience this ACO and what sort of protections are there for them? Will they have any choice as to whether or not they're assigned to an ACO or have to participate in an ACO? What kind of notice will they get? What kind of options will that notice give them? What happens if existing providers want to see me through an ACO, but I don't want to participate in that ACO? Does that mean that I have to suddenly pick different providers? How will this interact with what have been traditional freedom of choice protections that have been essential to making sure that consumers really can see the providers they want to see? Or, what happens – you know the typical consumer with – who is older and vulnerable and you know has chronic conditions may see 10 different specialists. What if two of my specialists are participating in an ACO, and the other ones aren't? How does that interaction happen? Am I forced to choose between my PCP and two specialists that are in the ACO, or you know can I go outside of the ACO, and how

will that interaction work? I think these are all issues that are extremely important to be – to addressing in order to make this work.

At the bottom line, the Campaign for Better Care takes the approach that, if we can get this right for the older adults with chronic conditions who are among our most vulnerable populations, then if we can make this system work for them, we will make it work for everyone. So I really urge you to think about how we can make sure that low-income, vulnerable older adults are well cared for as you roll out these new models.

Thanks.

Dr. Terri Postma: Great. Thank you very much.

Operator: Your next comment comes from the line of David Juba, with the Fundamental Clinical Consulting. Your line is now open.

David Juba: Yes. Thank you. I have a question about post acute care providers. I mean I know in the legislation and in the dialogue so far you know the emphasis has been upon primary care providers and also acute care hospitals, but I just wonder what thoughts you might have about expanding this to at least some of the ACOs, to include you know the full spectrum of post acute care providers, and I – and I say this partly because of my reading of the – so the policy establishment is that there's just a lot of benefit to be gained to Medicare in the large by reducing the rate of unplanned and unnecessary returns from post acute care to acute care. You know I wonder how you can accomplish this if you don't have the post acute care spectrum part in the ACOs. So I would encourage you to – I don't want to say require, but at least strongly suggest that at least some of the ACOs in the models that you're going to – you're going to test include a strong component of post acute care.

Dr. Terri Postma: Thank you very much.

David Juba: Welcome.

Operator: Your next question comes from the line of Richard Moed from CRE Care. Your line is open.

Richard Moed: Question about the use of technology specifically around fall detection, whether that would be included as something that an ACO could consider using to better monitor patients at home, and if they do have an accident get care to them quickly. Thank you.

Dr. Terri Postma: Thank you for that comment. We're in the very early stages of development, and we're interested in hearing any suggestions that you have in that area.

Richard Moed: Thank you.

Operator: Your next question comes from the line of Gerry Shea from AFL-CIO. Your line is open. Gerry Shea, your line is open. Your next question comes from the line of Bing Lu from New York City Chinese American Task Force. Your line is now open.

Bing Lu: Yes, thank you. We represent two successful IPAs operating in Chinese in New York City for – one is over 10 years, another is over five years, and the jointly the two IPAs represent more than 500 physicians, and we cover about more than 400,000 ethnic – mostly ethnic Chinese patients. About one-third or a quarter of them are Medicare beneficiaries. We're in the process of forming an ACO for the purpose of improving quality of care, the value and the outcome for Medicare beneficiaries.

Basically, just a little bit about our – where we are now. We have set out four strong elements in concerning our ACO. One is that we want to have a strong primary care foundation, primary care network coupled with easy access to community based specialty services. That's basically what we have been doing with the two IPAs. But we'll do the same thing for ACO. Secondly, we want to have a strong corporate governance. Earlier, you mentioned this structure of the ACO. We will put a lot of attention to corporate governance. Basically, this is going to be a physician led, physician organized network of practices, and we want to set the organizational structure right. And thirdly, we want to develop a strong IT infrastructure to basically do smart managerial and the clinical decision making based on a good IT infrastructure. Lastly, we want to implement strong internal check and balances, or we may call enterprise risk management, to both monitor how our ACO system is functioning as well as to monitor how the cares are delivered to the beneficiaries, to care and metrics like for the quality, the outcome and the cost.

Now, I say the two IPs have been successful. They have been successful on global risk or for-risk sharing basis with multiple Medicare Advantage managed care companies. This is across both IPAs and across different risk contract and over many years.

And specifically for today's conference, we would like to comment on a few points. Joint accountability among providers in the formation of – in the use of ACO, there – in our case, we think our prior successful

experience in terms of primary care physicians working closely with specialists, that gives us the confidence that we will actually be able to do it. But specifically for the ACO that we're forming, this will be physician – the physician, participating physicians will have the option of becoming investor and therefore shareholders for the ACO. So whether you are a primary care physician or a specialist, financially there is a joint accountability in creating value for ACO as a company.

Clinically, we want to heavily rely on a limited number of interoperable electronic medical record. So basically, the ACO wants to move in the direction were the use of different EMRs will be, to the – to the extent possible, limited you know among different practices. In New York City, we tremendously benefit from the – from the leadership of the Department of Health in their PCIP project, where they're trying to identify the three preferred vendors, and then many physicians who are newly adopting EMRs are kind of selecting from these vendors. So that helps. But eventually, we want to create a data hub, a data warehouse, where critical informations will be stored in the same central place where all of the ACO providers will be able to access and then retrieve data and for a real time clinical care. So this helps the joint accountability.

On the second question, costs and the quality measures. What we want to share or to emphasize is that we are put a lot of emphasis previously in our IPAs in terms of what's going to open access or advanced access or same-day appointment, and that is a big effort among the physician communities within our IPA, and we think that open access should be counted in the measurement because the open access provides better care for patients, and also it helps reduce unnecessary emergency room visits, or even hospitalizations, and this is just a purely simply better medicine if we can help physicians through ACO to develop towards a more open appointment system, which, in our experience, has been largely achieved in a majority of the physician practice.

On the third point, risk adjustment. We are – so we have two recommendations. One is that the shared saving program should encourage improvement on patient risks score over time. So if it's a three-year contract or five-year contract, in the event where the population under care, the average risk score improves over that period of time. The shared saving program should leave some incentive on the table to reward that kind of improvement. This is point one. Another point is utilization benchmarks (inaudible) ACO as an organization and for individual physician. So let's say if we do PCP based benchmark, we should consider the risk score of the ACO's patient population or that particular practice risk score. In other words,

benchmarking – utilization benchmarking need to be done in conjunction with the particular risk score so that we don't penalize certain practice or certain ACOs if they do happen to take care of sicker patient populations.

On the attribution of Medicare beneficiaries to ACO, we support our continued you know freedom of choice on the parts of patients, and that you know really forms one of the cornerstones for better care because if a patient doesn't feel he or she is being correctly or rightfully treated, he should have – or she have should have choice to be moved. And that should not change. However, at the same time, we think CMS, in implementing this shared saving program, should encourage patient to voluntarily choose a primary care physician to provide their continuity of care as well as to be their care coordinator or advisor. But this should not be limited to primary care. For certain disease – chronic disease management, it could be a specialist be the main caregiver, or continuity of care giver. But the idea should be you know brought to all the Medicare beneficiaries in order to improve the quality and the reduced costs.

And the other attribution – and of course, what follows is that if whether retrospectively or prospectively the patient is assigned to a physician who belongs ACO, maybe this should be measured on the basis of evaluation and management visits, let's say over 60 or 70 percent over a period of time in order to do the assignment of the patients.

Thank you for the opportunity.

Dr. Terri Postma: Great. Thank you so much for those comments and for sharing your experience.

Operator: Your next comment comes from the line of Steve Black-Schaffer from College of American Pathologists. Your line is now open.

Steve Black-Schaffer: And this has been very interesting so far. I'm speaking on behalf of our interest as pathologists in being assured that we have an opportunity to contribute to and participate in ACOs. By way of background, pathologists are often categorized as hospital-based physicians. We are medical specialists. The majority of us do practice in hospitals, but the services that we provide actually are quite ubiquitous. Clinical laboratory services are provided everywhere from small doctors offices through the hospitals' regional reference laboratories.

As a result, the patients whom we touch and the physicians with whom we work don't fall within very simple geographic boundaries. On the

other hand, the services that we provide and which we're optimally positioned to advise on the appropriate use of, are a very substantial part of medical care. If they are optimally provided, they can both save money and direct management very quickly. Sub-optimally provided, they can cost a great deal and lead to unnecessary investigation and delayed diagnosis.

Almost everything that we have seen by way of descriptions of how an ACO might work seems to be centered pretty much entirely on the idea that primary care medical services are going to be used to direct and define ACO characters, and we are concerned that this would not fit very well with any hospital-based physician, or indeed any specialist physician circumstances, particularly those of pathologists, for the reasons I've mentioned.

Finally, what we are interested in doing is figuring out a way that we can work with CMS and with our various local ACOs to try to figure out a way in which we can incorporate a service, which essentially every patient who gets medical care receives into what will undoubtedly, and probably appropriately, be a wide variety of models.

So our questions for you would be, do you have in mind or on tap in terms of the models that you are beginning to receive ones which incorporate pathologists in providing these services so that we can in turn help to disseminate those to our members, who can work as ACOs form across the country with the people who are forming those ACOs so that we will not have to invent what's going to be a rather complicated medical financial arrangement in multiple different locations, and will there be opportunities for us as an organization representing pathologists across the country to work with CMS to try to smooth the way for our participation?

Thank you.

Dr. Terri Postma: Thanks so much for those comments. As for your question, we're pretty early on in the development process. So what we know is what's stated in the statute currently. And so I appreciate your comments, and keep them coming. Thanks.

Steve Black-Schaffer: You're most welcome.

Operator: Your next comment comes from the line of Samuel Skootsky from UCLA Health System. Your line is open.

Samuel Skootsky: Yes, thank you. I'm calling from one of the larger academic medical centers on the West Coast. We have both a large primary

care base, and also a very large referral specialty base, and my question – what I wanted to ask about does not seem to have been addressed in any of the prior comments, and that is that in this notion of the ACO, which we support and we would like to participate in once we fully understand it, there's at least four kind of key issues. One is defining the population, which seems as though that is not really finalized yet, although it appears we need at least 5,000 members in the entity. Then there's the rules around the shared savings, and that's been described a little bit. I think I have a better understanding of that. Of course, care has to be made better and more efficient.

The last part, though, is – and this question comes with an assumption, and you can correct me if my assumption is wrong – I'm assuming that these members would be allowed to go to whoever they want outside the ACO if they wanted to, that this is not a locked-in plan. And assuming that assumption is correct – and correct me if I'm wrong on that – I wanted to know what incentives would be allowed to encourage patients, often for their own benefit, to stay essentially in network, if I can use that terminology. So for example, in some of the commercial insurance schemes that there might be, say, lower copayments if they stay in the network. They might get – they might have to pay less for drugs, for example. I don't know if that would mean less payments under their Part D copayments or something like that. So can you – can you comment on that kind of thing? What would we be allowed to do to incentivize patients to stay essentially within the ACO network?

Dr. Terri Postma: Thanks for your comments. No decisions have been made at this point, and we'd appreciate any suggestions or comments folks have around those issues.

Samuel Skootsky: What – does that mean that then you would be entertained to have such incentives?

Dr. Terri Postma: Beyond what's written in the statute, no decisions have been made about the program.

Samuel Skootsky: OK. Thank you.

Dr. Terri Postma: Thanks.

Operator: Your next comment comes from the line of Vicki Gottlich from the Center for Medicare Advocacy. Your line is open.

Vicki Gottlich: Hi. This is Vicki Gottlich from the Center for Medicare Advocacy and Ilene Stein from the Medicare Rights Center. We'd like to echo many of the comments that Leo Cuello made on behalf of nHelp and the

Campaign for Better Care, and we also want to talk about issues concerning patient-centered care and ability for patients to go see doctors outside the ACO network.

In addition to the issues that Leo raised, there are issues concerning what kind of notices people would receive, times of the notices, appeal rights in an ACO model. Would you follow the traditional A&D appeal system, meaning that you'd have to get to service in order – and pay for it in order to file an appeal, or would you file the – follow the Part C appeal system, which would allow you to file an appeal if the service had been denied? How are you going to distinguish ACOs from Medicare Advantage plans for individuals who are not comfortable going through a managed care environment? And we'd really like to encourage CMS to allow individuals to see doctors outside the ACO network.

In addition to the situations that Leo described as people seeing four or five doctors, some of whom would be in the network, some of whom would not, we also represent beneficiaries who develop a kind of illness or condition and go to a different part of the country to be cared for an adult child, for example. And if they're in managed care plans, this creates problems. If they are in the ACO, it would allow them more flexibility to go to another part of the country for caregiving issues.

Ilene Stein: In addition, I think that it is important that there be a focus on beneficiary education, what the definition of accountable care organization is, that this education be done in a consumer-friendly manner, because in order for this to work, there needs to be proper consumer buy-in. Also, I guess we have questions about – as far as offering incentives to key beneficiaries so that they actually participate in this system, whether other current statutory authorities you know has the power to create those incentives or whether there needs to be you know further congressional action to allow for those incentives to occur, because as we previously discussed, there – we didn't necessarily need incentives for a beneficiary that gets their services through the original Medicare to participate in an ACO that would limit the number of docs – limit the network of doctors they are able to see.

Dr. Terri Postma: OK, thank you very much for those comments.

Operator: Your next comment comes from the line of Tim Young from Summit Medical Group. Your line is open.

Tim Young: Thank you. I would like to echo many of the remarks that have been made, as well as many of the questions. I will have a few of those

comments and questions. Quick background about Summit Medical Group. We have 220-plus primary care physicians and an integrated medical practice in Knoxville, Tennessee. We take care of today approximately 80,000 Medicare lives and some time ago operated a global cap percent of premium risk arrangement, in which we assumed risks for both commercial and Medicare lives under an institutional and professional capitation arrangement. So obviously, we have a keen interesting in and are uniquely positioned in our region for the formation of an accountable care organization, and their community is looking to us as a leader to form some type of integration and an entity that would serve in that capacity in our region.

A couple of questions that I have and remarks that I have not heard otherwise mentioned in the previous comments include there's still a question that we have as to how this will integrate these accountable care organizations may integrate with Medicare Advantage products as to whether or not – back to this issue that was mentioned earlier regarding consumer choice, we'll – and really be given an option, or will those be prospectively we hope assigned to an accountable care organization, and if so, will they have options which include what is today traditional Medicare programs, Medicare Advantage program or potentially an accountable care organization? We would hope that the ultimate regulations would clearly address that such that accountable care organizations could clearly assess their risk and also the potential for members in terms of where they would go based upon benefit differentials, et cetera.

There's another question I have that never – that's not yet been addressed as well is we have not seen anything within the statute that would describe what the regulatory requirements are for financial reserves as it relates to the formation of accountable care organizations, and that perhaps could be listed under the Medicare beneficiary protections concerns issues, but my question is really what will the financial reserves requirements look like? This is effectively delegated risk arrangements, and having been in that space before, will those be governed by the state department of insurances, which varies state-by-state? Will this be – will the government determine – the Federal Government determine a national standard by which Federal Reserve or reserve requirements for claims processing, et cetera, will be conducted, and will there be performance standards related to the management and mitigation of risk associated with the provision of those services?

And I don't know if you want to wait and answer each of these questions separately or if you would prefer my you know continue on a

couple more and then respond, but I – has there been any discussions, comments yet about the reserve requirements?

Dr. Terri Postma: Like I said, no decisions have been made, and – but I appreciate you bringing up those issues, and we'd encourage you to bring up any issues that you might see and any other suggestions that you might have.

Tim Young: OK, the last item I would have would be to echo this issue related to shared savings and the timing of distribution. It's essential that in order to engage the provider community in meaningful behavioral change, which is necessary the product of any type of risk arrangement such as this, that the distribution of those funds be such that it's – that they can be timely distributed to provide a participate, and that would include hospitals, physicians, ancillary service providers or whatever the risk model and income distribution model look like for that region. And so it would be essential that that be made available very soon and allow that the ACO itself would be able to administer such a program.

I would also urge the body that's drafting the regulations for this to look beyond the physician group practice demonstration project because there are – there are significant concerns as you look at that as to how that income and risk distribution model worked as to whether or not in regions, given that there's a geographic variance across those – many of those regions as to what the Medicare premium for those respective lives are and how that would be – that might therefore need to be modified, not just as it was under the physician group practice demonstration project.

Dr. Terri Postma: Thank you very much.

Tim Young: Thank you.

Operator: Your next comment comes from the line of Sandy Marks from the American Hospital Association. Your line is open. Sandy Marks from the American Hospitall Association, your line is open. Your next question comes from the line of Sarah Thomas from the NCQA. Your line is open.

Sotas Chorter: Hi. This is actually Sotas Chorter from NCQA sitting here with Sarah Tomas. As the law requires, we very much support the idea that there be upfront qualifying criteria as well as specified performance measures for ACOs. I would like to reinforce some of the earlier comments about some key areas to think about in terms of qualifications, and these key areas do arise out of our review of research on what might help organizations to be successful ACOs.

So culture and leadership is certainly one that research has reinforced, sometimes hard to get at, but in many evaluations a key ingredient of success. Information systems have been mentioned. A strong primary care base and processes to align incentives to help the ACO achieve the utilization objectives. So really thinking about how to pull together the primary care, the specialists, the hospital (inaudible) that are included to align the incentives to enforce keeping the population as healthy as possible.

With regard to beneficiaries, I would like to emphasize the importance of really learning – thinking about how to promote a conversation between the beneficiary and the ACO about what the ACO has to offer them. I think you know some of the other commenters have spoken up in favor of incentives or not in favor of incentives. Outside of that, what you really want to promote is a very strong partnership between the ACOs and beneficiaries and think about how your regulations might encourage that.

I do want to say a couple of words about performance measures as well. Performance measures will obviously be very important. There are both timing considerations and small numbers considerations to take into account. It will take time to get the performance results from the ACOs. It will take time to develop – to have enough data to develop performance benchmarks. We don't have good data to do that now, and while the law says has the minimum of 5,000 beneficiaries, I think it will be very important to (inaudible) of the requirements that you come up with regard to enrollment size because that will very much impact what performance measures will end up being useful, especially taking into account the need for risk adjustment. You can very easily get into a small numbers situation, where you're not getting the kind of information you thought you might.

Thank you.

Dr. Terri Postma: Thanks very much.

Operator: Your next comment comes from the line of Rene Quashie from DBR. Your line is open.

Rene Quashie: I have no questions. Thanks.

Operator: Your next question comes from the line of Tanya Alteras from National Partnership. Your line is open.

Tanya Alteras: Thank you. I'm speaking on behalf of both of the National Partnership for Women and Families as well as the Consumer Purchaser Disclosure Project. The Disclosure Project is a collaboration of leading national and local employer, consumer and labor organizations that have expressed their commitment to improving quality and affordability of healthcare through the use of performance information, and using that information to inform consumer choice, payment and quality improvement. And so the issue of accountable care organizations and shared savings falls right into our round house, and we believe that ACOs, if done correctly, can really be the tool that increases quality and affordability of care, and my comments will echo many of those that have been made already, particularly by some of the callers who were representing the Campaign for Better Care.

We believe that in order to be successful, ACOs should result in significant improvements in quality and care coordination and that this will require creating a robust dashboard of measures that include topics such as clinical outcomes, functional status, appropriateness of care, patient experience, care coordination as well as cost from resources, and that will require developing and using a set of minimum benchmarks that providers must meet in order to reach performance goals.

We don't believe that physicians participating in ACOs should receive rewards for providing marginally effective care or care that is already routinely furnished. We also believe that ACOs should improve quality by eradicating disparities in care, which I know many comments have been made on this already. Essentially, high-quality care should, by definition, reduce disparities, and we believe that the ACO model should be held to this standard. So we think that data on race, ethnicity, language and gender must be collected for all patients and that performance measures that are used in these models must be able to be stratified according to this data so that disparities can be identified and addressed. And finally, we think that CMS should develop an evaluation plan that would monitor the impact of the shared savings program on healthcare disparities.

I'd also like to comment on the idea that ACOs must realize meaningful and significant savings, both in the short term and the long term, and we think that this can be accomplished by having meaningful measures of cost efficiency resource use, as I just mentioned. Also, setting minimum benchmarks that encourage innovations in care, and then once the shared savings programs have had some demonstrated success, moving on to models of shared risk and capitation. We think that a majority of the savings from these programs should be returned to beneficiaries and purchasers of care, and we would actually

advocate for 66 percent of those savings to go directly to beneficiaries and to the payer of the premium for that care, with 33 percent going to providers.

Another idea that has been mentioned before on this call, we think that risk adjusted payments should be incorporated to reflect the complexity of the patients and ACOs and to allow for appropriate levels of care coordination and transition activity. We think that CMS needs to continually monitor the healthcare marketplace once these programs are implemented to ensure that the model is not resulting in market consolidation that could lead to higher costs. We really believe that ACOs should foster greater clinical integration and coordination, but there is the potential there to create market consolidation, and there needs to be vigilance to ensure that that does not occur.

We would like to comment on the attribution issue. We would like to see assurances that attribution of beneficiaries to an ACO model is done through a very transparent process, with all appropriate patient protections in place, which others have already mentioned, and included in that is that there needs to be transparency of financial incentives that are available to providers that may affect the way care is delivered. We also would like to see patients having the choice of going outside of their ACO for care if they want or need and to have adequate access to specialists, and of course there must be an appropriate appeals process available to consumers.

And then finally, we strongly believe that in order to be successful, there needs to be alignment between the public and the private sector pairs. In order to represent a substantial cross-section of the market, ACO shared savings models need to include public and private sector payers, including Medicare, of course, and Medicaid and private payers. Multi-payer initiatives will provide more motivation for providers to participate. They'll ensure enough patient volume to reliably evaluate performance, and Medicare should consider multi-payer initiatives as a very important criterion for assessing which pilots to select to participate in this program.

Those are my comments, and I very much appreciate your consideration of these suggestions and ideas, and we look forward to working with CMS as progress is made on these regulations.

Dr. Terri Postma: Thanks very much.

Operator: Your next comment comes from the line of Mark Shields from Advocate Health Partners. Your line is open.

Mark Shields: I'm senior medical director for Advocate Physician Partners, which is the joint venture between Advocate Healthcare and 3,400 physicians in the greater Chicago metropolitan area, and we have considerable experience in the private sector with working with all of the carriers in the Chicago metropolitan area to drive quality, patient safety and cost effectiveness in a program that we call clinical integration, and we've been doing this for seven years. And I've provide it as background on some of these other questions that I have.

The first has been addressed by some prior speakers in some way, but I'd just like to reiterate the importance of providing incentives for consumers to participate in the ACO. We have found in our program, in which we have both HMO patients and PPO fee for service, that having patients who have an identifiable personal physician are able to have much better performance metrics on quality and patient safety and cost effectiveness. So we feel it important to allow an ACO to provide incentives to consumers to participate.

And then on a question that has not been asked is really would the ACO have an ability to – after make a pitch to patients to provide their – obtain their care from the ACO, would the ACO be able to exclude patients who consistently obtain a significant portion of their care outside of the network?

The next comment is related to the availability of Medicare claims data. The timeliness of this is essential. From our understanding, this was a significant problem with the group practice demonstration project, that the Medicare claims data was not made available. These are key tools to be able to monitor performance as well as to do care management. So having CMS provide this on a very timely basis to the ACO will be essential.

And then finally, the threshold for shared savings is an important issue. It's our understanding that the threshold was set in the group practice demonstration project of two percent savings before the group practice shared in any of the savings. Some of the rationale for that was the variability in spending for relatively small populations of Medicare enrollees, and I think it would be very important to modify that hurtle if the enrolled – number of enrollees was significantly higher or progressively higher, since the variability would decrease just on random chance. This is extremely important because we know from our experience that infrastructure is essential to improve quality, patient safety and cost effectiveness, and if the potential ACOs feel that there's really no opportunity to recoup those significant investment expenditures, that will make it much more difficult for organizations to

seriously consider participating in this program, which does certainly have some real opportunities to improve care.

Those are my comments and questions.

Dr. Terri Postma: Thank you.

Operator: Your next comment comes from the line of Mike O'Neil from Health Springs. Your line is now open.

Mike O'Neil: Hi. Good afternoon. Thank you for this opportunity. I'll be brief. I would echo and underscore everything just stated by Dr. Shields as well as earlier by Tim Young and others. Our experience as a management company for IPAs serving over 100,000 members is that the primary physician's linkage with the patient is vital to sustained improvement in clinical, and eventually cost outcomes, and I do think that the more evolved approach would be to have this be an incentive based system rather than prior gatekeeper models.

But I would only emphasize the importance of early success in the ACOs, both clinically and financially, that is really critical path dependent upon a primary care physician being able to have some connection and predictability with their patients, and those patients choosing to engage as that personal physician based upon the value of the care they're receiving inside the ACO, getting back to Dr. Shields' comments around the ACO's ability to create significant draw for patients to choose to seek care inside a system that is coordinated. It's consistent with some of the original tenants of the medical home, where coordination of care, even to the point of referrals so that the primary care physician is aware of care seeking and different specialists, and those specialists have an obligation to return that information back to the primary care doc to continue to coordinate care on behalf of the beneficiary. That is – that is the one item that I think stands as a foundation risk for broad not just adoption, but broad success of ACOs in the early years.

Thank you.

Dr. Terri Postma: Thanks very much.

Operator: Your next question or comment comes from the line of James Fouassier from Stony Brook University Hospital. Your line is now open.

James Fouassier: Thank you. Thank you so much for the opportunity to participate in this forum. Most of the provider organizations that are even

contemplating forming ACOs really have to start off by settling on some formal legal structure, as you've mentioned, will be one of the criterion. But there seems to be a great deal of confusion and concern over whether the structures that are adopted will run afoul of antitrust or a Stark or an anti-kickback legislation, and my question then simply is whether CMS has been in dialogue with the Federal Trade Commission and the Department of Justice to perhaps develop guidelines for the processes of actually formulating the legal structures that will be necessary to implement any definitive plans for an ACO so that the providers are confident that as they go forward in the development of their provider networks, they will not run afoul of these current legal restrictions.

Thank you.

Dr. Terri Postma: Thanks for bringing up that issue of concern.

Operator: Your next comment comes from the line of Nathan Kaufman, Kaufman Strategic Advisors. Your line is now open.

Nathan Kaufman: Yes. I'm a healthcare strategist. I work with about 100 different healthcare systems around the country. My primary area of focus is negotiation physician compensation. I just want to bring to your attention what happened in 2010, when you changed the fee schedule for cardiologists essentially overnight by reducing their fee schedule. The cardiologists either were going to leave town in many health systems, or demanded that their compensation be stabilized, and by the end of this years, I think probably around 65 percent of all cardiology groups will have moved from being private practitioners to being employed by their local health systems at a huge expense to that health system.

And, oh, by the way, in the course of that process, Medicare is cutting reimbursement to health systems, and the reason I bring this up is that if you look at ACOs just in isolation, I think you're going to miss the unintended consequences that are going to occur. One of the biggest ones is, my experience, is the typical private practicing physician, and this is confirmed by AMA's recent survey, is now limiting their practices with respect to new Medicare patients. Seventeen percent of the physicians nationwide reported they were eliminating 31 percent of the primary care doctors, that they were limiting their practices, and it was primarily due to low pay and the hassles associated with treating Medicare patients.

On the specialists side, we see specialties consolidated. We have one radiology group in Maryland. We have on orthopedic group in most

markets, one cardiology group and so on, and when I approach these various groups and suggest that they consider some sort of ACO, their response is, “As long as I can maintain my compensation, you can do whatever you want.” And the reason I bring this up is that, what happens in most of these markets, where you have consolidated specialists who aren’t particularly interested in participating in a local ACO that redistributes money from specialists to primary care physicians, as was outlined in Mr. (Hackwar’s) note to Mr. Biden in a recent congressional testimony.

So I think ACOs are a landmine. My bet is that invest a huge percentage of specialists, and even a huge percentage of primary care physicians won’t be interested, and that you can’t look at these things in isolation, but rather, you need to understand how they fit into the entire healthcare system, and in particular understand the unintended consequences, both to the patient and to the health system at large.

That’s my pitch.

Dr. Terri Postma: Thank you for those comments.

Operator: Your next comment comes from the line of Aimee Ossman from the National Association of Children’s Hospitals. Your line is now open.

Aimee Ossman: Thank you. This is Aimee Ossman, and I’m from the National Association of Children’s Hospitals, and obviously children’s hospitals don't care for a large number of Medicare beneficiaries, but they do care for a large number of Medicaid – children on Medicaid, who get their insurance through Medicaid. So we just had a couple of questions on whether there are some parallel activities going on within CMS on the pediatric ACO program, which is also in the health reform bill, and how much overlap will there be from the Medicare ACO, and then also the regulation that you've talked about releasing in the fall, will that apply to – will be on the Medicare ACO, or will it also apply to pediatric ACO demonstration projects?

Dr. Terri Postma: The statute for the Shared Savings program is Medicare specific, and – but as you mentioned, there’s an ACO for pediatrics, the demonstration. So to the extent that your suggestions or comments for integrating or to looking at ways that those and other value based purchasing initiatives can be aligned, that would be – we’d appreciate those comments.

Operator: Your next comment comes from the line of Meredith Hughes from Acevedo Consulting your line is now open.

Gina Savido: Hi. Thank you. It's actually Gina Savido. I'd just like to add something to the American Hospital Association's comments and reiterate how important timely data being reported to anybody participating in this projects is going to be, being someone who my firm has helped innumerable physicians attempt to participate in PQRI, and I believe CMS is following it by now and well aware of this.

One of the frustrations has been how untimely the data is, even in that current system. To give an example for anybody on the call who may not be familiar, it will October, probably, of 2010 that participating physicians find out how well they did in 2009, and by that time, if they're not doing in 2010, it may indeed be too late to do anything about it. It seems almost oxymoronic that that happens. And that any reports that be provided be clear. Again, I'm just echoing experience – physician experiences in the PQRI program. One of the doctor's overwhelming frustrations in addition to the untimely nature of data has been you know from their perspective, and obviously these are smart individuals, having such great difficulty in interpreting the data in any meaningful way.

Thank you very much. This has really been a great call, and I look forward to more outreach such as this from the agency. Thank you.

Dr. Terri Postma: Thanks a lot.

Operator: Your next question comes from the line from Alice Dong.

Alice Dong: Hi. This is Alice Dong. I'm the senior policy analyst at the Asia and Pacific Islander Health Forum. I'm representing the organization as well as the Campaign for Better Care, which Leo Cuello and Vicki Gottlich referred to earlier. I would like to echo some of the comments that Leo made with regard to election of race, ethnicity, language and gender data. This is especially important for the – for minority communities, and I'm hoping that CMS will look to the regulations that the Institute of Medicine issued on the collection of such data and that these include the need for granular data to the subpopulation levels. So not just Asian Americans in general, but really going down towards ethnicities.

I'd also encourage any practices that – any regulations around the practice of collection to emphasize the need for self-reporting that is self-identification of a patient with a race or ethnic group as opposed to having the provider state those – state those characteristics for the patient. In addition, we are hopeful that CMS will take a look at how to ensure the high – the high-risk and high-cost populations are included in the ACO models, and certainly in defining what high-risk and high-

cost populations are, recognizing that over-broad categories can help to hide some of the most at-risk populations.

Thank you.

Dr. Terri Postma: Thank you for those comments.

Operator: Your next question comes from the line of Katherine Schneider from Atlanticare. Your line is open.

Katherine Schneider: Hello. Thanks for the opportunity. I'm speaking on behalf of a health system who is participating in premieres ACO collaboratives, and we also have a couple of years of experience with the commercial population with a very innovative medical home model that was specifically designed for the chronically ill. I'm also a family physician, and specifically in my personal prior life, I led one of the PGP demonstration sites in Connecticut. So I want to just comment about medical homes and primary care as it relates to this.

As I'm sure you know many of the comments previously have alluded to and you're well aware of, primary care is really operating on a shoestring, if that, in many parts of the country, and really not with enough margin to invest in the kind of radical innovation and transformation that's necessary to achieve the kind of outcomes that we're hoping for, and that's even with the support of bigger infrastructures such as health systems, PHOs, IPAs, et cetera. And when this change is tied strictly to a fee for service model, which may or may not have some future savings you know a year, two years, three down – three years down the road out of the black box, very complicated methodology. It's just not enough to really get those primary care docs off the hamster wheel medicine of fee for service, and particularly when they're also providing care in other models that don't have the same incentives.

So there were several comments that I want to echo around multi-payer initiatives. And my specific question is CMS is embarking on a large multistate, multi-payer medical home demo, and I believe that the ACO language actually prohibits participation in the ACO plus any other existing demos, and I would just encourage you to look at that multi-payer medical home demo as not a competition with the ACO but really a critical, critical piece of infrastructure to get that transformation to support the kind of primary care system that we need. So that participation in other medical home demos not exclude from ACO world.

And furthermore, I want to echo what's been previously mentioned around alignment. Again, in my PGP experience, lesson learned, was it really helped with provider buy-in to be able to have that participation become really a substitute for and not an add-on to existing value-based purchasing reporting programs such as PQRI. If we're going to do this, we're going to do it as an integrated system. We want to report out once, not multiple times, and have it be on the most meaningful criteria.

Thank you very much for the opportunity to comment.

Dr. Terri Postma: Thank you so much.

Operator: Your next comment comes from the line of Sultan Rahaman from Doctors for America. Your line is open.

Sultan Rahaman: Hi. I appreciate you taking my call. I'm a family physician in Orlando. I've been seeing patients for over 20 years, and actually I've taken two hours off my schedule to see – to be on this call. I'm also a member of Doctors for America Grassroots Organization comprised mainly of primary care physicians. I have been over the last 20 years also been intimately involved with Medicare Advantage. I started as a Medicare Advantage provider back in the late '80s, probably around 1989, and as I see this ACO dialogue developing, I am getting – I'm getting dreams of Medicare Advantage 2.0.

I'm looking at this from you know high up. I'm – at this point, I admire the people talking about specifics and a lot of the bureaucracy stuff, but I have the sense that ACOs are trying to achieve what Medicare Advantage had promised the government and taxpayers to do to reduce costs of care, improve quality, access, the whole nine yards, and we know where we are with that today, and Medicare Advantage is being phased out of this bill. This is the same law that's bringing ACOs in, and we know that the experience of Medicare Advantage in terms of quality is not good a track record. The Medicare Advantage has not proven, generally overall, to have improved the quality of care outcomes with senior citizens.

At the same time, as far as savings and costs, yes, Medicare Advantage has reduced the cost of care in some areas, but those savings have not been distributed adequately or in an appropriate manner. The physicians, including myself, who have received bonuses for say some quality and utilization performance, I'm very grateful for it, because if I had to depend just on straight Medicare rates, then of course you know we're talking in the background of the

SGR catastrophe. I couldn't survive without some extra income from the bonuses that I have achieved.

So I have been part of receiving bonuses. But what I have to tell you is that the Medicare Advantage program has taken the savings, and a lot of that has gone to them, the middle man in the whole delivery of Medicare care. We have CMS, or what used to be HCFA, providing the funding. It goes then to companies like Humana to provide Medicare Advantage programs, who took a percentage off the top for themselves and their shareholders. Then you go to affect another layer called MSOs, or medical service organizations, which could be you know what ACOs are going to be. They take a percentage off the top for themselves too, administration. They get all the doctors together. They get those – they get – they bring the physicians together so that you have those 5,000 patients to make it worthwhile to take risks, but they take a percentage. Then at the bottom of it, you have the patient, that may get some extra benefits, and the primary care physicians get a little bit of the savings.

My hope is that ACOs do not go down that track again. My hope with the experience that I've had, even though I have benefited financially, is that we reduce the number of layers of not just bureaucracy, but skimming of profit and savings. We will end up where – by the – I feel that how it should really work, that we should have improved quality of care, better disease management of chronic illnesses, which I see everyday diabetics with lots of complications, CHFs, asthma, emphysema, et cetera. But the savings need to go to the – to the people that really should have it, which should be to taxpayers. It should go to physicians and other providers who are putting the work in, and it should go probably to the beneficiaries in some way. I do not figure that ACOs should be run in a manner where you have multiple layers of organizations, each taking a piece of the savings, and at the end of it, you do have savings, but it's not what you should have.

And I'm very concerned about that. I feel that what I'm hearing on this call is a lot of talking about you know the bureaucracy of it and stuff like that, but I think we might miss the target and end up having Medicare Advantage too. So I would like to get some comments. How are we going to avoid having this happen, where the savings just gets spread across and not this nightmare again?

One last comment is that why I think this is so vital – and I've taken two hours of my time – is that we are in a – the crisis with SGR right now, and it's because there is not the money to fix it. If we run issues properly, the idea would be to have the savings so that that saving can turn around and compensate physicians better. That money could be

coming from somewhere else. Right now there's – the SGR is going – is kicking in because there is no money. Nobody wants to pay for it, even though they feel that it's necessary. If this is run properly, then the savings should really be coming back to help physicians get better reinforced – reimbursement, other healthcare professionals getting better reimbursements, and with no extra cost to taxpayers.

So with that, I'd like to hear some response.

Dr. Terri Postma: Thanks. I appreciate those comments.

Operator: Your next comment comes from the line of Stephen Rosenthal from Montefiore Medical Center. Your line is open.

Stephen Rosenthal: Yes, hi. Thank you. I echo some of the comments. Montefiore is a large academic medical center in the Northeast, and it's had the opportunity over the last 15 years to manage a very large population at risk in all lines of business, Medicare, Medicaid and the commercial population and has a fairly expensive infrastructure for managing care and measuring our performance and has developed a fair number of interventions to focus on that. And some of what we've learned is that this is definitely doable, that care coordination can be effective if there is an organized group of providers focused on those kinds of things that have been previously mentioned by a number of the individuals making comments and that performance can be improved if there is a focus in concentration.

The exciting thing about the accountable care concept or focus is that it begins to really allow us to focus on the patient and the provider and their relationship as opposed to transactions at the insurance company level and is really focused on performance, and I think that's an important concept to continue to carry over.

One of the things that was mentioned earlier that I think is important to repeat is that three years may not be enough and that time is a critical element in this as you're changing behaviors, not only of the provider community, but of the population as we begin to educate them on the ways that we expect them to behave in this changing environment versus the continuous bouncing around of the transactions associated with fee for service.

And the other point that was made earlier, I think, that's important to mention is eliminating other shared service demonstrations from participating in the ACO. If one is an ACO, I think it would be important to take a look at that and allow more participation as they are synergistic and remember that the goal here, I believe, or the intent is

to actually improve the quality of care and the continuity of care of the population, and I think that would be important.

Associated with that is also the need to have both the states and the other payers, commercial payers involved in this process in some fashion. As we form the ACO structure, there should be partnerships within that beyond just the Medicare population, but there should be linkages to the Medicaid population, and certainly to the commercial payers, as there will be a synergistic benefit that they should all be sharing in, as many institutions and large provider networks will be shifting how resources is allocated, and those dollars need to be reallocated in order to support that activity. And so those sentinel benefits become critical for the larger systems that are entering into this process.

Also, as ACOs are formed and they're – those legal structures become identified, there should be some capability within the legislation to allow ACOs to contract with one another so that regions can benefit and that the technology that many of us are putting in place like regional health information systems and others begin to truly add value to the healthcare system considering the large investment that many of us are making, and creating those linkages could lead to linking many of the components of meaningful use, specific requirements around care coordination and that other innovative innovations should be incorporated in the legislation as opposed to separate demonstrations such as telemonitoring as well as home visits and other kinds of home-based services, since the goal is to provide the best possible care in the best location.

That's all I have. Thank you.

Dr. Terri Postma: Thanks very much.

Barbara Cebuhar: Mason, it's Barb Cebuhar, the moderator. I just wanted to let you know that the – Sandy Marks from the AMA was holding in the queue. I don't know if there's a way to let them go ahead?

Operator: Of course. We have Sandy Marks. Your line is open.

Carol Vargo: Hi. Thank you. This is Carol Vargo, not Sandy Marks, at the AMA. Thank you for the opportunity to comment today, and thank you, Barb.

Ensuring that the majority of U.S. physicians today, who are either in solo practice or in small groups of nine and under, are able to effectively participate in this new delivery model, it must be a top priority for CMS. The AMA is engaging physicians in an educational

effort on this new program and information on AMA resources for physicians, including our new CME seminar on July 12 can be found on the AMA website.

CMS must provide maximum flexibility in developing criteria for participation in order to ensure that organizations other than existing large group practices and hospital dominated networks can qualify. The Affordable Care Act allows for networks of individual physician practices to participate, and to ensure a competitive healthcare market, the participation of these entities should be encouraged, not discouraged, to participate by CMS and its rulemaking. CMS should work with the OIG to include explicit exceptions in the proposed rule to provisions such as the anti-kickback statute and work with the FTC to provide explicit exceptions to the antitrust laws for Medicare ACO participants. There should also be a plan in place for how these exceptions will continue to apply at the end of the three-year period to provide assurances to ACOs moving forward.

The AMA believes the PGP demo provides some important lessons. Patient selection methodology or attribution will be key. CMS should look to assigning beneficiaries to an ACO based on a (perality) of a particular specialty so that physicians can validate that patients actually have a condition and should therefore be included in the sample size for that ACO. The data collection tool used in the PGP demo was helpful in capturing and sharing data with CMS. The AMA urges that this tool also allow practices to verify their data after CMS has determined the incentive calculation.

In setting up the quality measurement standards for ACOs, CMS should consider that the PQI program includes only a small number of intermediate outcome measures related to diabetes, chronic kidney disease, ESRD and eye care. These types of measures focus on short-term outcomes, whereas true outcome measures are longitudinal and population based. Additional resources and time are necessary to gather an evidence-based assessed methodologies for risk adjustment and test outcome measures for feasibility and reliability prior to broad-based implementation. The success of ACOs hinges on the development of more accurate risk adjusters and efficiency measures than currently exist. It is especially important that improvements be made before any data is publicly reported.

ACOs should be allowed to report on a hybrid of nationally and locally focused quality measures related to their particular patient population; for example, asthma measures if providing care in a region with poor air quality. ACOs will need to report quality measures using HIT, but specifying quality measures for use in EHRs is a detailed process that

requires the development of new specification sets. The AMA PCPI is working on these specifications, but they will need to be tested to ensure physicians can consistently use their EHR to report quality measures.

Finally, the AMA urges CMS to devote resources to providing technical support to small, independent physician practices and others who need to better develop the capabilities to be able to gather, analyze, review and act on data on their patients' care. In addition, ACOs will need assurance that CMS will help them and provide data, for example, if patients assigned to an ACO obtain services from providers who are not in the ACO.

The AMA works forward to working closely with CMS on these issues as the rulemaking process moves forward.

Thank you very much.

Dr. Terri Postma: Great. Thank you.

Operator: Your next comment comes from the line of Jason Scull from the Infectious Diseases Society of America. Your line is now open.

Jason Scull: Hi. Thank you. It's always hard going after the AMA, but we also – IDSA also supports, similar to other callers who have made this point, maximum flexibility in crafting the rule this fall that will govern the structure of ACOs. And another important point that I don't think has been made is that in addition to measuring the quality and efficiency of patient care activities under an ACO arrangement you know I would also issue a plea to the Medicare officials that are crafting the regulation not to forget about non-patient care activities, such as, for example, the infection control activities providing ID physician and other infection control practitioners, and specifically on this point, in response to a request for comments in the 2009 physician fee schedule rule that proposed the establishment of an exception to the Stark wall that would allow for incident payments into shared savings programs under the Medicare program, but IDSA submitted detailed comments to CMS that really outlined how infection control activities, and specifically how the achievement of infection control benchmarks could fit into an ACO model or a shared savings model or an infinite payment model. And actually, we went so far as to have meetings with CMS officials in March of last year regarding our comments, but unfortunately neither our comments nor the proposal were addressed in either rulemaking last year or since the beginning of this year.

And then in addition, I would like to echo the comment – or he represented a pathologist just in general urge CMS not to forget about specialists in crafting the ACO regulation. And then finally, I believe that the first caller from the American Hospital Association urged CMS to hold a longer listening session in the future. I would actually encourage a face-to-face listening session, and this would be similar to, as I recall, what CMS did with value-based purchasing – the value-based purchasing, I guess, action plan that was supposed to come out in May of this year as well as the hacks listening session. Both of these occurred in December of 2008. It's my experience that face-to-face listening sessions really provide an opportunity for greater dialogue that quite honestly is sometimes lost on conference calls such as this one.

Thank you.

Dr. Terri Postma: Thank you for those comments.

Operator: Your next comment comes from the line of Bruce Fried from Sonnenschein. Your line is now open.

Bruce Fried: Hi. This is Bruce Fried. I'm calling on behalf of my clients; one, the California Association of Physician Groups, and two, Physician Groups for Coordinated Care. For those not familiar with CAPG, the California Association of Physician Groups is the association of 155 medical groups and independent practice associations throughout California, including 59,000 physicians who serve 12-1/2 million Californians, among them 1-1/2 million Medicare beneficiaries. I think it's fair to say that many, if not all, of CAPG's members represent physician groups that have evolved over – in many instances 20 years in the California model, where substantially all responsibility for clinical care and coordination have been delegated down to physician groups from payers, both public and private, and in that context, many will clearly be recognized as accountable care organizations.

CAPG has been working with the administration, with Congress, with the thought leaders at the Brookings Dartmouth Collaborative, and for the purposes of this conversation, I wanted to make just a couple of points. It is essential to, I think, the objectives of the Accountable Care Act that ACOs be successful. Failure is not an option. And to that end, it's CAPG's view that there not be a one-size-fits-all approach to shared savings, but that instead there be an approach that peers the incentives of shared savings to recognize the varying levels of sophistication that ACOs are going to present. There will be ACOs that are just going to have gotten started that will be learning as they go how to coordinate care, how to manage complex cases, how to

work together as clinicians and institutional providers, often for the first time, and it strikes us in those instances the shared savings opportunity really ought to be an upside opportunity but that the – there not be a downside risk.

On the other hand, for more robust, more sophisticated, more experienced ACOs, many of them from California, but as I say, my other organization physician groups for coordinated care involves physician groups from around the country. Many of them have been working in capitated arrangements with a high degree of coordination for some time. In those instances, either working in a shared savings arrangement where there is both a larger upside opportunity but also a downside risk would be appropriate. And then finally, in the most sophisticated ACOs, it's our view that there should be an opportunity for full capitation.

Now, I recognize that the Accountable Care Act does not allow for the Medicare Shared Savings Program to use full capitation, although partial capitation is permitted. But one of our recommendations would be for the traditional Medicare program ACO approach to work hand-in-glove with the Center for Strategic Planning, and more importantly its Center for Medicare and Medicaid Innovation, where the secretary will have very broad discretion to try all sorts of both delivery models and payment methodologies, and in that context, a fully sophisticated, very robust and experienced ACO could contract for full capitation. So I offer that.

I wanted to echo the point that we would encourage CMS, Dr. Postma, Jonathan Blum and other leaders to reach out aggressively to our friends from the Office of the Inspector General. It strikes us as highly important that there be clarity brought as to how ORG will view the referral arrangements within an ACO from the view of the Stark anti-referral law, the anti-kickback law. But while we have carefully looked, we, Sonnenschein, the law firm, have looked carefully at the fraud and abuse laws, and we do believe that ACOs can be structured in a way to not be offensive. It would be, I think, reducing the chilling factor that fraud and abuse laws will have to ACOs as they begin thinking about how they make referrals within this setting.

Finally, an important point. It is clear from the Accountable Care Act that this is not an any willing provider program, and to that end, it is going to be essential for ACOs to be successful that institutions and clinicians that participate in an ACO do show in a way that is disciplined and where all participants adhere to the practice protocols, care coordination policies that the ACO adopts for itself. To that end, CMS in developing the program ought to make it clear that ACOs are

authorized to fire, if you will, to disengage providers and clinicians that simply are not able to adhere to the practices that the ACO develops to achieve the kinds of quality, high performance and ultimate savings that we're all after here.

So with that, I will thank you and look forward to further discussion.

Dr. Terri Postma: Thank you for your comments and for expressing those concerns.

Operator: Your next comment comes from the line of Mike Barret from Ascent Care. Your line is open.

Mike Barret: Thank you. I appreciate the opportunity to comment on the accountable care organizations and the difficult and exciting opportunity to consolidate accountability between the patient, the primary care specialists and other providers. Specifically to patient attribution comes back to an agreement or a set of agreements between participating providers and the plurality of care within that. We don't see anything that would preclude patients being able to, in effect, voluntarily opt out. We think that it should remain. One of the things that we looked at from a management tool standpoint, though, is the access rules to some of the acute providers such as skilled nursing facilities and home health and perhaps a waiver methodology for replacement of high-intensity service providers in lieu of – or something replaced with skilled nursing and home health might be one of those values of providers and beneficiaries for pretty much playing by the rules or sharing accountability with their physician partners.

And then lastly, to identify the difference, tools and techniques to manage chronic care versus episodic and catastrophic. We look at the accountable care organizations as really being primarily focused at population of chronic management with intermittent catastrophic and episodic management.

Thank you for the time to make a comment.

Dr. Terri Postma: Thank you.

Operator: Your next comment comes from the line of Lee Spangler from Texas Medical. Your line is open.

Lee Spangler: Hello. This is Lee Spangler with Texas Medical Association, and my inquiries, which I hope will be addressed sometime in the process, deal with, in essence, the great investment that's going to actually take place in terms of time, energy and resources to create ACOs, and yet the law itself, PPEC itself, provides that there's no administrative or

judicial review regarding the determination of whether or not an ACO is eligible for care savings or what those shared savings might actually be.

In order to give people certainty so that they're willing to undertake these efforts, I would appreciate – and I think that the physicians of Texas would appreciate – some delineation of what kind of dispute process you might anticipate putting in place without regard to the fact that the law says there's no review regarding the amounts that might be paid in terms of shared savings later. It's – that's the kind of certainty that will allow physicians and others to plan to take the first step in creating ACOs, and I think everyone wants better care for Medicare beneficiaries.

And then also, the required contract period is three years, and that does not necessarily mean that the structures that are created may last the entire three years. So if there is, for whatever reason, some sort of dissolution of an ACO in those three years, a discussion or some sort of guidance in terms of how that might affect the physicians and other entities and professionals who have participated in that ACO in regard to their Medicare participation – in other words, would it have an adverse effect in that the ACO was unable to meet all of its obligations as required in the three-year period? And those are curiosities that I think are important and that physicians would like answered.

And with that, I'll let you go to the next call.

Dr. Terri Postma: Thanks very much.

Operator: Your next comment comes from the line of Dr. Gus Kious from Huron Hospital. Your line is now open.

Gus Kious: Thank you very much for the chance to comment. I'm the president of Huron Hospital, one of 11 Cleveland clinic hospitals for – in East Cleveland, a very poor suburb of Cleveland. I'm formerly a medical director with managed care for about eight years back in the '90s. I have three things to add to this comment period. One is that I think that we would be well served if a standard risk war was published prior to the enrollment of enrollees and that that be communicated to those enrollees so that it's a transparent process as to what we're trying to do to improve their health and their overall utilization of resources. I think that it's important that it be voluntary rather than an assignment to an ACO as well.

Second major point is around chronic disease populations. Your number of 5,000 may be a little bit high for some groups. We've noted

that if you were to take patients with ESRD alone, it would require a much smaller population to be able to manage effectively. But I would suggest that the population would be any one of the following; diabetes mellitus, CHF, COPD, ESRD, and I would advocate strongly for a chronic disease population rather than a general Medicare population. I think some of us have expertise in managing that.

The third point is that I believe that the electronic medical record needs to be used in order to put off the necessity for understanding what the claims data says 18 months later. With an electronic medical record, you can answer most of these questions, and I think it should include post-acute care, but not obviously out of area care, as we can't manage that care.

Those are my comments. Thank you.

Operator: Your next comment comes from the line of Brad Jackson from U.P. Rehab Services. Your line is open.

Brad Jackson: Hi. My name is Brad Jackson. I'm a physical therapist clinically trained working on an MBA, representing a organization that does partnership relationships with nursing homes, outpatient clinics and hospitals for therapy services. I also live in a very rural area of the United States in Marquette, Michigan. It's in the upper peninsula of Michigan. The population is approximately 10 to 15 people per square mile, and I'm very thoughtful of the ACO as a quality driver, but also concerned about the monopolistic, if you will, opportunities that arise in a lot of our small communities with single hospitals and perhaps with two or three external providers to that hospital system, and I'm hopeful that CMS will provide guidance in terms of encouraging ECOs to invite community providers into the process to preserve patient choice, and at the same time kind of tying it back to meaningful use stimulus money, that there will be some guys from CMS to encourage recipients of meaningful use monies to turn that resource outward to the communities, and I think this is particularly true in rural areas such as the upper peninsula of Michigan.

Another comment was the patient centeredness element, and I am, again, thoughtful just to kind of reiterate how important preserving competition is. I think that ACOs, a lot of the discussion has been aligned with discussion of how health systems will pursue integrating these services into an ACO format. But again, some of the best providers and the best quality drivers for patients sit outside those systems. And again, I hope CMS will provide fairly strong guidance to make sure that those outside providers have opportunities to participate.

Last quick comment, to reiterating numerous comments before, I do think that the post-acute care system is important in terms of getting a total alignment. Many patients obviously exit the acute care system into other venues of care, attract the CMS data that you know is trying to recoup some of that 17 billion that's lost to preventable readmissions, and I've seen figures on the order of seven to eight billion that's accountable to nursing homes. And so, again, I think total alignment will be achieved when everybody within the ACO, both in the acute care setting and post acute care setting, is integrated.

Thank you for your time, and I appreciate the opportunity to comment.

Dr. Terri Postma: Thank you.

Barbara Cebuhar: Thank you, again, for your comments. I know we may have a few folks left in the queue, but we are very close to our final time period, and I thought I might give Dr. Terri Postma an opportunity to provide some closing comments.

So Terri, you want to go ahead?

Dr. Terri Postma: Yes, I just wanted to thank everyone for your time today. Thank you for your suggestions and comments, and also for sharing your experiences. It's really important for us to hear those things moving forward. We'll be setting up an e-mail box to solicit additional comments in the future. We'll notify you all when that's done by a list serve. But in the meantime, thank you, once again, for your time, and we look forward to working with you as we move forward.

Barbara Cebuhar: I also want to let folks know that we will have a audio recording and a transcript of the Special Open-Door Forum. We'll be posting the Special Open-Door Forum website, and you can see that probably starting Wednesday, July 7.

And Mason, we are, I think, finished with the call. So I really do appreciate everyone's help and your insights. And I don't know if there are any further instructions, Mason.

Operator: There are no further instructions; although the total line of participants that we did peak at was 1,632 participants on at one time. And this does conclude today's conference call. So you may now disconnect.

Barbara Cebuhar: Thank you very much.

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