UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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MSSP ACO NOTICE OF PROPOSED RULEMAKING

OPEN DOOR FORUM

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TELECONFERENCE

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THURSDAY
MAY 12, 2011

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The Open Door Forum convened via teleconference at 10:00 a.m. Eastern Daylight Time, Barbara Manning, Moderator, presiding.

PRESENT:

CHRISTIE HAGER, MPH, JD, Regional Director, Region I
WILLIAM KASSLER, MD, MPH, Chief Medical Officer, Region I
BARBARA MANNING, Office of the Regional Administrator, Region I
TERRI POSTMA, MD, Medical Officer, Performance Based Payment Policy Staff
JAYE WEISMAN, MBA, PhD, Regional Administrator, Boston and New York Regions

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

11:04 a.m.

MODERATOR MANNING: Thank you. Good morning, everyone. I would like to thank all of you for attending today's call on the proposed new rules to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients, through Accountable Care Organizations or ACOs. My name is Barbara Manning and I'm with the Centers for Medicare and Medicaid Services Regional External Affairs Team in the Boston Regional Office. I will be the moderator for today's call.

I would like to begin by introducing Dr. Jaye Weisman, Regional Administrator for the Centers for Medicare and Medicaid Services. Dr. Weisman is a former Medicare and Medicaid provider who joined the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services, to serve as the Regional Administrator for the Boston and New York Regional Offices of CMS. Dr. Weisman promotes

the vital work performed by the agency in maintaining and improving the nation's health care in the six New England states and New York, New Jersey, Puerto Rico, and the U.S. Virgin Islands. Dr. Weisman holds a bachelor's degree from the University of Chicago, an MBA from the City University of New York, and a PhD from St. Johns University.

We also have Dr. William Kassler, Chief Medical Officer for the Centers for Medicare and Medicaid Services, Region I, with us, as well. Dr. Kassler is the lead for the coordination of ACOs in the six New England states. He was part of the team that our speaker, Dr. Postma, led, that wrote the ACO rules. Dr. Kassler is currently working with the CMS Innovation Center to develop another ACO demonstration project.

Now, Jaye, would you like to begin?

DR. WEISMAN: Thank you, very much, Barbara. Thanks for everybody on the phone for taking time out of their busy schedules to attend this listening session on

the proposed new rule to help doctors, hospitals, and other health care providers to better coordinate care for Medicare patients through Accountable Care Organizations or ACOs. So we'd like to welcome consumers, clinicians, employers, hospitals, health systems, state representatives, health care experts, everyone on the phone. Welcome to our Regional meeting.

The U.S. Department of Health and Human Services released, on Thursday, March 31st, the proposed new rule to help doctors, hospitals and other health care providers to better coordinate care for Medicare patients through Accountable Care Organizations. ACOs create incentives for health care providers to work together to treat an individual patient across care settings, including doctors' offices, hospitals, and also long-term care facilities. The Medicare Shared Savings Program will reward ACOs that improve or deliver high care quality and lower growth in health care costs, while putting patients first. Patient and provider participation in

an ACO is purely voluntary. And that's of importance to note.

The proposed new rules will help doctors, hospitals, and other providers form ACOs and are now available for public comment. HHS also announced it will hold a series of open-door forums and listening sessions during this comment period, including this one, to help the public understand what the Centers for Medicare and Medicaid Services, the agency administering the ACO Program, is proposing to do, and to insure that the public understands how to participate in the formal comment process. And these forums are being held nation wide.

So this is one of the listening sessions where we will inform you of the contents of the Notice of Proposed Rule, and we will respond to some questions you may have on the Proposed Rule. But we would like to make it clear, up front, that this is not a forum for submitting formal comments on the Notice of Proposed Rule. We will, however, accept your questions during the Q&A portion

of today's program and we will also have available transcripts of this and of the other open-door forums and listening sessions on our cms.gov website, along with other fact sheets and relevant information about the Proposed Rule. With that, we will pass it back to Barbara Manning to go over the formal comment process with you.

MODERATOR MANNING: In submitting formal comments to www.regulations.gov, please refer to file code CMS-1345-P, P as in Peter. Because of staff and resource limitations, we cannot accept comments by facsimile, that's faxed transmission. You may submit comments in one of four ways that are outlined in the Notice of Proposed Rule Making: electronically, at www.regulations.gov, by regular mail, by express or overnight mail, by hand or courier. Please refer to the e-mail invitation for this event for detailed information regarding the ways you may submit your invaluable comments to us.

The Proposed Rule, along with joint CMS OIG notice, is posted at

www.ofr.gov/inspection.aspx. For more information, read the fact sheet at http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html. Formal comments on the Proposed Rule will be accepted up until Monday, June 6, 2011. CMS will respond to all comments in a final rule, to be issued later this year. Now, it is my pleasure to introduce Christie Hager. Christie was appointed Regional Director of the U.S. Department of Health and Human Services, Region I, in April 2010. Previously, she was Chief Health Counsel to the Speaker of the Massachusetts House of Representatives during the development, drafting, and first three years of implementation of the Massachusetts Health Reform Law enacted in 2006. Christie is currently on the faculty of the Harvard School of Public Health and has taught in graduate programs across New England. Christie holds an AB from Smith College, an MPH from the Boston University School of Public Health, and a JD from the University Of Connecticut School Of Law. Christie?

MS. HAGER: Thank you, Barbara. Good morning, everyone on the phone. I am so pleased to be here this morning, with Jaye and Barbara. As Secretary Sebelius' Senior Representative to the six New England states of Region I, I'm fortunate to work very closely with Dr. Weisman on matters relating to outreach and education of programs administered by CMS. Of course, the Affordable Care Act has been a priority agenda for us in the year since I was appointed, with the new authorities and responsibilities, across other HHS divisions, with offices in Region I, including HRSA, Administration for Families and Children, Administration on Aging, and that's just a few examples. But CMS and my office have worked closely on the broad range of ACA provisions that seek to address quality, costs, and access.

I've gained a new perspective while working with the six New England states on health reforms. We are in a region characterized by a long and strong tradition of innovation in health care delivery and

payment system reform, which has taken place without nearly the tools that are now available to states through the ACA. This morning's focus on accountable care organization is an example, not only of new resources for supporting the states in such innovations, both new and ongoing, but also of the power of the alignment of the agendas of HHS and our partners in the states.

And now, I'm happy to introduce Dr. Terri Postma, Medical Officer and Advisor in the Center for Medicare at CMS. Before joining CMS, she completed a public policy fellowship with the Senate Finance Committee, during the Health Care Reform debate. And, following the fellowship, Dr. Postma took up her post at CMS, where she advises senior leadership on policy issues related to Medicare payment systems and quality initiatives. Particularly, value based purchasing initiatives, such as the Medicare Shared Savings Program, resulting from passage of the Affordable Care Act. And now, Dr. Postma, we look forward to your overview of

the new Proposed Rule.

DR. POSTMA: Thank you, so much. Thanks for having me today and for joining us on this call. We're real excited to share with you some of the details of our Proposed Rule for the Medicare Shared Savings Program. As Christie mentioned, I am a Medical Officer here at the Center for Medicare. I trained as a neurologist. But I have spent the last couple years working on issues related to health care delivery system. And I've been privileged to spend the past year here at CMS, working on the development and implementation of the Medicare Shared Savings Program. So I've been asked to take a few minutes, today, to give an overview of the staff proposal.

The Medicare Shared Savings Program was mandated last year as part of the Affordable Care Act. It establishes a voluntary program that incentivizes Medicare providers and suppliers to form ACOs, Accountable Care Organizations, to improve the quality and efficiency of care delivered to Medicare fee-for-service beneficiaries. The

Proposed Rule was published about a month ago. It was issued on March 31, 2011, and the comment period will end on June 6, 2011. We're seeking comment on a wide variety of issues in the Proposed Rule. And we're looking forward to getting those comments from you.

As was mentioned, one of the places to submit comments is through www.regulations.gov. I also wanted to just remind you that fact sheets and a link to the proposal, as well as links to concurrently posted notices by FTC, DoJ, and the Proposed Joint Waiver by OIG and CMS, those links can also be found at www.cms.gov/sharedsavingsprogram/. It's a great web resource and I encourage you to visit it.

Anyone here, who's been involved in our health system, whether as a provider or a patient or the family member of a patient, knows that our health care system is fragmented. It's developed over time, in pieces. A hospital is developed over here; a

clinic practice over there; a home health care center over here. And it developed without real conscious or well-designed connections between those pieces. Fragmentation of payment, particularly fee-for-service payment, reinforces that fragmented care. The Shared Savings Program is the new approach to the delivery of health care, aimed at reducing that fragmentation, improving population health, and lowering overall health care costs by promoting accountability for the care of Medicare fee-for service beneficiaries, improving coordination for services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesign care processes. Participants continue to receive fee-for-service payments, but the way that they've joined and organized is rewarded, each year, with an incentive payment for demonstrating high quality and efficient care delivery. It should be emphasized that this is not a managed care model. It's an incentive for providers of fee-for-service care to improve the quality and efficiency of

care delivery to fee-for-service Medicare beneficiaries.

If you've heard our administrator, Dr. Don Berwick speak at all, he talks about the three part aim. That is better care for individuals, better health for populations, and lower growth in expenditures. He believes that, to meet the mission of the Shared Savings Program, an ACO should embrace several goals. First, putting the beneficiary and family at the center of care by honoring individual preferences and values through shared decision making. Second, remembering beneficiaries over time and place. That is ensuring beneficiaries no longer bear the burden of making sure all their health care providers have the information about them that they need to provide high quality care. Three, the ACO should attend carefully to care transitions as patients move along the care continuum. Four, ACOs should ensure that waste is reduced and that every step in care adds value to the beneficiary, including proactively preventing illness and promoting

population health. Five, the ACO should proactively manage the beneficiary's care through, for example, preventive care reminders at the point of care. Six, the ACO should be continually collecting, evaluating, and using data to improve care delivery and patient outcome. Seven, the ACO should be continually investing in a work force to build their skill, knowledge, and team work. And finally, the ACO should be innovative. It should enhance the quality of care, improve patient satisfaction, and control the growth of health care costs by continually reinventing care in the modern age. And you'll see -- hear some of those themes as I go through our proposal.

As many of you know, the concept of ACOs grew out of the Dartmouth Atlas Project work on Geographic Variations in Cost and Quality. MedPAC also featured the concept in its June 2009 report to Congress. And, during the development of this health care reform provision, Congress drew from these expert sources as well as from the Physician

Group Practice Demonstration here at CMS. The PGP Demonstration showed promise as a model for improving the quality of care delivered to a Medicare fee-for-service population, while also controlling growth in expenditures. In the first four years of that demonstration, all ten PGP participants demonstrated quality improvement in measure modules and six of the ten groups received $78 million in savings.

Now, the law for this provision states that ACOs must meet a number of eligibility criteria. They are: the ACO must agree to become accountable for the quality, costs, and overall care of the Medicare fee-for-service population assigned to it; the ACO must agree to participate for not less than a three year period; the ACO must have a mechanism for shared governance among the providers that have joined together to form the ACO; the ACO must also have a formal legal structure that will allow it to receive and to distribute shared savings payments to its participants; the ACO must have a sufficient number of primary care professionals for the

assignment of at least 5,000 beneficiaries; the ACO must have a leadership and management structure that includes clinical and administrative systems and the ACO shall provide information regarding the ACO professionals as the Secretary determines necessary to support the assignment of beneficiaries, implementation of quality and other reporting requirements, and determination of shared savings payments. The law further goes on to say that ACOs must define processes to promote evidence based medicine and patient engagement; to report quality and cost measures; and to coordinate care. Finally, the law states that the ACO must demonstrate that it meets patient centeredness criteria, as defined by the Secretary.

We've made proposals around each of those things in the Proposed Rule. How to implement and to determine whether the ACO is meeting those eligibility requirements, in order to participate? The existing and newly formed organizations, we've proposed, are

eligible to participate in the program, but must also meet all of those other eligible criteria that are in the law. ACO entities could include ACO professionals in combination with each other or with hospitals and we've proposed to use the Secretarial discretion afforded by the law to expand the list of eligible entities to include any other Medicare provider/supplier who joins with the statutorily identified group. And so, one of the eligibility criteria in the law is that the ACO must have at least 5,000 Medicare beneficiaries assigned to it. Any Medicare enrolled providers -- we propose that any Medicare enrolled provider may participate. But they have to be joined in such a way that they can meet that eligibility criteria. So while any Medicare enrolled provider/supplier is invited to participate, they have to form an ACO that has a primary care physician core, sufficient to assign at least 5,000 beneficiaries. We've also proposed, in the Proposed Rule, that Method 2 CAHs that bill for physician/primary care services might be

able to comprise the primary care core and, therefore, participate independently. We've also proposed that ACOs would be incentivized to include FQHCs and RHCs as participants through a higher potential sharing rate.

We heard a lot of stakeholder concerns, initially, after the passage of the Affordable Care Act, that they were concerned that, by joining together, they may run afoul of anti-trust laws and other legal issues that would bar them from joining together in the way that the law anticipates. So, as part of the coordinated interagency effort, we worked very closely with FTC, DoJ, and OIG to insure that newly formed ACOs could participate in the program without being concerned that they'll get in trouble because of the anti-trust laws. The anti-trust policy statement, which was displayed on the same date as the Proposed Rule, and again, there's a link to that on our website, outlines and solicits comment on the proposed safe harbors related to the creation and operation of ACOs and applies to collaborations formed after the

passage of the Affordable Care Act on March 23, 2010. A key component to the anti-trust policy statement is the primary service area or PSA calculation for percent share for common services. The ACO participants who have joined together must calculate PSAs as part of their application process. The PSA calculations indicate whether an ACO applicant must undergo expedited anti-trust review as part of the application process. ACOs undergoing the anti-trust review must have a letter of approval from the anti-trust agency before entering an agreement with CMS. This would apply to ACOs with a calculated PSA share of greater than 50 percent. The ACOs with a PSA share of 30-50 percent may also request an expedited review. Or, they may comply with a list of good market conduct principles or go without assurance. ACOs with PSA shares of less than 30 percent meet the anti-trust agency's safety zone, as proposed in the anti-trust policy statement and no review is necessary. Additionally, as described in the anti-trust policy statement,

an ACO that meets a rural exception would apply for the safety zone. Again, I encourage you to go to our website and find the link, which will lead you to that anti-trust policy statement.

In the Medicare Shared Savings Programs, CMS has proposed that ACOs be primarily provider driven. We've defined an ACO participant as a Medicare enrolled group of providers or suppliers. And these ACO participants, according to the law, must create a legal entity. We've proposed that the legal entity be recognized under state law and then also, according to the law, it must have a form of shared governance. We've proposed that the governing body must give the ACO participant proportionate and appropriate control over decision making. For example, decision making over how best to redesign care processes or how best to share any shared savings amongst participants. While the ACO participants may join with entities such as entrepreneurs or health plans, the ACO participants themselves, that is the Medicare

enrolled providers and suppliers, must retain 75 percent control over the governing body. The governing body must also include beneficiary presence. The ACO must demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aims that Dr. Berwick talked about, of better care for individuals, better health for its population, and lower growth in expenditures.

Clinical integration is also an important part of the discussions that we've had with FTC and DoJ. Clinical integration, we've proposed, is demonstrated by having an experienced executive team whose focus is quality improvement, clinical management by a local, senior-level medical director, and financial or human investment in the performance and success of the ACO. We've proposed that ACOs must also be working towards building a health IT infrastructure that enables collection and evaluation of data and provides feedback to practitioners at the point of care. We've proposed that 50 percent

of primary care physicians must be meaningful users by the end of the first performance year.

The Proposed Rule also encourages proactive and person centered care. Eligible organizations would have mechanisms for routine self-assessment, internal monitoring and reporting for continuous improvement and promotion of evidence based medicine, beneficiary engagement, coordinated care, population health in addressing health disparities, and internal reporting on quality and cost measures. Additionally, the ACO would have a person centered multi-strategized focus and continuous improvement around person centered activities.

Last fall, we initiated a request for information which had a number of questions in it, to help us form our Proposed Rulemaking. We heard from stakeholders how important patient data can be for an ACO. So, while this proposal anticipates that ACOs would be working toward developing health IT that would allow them to share information

between providers, we recognize that groups of providers may not have complete data on care delivered to their fee-for-service beneficiaries outside their organizations. In order to promote ACO success, we've therefore proposed to make available beneficiary identifiable data for patients seen by ACO primary care providers. And those beneficiaries would have been notified about the potential of data sharing and not declined to have CMS share their data. Of course, legally, we're restricted from sharing any data that contains information about alcohol or substance abuse, except with express beneficiary consent.

We've also proposed to create aggregated data reports to provide both initial feedback as well as quarterly feedback during the performance period to ACOs on expenditures and utilization, in addition to the annual feedback on financial and quality performance, for the purposes of sharing and saving. As previously mentioned, and in accordance with the law, in order to

participate, the ACO must be willing to become accountable for the Medicare fee-for-service population assigned to it. I should emphasize here that, unlike a managed care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see, regardless of whether that practitioner is participating in the ACO or not. It's a difficult balancing act and it's a challenge. But, because of this, when we refer to assignment, what we're really talking about is the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the standards necessary to achieve an incentive payment for improving the quality and efficiency of care delivery. Beneficiary assignment is the basis for establishing and updating a financial benchmark, quality measurement, and performance and focus of the ACO's efforts to achieve the three-part aims.

We relied heavily on our experience with the PGP Demonstration to develop a similar previously successful

methodology for the assignment of Medicare fee-for-service beneficiaries. We've proposed that beneficiaries be assigned to the ACOs based on a plurality of allowed charges for primary care services from primary care physicians with specialty designations of internal medicine, general practice, family practice, and geriatric medicine. We're also proposing a retrospective assignment, but with prospective data sharing. We believe this creates an incentive for ACOs to standardize care processes and to treat all Medicare patients the same. But it also aids the ACOs in understanding their patient populations and proactively redesigning care processes for them.

As I mentioned, beneficiaries continue to be able to see any provider they choose, even if that provider is not a member of the ACO. Beneficiaries would be informed that their provider is participating in an ACO at the point of care; told what it means for their care; and provided an opportunity to decline to have their claims data shared.

Beneficiaries may request to work with their physicians to craft an individualized care plan. And through experience of care survey and participation in shared governance, the beneficiary would contribute to continuous improvement and quality of performance evaluation of their providers.

The Medicare Shared Savings Program will be monitored closely. The law states that penalties are to be imposed on ACOs that avoid treating high-risk beneficiaries in an effort to improve how their efficiency of care might look. So we'll be monitoring the program closely. There will be a mechanism for terminating ACOs that are avoiding at-risk beneficiaries or who exhibit poor quality performance. ACO agreements may also be terminated for failure to notify beneficiaries, for public reporting non-compliance, or for falling short of a number of program integrity issues that we've proposed in the Rule. And again, we're seeking comment on all these things and are eagerly anticipating your suggestions to make

the proposal better.

We've proposed a two track approach for ACOs participating in the Shared Savings Program. ACOs may choose to participate in one of two tracks. Both tracks involve the statutorily required three-year agreement to participation. But, within those three years, two tracks are possible. One is an initial three-year agreement comprised of two years of one-sided shared savings with an automatic transition in the third year to performance based risk through two-sided shared savings and/or losses in the final year. The second track is a three-year agreement of two-sided shared savings and/or losses throughout the entire three years. All ACOs who elect to continue in the program after the first agreement period must continue in the second track. We believe this approach provides an on ramp or entry point for organizations to gain experience and transition to performance based risk arrangements, while also providing the opportunity in the second track for more

experienced organizations to enter the program immediately into risk based arrangements with the opportunity for greater rewards. The ACO may share in savings if actual assigned patient population expenditures are below an established benchmark and if savings exceed the minimum savings rate which is required by law, and they meet the quality performance standard. ACOs are eligible to receive a shared savings up to 52.5 percent under the one-sided model and up to 65 percent under the two-sided model, depending on quality of performance and whether or not they include FQHCs or RHCs as participants. Other differences in the model give greater rewards to ACOs choosing greater risk through the two-sided model. For example, in the one-sided model, savings are shared after a two percent threshold with certain exceptions, while in the two-sided model; savings are shared from the first dollar. Again, this is a proposal. We're seeking comments on it and are eagerly anticipating them. And, I also want to remind you that ACO participants continue to be paid

under regular Medicare fee-for-service payment systems throughout the course of the agreement period.

Quality measurement and performance is an important part of the program. Measures making up the quality performance standard; and the law states that an ACO is not eligible to receive a shared savings payment unless the quality standard is met -- so we've proposed making up the quality performance standards to support the three part aims, focusing on better care and better health dimensions. We've proposed five domains for measures: one, preventive health; two, at risk and frail elderly populations; three, patient or care giver experience of care; four, care coordination; and five, patient safety. Consistent with statute, measures include process, outcome, and patient experience of care measures derived from claims data, survey data, and medical records. We've proposed to set the quality performance standard at the reporting level for the first year of the program. This means that ACOs who

report fully and completely would receive the highest percentage of shared savings available under their model, regardless of the scoring on the domains. That is up to 50 percent in the one-sided model and up to 60 percent in the two-sided model. The additional 2.5 percent that I mentioned earlier or five percent would come from FQHC or RHC participation. In subsequent years, we have proposed that shared savings payments would be linked to quality performance based on a sliding scale that would reward both attainment and improvement of the ACO qualities. So, for example, higher performing ACOs in each domain would receive a higher share of savings. Higher performing ACOs in each domain would also receive a lower share in their loss rates, should there be a loss.

We proposed measures that align with other value based purchasing initiatives, such as the Physician Quality and Reporting System, an EHR Incentive Program, as well as the National Quality Strategy of the Department of HHS and private sector

initiatives; in particular, HEDIS measures. The Affordable Care Act specifically states that ACOs cannot participate in more than one Shared Savings Program at a time, including the Independence At-Home Initiative or any shared savings demonstration, such as those that may be coming from the Innovation Center.

Speaking of the Innovation Center, Congress created the Innovation Center under the Affordable Care Act under a different provision and gave the center the authority and direction to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those who have Medicare, Medicaid, or CHIP benefits. We're working closely with the Innovation Center as ACO models are developed for testing there. And we plan to use the results of those demonstrations to important changes -- positive changes in the ACO Shared Savings Program over time.

In summary, we believe the Medicare Shared Savings Program represents a

new approach to the delivery of health care in that reducing fragmentation, improving population health, and lowering overall growth in expenditures in a Medicare fee-for-service population. And I just want to give you that website again. It's a wealth of information. There are fact sheets. There are links to those other concurrent notices that were put out by FTC, DoJ, the IRS, and also the Joint Waiver proposed by OIG and CMS. And that website, again, is www.cms.gov/sharedsavingsprogram/. So that's a real brief look at the program, at some of the proposals. Again, we're eagerly anticipating your comments. The more specific those comments can be the better. And, you know, at the end of the day, it will help us inform the final and make the Shared Savings Program a strong and effective program. So thanks so much for inviting me today. Thanks for joining us today. And I'll turn things over to Barbara.

MODERATOR MANNING: Thank you, Dr. Terri Postma, for joining us today. Operator,

we're now ready to open the lines for questions.

OPERATOR: Thank you. At this time, we'll begin the question and answer session. If you would like to ask a question, please press *1. You will be prompted to record your name. You may withdraw your question by pressing *2. Once again, to ask a question, please press *1. Once again, to ask a question, press *1. We have a question from Terese Theister. Her line is open.

MS. THEISTER: Thank you. I was unclear on whether a provider can join more than one ACO.

DR. POSTMA: Great. Thanks for asking that question. We do talk a bit about that in the proposal. One of the concerns is an anti-trust concern. And what we've proposed is that the ACO participant, the Medicare enrolled providers and suppliers, would submit to us their taxpayer ID numbers. So, that's going to be the basis that forms assignment and for identification of the ACO participants. Now, what we've proposed is

that -- and because we need to insure a unique beneficiary population for each ACO, and there may be multiple ACOs in a certain region -- we've proposed that those taxpayer IDs upon which assignment is based should be exclusive to a single ACO. And so that means PMs which have primary care physicians with those designations that I mentioned would have to be unique and exclusive to a single ACO. But, beyond that, any of the providers or suppliers that are participating upon whom assignment is not based would not have to be exclusive to a single ACO. So its really sort of balanced between the operations, the necessity of having a unique beneficiary population, balanced with the need for there to be the opportunities for participation in multiple ACOs.

Now that's within the Shared Savings Program. Providers may not, according to the law, participate in multiple CMS initiatives. So, for example, a provider can't participate in both the Shared Savings Program and in an ACO demonstration through

the Innovation Center. But they may participate in multiple Shared Savings Programs, ACOs, if assignment is not based on taxpayer IDs.

MS. THEISTER: I am calling from a laboratory -- specialty laboratory. So we're trying to figure out our role in ACOs. And we serve a national population.

DR. POSTMA: Right. So, in that case, assignment is not proposed to be based on specialists or on laboratories or on hospitals. The law tells us we have to assign on the basis of primary care services rendered by primary care physicians.

MS. THEISTER: Okay.

DR. POSTMA: So, in your case, your lab would not need to be exclusive to a single Medicare Shared Savings ACO.

MS. THEISTER: Okay. Thank you.

DR. POSTMA: Sure.

OPERATOR: Once again, to ask a question, please press *1. We have a question from Chris Sandruso. Your line is open.

MR. SANDRUSO: Yes. Hi. I was

just curious how you envision the role of hospices with ACOs, whether they should be included or if the client should -- or the beneficiary should go back to a fee-for-service if they become terminal?

DR. POSTMA: Okay. Thanks for the question. What we had -- because this is a new program and because we have a little bit of experience in ACO-like Shared Savings Programs through the PGP Demo, we don't feel like we have enough experience to dictate or define how an ACO or what collection of providers or suppliers creates the best opportunity for improving quality and efficiency in care. So what we've proposed is that the Medicare enrolled providers and suppliers that want to join together to form an ACO to participate in this program will work that out for themselves. You know, you're the folks on the front lines who understand your situation in your geographic region. You understand the patient population in your region. And that's going to be different across the country. So it's really

up to the providers and suppliers who want to participate to join together in a way that makes sense to them. And so we've not made any proposals around specific entities that must be included, with the exception that the groups must be able to meet the eligibility criteria, as defined in the law. And one of those is that the necessity of having a primary care physician core upon which to assign those 5,000 fee-for-service beneficiaries.

MR. SANDRUSO: Okay. Thank you. That's helpful. Thank you.

DR. POSTMA: Sure.

OPERATOR: Once again, to ask a question, press *1. Our next question comes from Gloria Pullman.

MS. PULLMAN: Yes. Good afternoon. Thank you. I'm a little puzzled about the expectation where ACOs are expected to service at least 5,000 beneficiaries. I have to wonder, is this realistic expectation for all ACOs, regardless of their size and resources?

DR. POSTMA: Yes. Thanks for that question. As I mentioned, that is one of the criteria that the law lays out. And so, I believe that part of the reason -- I'm only speculating, but I think that part of the reason was that lawmakers felt that there needed to be at least 5,000 for some statistical stability in the population. And so, by law, the providers and suppliers gathering together to form an ACO to participate in this program would have to have at least that number assigned. There are opportunities for folks that are closer to that smaller size and we've made some proposals around the sharing rates for providers and suppliers who have gathered together who have less than 10,000 beneficiaries to make the sharing rate a little more level playing field for providers and suppliers who are closer to that 5,000, versus the ones that may have, you know, several tens of thousands. So I think there are opportunities on both ends, but we're actively seeking comments on challenges that

may be posed by groups who are either at the high end or the lower end.

MS. PULLMAN: Thank you.

OPERATOR: At this time, there are no further questions.

MODERATOR MANNING: We will stay on a little bit longer and see if there is anybody else.

OPERATOR: Sure.

MODERATOR MANNING: Yes.

OPERATOR: Once again, to ask a question, press *1. Aaron Mitchell, your line is open.

MR. MITCHELL: Okay. I was just wondering about -- with the -- you mentioned that beneficiaries will be assigned to an ACO. They can pursue care outside of the ACO. If they choose to pursue care with a provider who is a part of a different ACO, is that somehow counted as detrimental to the assigned ACO?

DR. POSTMA: Thanks for that question. You know, this is an area that I think we and stakeholders out there have grappled with. Because, normally, when you

talk about assignment, immediately, you think about a managed care setting where there's an agreement with both the patient and with the providers that that patient will only receive care within a certain network of providers. Well, this is a new opportunity to create efficiencies of care and improve the quality of the Medicare fee-for-service population. And, as you noted, Medicare fee-for-service beneficiaries have the freedom and the flexibility to go and see whatever providers they want to see. So one of the challenges is to devise a methodology that will assign these Medicare fee-for-service beneficiaries in a way that's fair to the ACO, that is in a way that looks at where the beneficiaries received care over the course of the year and say yes, ACO, you actually are the one who saw this beneficiary the most and were accountable for the care over the course of the year. So that's one challenge. And the other challenge is to devise a methodology that will uniquely assign Medicare fee-for-service beneficiaries. So, there may be a couple of ACOs in the same

region. So how do you make sure that you're not assigning beneficiaries to multiple ACOs and that multiple ACOs are being rewarded, in essence, for this same beneficiary over and over? And so, we took some lessons learned from the Physician Group Practice Demonstration and details of that demonstration can be found on the CMS website. But that's a demonstration that was designed similarly to how the law drafted the proposal and that demonstration looked at a Medicare fee-for-service beneficiary population. They had a methodology for assigning. It was based on the plurality of services rendered by a group of practitioners. What we're proposing is that that group of practitioners be specifically identified types of primary care providers who are participating in that ACO. And other options are assigning on the basis of majority. We've also talked about number of visits, versus allowed charges. And we've proposed assigning on the basis of allowed charges. And so, in that way, and doing that in a retrospective fashion, so that we look

back over the course of the year to see where the Medicare beneficiaries received a plurality of their primary care services and then assign them or attribute them to the ACO. And so, while beneficiaries may be seeing providers from different ACOs, the way that assignment methodology is calculated will result in a unique population for each ACO. So I hope that that helps a bit. I know it's a little detailed and weedy and all those details can be read in the proposal. But we think that this is the best way to truly tell where a fee-for-service population who is free to see whoever they want to see, to truly tell where they received the plurality of their care and, therefore, who was responsible over the course of the year for that care. But again, recognizing that the nice thing about managed care is that you know, up front, who your beneficiaries are and can direct care processes -- redesign care processes around that population. So, as I mentioned, what we've also proposed is to give the ACOs a lot of information, up front, about who is likely

to be in their population. And we know, from modeling out some of the aspects of the Physician Group Practice Demonstration that when we used this methodology and we looked at the PGP Demonstration results, what we found out through modeling was that approximately 80 percent of the population that was used in the bench marking period would also be assigned at the end. So, about 80 percent of the fee-for-service population remains with their current providers. There is some movement.

OPERATOR: Once again, to ask a question, press *1. Our next question comes from Terese Theister.

MS. THEISTER: Hello. Is there -- do you have any idea how many ACOs are forming at this time? Or if there's a database that you can go to, to see this?

DR. POSTMA: Yes. I think what I'm hearing in your question is a couple things. One is if I'm a provider, how do I find out if there's an ACO developing in my area? And right now, we don't have that available. We're welcoming comments on what

ways we can help facilitate the development of ACOs in that respect. But, for right now, it's really through conversations through local providers. So maybe if you're considering participating in the program, one thing you can do is contact a local hospital or your local primary care providers and see if they've thought about participating and if they have or if maybe they know somebody who's talking about participating and in getting a group of providers together to do that. But, in terms of how many may be participating, there's an analysis at the end of the proposal by our actuaries of the program, the costs and so forth. And they estimated -- I'm going to quote this incorrectly -- but I recall it was a median of, I believe, 80 ACOs across the country, is what they projected. Now, of course, that can change. And it may change, depending on what, you know, what the final rule is for the program. But that's what our actuaries projected.

MS. THEISTER: They're estimating that for the first year or for the program,

itself?

DR. POSTMA: I believe it was for the first three years.

MS. THEISTER: Okay.

DR. POSTMA: But again, don't quote me on that. Go to the impact section. It's at the end of the proposal. And there's a detailed actuarial analysis.

MS. THEISTER: Thank you.

OPERATOR: Once again, to ask a question, press *1. Our next question comes from Mishan Mitchell.

MR. MITCHELL: Yes. I was just wondering. You mentioned that ACOs should be organized around a core -- basically a control -- a core of control of ACO professionals, including the primary care specialties that you described earlier. Will there be any kind of requirement for ACOs to allow independent care practitioners such as optometrists or podiatrists or dentists to be allowed to participate in specific ACOs? Or is that completely up to the individual organization of the ACO?

DR. POSTMA: Thanks for the question. So, as the law envisions this program, it's a group of providers and suppliers who may or may not currently be financially integrated or clinically integrated, getting together to form these Accountable Care Organizations. And what we've proposed is that -- and the statute talks about ACO professionals, which they define as MDs, DOs, NPs, PAs, and clinical nurse specialists. ACO professionals in independent -- like a network of independent ACO professionals, ACO professionals in group practice arrangements, ACO professionals who combine with hospitals, either through joint ventures or as employees of the hospital. So the statute talks about those types of groups getting together. The statute also gave us discretion to expand that list. And so, what we've proposed is that any Medicare enrolled provider or supplier is welcome to join together to form an Accountable Care Organization for purposes of participating in this program. But, if they do, they must meet

the eligibility criteria laid out in the law. And one of those is that that group must -- we must be able to assign at least 5,000 Medicare fee-for-service beneficiaries on the basis of primary care services received by primary care physicians. So whatever groups get together must have a primary care physician core, in order for us to -- or in order for them to meet the eligibility requirement of at least 5,000 beneficiaries assigned. And again, we did not make any stipulations or restrictions on who could or could not join together. But all we're saying is that any Medicare enrolled provider/supplier may join together to form these Accountable Care Organizations and apply for the program. But they have to meet the eligibility criteria. And then we've talked a little bit about the governance structure. The law says that that group that forms has to have a mechanism for shared governance. And that mechanism allows them shared decision making on how best to implement care coordination; how best to share shared

savings, when they receive it. Those sorts of things. And so what we've proposed is that that governing body, that mechanism of shared governance, must be comprised of at least 75 percent of the Medicare enrolled providers and suppliers and that those Medicare enrolled providers and suppliers have to have a voice on that governing body. So it can't just be one entity that's sort of controlling everybody else. It really has to be collaboration and a collaborative effort.

MR. MITCHELL: Sure. That -- that makes sense. I was concerned about beyond that -- the core of the primary care specialties.

DR. POSTMA: Yes.

MR. MITCHELL: Is -- would an ACO be able to restrict involvement of other independent care providers. For instance, I'm an optometrist. If I wanted to establish an ACO, I understand I'd have to meet all the criteria. That absolutely makes sense. That's spelled out very clearly.

DR. POSTMA: Yes.

MR. MITCHELL: But would an ACO be able to restrict optometrists from joining? I mean, so I don't have any intention of trying to establish an ACO. But if I was to try and join one --

DR. POSTMA: But were you saying, once it's established --

MR. MITCHELL: What's that?

DR. POSTMA: You're saying, once it's established?

MR. MITCHELL: Sure. Once it's established or if I wanted to -- basically, can an ACO pick and choose what kind of providers it -- it organizes with? Or should they -- I mean, I anticipate they they're not required to include, you know, kind of a demographic representation of providers in the region, but -- but would they like -- can they kind of set up their own specifications and decide not to include certain providers?

DR. POSTMA: Well, we haven't made any proposals specifically around that particular aspect. Again, we really tried to maintain a lot of flexibility and the

opportunity for ACOs to innovate in their -- you know, understanding that they know best their region and their population. And so, I would say if you're interested in joining an ACO, again, talk with the folks in your region and see if they're talking about developing one or having one and express your interest in that. And it's really up to the folks who are all interested and thinking about doing this to decide how best to get together. And there's ample opportunity for folks to be involved, even if assignment is not based on them, folks bring different opportunities for care coordination with them. They bring different skill sets with them that may be important to coordinating quality and coordinating the care. So, just because assignment isn't based on a particular provider, that provider may be real important to helping to improve the quality and efficiency of care delivery to the fee-for-service beneficiaries in the region.

MR. MITCHELL: Thank you.

OPERATOR: Once again, to ask a

question, please press *1.

MODERATOR MANNING: Operator, do we have any other callers?

OPERATOR: There are no further questions.

MODERATOR MANNING: Thanks. I think that this then ends the question and answer period for the session today. I'd like to thank you for your participation on today's listening session. Please note that for those of you that may have missed some of the calls or if you have colleagues or friends that were unable to join us today, a transcript of this call will be posted at http://www.cms.gov/sharedsavingsprogram/, along with fact sheets and other relevant information about the proposed Rule. Thank you and have a good afternoon.

(Whereupon, at 12:07 a.m. the teleconference was concluded)