CENTER FOR MEDICARE & MEDICAID SERVICES

Moderator: Mandy Cohen
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1:30 p.m. ET

Operator: Good afternoon, my name is (John), and I'll be your conference operator today. At this time I would like to welcome everyone to the Center for Medicare and Medicaid Services Conference Call.

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

Mandy Cohen, you may begin the conference call.

Mandy Cohen: Thank you; and thank you to everyone who has joined the conference call today. This is Mandy Cohen from the Innovation Center at CMS, and I'm joined by my colleagues here who are here to provide you an announcement about three new initiatives from the Innovation Center around Accountable Care Organizations.

I just want – before I turn the program over to (Dr. Berwick), I just wanted to remind folks that this call is for stakeholders only and its closed to press, and we will be taking questions at the end of the call, and if you do have any additional questions you can visit the Innovation Center Website at www.innovations.cms.gov.

And now I'll turn the program over to Dr. Berwick, the CMS Administrator.

Donald Berwick: Thanks a lot, Mandy, and thank you all for joining us on this call. I'm excited about the announcements that are being made today. I want to share with you some of the background and then I'll be joined by my colleagues from Medicare and the Innovation Center.

We are here this morning to – this afternoon to discuss some new options for – that will apply to a range of providers across the healthcare spectrum who are considering becoming a part of the Program for Accountable Care Organizations, that's part of the options in the Affordable Care Act.

Accountable Care Organizations (ACOs), is one of the most innovative ideas in the Affordable Care Act, in my opinion, helping us to move toward a healthcare delivery system that is high quality, meeting the needs of patients and families and sustainable over the long haul. We know that the better path, the right path towards sustainability, it can't be – it shouldn't be through cutting care or slimming down coverage, or withholding services from people. It has to be through changing care, through improving care, to make it both sustainable and high quality, and we can have that. We can have better care, better health, and lower costs if we put patients at the center of the healthcare delivery system, and change that delivery system to better perform to meet those patients' needs.

The Accountable Care Organizations, the ACO, is one really important route to that vision. The idea behind the Accountable Care Organization, the ACO, is to encourage and support physicians and hospitals and other providers of care to reduce cost by providing better quality care, and then to reward those providers for success in doing that by allowing them to share in the savings that would result.

This would lead to better, more coordinated care for patients, and at the same time deliver savings to those patients and families and providers and taxpayers. This is about rewarding the quality of care that's delivered, not just the quantity of services delivered. So ACOs aren't just a new way to pay for healthcare, they are a new and better way to deliver healthcare.

Two months ago, CMS published its initial proposed rule on how to implement the ACO Program, and we are now in the midst of the Public Comment period which closes on June 6th, which allows us to listen very closely to input from all sorts of stakeholders, so that we can modify and improve the proposed rule into an even better final rule. That's a very challenging job because the ground rules for ACOs have to strike several important balances.

For example, they have to give providers incentives to achieve savings and tools through improvement of care to help them coordinate and improve care, but we also need to make sure that providers of care don't skimp on care; they don't withhold care when it's needed. We need to make sure that if patients get much better coordinated care, but we don't need to burden providers with (graphs) or regulations in the effort to encourage them to do that. It needs to enable close relationships between primary care providers and specialists, but we also, under the law, need to make sure that the patients and ACOs retain the right of choice. They have the right to see any Medicare provider they want. ACOs need data, the patients also need guarantees that their privacy will be protected.

These are all important balances to strike, and it's important that we get those balances right, since the Accountable Care Organizations are a critical model in reform of the healthcare delivery system. Because they're so critical, their proposed rule has, understandably, been the center of attention and has attracted lots and lots of comments since the release of the proposed rule, and that's good news because we are in this period of listening and dialogue which – we will do a better final rule. We are reaching out with our partner agencies to hold feedback sessions, to solicit input from all sorts of stakeholders – physicians and hospitals and patient advocates and many more on the proposed rule, so we can get the right balances (struck) in the final rule.

As we work toward that balance, even now, today, we are announcing a series of new initiatives that will help us hit the ground running, and will give providers, from many different kinds of backgrounds, and many different size, as the ability to participate in the (ACO) program, and let me describe three initiatives we are announcing today for starters from the Innovation Center.

The first initiative is the Pioneer ACO Program. The Pioneer ACO Program is going to offer an accelerated the pathway to forming an ACO for providers of care who are already ahead of the pack, who are already able to offer coordinated care, they have the infrastructures, the information systems and models that they're familiar with already, so they are ready to start now, even before the new regulations go into effect.

The Pioneer ACO Program will allow provider groups to move very rapidly from a Shared Savings payment model to a Population-Based payment model on a track that's consistent with – synergistic with – although it's separate from the Medicare Shared Savings Program reflected in that proposed rule. The Pioneer ACO Program is designed to work in coordination with private payers, by aligning incentives with private payers for the providers, and that will help the providers improve quality and help (back to) patients right across their practices. So that's the first announcement – the Pioneer ACO Program.

The second announcement is a request – it's a request for comments on a proposal from the Innovation Center in CMS to provide upfront payments, advanced payments to providers who want to form ACOs but who don't have the capital to create one. They can't afford it, start the information systems or the care coordination services that will make up the improvements and care that the ACOs can rely on. Some of the early comments we've been receiving on the Proposed Rule, do suggest that some providers lack ready access to the capital they need to invest in these infrastructures and coordinating staff, and so on. And providers who lack access to the capital could make those investments by accessing shared savings early under this proposal for advance payment on which we are now going to seek comments.

The third announcement today is for all providers who are interested in forming an ACO. The CMS Innovation Center is about to offer a series of four ACO Learning Sessions – supports to help providers who want to hear how to build ACOs. Participating in these learning sessions isn't going to be factor at all in the selection of qualification of participation of any CMS – any provider in the CMS ACO Program, but these supports are going to be very

useful in giving providers access to knowledge and expertise if they need to set up ACOs.

So those are our three announcements today. A Pioneer Program, an advanced – a request for comments on an Advanced Payment Model, and a Learning and Assistance Program under the Innovation Center.

In all of this we've been really impressed by the level of engagement on this topic, we are getting lots of feedback, lots of dialogue, people seem to do – to be sensing that we are at threshold of an important and a very, very productive change. And coming up with a workable, promising framework for ACOs that allows many to play based on the stakeholder feedback is going to be well worth the effort.

With that as background to these rules, we are happy to take your questions. I'm joined here by Jon Blum who heads Medicare; and Rich Gilfillan who is the Head of the Innovation Center, and Peter Lee the Deputy Head of the Innovation Center, and we are opened for questions now.

Mandy Cohen: Thanks. Operator, we are opened for questions.

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

Your first question comes from the line of (Lisa Gravert), from American Hospital. Your line is open.

(Lisa Gravert): Thank you; and thank you very much for holding this call today. I had a clarifying question for the Pioneer ACOs. What are the requirements that are built in, is it for ACOs to have at least 50 percent of their total revenues derived from outcomes-based contracts at the end of the second-performance year? Can you expand a little bit about what you mean by 50 percent, would that 50 percent include their Medicare portion of business? And also, can you expound on the outcomes-based contracts, exactly what you're targeting there?

Donald Berwick: Sure, I'll invite Rich and Peter to comment, just generally. It is as you say, what we would like is for the Pioneer ACOs to be regarding the management of better coordinated care for patients right across their patient panels – Medicare patients and others, that's – so we are really encouraging synergy here between the commercial payment side of their work and the Medicare side.

Rich and Peter, do you want to comment?

Male: Well I think that's exactly right, Don, and we would include the Medicare portion of their – of their business in that calculation, yes. So we are thinking that they may have other contracts with other payers that might account for 25 percent, and then Medicare, their Fee-For-Services, and Medicare would account for another 25 percent as an example. So it's really about encouraging folks to move aggressively into the new (area), and many of these organizations already have a significant part of their business operating under these contracts. And when we say outcomes-based we think that whether it's a Shared Savings Model, or some other approach, that aligns the efforts of the organization with producing better health, better care, reduced cost through improvements, those kinds of models are very significant in how they are structured in contracts.

So the general notion that they are outcomes-based, as opposed to based simply on volume, is what we are after, and built into that would be an expectation, there would be substantial quality incentives as part of the calculation that they will be reimbursed in other models.

(Lisa Gravert): If I could just ask one clarifying question. Would you include participating in, say for example, a hospital value-based purchasing program as an outcomes-based contract?

Donald Berwick: We will probably have to understand it in a little more detail, and one of our goals will be to understand and engage, really, in a conversation with the industry around what that definition should be and whether or not a particular contract seems to be sufficiently congruent with the overall outcomes, the three-part aim outcome that we are after. I think that's what's central; we are

after folks who are interested in pursuing those same three-part aims of better care, better health and reduced cost through improvement.

Mandy Cohen: Thank you (Lisa); operator; next question?

Operator: Your next question comes from the line of (Scott Pingree), from (Intermont College). Your line is open.

(Scott Pingree), your line is open.

Your next question comes from the line of Steven Bernstein from University of Michigan. Your line is open.

Your next question comes from the line of Emily Brower from Harvard Vanguard. Your line is open.

(Marci Sindell): Hi, and so it's (Marci Sindell) from Harvard Vanguard. The question relates to the quality measures that you're envisioning for this program. So one of the concerns about the 65 quality measures in the Shared Savings Program is that it's not clear what the threshold where comparisons are going to be since many of the measures are not currently measured today by either the Medicare Fee-For-Service, or Medicare managed groups. What are you thinking around the quality measures for the Pioneer ACO Program, and how they're different?

And then the second part of the question is whether you can elaborate a bit on how this works with private (peers)?

Donald Berwick: (Oh, it's the private peers). On the quality side I'll just make a comment. This is Don, (Marci), how are you?

(Marci Sindell): (OK).

Donald Berwick: This is – this is a very important balancing component of both the Proposed Rule and the Pioneer Program as we reward organizations for reducing costs we have to work with them hard to watch quality to make sure care is improving, and that costs aren't being reduced by withholding (unit) care, so the quality metrics are crucial. As you've said, in the proposed rule we've listed 65 proposed quality measures, we will be taking feedback on these,

learning what the – how people regard them and coming up with the package of metrics that will be best to use in the final rule.

Our commitment is to align the quality metrics system of the Pioneer group with the main stream by 3022 ACO Proposed Rule. Rich, you may want to comment on that, and also on the first part of (Marci's) question.

Rich Gilfillan: I think that – I think that covers the issue on the – applying metrics. I think on the alignment with private (peers), our goal will be to that – again, if you're operating under an outcomes-based program, then we are interested in aligning with you if you were to produce those Three-Part Aim outcomes. So the first question, is clearly – if you have other business arrangements that supports you pursuing the Three-Part Aim outcome, we – whether we all – we expect we will end up using the quality metrics that ends up being the basis for the Shared Savings Program which, as you can tell from the metrics that are in there today, oftentimes – and in many cases – align with other initiatives that are out there, so that will – that will have evolved as we see the final rule, but our expectation is that we will be well aligned, we think, on the three dimensions, if you will, of the triple aim.

Operator: Your next question comes from the line of (Vic Stanley) from Florida Accountable. Your line is open.

(Vic Stanley): My question is – there is a 50 percent mandatory EMR for new ACOs in the State of Florida. Only 19 percent physicians are on EMR, and clearly EMRs are being given by hospitals that are wanting to acquire physician practice, therefore, clearly missing the Triple Aim, not just for Medicare but for Private Peers as well. In this new Pioneer Program, will there be some allowances to build out to 50 percent EMR?

Donald Berwick: I'm going to let Jon go and comment on this (Vic), but first that is a second-year requirement not at the entry point to the ACOs, and this is something we are taking comment on. I mean, among the comments we will be receiving, will be about the EHR requirement, we look forward to hear how (Pete) will comment on it. Peter Lee has a comment, maybe...

Peter Lee: Certainly because relative to the – in the Pioneer ACO it is – by the end of 2012 – so folks will have two years to be at that 50 percent primary care, meeting the EHR Standard, and that's for the Pioneer Program specifically; but on the base program we are still comments on that provision, we've heard a lot of concerns regarding the 50 percent threshold, but we are still in the comment phase and that's – would be addressed in the final rule.

Male: The question is (to Dr. Jonathan), (Jonathan) this is (Inaudible).

Jonathan Blum: How are you?

Male: How are you, Jonathan? The other question is, for the independent practitioners in Florida which is 80 percent of Florida that are wanting to do ACOs, is CMI looking at methodology where they can, you know, have a sit-down meeting and help them in promoting this concept of CMS because at this point the acquisition of physician practice by hospitals is at full (state), and I don't think that their aim is to reduce cost actually to acquire physician practice to make sure that they have control.

Jonathan Blum: Right, so part of – part of today's announcement is to also talk about the assistance that the Innovation Center is considering proposing to help organizations participate within (innovative) program. I'll turn it over to Rich to talk about that assistance.

Rich Gilfillan: Yes, I think we realize that – I think it's – if we think about the spectrum of the delivery system, we have different types of – providers (inaudible), in terms of their ability to both deliver CMS coordinated care today and their ability to kind of get into the ACO world in the future. We know that there are some folks that, on one end of the spectrum, are already providing that kind of care and have all the – all the capabilities and are ready to go, and on the other end of that spectrum are folks who are providing traditional office space, perhaps. Primary care or (office) and hospital-based care that traditionally people service without the wherewithal to enter into this new world of ACO; so we understand that's the spectrum; and really what we are offering today, is a suite of products that – or opportunities that address people at different places in that spectrum.

So for folks who are ready to go and provide services, the Pioneer Model is there for them to move rapidly and share what's possible, what – show the country what's possible in terms of delivering better outcomes for folks (that seeks service) with Medicare.

For folks who are not ready, we are offering the assistance program, or we are offering – we are asking for comments on that (part of assistance programs), and advanced programs, and that may include doctors equipped providers – it could include other kinds of providers who don't have either the capabilities today, and don't have the access to capital.

So we want to know from you all, what should that form of advanced payment look like? And we are open to different suggestions – that we are sensitive to some of the issues that you've raised, and – so we are addressing both ends of that spectrum today, that assistance would be for people who go into the Shared Savings Program, and then finally, the third piece, is the educational opportunity that we are offering, whereby we are going to try and bring the best ideas in the industry today from those folks who have been doing this, who know how to do it, and making available to all those folks who are interested in providing this type of care, but don't have those capabilities today.

So between the Shared Savings Program, and the programs that we are announcing today, we think we have a nice suite of offerings that make up Medicare's overall approach and strategy for helping providers become ACOs.

(Vic Stanley): Thank you.

Mandy Cohen: Thank you. Operator – your next question?

Operator: Your next question comes from the line of David Morales from Steward Health Care. Your line is open.

David Morales: All right, thank you. My question is in regards to the payment. Let's assume that 25 percent of your volume is Non-Medicare, how do you propose to pay for that side of the ledger, the Non-Medicare bodies of volume.

Donald Berwick: This is Don, David. The Pioneer Program, like the ACO Program, and the main rule involves payment from Medicare patients. We are looking for organizations that can align the incentives and the business plan they have for care with their Private Book of Business as well, but that would be up to the contracts or relationships they have with the commercial payers. Is that right, Rich?

Rich Gilfillan: Yes, I think – and we also know that there are fixed costs and invariable costs that an organization that's seeking to become an ACO will face, and so we are interested in input on how people – on how we (ought to) think about that, and how you all are thinking about it in the delivery system. So that's the purpose really of asking for input, and we would hope, and we know that there are many private insurers out there today that are interested in helping provide assistance, get up and going – fill their ACO capabilities. So we would hope their offering will be parallel activity coming from the Private Industry side.

David Morales: Right; and this is the period open to comments on that part of it, and I only ask because (we), for example, had a significant number of lives in the contract Non-Medicare, but we would qualify for the Pioneer Program, so aligning those three sides of our book of business would be critical for us.

Donald Berwick: We would be very interested in your comments on that, and it will help guide us.

(David Morales): Right.

Mandy Cohen: Thank you. Operator – next question?

Operator: Your next question comes from the line of Michael Fox from Dean Health Plan. Your line is open.

Michael Fox: Thank you. Yes, you had indicated as part of the – one of the objectives of Pioneer ACO is to accelerate the movement from Fee-For-Service and Shared Savings to population-based payments by the end of – I think it's the end of year three. Can you go into a little more detail about what that methodology approach would be toward the population-based payments? Do you see these

as being (capitated-based) payments? Or, when you say population-based payments do you mean (inaudible) based on sort of health conditions?

So if you – if you could provide a little more clarity around what you mean by that; and then the second part of your question has to do with some of our – some health plans also serve Medicare, I mean – so they obviously have commercial members, but they also have a Medicaid line of business, and to the extent that all – you know, everyone is sort of going to be served through this ACO model and all the efficiencies that are created through the ACO also, translate and filter down to Medicaid people that are seeing Medicaid patients. Many states, the way they deal with Medicaid rates, it's (all-encountered) base, so the more efficient we become in the delivery of services to Medicaid the more the rates get ratcheted down, because that creates the new base for rates in that – in the following year.

So it would be nice if CMS could also align those two things where they are sort of creating the incentives for those plans and really have a broad spectrum continuum of the products that they offer to their members from commercial to Medicaid to Medicare, so those things are all in alignment and you're not – you're not penalized for being efficient – you know, being (incentivized) in one area for being efficient, and then penalized in another for being efficient.

Rich Gilfillan: Let me just address the Medicaid – this is Rich Gilfillan, Michael – the Medicaid side of this is very important to us. We are working closely with Cindy Mann, who runs the Medicaid office, and with (Inaudible) who runs the (Inaudible) office, and we are very interested in solutions that include Medicare, Medicaid and CHIP recipients or beneficiaries so – and we are also getting a number of inquiries from states who are interested in finding ways to align their approach with the efforts coming out of Medicare.

So I think it's a natural fit, and whether or not it's a state with – that does its Medicaid business through health plans, or whether it's a state that does – has the Fee-For-Service approach, I think we are finding interest everywhere and we would hope that health plans would be interested in aligning their arrangement with providers with the approach we are describing.

In terms of population-based payments, we are – there is a model in the RFA, the Request for Applications, which is on our Website, which describes one approach. We've also asked folks to think about alternative approaches and give us suggestions. But basically, the model that is described there involves a reduction in Fee-For-Service payments, (key) ACO providers and pro-beneficiary payments of the population-based payment approach.

Michael Fox: Thank you.

Operator: Your next question comes from the line of Dale Hamilton from Community Health & Counseling Services. Your line is open.

Dale Hamilton: Thank you. I'm just curious in terms of – if there are any planned discussions about the inclusion of some important sectors of the healthcare system that have been excluded from ACO participation?

Donald Berwick: Dale, are there particular sectors you're asking about?

Dale Hamilton: Home care and mental health.

Donald Berwick: The statutory model for the ACO as a primary-care-based model, and there are certain restrictions we have as to how we can identify patients with the providers centered in the primary care world. So we are following the guidance Congress gave us in centering the ACO patient alignment process on primary care. My own belief is that ACOs that are serious about better care, better health and lower costs, will be reaching out very, very strongly to Behavior Health, to – they will be focusing on, particularly, populations that have particular disease burdens, because that's the way that they'll improve both the care of the population and their own prospects for shared savings, so I do think this ACO (policy) is going to be good news for populations that have significant burden, and – for Behavioral Health.

Jon, you may want to comment further on this.

Jonathan Blum: No, I think that's right. I think while we have rules as to how we have to assign beneficiaries to an ACO, we have – we have built up proposed rules to really encourage the development of very integrated healthcare delivery

systems from health – Behavioral Health, have great potential to better manager, better coordinate care that should be a huge benefit to an ACO structure.

Rich Gilfillan: One other thought, this is Rich – and you know, the ACOs (up to this part), have a much broader set of activities that we are pursuing within CMS, to support the delivery system as it transforms into this future of a seamless coordinated safe care system. And we have many initiatives that are moving in that direction. One, specifically getting to this point of Behavioral Health, would be the Medicaid Health Home Initiative under which State can apply for reimbursement match of 90 percent for program that provide Health Home services, and we are hearing from states and working closely with states to develop Health Home Programs that have a strong associate on Behavioral Health and Home Health services.

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

(Bob King): Yes, hello. This is (Bob). (Inaudible) quality (inaudible) and I'm thrilled with the announcements today, we are working with several organizations that show already, and I think this is going to move us forward a lot more quickly.

One of the focuses of the French Healthcare Ministry is the Pareto Chart focusing on the vital (few), and one of the other things that thrilled me is the push to get significant results in the next three years, and I'm wondering if you could comment on – to what extent you're being able to focus your work on a proven methodology as people are applying for this? Rather than more just – casting the net really wide and not getting those significant results.

Donald Berwick: Well, (Bob), it's great to hear from you. How are you doing?

(Bob King): I'm doing well.

Donald Berwick: The smart ACO is going to focus a lot of energy on the vital few, on the patients of families of greatest need, because that's where – that best improvement in care, and frankly the most savings in cost will come from, from providing better care to those particularly-stressed individuals. We

know that there are great (medical) care out there, one of the other important functions in the Innovation Centers, is to be able to identify and help spread – the (Inaudible) Care focus largely on chronically ill people because that's where the better care, better health, lower-cost fees are achieved. I do think there are many, many programs and approaches to better care that are ready for use, so already well proven and ready to pick up, and I expect ACOs to be very interested in finding and adopting those best practices.

(Bob King): Great, thanks.

Mandy Cohen: Operator, we have time for just one last question.

Operator: Your next question comes from the line of (Charles McLean) from the McGarey Medical Foundation. Your line is open.

(Charles McLean): This conference call format, (really) models good participant engagement. I'm wondering, how important is scalability – (clonability) of approach pertaining ACO startup funding, and do you have criteria for scalability to guide applicants? It's an area of inquiry that I'd like to hear more about as part of your learning sessions?

Donald Berwick: Can you say a word, (Charlie), on more about what you mean by "scalability"?

(Charles McLean): Yes. I believe one of the criteria was – how effectively can an innovative, existing program, be cloned for application elsewhere? As an innovation, how transferable is it, and with what guidelines?

Donald Berwick: I understand. You're correct, the Innovation Center is very interested in discovering and nurturing and studying innovations which have – which can be spread, in fact, as part of its charge, being able to find those great examples, and then give them to the secretary for her to put in the regulatory language or find other mechanisms to spread and fuse change. The Pioneer ACO Program, I think, will be a good example of that by taking up to 30 organizations that are really able to create the cutting edge of the kind of improvements we are looking for over the ACO Program, but for all it will be

instructed to everyone about how to make that program more and more vibrant. Rich?

Rich Gilfillan: Yes, I think that – we are interested in scaling right from the get-go, and so we are interested in hearing from folks that have plans about how they think their models were as ACOs, or other models that we will be testing. How they think they could be more widely disseminated, and one of the reasons for being engaged in the Learning Systems and the Accelerated Development Sessions, is exactly that. It starts the process of scaling, and to kind of feed those best practices across – from pioneers, from folks who've been doing this, to folks who are just starting to learn. And so we think this could be an important dynamic created nationally, where folks – actually they will be (ready) and going in both directions, from folks new to the business to the pioneers and the other way, and we are going to find out, together, the best ways to kind of spread as well as build ACOs; and that's part of our plans in – for all the models from the Innovation (inaudible).

Mandy Cohen: And with that, I just have a few parting remarks about how – if you joined this call late you can call into the number 1-800-642-1687, use the same access code that you just used, and you can hear this call in its entirety for the next two days.

Also if you wanted any more information about any of three announcements that you just heard about, you can visit the Innovation Center Website at www.innovations.cms.gov; that's "innovations" with an S, dot CMS dot Gov. You can also send in comments on the Advanced Payment Initiative to: advpayaco@cms.hhs.gov. That's advpayaco@cms.hhs.gov.

And thanks, again, to everyone who joined today on the call.

Operator: This concludes today's call, you may now disconnect.

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