Centers for Medicare & Medicaid Services

Moderator: Rosie Egan
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Operator: Good afternoon. My name is (Shannon) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Healthcare system delivery reform Philadelphia region conference call. All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be a comments session. If you would like to state a comment, please press star and the number one on your telephone keypad. If you would like to withdraw your comment, press the pound key.

Thank you. Ms. Lorraine Ryan, you may begin your conference.

Lorraine Ryan: Thank you (Shannon). Good afternoon. I would like to thank all of you for attending today's call on healthcare delivery system reform. My name is Lorraine Ryan and I am with the office of the regional administrator in Region III, which is the Philadelphia regional office of the Centers of Medicare & Medicaid Services, more commonly known as CMS.

To start things off, it's my pleasure to introduce Health and Human Services Region III Director, Joanne Grossi. As Regional Director, Joanne serves as the Secretary's key representative in this region in working with federal, state and local officials on a wide range of health and social service issues. Welcome Joanne.

Joanne Grossi: Thank you Lorraine. Good afternoon everyone and thank you for taking time out of your very busy schedules to participate in our listening session today. As everybody knows, the healthcare reform legislation, historic legislation as it was, the Affordable Care Act passed more than eight months ago and this

legislation makes healthcare more accessible, affordable and effective for all Americans. Another thing the ACA does though, it also provides an important opportunity for innovation within CMS and Medicare. So today's session is just about one opportunity for engagement and dialogue on some of the most significant ways in which the healthcare system is going to be transformed in collaboration with you. So please know that going forward, I will be available to you as Secretary Sebelius's senior representative in the region. Again, I want to thank you for being on the call today and look forward to listening to your thoughtful comments.

Lorraine Ryan: Thank you Joanne. It is now my pleasure to introduce Nancy O'Connor, regional administrator for the Centers for Medicare & Medicaid Services Region III, who will be the moderator for today's call. In her role as regional administrator, Nancy oversees the external affairs operations of Medicare, Medicaid and SCHIP programs in the six states that comprise Region III. Those states are Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia. Nancy promotes the important work performed by the agency in maintaining and improving the healthcare for Medicare and Medicaid beneficiaries. Nancy, would you please begin.

Nancy O'Connor: Sure. Thanks Lorraine. And thank you everybody for taking time out today to join us on this listening session on healthcare delivery system reform. I'm delighted that we have so many callers on the line today. We have a broad range of stakeholders on this call representing healthcare consumers, clinicians, employers. We've got hospitals on the line. We've got state representatives and government agencies, advocates and others. So welcome everybody. We look forward to listening to you today and hearing your input on this important topic.

I think it goes without saying that all of us want the highest quality healthcare possible in a system that delivers that care in a coordinated and integrated fashion. One, it eliminates waste and encourages the prevention of illness. Medicare and Medicaid programs tie up a lot of money for a system that is fragmented, disorganized and at times fails to meet patient needs. Some of these problems are a result of existing payment and delivery systems that

simply don't reward quality outcomes. However, right now CMS is on the precipice of making a meaningful change to the healthcare system.

Just as Joanne said, through the Affordable Care Act, CMS has a real opportunity to work with the public and private sector to make improvements to our nation's healthcare delivery system. So the purpose of today's session with you is to listen. We want to hear from you on how CMS can best undertake the important work of reforming our nation's healthcare delivery system.

Now you are going to hear from three leaders at CMS; Dr. Richard Gilfillan, Sharon Donovan and John Pilotte who will briefly talk to you about the Accountable Care Organizations Shared Savings Program, the Center for Medicare and Medicaid Innovation and the Federal Coordinated Healthcare Office.

All of these things are new at CMS and each of these areas is at a different stage in development. That being the case, we want to bring you into this process, which is why we want to hear your thoughts about these areas today. So we will be taking your comments following some brief remarks from our guest speakers.

So now I'd like to introduce our first speaker, Dr. Richard Gilfillan, the Acting Director for the Center for Medicare & Medicaid Innovation. Dr. Gilfillan works with CMS leadership to develop and implement innovative programs that will help improve and update the nation's healthcare delivery systems. Dr. Gilfillan is very new to CMS. In fact he just joined the Agency in July and as Director of CMS's performance based payment policy staff, he is the person responsible for overseeing Accountable Care Organizations and value based payment initiatives.

Now before joining CMS, Dr. Gilfillan served as President and CEO Geisinger Health Plan and Executive Vice President for System Insurance Operations at the Geisinger Health System in Danville, Pennsylvania. Dr. Gilfillan began as a family practitioner and we are delighted to have him on the call today. So I'll turn the call over to you. Dr. Gilfillan?

Richard Gilfillan: Thanks very much Nancy and I appreciate the opportunity to be here and a hello to lots of friends in New Jersey, Pennsylvania, Virginia; all states I actually spent a fair amount of time working in over the years. So it's a pleasure to be with you today. And on behalf of Don Berwick and the rest of the CMS team, I just would like to say that we are all thrilled, privileged and honored to have the opportunity to work with you all in finding ways together to try and improve the healthcare and costs of care for people in your region and across America.

We have a new mission here at CMS and that mission is to be a trustworthy partner and a constructive force for continual improvement in health, healthcare for all Americans. Those words are carefully chosen and obviously that's not been the mission of CMS in the past.

But I wanted to take a moment to reflect on that and particularly on the issue of a trustworthy partner, we do believe that the way to make healthcare better for all is to find ways to work with people out there delivering healthcare, people in the healthcare system.

And so this call is about listening to you, hearing from you and it's just the beginning of our effort to reach out and find ways to work with you all to that end. And when we think about being constructive, of course we kind of think, a force towards what and the way many of us have thought about this I think in the past is remember when people are out there working hard every day to deliver great healthcare to both and doing wonderful things and finding new ways to deliver care.

But unfortunately, we still have a system that is , as was stated earlier, somewhat fragmented at times, not well coordinated and we know that it is creating a cost structure and cost of care that is just not sustainable and we know it also creates and leads to some variable outcomes from a quality perspective.

So we are interested in working with you to find a way to move that system of care. So what might be considered fragmented care would need a seamless

care approach that would seek to deliver those three outcomes of improved health, improved care and reduced cost through continuous improvement.

That's the goal. We believe that to do that we can -- we need to change the way we support the healthcare system, through our payment mechanism, throughout other administrative mechanisms and we really want to learn from you all, how to best do that. Today we're talking about three new areas of the federal government that are really focused on trying to learn how to do that and that is to support you better in that effort.

First, the CMS Innovation Center. The Innovation Center was established by the Affordable Care Act and it's an important new tool for CMS to accomplish this mission. It's -- in effect, it provides CMS with the engine to change the way we support in pay-per-care we award providers and healthcare professionals for delivering best care in those -- ultimately those outcomes we mentioned.

We know that we can't do this alone. We -- as someone else mentioned, we spend about $800 billion a year for Medicare and Medicaid. That's about one third of the total spend for healthcare in the country. We know we need to work closely with other payers, large employers, other stakeholders to work and find ways of working together in the delivery system with providers to deliver that new care model.

The Innovation Center is well positioned to do that because it has several new authorities that are different from what has been available in CMS in the past. We have significant financial resources, approximately -- not approximately -- exactly $10 billion over 10 years.

We have some greater authority with regard to some of the constraints of operating within the federal government so that we don't have to consider budget neutrality and we don't have to respond to the requirements of the Paperwork Reduction Act and that allows us to be more nimble in finding new ways or new models of care.

And finally, we have the authority -- the Secretary of Health and Human Services has the authority to change Medicare's payment policy if the center

can identify new models of care and new models of payment that significantly improve quality or keep quality the same and reduce costs. So rather than have to go back to Congress to have new legislation passed, the Secretary through regulation can change Medicare's payment policies if we can demonstrate that they do indeed -- the new models do indeed improve costs.

How do we think about work? Well, right now we think about new models of care and payment at three levels. The first is patient care model. That is how do you deliver the best hip surgery, the best back surgery, the best (OB care). We're interested in innovation, new ways of delivering those kinds of services.

The next level of care that we're interested in is how do we support new mechanisms to coordinate care, to provide that seamless coordinated care experienced for patients. How do we support medical homes, ACO's, other similar sorts of mechanisms, models that seek to integrate care across multiple sites of care?

The third level that will be working on is at the community care. This means finding models that bridge across systems of care, right up to the community level with a focus on population health outcomes and ways to impact the determinants of health that are offered and overlooked by our current healthcare systems.

So our core work then is to identify, evaluate and spread new care models that have that impact of improving health, healthcare and cost. That's our basic mission and we began working on that mission a couple of weeks ago when we announced four new programs that CMS has initiated to start this work of supporting delivery system reform.

First, we will be working in coordination with other components at CMS to launch a multi payer medical home demonstration project that enables Medicare to participate in state based medical home initiatives. This will allow us to participate with eight states, Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota to support what we believe will be over 1,000 medical homes serving almost 1 million Medicare beneficiaries.

Second, we will be working with our Medicaid colleagues as they release the Medicaid health home state planned option that was created under the Affordable Care Act. This program will provide 90 percent federal funding for the first two years of any state based medical health home, Medicaid health home pilot program.

Third, the center will be supporting advanced primary care medical home demonstrations in federally qualified health centers in close collaboration with the Health Resources and Services Administration. Finally, the center will be support of the new Federal Coordinated Healthcare Office on new models that are aimed at evaluating ways, new care models that better integrate care for individuals who are eligible for both Medicare and Medicaid.

Easily some models for testing will help us accelerate the implementation of the Affordable Care Act. We will continue to engage in this kind of public, private joint action that we are talking about here today to enable a significant improvement of healthcare quality and population health as well as significant investment in the efficiency of coordination in care.

None of this will be easy. We all have a lot of work to do in changing the way we support you and in the way care is delivered. There is plenty of work for us all ahead. But we know we want do this alone. This is not simply a government activity. This is fundamentally an activity that will occur in the delivery system and our goal is to be a good partner and a good supporter of you all as you change the way healthcare is delivered.

Thank you very much for your time and being with us today. I think we'd like to hear a great deal about your thoughts regarding the Innovation Center. But now I want to turn it over to my colleagues to talk about the ACO program and the federal qualified -- Federal Coordinated Healthcare Office.

Nancy O'Connor: OK, thanks Dr. Gilfillan. And we do have a couple of more speakers today. Our next speaker is Sharon Donavan and in October Sharon became the Director in the Division of Program Alignment in the Federal Coordinated Healthcare Office. She has a lot of experience working in CMS in the Medicare Enrollment and Appeals Group on low income beneficiary access

issues and she -- Sharon has also worked in the Center for Medicaid and State Operators in the Medicaid managed care waivers and demonstration area. So Sharon, I'll turn the call over to you to make some remarks.

Sharon Donovan: Thank you Nancy and thanks to everybody for again taking the time to listen to us today. The Federal Coordinated Healthcare Office was created under the Affordable Care Act, specifically section 2602. It's really clear from reading that statute that our job is to make the care experience better beneficiaries who are eligible for both Medicare and Medicaid.

In large part that depends on improving the relationship between states and the federal government, as well as both partners in delivering and providing care for this population. We're working towards a seamless coordinated care system. There is no better opportunity to this than for individuals who are dually eligible for Medicaid and Medicare. Over 95 percent of those eligible are in the fragment fee-for-service system and we spend upward of $300 billion combined annually on their care. So again, this is a great time for a delivery system and payment reform and a great population with which to do it.

So this covers our office and we're up and running and currently our office is focused on two areas. The first is program alignment and in that area we're identifying everyplace where Medicare and Medicaid bump up against each other. These include administrative, regulatory and statutory misalignments. We're coming up with literally a list and the list is populated with anything and everything where these two programs work at odds with the beneficiary having a seamless experience. We'll be prioritizing that list and turning around and making it very public. It will be a transparent, living document that is shared continuously with stakeholders and we will continue to add to it and to improve it. And we would encourage you to submit any ideas to email box, which is fchco@cms.hhs.gov. We'd love to hear from you and we'll reiterate it later.

On the list has been developed with lots of input so far from external as well as internal stakeholders and we look forward to continuing to perfect it. The second area we're working on -- the demonstrations mentioned by Rick just

now in his comments. They have to do with new demonstrations and models involving testing innovation in the new delivery system and payment models for dual eligibles. And these are models that fully integrate the Medicare and Medicaid services that these recipients are eligible to receive. This means an acute care services, primary care services, long term care services and support and behavioral health services. So it's important again that there is integration of all these services for the beneficiaries.

We will be working first with states. We announced a few weeks ago, the upcoming availability of design contracts of up to $1 million each for up to the 15 states. That solicitation will be out sometime this month. We will partner with the Innovation Center to further explore other opportunities for the integration of care services with financing for due eligibles as well. I would encourage you to make sure that we have all of your input and feedback and look forward to hearing the rest of this call.

Now I'll turn it back over to you Nancy.

Nancy O'Connor: OK, thanks Sharon. And our final presenter is John Pilotte, Acting Director of the performance payment policy staff in CMS and John manages the staff responsible for designing and implementing the Medicare value based purchasing programs including the Medicare Shared Savings Program and the physician value based payment modifier and his group also oversees the development of value based purchasing plans for ambulatory surgical centers, skilled nursing facilities and home health agencies.

So John, I'll turn the call over to you to make some remarks.

John Pilotte: Thank you and welcome everyone. I'd like to share with you today, Dr. Berwick's vision for the Accountable Care Organizations and provide a brief overview of the Medicare Shared Savings Program and as well as pose several questions that we recently announced in a request for information around the Medicare Shared Savings Program for you to consider providing comments today on -- or through our ACO mailbox at aco@cms.hhs.gov. Recently Dr. Berwick described the Accountable Care Organizations or ACO's as a new approach to delivering care that reduces fragmented, unnecessary, care and

excessive cost growth for the Medicare fee-for-service beneficiaries. By promoting population health management, coordination of part A and B services and encouraging provider investment in infrastructure and redesigned care processes.

Accountable Care Organizations will promote the delivery of seamless coordinated care that you've heard a lot about today. That promotes better health, a better experience and lower cost by putting the beneficiary and family at the center of care, remembering patients and their medical histories over time and place, attending carefully to hand offs care as patients move along the continuum of care, proactively preventing illness and promoting population health, especially for chronically ill beneficiaries and at risk populations which are highly prevalent in the Medicare population as you all know.

Tracking and reporting outcomes and giving timely feedback to providers in a data rich environment with IT infrastructure and innovating and improving approaches to achieving better health, better care and lower growth in expenditures for its patient population and then continually investing in team based care and its workforce. There are several elements to ACOs that Dr. Berwick outlined for his vision for the program as called for in the Affordable Care Act. Existing and newly formed organizations are eligible to apply to participate in the Medicare Shared Savings Program, including group practice arrangements, physician networks, joint ventures and partnerships of hospitals and ACO professionals and hospitals employing ACO professionals and by ACO professionals we mean physicians and practitioners as defined in the statute.

The Secretary may also include other providers and suppliers of services at her discretion. Under the Medicare Shared Savings Program an ACO will accept responsibly for an aligned patient population and procedures and processes in place to promote evidence based medicine, report on quality and cost majors, coordinate care and the patient centers. Furthermore, Accountable Care Organizations must have sufficient capacity to provide primary care services for at least 5000 aligned patients.

The aligned patient population is the basis for establishing and updating the financial benchmark, assessing quality and financial performance and focus of Accountable Care Organizations efforts to improve care and reduce growth in Medicare spending. ACO providers continue to be paid under regular Medicare fee-for-service payment systems and are eligible for shared savings if they meet the quality performance standard and the spending for their aligned patient population is below the updated benchmarks.

ACOs will be responsible for reporting quality measures including clinical care processes and outcome measures, patient and caregiver experience of care and utilization such as those that focus on ambulatory care sensitive conditions. We welcome your thoughts and comments today on the above as well the following questions that we recently published in our request for information.

Specifically, they are what policies or standards should we -- CMS consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare shared savings program and the ACO models tested by our colleagues in the Innovation Center led by Dr. Gilfillan. What payment models, financing mechanisms or other systems might we consider, either for the shared savings program or as models under the innovation center to address access to capital issues for small practices? In addition to payment models, what other mechanisms could be created to provide access to capital again, especially for smaller physician organizations?

The process of aligning beneficiaries that we talked about previously is important to ensure that expenditures as well as any savings achieved by the ACO are appropriately calculated and that quality of performance is accurately measured. Some argue it is necessary to attribute beneficiaries before the start of a performance period so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance.

Others argue that the attribution should occur at the end of the performance period to ensure that ACO is held accountable for care provided to beneficiaries who are aligned to it based upon the services they actually

received from the ACO during the performance period or the ACO providers during the performance period. So how should we balance these two points of view in developing the patient attribution models of the Medicare shared savings program and the ACO models tested by the center for innovation?

Our next is how should we assess beneficiary and caregiver experience of care as part of our assessment of the ACO performance? The next question is what aspects of patient-centeredness are particularly important for us to consider for the Shared Savings Program and how should we evaluate them? The next question is what quality measures should the Secretary use to determine performance in the Shared Savings Program? The next question is what additional payment models should CMS consider either under the authority provided for partial capitation and alternative models, or the authority under the Innovation Center and what are the relative advantages and disadvantages of any such alternative payment models. Finally, how should beneficiary communications about ACOs be handled and what should be communicated to Medicare beneficiaries about the Medicare Shared Savings Program and Accountable Care Organizations.

We welcome your input on all of these, both today or through our ACO mailbox at aco@cms.hhs.gov and I thank you for the opportunity to participate and we look forward to your thoughts and comments on these.

Nancy O'Connor: OK, thank you John and thanks Dr. Gilfillan and Sharon for your remarks. I know that was a lot of information for our callers. I hope the information was helpful and provided some context and I think everyone would agree that CMS has been given a challenging and exciting opportunity and we recognize and it's been said that in order for us to be successful, it's important that we engage as many stakeholders as possible to get your input.

So your remarks today are not considered to be formal or official on the record remarks. CMS though is very interested in your comments, in your inputs, since these programs are still being developed. If you have thoughts or comments after this call is over, we do have some email boxes set up to receive your comments and we'll share those email boxes with you at the end of the call along with a website to get additional information.

So now we'd like to hear your thoughts. As I said and as it's been said, we are very interested in hearing your comments about what you've heard today. If you would like any of the questions repeated, we will be glad to do that but it's your chance; it's your opportunity to give us some input. And I'd ask that when you speak, try to let us know your names, your affiliation, and what area you are particularly commenting on. For instance the Accountable Care Organizations, the Innovation Center or the Federal Coordinated Healthcare Office.

So with that, operator let's open up the phone lines for our callers and let's hear their thoughts and comments.

Operator: Again, in order to state a comment, please press star, then the number one on your telephone keypad. Your first comment comes from the line of Kathy Roe. Please state your organization. Your line is now open.

(Kathy Roe): Hi. My name is Kathy Roe. I'm calling from Partners in Freedom. I had a question just concerning what Dr. Richard Gilfillan had spoken about. He mentioned that there would be several states involved in different programs and I just wanted to -- I wasn't sure if he had mentioned that New Jersey would be involved in whatever would be forthcoming? You said it was to include like 15 states but I didn't hear.

Nancy O'Connor: Yes, Rich can you repeat the states that were with the medical home demonstration I believe, the state based medical home demonstration. I know Pennsylvania is included which is in Region III but could you just go through the other states?

Richard Gilfillan: Yes, sure. I'm sorry. I'll repeat them. The states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota.

(Kathy Roe): So do we know if there will be any such programs coming to New Jersey that are like that, some sort of pilot?

Richard Gilfillan: Well I would say that -- we are -- in the Innovation Center we're interested in continuing to explore opportunities to work with folks in new areas of medical

homes, ACOs, bundle payments, patient state initiatives and any other models that we think will have real promise in improving the outcomes we've discussed. So the answer is we will be looking for more proposals from folks who are not at that point yet. We will be looking for more proposals and as we do I'm sure there will be opportunities in that region.

(Kathy Roe): OK, yes. Because we already have patient centered medical home status in our practice but we didn't know if Medicare was going to be offering any such pilots in conjunction with that.

Richard Gilfillan: Well I would ask you to keep an eye on our website. It is innovations.cms.gov and we -- while it just came up over the past two weeks, we'll be putting up more information up there continuously. We will not too far down the road have a forum up there that you can use to provide us with input and suggestions.

(Kathy Roe): Thank you.

Richard Gilfillan: You bet.

Nancy O'Connor: Operator, are there other comments?

Operator: Yes, your next comment comes from line one (Lori Rose). Please state your organization. Your line is now open.

(Lori Rose): Medical Society of Delaware.

Nancy O'Connor: Hi (Lori).

(Lori Rose): Hi. How are you?

Nancy O'Connor: Good.

(Lori Rose): Good. I actually have two questions regarding ACOs. The first one is, everybody is expecting guidelines to be published by the secretary of HSS, and they said late fall and I haven't seen anything yet. Obviously we're about to hit winter. So I wanted an update on that, when the guidelines would be published. And then secondly, has there been any more discussion with the

FTC to loosen the antitrust concerns that physician practices have in creating ACOs?

Nancy O'Connor: OK, well (Lori), we're not really answering questions but we did hear you want that information. I would suggest that you keep an eye out on the website. We still have a couple of more weeks until winter from what the calendar tells me. But seriously, just keep an eye on the website about the regulations that are forthcoming.

And as far as the other issue, I would ask that you send that into the websites that we will be giving you later on in the program. I think the Accountable Care Organization website, which is aco@cms.hhs.gov, would be the appropriate place to send in that question.

(Lori Rose): OK, thank you.

Nancy O'Connor: OK, thank you.

Operator: Your next comment comes from the line of (Don Liss). Please state your organization. Your line is now open.

(Don Liss): (Don Liss) from Independence Blue Cross. I want to take the opportunity to thank CMS on behalf of the project, the ongoing medical home project going on in South Eastern Pennsylvania and across the state and take the opportunity to express our excitement about CMS selecting Pennsylvania for continuing. Our question or perhaps comment for Dr. Gilfillan is you could speak to how flexible should we expect CMS to be in working with health plans in the private sector entities and the operation of the advanced primary care demonstration that essentially will be the second phase of our ongoing work.

Richard Gilfillan: Well hello Don. The (MADCP) Initiative will not be managed directly out of the innovation center. It will be managed from the ORDI group, down within CMS. But we are working closely to make sure that we present a somewhat common approach to the America home initiative. That's a little difficult, knowing that there is eight states and multiple models et cetera but I think our intent is to be flexible and to recognize that it's important to present a kind of simple straightforward non-ambiguous approach to primary care practices so

that they can kind of focus in a particular way on some common metrics, et cetera. So I think our interests are making sure that when we invest in these and in other programs, that they are squarely focused on delivering on that three part aim of better health, better care and lower costs, that being lower total for capital cost. So we'd like to see a focus on those outcomes but we recognize that exactly how that plays out in different markets is part of the excitement of the (MADCP) program and the opportunity to learn a great deal from what will be no doubt some different approaches.

(Don Liss): Thank you. And again, we're still thrilled to be part of that project.

Nancy O'Connor: And Don to the (inaudible) if you have other ideas around parameters where we can be more flexible or we can be doing more, you can share them with us this afternoon or just send an email.

(Don Liss): Great. We're just getting started with the existing projects. We are working with the state contractor in establishing what sort of efforts that will get project moving forward and we look forward to the opportunity to share our thoughts and work with the CMS staff.

Nancy O'Connor: OK, great, thank you.

John Pilotte: Nancy, this is John Pilotte. I wanted to actually clarify one thing to the prior individual who asked a question from the -- I think the Delaware Medical Society. And to give all just a quick update. We plan on, right now to publish the notes for proposed rulemaking in January. So I would look for it around the 1st of the year. And with respect to the antitrust issues, we had an open door forum earlier this year that many people participated in, including the FTC and the Department of Justice. And we continue to be in conversations and dialogues with them around antitrust issues and clinical integration issues and so forth. So those processes are ongoing and we are working collaboratively with the other departments on this issue.

Nancy O'Connor: Thanks John. I think that helps to clarify. Operator, do we have any other comments?

Operator: Again, we would like to remind participants that if they have a comment, they may press star then the number one on their telephone keypad. Your next comment comes from the line of (George Gregoratos). Your line is now open.

(George Gregoratos): Yes, this is (George Gregoratos) with Quantum Health. My comment is -- the ACO concept seems to be rooted in the outcomes that CMS achieved with the physician group practice demonstration and my comment relative to that is, within that demonstration there was a feeling on the amount of savings that could be shared with -- between the physician or hospital ACO like organization and CMS and it seems to me that the feeling in many ways dictates how much potential health delivery change we might actually drive. So my comment would be that you would raise the ceiling on any shared savings so that in fact you might motivate and incent organizations to drive bigger change than they may have done in the PGP demo.

Nancy O'Connor: OK, thank you for that comment (George).

Operator: Your next comment comes from the line of (Dolores Osborne). Your line is now open.

(Dolores Osborne): I'm not quite sure who to direct this question to; I'm coming to you from a patient point of view, from a cardiology office and that has to do with transportation. Medicaid offers transportation to patients who are on Medicaid, but there's no such offer for Medicare patients who are only drawing social security and do not have the funds to get to doctors' offices and so on. Is there a criterion for that or is there a model for that?

Nancy O'Connor: I don't know if anyone – any of the speakers want to comment, but it's clear that that's a need that you're expressing and we will definitely take that comment forward.

(Dolores Osborne): Thank you.

Nancy O'Connor: Operator, are there comments.

Operator: Yes you do have a comment from the line (David Jubilus). Please state your organization. Your line is now open.

(David Jubilus): Hi this is (David Jubilus), (Fundamental Pinnacles Consulting), we operate the post cure care for sod across the country. And I guess it's a comment but it's got a question mark at the end of it and if you don't have – if you can't respond today that's fine.

On the notion of the ACO attribution of beneficiaries to the ACO, it kind of confuses me. Will the beneficiary know that they are enrolled in an ACO; that is I guess a mass – it is the model that the ACOs will go out and recruit Medicare beneficiaries, who then know an agree to be part of an ACO. Or is this a block from the beneficiaries perspective; are they blind; is there a medic here, there'll be in the ACO, but they won't really know it and therefore won't participate actively as an ACO participant. Can you guys address that?

John Pilotte: Yes, hi this is John. The stuff you talked about aligning beneficiaries; in one of the areas we've heard a lot about is when you do that retrospectively, like we did under the suggestion group practice demonstration, where at the end of each performance years, we align patients to each of the organizations, based on the people I saw during the course of the year.

So it's actually based on their actual utilization and that's created lot of opportunities for those organizations to standardize their care coordination activities, their quality improvement initiatives, initiatives and activities around for all their patients that they saw during the course of the year.

And that's one of the areas that we thought a lot about the – around the needful prospective alignment, full organizations have more information about who those patients that they're serving may be, during the course of the year or during historical periods and so forth and so.

I think those are all issues that will – we're seeking input on from a variety of stakeholders right now. So there'll be issues that will be addressed as part of our NPRM.

(David Jubilus): Thanks for the comment, I guess the simple motto was, the organization itself, the ACO could: a) At the beginning of the set of all – the timeframe know who its panel is; or b) At the end know who its panel was, but I guess the

other part of this – but c) Do the panel members themselves as the beneficiaries ever really know that they're in an ACO and does that make a difference?

John Pilotte: Yes, I will also say as part of the physician group practice demonstration that provides a rule, requires to notify patients as part of the physician group practice demonstration and the implications of that for services that are provided to patients they saw.

So I think that is another area, as I mentioned earlier, we'd like to get input on and it's a round – what information should be communicated to beneficiaries about their providers participation and accountable care organization arrangement.

(David Jubilus): Thanks John.

Nancy O'Connor: Operator, are there comments.

Operator: Your next comment comes from the line of (Gordon Woodrow). Please state your organization. Your line is now open.

(Gordon Woodrow): Yes I'm with Care Partners plus the company that has technology that engages the patient at the time of care. Hello everyone and thank you very much for giving us all an opportunity to comment.

My comment also has a question at the end of it. I'm just interested in a process, perhaps Dr. Gilfillan can clarify this, but the demonstrations that you're talking about in the name states, particularly Pennsylvania; they will all be basically one tree leaf, state crowning mechanisms.

Otherwise the state will be in equal partner with CMS in the process of the many technologies.

Rick Gilfillan: I think – not sure I follow your question but I think we will be working closely with the state and to the extent you have work that would normally be – approaches that you'd normally use through the state, I would suggest for now you do that; yes.

(Gordon Woodrow): OK.

Rick Gilfillan: Because that problem is to work closely with the state and with the other payer that are already engaged and I think that probably would be the best way to ensure that it's consistent with the overall approach of the state particular program.

(Gordon Woodrow): OK, all right, well, it's a great opportunity for engaging the patients and looking forward to it. Thanks very much for giving us all this chance to talk.

Operator: Again if you have a comment you may press star and the number one on your telephone keypad. Your next comment comes from the line of (Martin Quary). Please state your organization. Your line is now open.

(Martin Quary): Thank you; you just discussed it on the prior question about the issue of cohesion and I think that's probably that's it for now, thank you.

Operator: Your next comment comes from the line of (Peter Littman). Please state your organization. Your line is now open.

(Peter Littman): Hello I'm a family physician and analyst of the systems. The goals altering of primary care and the patient centered medical home and as is seen by the recent Massachusetts experience; that relies on the supply of PCPs and the supply is getting stretched to the limit.

A huge problem for health care reform is the supply of primary care and as everybody knows, tip toes around. The big issue for the supply is lower overall reimbursement in salaries and primary care and there's no more money in the system to pay more.

And I had a thought that instead of increasing payments, if we could reduce costs and frictions in the system for primary care that would improve the bottom-line and would reduce the aggravation of practice.

And a recent health affairs article noted that it's around $85000 per physician, dealing with insurance companies and insurance company requirements. And

my experience from being on the frontlines is that 99.99 percent of that is wasted.

And the insurance companies, regardless of what they say, tend to be abusive and this includes Medicare. So that, for example, they will pay for an office visit and not the year analysis; and then if you don't go right to the wall with them, on the year analysis, then you don't have to get paid for another year analysis.

They'll know that one in three can just be dropped and they can drop other stuff as well and with all their denials, I'm sorry I've been on the frontlines, they do this; and I get all sorts of bureaucratic things that come down to – they just won't pay until we do more and have to harass them.

This is an enormous cost, it creates enormous friction, enormous aggravation, and it doesn't take care of any patients and I would suggest that we go to the restaurant model of paying for a meal, and that is simply required that all insurance companies including Medicare, Medicaid, offers compensation, no fault et cetera. All be required to pay for primary care, at the time of service with a debit card. That is they make a binding declaration that the person is or isn't covered. And of course they say someone isn't covered, they're going to deal with the anger of the patient.

But they make a binding decision at that point and then based on a C schedule they make a payment. The costs on that are enormously lower than the $85000 we're paying now per physician.

And that acts as a direct, shall we say, subsidy; put the money into the primary care system, which then allows us to be able to implement elements of the patient centered medical home and expand our practices and it makes it possible to recruit other practitioners to primary care.

The other factor is the pre-approval and drug formulary policies and so on; which in my experience, again 99 percent of the time have no effect, except to deny care. And when they do it usually ends up increasing costs, rather than decreasing.

Because if you prevent somebody with severe gerd from getting twice a day PPI therapy, then they end up getting an endoscopy and see the gastroenterologist a few times; possibly has a frontal placation and that doesn't save anybody any money.

If we just let the primary care physicians do their job and say, "Look this particular needs twice a day PPI therapy." Remove all that friction and I think that we can – and this will have to be done on the federal level, because one insurance company would be reluctant to do it on their own.

We would have enormous improvement in the quality of life of primary care physicians and would allow us to stop paying so much attention to, "Can we get paid for this"? To "How do we take better care of people"?

Nancy O'Connor: OK, thank you very much. I really appreciate your thoughts there and I can hear your frustration so thank you very much for those remarks.

(Peter Littman): Thank you for listening.

Richard Gilfillan: If I could – this is Rick; I just would suggest that you keep an eye on our website, as I mentioned earlier, innovations that send us back up. And we will have proposals out there or a forum for people to give us suggested models, suggested patent models to consider casting.

And if you would we'd be happy to look at a specific suggestion like the one you've made and put it into our thinking about priority projects to pursue. So thanks very much for your thoughts and that's probably the best way, if you could keep it – get it into our systems so we can get it into our consideration.

(Peter Littman): Does that system exist yet?

Richard Gilfillan: The website does, the format will be up in a couple weeks.

(Peter Littman): All right thank you very much, thank you for listening.

Richard Gilfillan: You bet.

Operator: Your next comment comes from the line of (Rachael Hemmer). Please state your organization. Your line is now open.

(Rachael Hemmer): Hi my name is (Rachael Hemmer), I work for the client JCC here in Pennsylvania and we're a comprehensive community center that deals with everyone form children to elderly, but have a significant ageing services network.

And I guess my question was, I've hear a lot about how you want to – I'm not sure who to address the question to but – about making seamless services available, working with patient centered practices.

I'm curious, how would you approach the ageing network; looking at various transportation and access to federal service and when people aren't at the doctors, what are they doing and how are they doing things that will improve their quality of life or are they – those kinds of things.

I was curious that has anyone approached the ageing network and how you're dealing with what will be the triple A's in the department of aging, in that respect, and so I was curious.

Nancy O'Connor: Hi Rachel, it's Nancy. We do work with the ageing network but I would say that if you have specific experiences that have worked or ideas for us to consider on a broader scale that you submit those comments to us or you can talk about them now; your positive experiences, that we'd be very interested in hearing your experience and what you think works.

(Rachael Hemmer): Well, I think that will be fine. We see a lot of people aren't able to get to the doctor, either because of transportation or other issues, so we get them to the doctor on time. But looking at some kind of a merger between health care and the ageing services network, I guess it's something that I was thinking about.

We're looking at how we can move to a model like that, where we have – we oversee for senior centers, so we have people onsite, we have over 600 seniors a day onsite. We have also are in their homes doing meal delivery as well as

engaging those seniors who are able to volunteer and so we look at how we can engage the seniors in health and wellness, in a very serious manner.

And one way to do that is to merge our system with healthcare and looking at how, if they can come here then they can access other systems connected to these management prevention, those kinds of issues and is it then a cheaper model offer because we're also with them five days a week so things are caught quicker and those issues – so that's – they're not that sophisticated, at this point we're moving towards that model and I'm looking at models apparent in that manner so.

Nancy O'Connor: OK, thank you, thanks (Rachael). Any comments from our speakers; if not we'll go to another person on the line, operator.

Operator: You do have a comment from the line of (Mitchell Goodman).Your line is now open.

(Mitchell Goodman): Thank you. I'm with (Dwayne Morris), so we're a in a law firm in Philadelphia. I'm just really curious about the capital formation strategies and whether or not that's an appropriate issue to put on the website.

Because I don't think it's easy to discuss that over the conference call.

Nancy O'Connor: OK, we will take that as something….

(Mitchell Goodman): I'm asking a question, is that an – people concerned at all about capital formation over the question related to it. I just want to make sure that that's the appropriate forum to have that discussion.

Nancy O'Connor: Yes, if you have that question please submit that to the website.

(Mitchell Goodman): OK. Thank you.

Nancy O'Connor: Are there other folks on the line.

Operator: Yes you do have a comment from the line of (Holly Goldman). Please state your organization. Your line is now open.

(Holly Goldman): Hi, I'm calling from (Green Spring) internal medicine, which is my private practice and also as the representative of the narrow end American college of physician's health policy committee.

Much of what we have been talking about lately is the income disturbance between primary care physicians and specialists and lot of what really drives that is the orientation of Medicare payments toward procedures rather than toward evaluation and management and as we move toward patient centered medical homes models, I think that there seems to be a little bit of hope at least in recognizing a lot of the intellectual work that primary care doctors are doing, at a low cost, saving the health system a great deal of money and possibly some of that savings can be transmitted toward increase payments for primary care doctors.

One of the biggest concerns that we have is that even though there are some considerations on the channel about repaying medical school loans for doctors who go into primary care. The work force issues will still become confounded by the fact that primary care doctors are paid about half as much as the specialist.

Even though often times they're doing more work and I'm wondering what Medicare is really doing to address those concerns?

Nancy O'Connor: OK thank you for that comment and I don't know if any of our speakers want to react to that, but we will take that as a comment and a concern. Operator

Operator: Your next comment comes from the line of (Bask Heed). Please state your organization. Your line is now open.

(Bask Heed): Good afternoon thank you. Yes, (Bask Heed) form the consumer health collision, also the Pennsylvania campaign for better care. I just have a few comments regarding the development of ACOs.

Coming from the consumer perspective, we want to ensure that there's strong patient protections, such as transparency, we touched on another call that we'd like to see that beneficiaries are not only notified when they contributed to us

and to an ACO, but that they're also made aware that their provider may have a new financial incentive to limit their care.

We want to ensure that there's proper network adequacy; that they have – ACOs have a network of health care providers that meets the needs of all enrolled patients, including high risk and high cost populations.

We want to ensure that there's an opportunity for appeals that patients have access to an external appeal and when we're looking at incentives blockings, ACOs should seek to maintain high patient enrollment by providing better care; that the patients are given the choice to opt out.

I just have one other comment regarding quality. We want to ensure that what FE's new models are developed; that we're using peace and experience and patience; reported outcome measures as a part of the process in determining the quality. That's all.

Nancy O'Connor: OK, thank you very much. That was a very interesting – your comment there and we'd really appreciate it if you could also send them to our website and possibly put in elaborate or put in some specific examples about your thoughts on network adequacy or better care, some of the other areas that you talked about.

(Bask Heed): Well, thank you.

Nancy O'Connor: Thank you; operator.

Operator: Your next comment comes from the line of (Mari More). Please state your organization. Your line is now open.

(Mari More): Yes, my name is (Mari More) and I'm with meals on wheels, here in Lancaster Ohio. I'm an on shift volunteer, I have been one for 15 years and especially the last few years, I've become aware of LIS and the benefits of LIS for the low income beneficiary.

And I think it's a good program, though I do come across a lot of people who don't quite fit within those guidelines. Their income and their resources are

just a little bit high and there just seems to be quite a bit of a struggle for these people to be able to pay for their medications and I see that there is quite an endeavor and a lot of work that goes into finding the people that fit the LIS category.

But there isn't very much that is or seems to be done for the people who kind of fall in the cracks; whose income is just a little bit high and who are really struggling to be able to pay for their medications and I just thought I would fill that comment out to see if there's anything that can be said or directed towards that issue. Thank you.

Nancy O'Connor: Thank you for your comment; operator.

Operator: Again if you have a comment you may press and then the number one on your telephone keypad. Your next comment comes from the line of (Jean Entinuty). Please state your organization. Your line is now open.

(Jean Entinuty): Hi my name is (Jean Entinuty) and I am my organization; I'm a small primary care physician in the state of Maine and I realize this is a Region III phone call, but I heard about this call so I'm very glad to be here.

And my question is about what the CMS folks may be thinking about doing about many small independent practices? I know many small independent practices across the country. And many of us have really stepped up and done work; often significantly, our own financial and personal risk.

And many of us have data on increased quality and lowered costs, but we have no way to have a voice. We can't join up, we can't really gather up 5000 lives and I wonder what CMS is thinking about how we might become involved in projects.

I have been cut out off paid pilot projects here in the state of Maine, because my practice is too small; although I've exactly the work that folks are looking for and I wonder what your thoughts are about how to gather us up or how we can become involved and how we can share in the savings that we have been producing.

(Terry Postma): Hi this is (Terry Postma), I work with John Pilotte in the Performance Based Payment Policy Staff with ACO Medicare shared Payment Program involvement and I just want to say that that's a great comment and once we get the proposed rule out – I know it's hard to take time away from practice, because you guys are so busy.

But if you could take a couple of minutes to share your thoughts with us on that proposed rule; it would be really valuable to us.

(Jean Entinuty): And will you give us – could you give us now an email address or something. How do we stay in touch? I know about the Innovations website; I can continue to go there; but any guidance?

(Terry Postma): Yes for the Shared Savings Program; if you want to send comments to aco@cms.hhs.gov; they'll come to me.

(Jean Entinuty): And would you be kind enough to state your name again; was it (Julie)?

(Terry Postma): It was (Terry Postma). OK.

(Jean Entinuty): Thank you very much.

(Terry Postma): Thank you.

Operator: There are no further comments on the phone lines at this time.

Nancy O'Connor: OK operator let's just give it another minute, in case anyone is trying to get in or would like to make a comment.

Operator: I would take a moment to remind that the instance that they do have a comment; they may press star and the number on the telephone keypad. You do have a comment from the line of (Sarah Goldstein). Please state your organization. Your line is now open.

(Sarah Goldstein): My organization is community care behavioral health, but I don't know if this is – this is what I understand that from the proposed health care reforms, none of the proposed have outpatient mental health benefits as coverage and I don't understand why a person has to be in severe crisis to get covered outpatient

mental health benefits. I don't think it's very fair that a person has to be in crisis to just see a therapist or doctor and get covered.

We fought and fought for parity, for drug and alcohol benefits to see a doctor, a psychiatrist or a therapist. And not for a lot of visits; for 26 visits a year for something like that; but if even with PA share care now mental benefits.

And this isn't really fair because it's not really getting coverage, you know what I mean. And I don't think it's very good; you have to get on – you have to be on welfare to get behavioral health benefits; if you don't have insurance or if you don t – if you aren't employed.

There's a big job factor if you're in crisis or you're employed. If you're on PA share care you don't get benefits. So I don't think that's very good; and that's my comment.

Nancy O'Connor: OK, and thank you very much for that comment; we appreciate it and if you could, could you please send that to our website at aco@cms.hhs.gov. Of course I'll organize that data and not sound irrational.

(Sarah Goldstein): Thank you.

Operator: Your next comment comes from the line of (Irene Anderson). Please state your organization. Your line is now open.

(Irene Anderson): (Irene Anderson) SMC business counsel. I was wondering the pilots that are being offered; is there a chance that those would be refunded or is that – that's not discretionary funding; that's a port closed; it's appropriated?

Nancy O'Connor: (Rick) do you want to answer that question? To my knowledge, no; there is no – I'm not aware of anything that would be refunded at this point. If you have that concern, I will be glad to – if you'd like to send it into our website that will be fine.

(Irene Anderson): I am – really want to support these things as much as we can, because I know we have to control health care across and I just want to learn more about them, so I guess the thing to do is just keep watching that website.

Nancy O'Connor: Yes it is.

(Irene Anderson): OK thank you.

Nancy O'Connor: And if you do have ideas or thoughts on how we can improve the health care system, especially with what you've hear today, please send them into us.

(Irene Anderson): OK thanks.

Nancy O'Connor: Operator, are there other comments.

Operator: There are no further comments on the phone lines at this time.

Nancy O'Connor: OK. Let me just give it one more minute,

Operator: You do have a comment from the line of (Holly Doming). Please state your organization. Your line is now open.

Nancy O'Connor: OK.

Operator: Your line is open.

(Holly Doming): Hi and thank you again for letting us join in, on this call. One of the questions that has occurred to me – I'm calling again from Baltimore, form Green Spring internal medicine.

Is the cost of durable medical equipment and that in many cases the cost is motorized wheel chairs and other very expensive health care equipment, is never – never seems to be recovered by Medicare and one of my patients is a director of a nursing home in (Calsida).

He has a whole room full of motorized scooters that are just parked there after patients have passed away. And I know that there are lots of cost concerns about – like a lot of cost concerns in Medicare seem to focused on suggestion compensation but I'm wondering if there is also some focus on recovering the cost of durable medical equipment, that seems to be wasted in the system. These devices for example cost about $10000 from what I understand.

Nancy O'Connor: OK, I definitely hear that as a concern so I'd appreciate it if you could send that concern into us and if you have any ideas there on how we can make improvements or do a better job, please share them with us.

(Holly Doming): Thanks.

Nancy O'Connor: Operator, are there other comments?

Operator: You do have a comment from the line of (Gary Baron). Please state your organization. Your line is now open.

(Gary Baron): Yes I'm with the graduate school of public house at the University of Pittsburg; and obviously the way to save the most money through primary prevention. The more public health approach and I believe Dr. Gilfillan mentioned some programs dealing with community level.

Issues help disparity and population based programs potentially. Could he discuss that a little more; expand on what he said?

Nancy O'Connor: Dr. Gilfillan do you want to expand on that? We are going to be – you will be seeing more from our website on population based health outcomes and programs that we will be running. If you do have some ideas or things that you think would work I think there for you to put forth your ideas and in the meantime, please feel free to send us comments or some thoughts.

(Gary Baron): OK, thank you.

Nancy O'Connor: OK, thank you. Are there other commenters on the line?

Operator: You do have a comment from the line of (Peter Zeeman). Please state your organization. Your line is now open.

(Peter Zeeman): I just wanted to clear that we go out health insurance companies to sell national health care policy and that's led to many of the irrational situations; such as, the person who was talking about with durable medical equipment, with coverage, with transportation; and I point out that the ophthalmologist send jitneys around to pick up their patients for cataract evaluations.

So if the money is in the system the transportation is available. Thank you.

Nancy O'Connor: OK, thank you, I think that's up to the third comment we've heard today on transportation. So please send us your thoughts on that and idea that you have or things – concerns that you have; we're very interested in that.

Operator, are there other comments?

Operator: There are no further comments on the phone lines at this time.

Nancy O'Connor: OK well I do want to thank all of you who have joined us on the call today, for your thoughts and expressing your concerns on – as you can see CMS is part of creating the health and healthcare we need.

It's very important to us and we really value all your inputs and insights and again I want to thank Dr. Gilfillan, Sharon and John for helping us understand more about these new programs and the potential role that groups and individuals can play as CMS moves all of these efforts forwards.

So thank you again for everyone who dialed in and participated on today's call. Lorraine is going to provide you all with instructions for making any comments by email or if you would like to access the recording of this call, she'll give you that information as well as where you can find some additional materials.

Again, it's important to just keep an eye on these websites and please feel free to send us your thoughts, comments, your concerns at these websites, because we're monitoring them and we are taking your input very seriously.

So thank you and Lorraine do you want to give some information there.

Lorraine Ryan: Sure thank you Nancy. If you were unable to provide your comments today or if you have something that you would like to share, on today's call that may have occurred to you afterwards; we have a full place of doing that.

To comment on Accountable Care Organizations, you may send your comments to email address aco@cms.hhs.gov. To comment on the federal health care office, issues related to that; you may send your comments to

schco@cms.hhs.gov. For information on the innovation center you may go to the website www.innovations.cms.gov; at this site you can also sign up for emails, be part of the twitter alerts and the RSS news feeds.

There will also be an email box that will be launched shortly, so you'll be able to monitor that, when you go on the site. For those who have missed some of the call or if you have colleagues or friends who are unable to join us today; the presentations will be available to an on court feature, in approximately two hours after this afternoons call.

The recording will be available until Monday December 13th. To access the on court feature you can dial 1800-642-1687 and use the same ID, participant code that you used for this call and that ID code again is 28945473.

Thank you all and have a good afternoon.

Nancy O'Connor: Thank you very much for your participation and operator this concludes the call today, thank you.

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

END