Centers for Medicare & Medicaid Services

Moderator: Susie Butler
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Operator: Good afternoon. My name is (Jessica) and I'll be your conference operator today. At this time, I'd like to welcome everyone to the healthcare delivery system reform conference call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a comment session. If you would like to make a comment at this time, please press star then the number one on your telephone keypad. If you would like to withdraw your comment, please press the pound key. Thank you. Ms. Susie Butler, you may begin your conference.

Susie Butler: Thanks, (Jessica). I'd like to thank everyone for attending today's call on healthcare delivery system reform. CMS is working to improve our healthcare system. We have begun to implement our new vision to be a constructive force and trustworthy partner for the continuous improvement of health and healthcare for all Americans.

The key to accomplishing this vision is transforming our current, fragmented, high-cost delivery system to one that delivers a seamless care experience with better health and healthcare for patients at a lower cost through improvement.

CMS has been given a great opportunity under the Affordable Care Act to improve our healthcare delivery system and provide new ways to deliver streamlined, seamless care with better quality and at reduced cost.

This is an enormous, challenging and exciting opportunity for CMS, but we cannot do it alone. We need your help. Today, you'll hear from three leaders here at CMS, in charge of three different programs, all at different stages of development. As our stakeholders, we're very excited to engage you in this process.

First, we'll hear from Jonathan Blum, CMS Deputy Administrator and Director of the Center for Medicare. He'll be sharing about the Accountable Care Organization Shared Savings Program.

Next, Dr. (Rick Gilfillan) will talk about the newly launched Center for Medicare and Medicaid Innovation.

And finally, Melanie Bella, Director of the Federal Coordinated Healthcare Office, will outline the work of her area.

So, John, would you like to start?

Jonathan Blum: Great. Well, thank you very much. I don't want to take too much of our time, but I just want to offer a couple of thoughts regarding the shared savings program or the ACO program that CMS is currently working to implement.

Our very firm goal is to have the shared savings program stood up and started by January 1st, 2012. And we're going through the process right now of developing proposed rule that we expect to be issued sometime later this late December or some time early next year.

CMS recently put out a request for public information to solicit more information on some more questions that I'll go through in a second. But we are really trying to approach our work going forward and today, as one of – trying to get as much input as possible, as much information as possible, and CMS putting out the RFI is within that spirit, but we are very much committed and very much on track to have the program up and running by January 1st, 2012.

As we have talked about the shared savings program and as we have thought about it, we really see it as a program that's going to elevate the traditional fee

for service Medicare program, a program that today focuses on discrete payments for discrete services.

We would like to see the ACO Shared Savings Program transform the fee-for-service program to be one with our patients, have charities for patients to have complete care at home, and to really think about the ACO program as doing something different, something elevated both on quality and on cost than the traditional fee-for-service program.

We are seeing this model as one that can be seen as kind of multiple fronts. We see it as a model that will be attractive to large integrated hospital systems. We see it also as being attractive to group physician practices and also solo practitioners working in concert with each other.

So we really want the shared savings program to be flexible, to meet different models of care, but at the same time, one that can both elevate quality, it can also reduce cost of the overall program.

Our RFI that was put up November 17th but – that we are requesting comment by December 3rd. As a couple of key questions that CMS is particularly interested in understanding that hopefully today's telephone call will also help bring forward more discussion, the first question is going to the notion of trying to make the ACO shared savings program very attractive to solo physician practitioners. How can CMS develop rules that will make the program very attractive to small physician practices, solo physician practices?

Again, we really want this model to be a program that's flexible, that can appeal to physicians working in all different contexts.

The second question is, which payment models or financing mechanisms can CMS consider to ensure that it provides sufficient capital for small physicians or group practices to participate within the shared savings program? How can we ensure that beneficiaries understand the program and they can understand that their physician healthcare provider is part of an ACO program?

Question number four, how should CMS take in to account and assess the beneficiary experience and the caregiver experience to ensure that the high quality care is being enhanced?

Question five, how can we develop rules that emphasize the notion that the ACO shared savings program should be patient-centered?

Question six, how should we think about shared savings and how that relate to quality improvement? For example, should organizations that do better on the quality scale be able to retain more of the shared savings than those that don't need the full objective?

And last question is, what other payment mechanisms other than shared savings should CMS consider both in the context of the permanent national program, but also in the context of the center for innovation – that my colleagues will talk about – should CMS consider going forward?

So with that, I'll stop and just thank everybody for their participation today, then turn it over to my colleague, (Rick), to go through some of the thoughts about the innovation center.

(Richard Gilfillan): Thanks, John.

And thank you to everyone who took the time of your busy day to join us today and to share with us your ideas about the different activities here at the Center for Medicare and Medicaid Services.

I am the acting director of the Center for Medicaid and Medicare Innovation. We just went live, if you will, a couple of weeks ago and I want to give you a little bit of background on the center, how we're thinking about our role within CMS and some of the unique opportunities that the legislation provided for the Innovation Center, and tell you a little bit about the activities we have underway and then a little bit of kind of our theme of how we're going to operate going forward to kind of accept the context and stage for you all to what will hopefully be a lively conversation.

Susie mentioned the mission for CMS and that is to be a constructive force and a trustworthy partner for continuous improvement in the health and healthcare of all Americans.

If you think about that for a moment and think about healthcare and the way we have delivered healthcare over the years here in the United States, you know you our current system is somewhat fragmented at times, at least, it feels that way, at times for people – as they move through it. And we know that we pay a lot for our health care and that the results have been highly variable in quality; quality that's been very good in some areas and not so good in other areas.

The vision is to see that change over time – and see that our system transition to become a system that offers a more seamless, coordinated care approach for patients. And the outcomes for that system, we'd like to think of as having three parts—one, better health for people; two, a better care experience for people; and three, lower cost through that continuous improvement that we're trying to support.

So if you think about how CMS pays for things today, we pay for things in fragments. And the legislation created the Center for Innovation as a way to help CMS find new ways to support that new approach to care and payment; that new seamless care approach that's delivering on that three-part theme – better health, better care and reduced costs through improvement.

In establishing the center, the Congress provided a number of unique capabilities and support for the Innovation center itself. They provided $10 billion in financing over 10 years. They exempted the Innovation Center from some of the usual requirements for evaluating new ways of delivering care.

And they said, if it turns out the center can demonstrate that new approaches to care, a new care model, a new approach with the paying for care, can actually improve quality and reduce cost, then the Secretary can then change Medicare's fundamental approach to paying for services to that new approach, thereby, supporting hospitals, doctors, other care providers as they deliver that new, seamless care experience for patients.

So the center is in a good position to work as a partner with providers of all sorts and stakeholder groups of all sorts across the healthcare industry to find new care models and new models of payment that support that new approach to care. So the mission for the center is to identify, evaluate and support and diffuse new care models.

Let me just give you a little bit of deeper understanding of to how we're thinking about those care models. We think about them on three levels. The first is at the patient care level. This is the level where we think about what is the best way to deliver OB care; what's the best way to deliver back surgery or other types of acute services, so one point of innovation that we're interested in exploring is around patient care models.

The second level of exploration we're interested in is looking at systems of care that bring that seamless experience and that bring coordinated care to patients. So how do we support and evaluate medical home models? How do we support and evaluate alternative ACO models as John described?

The third level is to think about what can we do at the level of the community to improve the fundamental, ongoing determinants of health in a population? So we'll be looking for opportunities to be involved in population-based, community-based models of care.

It will be essential as we do this to think hard as we start out about how we will evaluate the outcomes of these new care and payment models. So if you want to think for a moment of how can you approach the Center for Innovation with proposals for new care models, think about it this way, think about a patient and think about needs for patients that are being unmet today.

And think about new programs that can improve the experience for that patient, for that population of patients that they represent. And then, think about how you can measure the outcomes of those new care models as those new payment approaches so that we can demonstrate real change all along those three dimensions of better health, better care and lower cost.

That's how we will be thinking about our work. Looking for care models and payment models that we can connect right back to patients and their needs and

think about new programs, new approaches that improve on that patient care to deliver the outcomes that we described.

So where are we right now? Over the next 90 days, we are engaged in four basic activities. First, we've opened our doors officially with a Federal Register notice in mid-November. We're doing the startup basics. We're hiring staff. We're building out some of the core functions; we're going through the budget process.

Second, we're beginning a planning process to develop an ongoing operating plan for the center. Central to this effort is to reach out to stakeholders of all sorts. And this call is part of that effort to get as much input as possible as we can from you all about what you think we should be focused on and about ideas from you about how we should operate, how we should go about making sure that we stay grounded in patient needs and patient care and can work with you as a constructive partner to help you develop and support you in developing new care models that will deliver those three outcomes.

Third, we're actually out there soliciting ideas. We'd like to hear from people about some specific ideas about projects we might pursue, care delivery models that you might be interested in developing. We're not at the point of taking formal proposals, but we will be sharing with the industry on our website shortly, a way that you can provide us direct feedback and suggestions for a model that we should evaluate.

And fourth, we are actually beginning the work of supporting new care – new models of care. To that end, as part of our announcement, we introduced four new delivery models, new initiatives, two of which were sponsored directly by the center and two of which are being supported by other components of CMS.

First, we will be working with our colleagues in ORDI, one of our other components in CMS, to launch a multi-payer, medical home demonstration program that enables Medicare to participate in ongoing and pre-existing state-based medical home initiatives.

We announced eight states that will be participating in this demonstration. They include Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota. In all eight states, we expect to include over 1,000 medical homes, serving over almost over 1 million Medicare beneficiaries.

Second, we announced that we'll be working with our Medicaid colleagues as they release the Medicaid health home state plan option that was created under the Affordable Care Act. This program will provide 90 percent Federal fund matching for the first two years of any state-based Medicaid health home private program.

Third, we announced that the Innovation Center will be supporting the development of advanced primary care medical homes in Federally Qualified Health Centers. We expect this to include over 500 FQHCs which will support almost 200,000 patients in a new medical home program.

And finally, the Innovation Center will be supporting the Federal coordinated healthcare office on demonstrations that are aimed at evaluating care models that better integrate care for the duly eligible population.

These models are all about getting us active in the delivery system, working with folks out there, providing care everyday to patients and trying to find those new models of care that will deliver improved health, better care and lower cost over time.

So this is an ambitious 90-day agenda, we feel. We are anxious to have a lot of conversation with you all today. We appreciate you're taking the time. I just want everyone to know that we are – we look out there in the industry to see partners and we will be coming forth to kind of work with you. And we know we are finding already many folks share our goals and are very interested in these new models of care and new payment mechanisms.

With that, I'd like to turn the mic over now to Melanie Bella who is the head of the Federal Coordinated Healthcare Office – Melanie?

Melanie Bella: Thank you.

And I want to echo the things to all of you on the phone today for the work I'm going to talk about. Stakeholder input is particularly critical at this time.

I'm just going to spend a few minutes to give you the highlight and overview of the Federal Coordinated Healthcare Office which as was mentioned was created as part of the Affordable Care Act, specifically, in Section 2602. And there are a number of goals and responsibilities listed in the statute for the office.

I would say, generally, there are two main themes that emerge. One is to improve the beneficiary experience broadly. So there are about 9 million individuals who are eligible for both Medicare and Medicaid. And our job is to fix all the places in those two programs that create barriers and problems for a seamless experience of care for beneficiaries.

And the second common theme that you'll see in the statute, it really has to do with improving the state and Federal relationship, so the state and Federal government share responsibilities and financing. Now, that's an important piece for the care of these individuals. And so, improving the coordination and the incentives between the two governments is also very important.

In order to attack our work, we've organized into two main areas. One is the program alignment. And in that area is that it literally is going through and finding every single place where Medicare and Medicaid bump up against each other and create problems from the beneficiary perspective.

So working with the variety of stakeholders, including (inaudible) plans?, advocacy organization, providers and others, we are assembling a list of all these program misalignments. We are looking at the impact of fixing each of those areas, and how many beneficiaries would it help. We are then looking at what kind of action will that require—would it be administrative or regulatory or statutory, and then using that to prioritize the order in which we'll attack those things on the list.

Everything that makes the list is very important, but we want to be clear about expectations in terms of how quickly we can accomplish those things and how many beneficiaries we can impact most effectively and most quickly.

That is going to be our living document, but we are committed to making it a very public document and we want to get stakeholder input on that document. So that will be something we'll release in the near future. In the meantime, we encourage folks to send us all of the things that they see in their daily lives where the programs are bumping up against.

And we have a mailbox established for that purpose which we'll be at – I believe, shared at the end of today's call.

The second major area that we're working on is models and demonstrations. So, Rick just talked about the goal of the innovation center is really to look for new care models and new payment systems and nowhere could we see that more important than in the care for dual eligibles.

The majority of the folks - probably over 95 percent – are in fragmented fee-for-service systems. And we're spending upwards of $300 billion total every year on care that isn't optimal.

We know we can do better for the beneficiaries. We know that we can hit the three part aim of better health, better care and lower cost through improvement. So, we will be working with the innovation center to support demonstrations around new care models and new payment mechanisms for programs targeted at duals.

The first area that we're going to target are the states and that is because of the interrelationship between the states and the Feds. It's critical to have that partnership at the table.

A couple of weeks ago, we announced the upcoming availability of demonstration contracts of up to $1 million for up to 15 states. And the solicitation package for those contracts for states will be coming out shortly, early December.

And we expect states to use these opportunities to work on the design and implementation of a demonstration model, focused on improving the delivery system and the payment mechanism.

With that, I think the only – the couple of things I'll reiterate is this office will be working closely with both MedPAC and MACPAC. And the office will be available on an ongoing basis to constantly be talking with stakeholders of all forms.

And so certainly, I'll look forward to your comments today. We look forward to your comments via email and other forms in the short and long term to ensure that we are incorporating stakeholder insights. So, thank you very much.

Susie Butler: Thanks, (Melanie).

Thanks, (Rick).

Thanks, (John).

Thanks, everyone. You shared some important information today.

We're now going to move into a time when CMS is going to listen to the good thoughts and ideas from all of you on the phone. Let me remind you once again of the ground rules now that I'm going to go over and that I alluded to at the beginning of the call.

CMS has shared about some programs that are in development and in different stages. So, there are certain things that we can engage with you on and most of the time we're going to listen. But I'll assure you, there's a group of folks both on the phone and around the table with me in the room that are listening.

So, let me tell you what we are doing and what we're not doing. This is not a formal response time. Don't think that when you comment today that that's part of a formal comment period. This is just a chance for us to exchange ideas and talk about different thoughts and modes that you may think might work. It's a chance for us to hear some of those ideas and to put those into the

hopper as we consider a lot of different ways to approach things that we're discussed today.

The other thing is we were definitely in a listening mode. As your facilitator, I may ask a clarifying question or two or one of the speakers may do that in a follow-up role, but we're really here today to listen to you.

Please try to keep your remarks to two minutes or less. We'd like to give as many people on the line a chance to talk as possible. And if for some reason you have a colleague that you know should have been listening to this call today but just couldn't make it, there is a chance to listen to today's comments from the experts and also submit additional comments via the encore feature. And I'll go over that at the end of the call.

So, (Jessica), we're ready to open up the lines for comments. When you speak, please make sure to let us know your name, affiliation and what area of these three that we talked about today your comments are addressing. (Jessica), we're ready.

Operator: At this time, I'd like to remind everyone, in order to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the roster. Your first comment comes from the line of (Darlene Tunis) from Baptist Hospital. Your line is open.

(Darlene Tunis): Hi. I'm just hoping that (Rick) and (Melanie) can talk more about the solicitation project.

And I know, (Melanie), you mentioned that you thought of soliciting outpatients in early December and they're worth up to $1 million. Can you just talk more about who the specific partners can be? Are you talking about group practices? Are you talking about hospitals? And what – and can you just spread some more information about what will be coming in December? What will be required? Will it be like the (inaudible) administration? Will it be that sort of the same process?

Melanie Bella: So, I think you need some more details. As I mentioned, the first round of demonstrations will be targeted to state Medicaid agencies, so the applicants will be state Medicaid agencies.

(Darlene Tunis): OK.

Melanie Bella: But within each one, I'm sure that states will work with different partners. But the applicant will need to be the state Medicaid agency.

What will be coming out in early December is the solicitation package or the request for proposals. These will be contracts so there will be a proposal and a review process that will need to be followed by the applicant's state.

(Darlene Tunis): And are you looking to partner with hospitals by any chance in any of these measures along down the line?

Melanie Bella: We certainly know that hospitals and any number of providers are critical partners in these areas. Right now, we're focusing on the state administrations and we'll be working out a longer term plan that will communicate as it evolves.

(Darlene Tunis): All right. Thank you.

Operator: Your next comment comes from the line of (Inaudible), M.D. from Hickory Trail Hospital. Your line is open.

Male: Yes. I'm a child psychiatrist – I'm sorry – and I've been working with two areas for children. And the care for children who are in foster care and the state agencies here is very fragmented and also as, you know, are very – there's a high rate of over- utilization. And I have sort of an idea in mind and to – just wondering how would I pursue this in future? I don't know if that's something that you guys can comment on, so two areas children who are in foster care and also in Alzheimer's care. So, thanks.

(Richard Gilfillan): Yes, thank you. This is (Rick).

If you would, keep an eye on our website, www.innovations.cms.gov. And we will have, up and not much farther down the road, a tool that will allow

you to provide us with more specific input. I think great areas of need and we really are interested in folks thinking through, you know, starting right there at those kinds of patient needs and think about programs that we could – we should consider that might be able to have a significant impact on the population.

Operator: Your next comment comes from the line of (Dania Polenker) from FEIU.

Your line is open.

(Dania Polenker): Yes, thank you.

This is a question – although it's specifically for the center for innovation, I think it can expand more and it may be something that you can't answer but consider as a comment.

But the question is if there's been talk about looking at programs that are trying to aim to actually – within that one group or service area to adjust workforce shortages by expanding responsibility of current direct care workers, things such as bringing long-term care workers into the primary care team or expanding to team-based care that may depend less on the primary care doctor if there's going to be a short – if there's a shortage in that area of primary care doctors and working more with direct care workers.

(Richard Gilfillan): Yes. This is (Rick). Just a thought on that, I think one of the hallmarks of some of the medical home programs that we've seen in our evaluation of proposal process and people have talked about is the importance of having everyone on the team operate at kind of the top of their training and/or license.

And so I think that there's a very natural opportunity within many of these new care models to think about expanding both the individuals who are on the care team as well as their responsibilities and the capabilities within the care process.

So, I think we are – we expect to see that happening in the – within those models of care. And again, if there are specific suggestions for models that we could evaluate and that, you know, kind of sit within our scope of

authority, we'd be happy to learn about them and put them in the process for evaluation.

I should be clear that, you know, if you look at the legislation for the Innovation Center, it's very specific and it talks about the importance, first, of models of care and payment mechanism that reduce the overall cost of care.

So, it's important for us to think about that and that's why I emphasized that the notion of these really are three dimensions we need to think about. So, if you think about care – the alternative models of care think about how it's going to improve the health of a population of folks. Think about how it's going to affect the care experience those people have. And think about how it's going to affect the overall cost of providing care.

And certainly, by expanding the care team, you know, one could – one might make a strong case if there's an opportunity to deliver care more efficiently with reduced costs over time.

Susie Butler: Thanks, (Dania).

Operator: Again, to make a comment, please press star one on your telephone keypad. Your next comment comes from the line of (Rick Abram) from New York State Medical Society. Your line is open.

(Rick Abram): Thank you very much, folks. I really appreciate the opportunity both to listen in and to ask these questions or make these comments.

My question or comment is for (John). And it goes to the heart – I hope it goes to the heart of really the two questions you asked and that is how can CMS make the shared savings program appealing to individual physicians? And secondly, what payment models will ensure adequate capital to the independent physicians?

And you know, (John), from where I sit at the medical society of the state of New York and in speaking with so many of my independent or small group practicing members, the problem that they have, if you will, is not on the back end with a payment supplement that would come to them by achieving

meaningful use and installing electronic medical record systems in their offices.

Their problem is upfront. They have absolutely particularly in the primary care specialties, but also specialist physicians. If they're in a small group or independent practice, they have absolutely little or no capital to make that initial investment. And it's not just the hardware or software. There's a lot of planning and training involved.

So, my question is that has CMS considered hopefully a grant – a small grant program but certainly a low or no interest loan program in order to enable these individual and small group practices to get in the game. Because in order to be that (ACO), they're going to have to have sophisticated electronic health records that are interoperable.

And here, because of the lack of capital, that's just isn't an option at least in New York. Any comments you might have at this time would be greatly appreciated. And once again, thanks for the opportunity.

Susie Butler: (Rick), thank you so much.

Operator: Again, to make a comment, please press star one on your telephone keypad. Your next comment comes from the line of (Rebecca Shecklehoff) from National Council on Aging. Your line is open.

(Rebecca Shecklehoff): Thank you. I just wanted to recommend that CMS take into consideration the chronic care health management program model. I think it speaks to exactly what (John) had alluded to with reducing cost, studies for the south management have shown reduction and utilization effect, fewer days in the hospital, trends towards fewer outpatient visits and hospitalizations. So, in that sense, the chronic care self management program model would help reduce cost.

It also is a patient-centered care model. So, again, speaking to the (ACOs) and the innovation center's areas of interest, it involves patient in the care management which helps educate the patient so that they can have better

communication with their physicians. It reflects the health and human services multiple chronic condition framework initiative.

So, we would strongly recommend that CMS take into consideration this model. And we'd be happy to follow up and share different additional information. We should emphasize that the program model is a community-based setting model. However, there is an online version available, so it does speak to many people in different settings. Thank you.

Susie Butler: Thanks, (Rebecca).

Operator: Again, to make a comment, please press star one on your telephone keypad. Your next comment comes from the line of Margaret Reagan from Premier. Your line is open.

Margaret Reagan: Thank you. Today, Premier Health Alliance, I would like to raise the issues of quality cost-savings and structure that we believe CMS must consider (inaudible) regulations around (ACOs). And I appreciate you all's comments in the beginning.

But the points that we'd also like you just to refocus on because (ACOs) are at the early stages of development, CMS should be flexible and recommend the many different (ACO) structure and payment systems provided that the organizations are truly accountable for the population they serve.

(ACOs) must be measured based upon the clinical quality and the outcome experience of care, not just the efficiency in cost-savings. We believe this is consistent with the Affordable Care Act. And is the most effective way to reduce the waste, we're also ensuring that people have access to the highest quality care.

Therefore, Premier believes the most important thing is for CMS to focus on near term is the outcome achieved by the (ACO), not the structure or the processes. Thank you.

Susie Butler: Thank you so much.

Operator: Your next comment comes from the line of (Tiffany Noel Brown) from Own your Health. Your line is open.

(Tiffany Noel Brown): Hi. Thank you for allowing us to engage with you. I really appreciate it.

I'd like to encourage you to keep in mind some models that help patients and families stay healthy and not only restrict yourselves to one but maintain chronic care and address (few) issues, and then also to expand patient center to include (family) center as well.

Susie Butler: Thank you, (Tiffany).

(Tiffany Noel Brown): Thank you.

Operator: And you have no further comments at this time.

Susie Butler: Well, again, hold for just a second. I'm looking at some of our speakers here to see if they have anything else they'd like to add to the conversation.

Operator: You do have a comment from the line of (Mercy Saw).

Susie Butler: OK.

Operator: From American Pharmacists Association.

Susie Butler: Great. Hi, (Mercy).

Operator: Her line is open.

(Mercy Saw): Hi. Good afternoon. Thank you so much for the conference call.

I wanted to just emphasize our support for looking at the continuative care between the patient and all of their healthcare providers and encourage you all to consider how the regulations can reflect the healthcare providers especially pharmacists to know their non-provisioned providers that may not be in the office setting with a small group practice. But many wanted to work with them to help manage the care of the patient so that there is more coordinated

care for medication management and then information flow between the different practitioners.

So, we will be submitting some information that reflect some of the success that we've seen with the (APT) Foundation projects who are related to (Ashville) and diabetes management and helping engage the patient to be a coach for them to better manage their own care. So, get to your point of improving the quality of care experience for the patient, but also it includes roles for the pharmacists in working and part of the care team to help with primary care specialty care and that flow of information between them all.

So, I wanted to just queue that up and we will provide some additional detail to appropriate (avenues). Thank you.

Susie Butler: Great. (Mercy), thanks a lot.

Operator: Your next comment comes from the line of (Leo Smith) from Medford Government Solutions.

Your line is open.

(Leo Smith): Thank you very much. I really appreciate the opportunity to participate in this. I just heard about the (ACO) just last Wednesday. I tried to do a lot of research on it over the week and then I've learned a lot already just listening to what you've got to say.

My interest, of course, my background is IT, medical IT, so my interest has been more in what kind of systems we might be able to implement that would provide just the three elements that you said. But I like to add two more to it besides improved quality of care and improved outcomes and lower patient cost over time.

But I also would like to look at some of the other things that we could do for continued seamless service, which would be – and I feel might have one single group of people who are receiving care from multiple ACO physicians, for example, or something like that. But the electronic record, I see that it's key.

I also see that if you're going to really continue to improve the care, we need to be looking at a wider spectrum of care as mentioned earlier about child behavior. But looking at all of the PTS and TBI problems, other behavioral issues all need to be included in that and some kind of a continuation of that medical record, we're looking at all of the different clinical guidelines, and even behavioral guidelines et cetera has all come into play there. That's my single thrust. That's what we've been working on for health care payers for the last four to five years. So what we might have is some basis for it, how would we get to demonstrate that.

Susie Butler: I'm looking at (Rick), yes.

(Rick): Well I think – I think it is, you know, I mean the IT side of many of these innovations will be will be important and that if there are specific narrowly defined models that people want to fit sometime and at some point bring to our attention that suggest that, you know, this is an IT solution in a particular setting will make a difference that we can see and determine and measure, we'd be interested in hearing about it.

Oftentimes I think we're going to see IT advancements, within a broader context of the medical home or in the hospital system of other delivery system of care or – but there are – you know, we are interested in hearing about them and interested in technological approaches to care that really do make a big difference in – people are interested over time in technology that is maybe disruptive of normal care approaches, that, you know, people, remote monitoring as an example has been talked about as something that might dramatically change the way we think about caring for people with chronic illnesses.

So, you know, we're open to hearing about those kinds of models. Certainly some of them may involve new approaches to pay for things that haven't been – we haven't paid for traditionally and that we are opening, we will be open to proposals like that, certainly. And again, I would keep an eye on, on our website for an opportunity to kind of feed us more specific suggestions.

(Leo Smith): Thank you very much, (Rick).

(Rick): Thank you.

Operator: Your next comment comes from the line of (Chester Storny) from APS Healthcare, your line is open. (Chester Storny) your line is open.

Your next comment comes from the line of (Linda Battaglini) from Emerson Hospital, your line is open.

(Linda Battaglini): Hi, good afternoon. I'm calling from – I'm interested in your question about what would improve the potential for solo physicians to participate because I'm calling from a community hospital that has a (PHO) with it, and many of the fellow physicians have found the ability to participate and in some initiatives geared at improving quality and reducing cost through the (PHO). But is there anything in your study that is looking at the participation of small community hospitals in the future? And what would facilitate their participation because that's – there maybe a vehicle for these solo physicians to have a part in a larger undertaking?

Susie Butler: (John), would you like to field that?

(John Pilotte): Yes. The statutes talk about it, specifically, it's sort of four organizations and I think that certainly (PHOs) I think small community hospitals could fit into those either potentially as stand alone entities or coming together with other organizations, practitioners, providers in the community and so forth.

The statute for the share savings program. It talks about eligibility for physician group practices. It talks about hospitals employing physicians, joint ventures between the two, as well as a physician network organization. So I mean I think that there are potentially opportunities for organizations that could come together either in new ways or to sort of leverage existing sort of organizational structures to participate in that.

That would just echo the – and encourage you to – as the previous caller from the New York State Medical Society to – if you think of new ways to encourage small physician practices and solo practice to come together for purposes of, you know, the shared savings program and to submit comments

formally to our request for information which was published in the Federal Register on November 17th and the coming closing date is on December 3rd.

But specifically as around sort of access to capital issues and the scope for – to take an opportunity to provide formal comments on your thoughts and ideas about sort of how we can address that, whether they be targeted more at smaller providers across the board or just individual physicians and small practices physicians as well because they're considered – we're certainly interested in better understanding some of the, you know, the barriers and challenges that those provider face but also in creative ideas in terms of how we can reduce some of those as well. So thank you for the question.

Susie Butler: Thanks, (Linda).

Operator: Your next comment comes from the line of (Kate Brian) from National Women's Health Network, your line is open.

(Kate Brian): Hi, first I want to thank you for hosting this conference call. I wanted to ask about – further about (John)'s question regarding how to ensure beneficiaries understand the program and that they are part of an (ACO). I'm also calling as part of the campaign for better care and wanted to first thank you for the question because we really do want to emphasize the importance that beneficiaries are informed of the (ACO) assignment and I wanted to ask if CMS is considering or what ways of considering and ensuring this kind of transparency and if they have any current ideas or models for making sure that beneficiaries understand what that means?

Susie Butler: (John), do you want to respond?

(John Pilotte): Yes. I mean, we are looking at issue. Transparency is obviously an issue that's important to the program. And in particular an area of importance to Dr. (Berwick) and we are looking at ways to best encourage that under the program and obviously that the statute talks about beneficiaries and protections particularly around the at risk and monitoring for at risk patients and so forth.

And so, we are looking at ways and avenues to ensure that there is not only transparency but, you know improved communication and awareness at the beneficiary and provider level of what it means to be associated with an (ACO) or to be using an (ACO) provider. So we welcome your thoughts and ideas on how best to, you know, coordinate and present that information as well, given the complexities around the program and so forth.

And I would also encourage you to submit comments formally, particularly around ideas around beneficiary communication and how to encourage that and to ensure consistency in that vision and understanding at the beneficiary level. So I appreciate the comment.

(Kate Brian): OK, thank you.

Susie Butler: Thanks, (Kate). Thanks, (John). I should let everyone know that (John) (inaudible) has been answering the last two question has been (John Pilotte), who's the acting director for Performance Payment Policy (Staff) in the Center for Medicare and he's responsible for a lot of the (ACO) work that's being endeavored now. We're ready for our next question (Jessica).

Operator: Your next comment comes from the line of (Michelle Gatti) from (Stanley's USA), your line is open.

(Michelle Gatti): Hi, thank you very much for the opportunity to comment on this. We are following the (ACO) development and are a little concerned about the – what seems to be a focus primarily on the physicians and hospitals as elements of (ACOs) and knowing that these are meant to start in the Medicare population.

We would just like to stress the importance of ensuring the involvement where appropriate of post acute care providers as well as long-term purposes and support providers. I think there's often this divide between acute care providers and more long-term type care of providers. And I think in order to fully integrate the system and provide lower cost and higher quality care; we're really going to need to try to bring these providers together to make sure that they are working together along with the continuum of care.

Susie Butler: Thanks, (Michelle). I think Melanie wants to say something.

Melanie Bella: And (Michelle) I just want to say thank you for your comments. Certainly we'd recognize for complex patients especially those who are eligible for Medicaid and Medicare that the post acute and the long term services and support are critical. And there's widespread support here for making sure that the models accommodate the full needs of patients, particularly in those areas that warrant it. So thank you.

(Michelle Gatti): Great thank you.

Operator: Your next comment comes from the line of (Chester Storny) from APS Healthcare, your line is open.

(Chester Storny): And again echoing the comments of others, thank you for holding this open forum today. Two comments, one would be just a question about the – you may have mentioned and I missed it, is about having a continuation of open forums as you go forward to keep us abreast of what is happening. And two, as you – as states apply for the health home demonstrations, or the state (plan) amendments, is there a way that CMS can make that information available through its website as to which states are interested in that?

Susie Butler: Yes, we'll take that information back and make sure that there are ways for that information to get out, and I'd also encourage you – you're participating today because you are a member of one of our open door forum Listserves or one of our partnership Listserves, I want to make sure you avail yourself of the opportunity to sign up for the various Listserves, and I'll put in a little plug here for my friends over at the innovation center. If you go to their website and that is innovations.cms.gov and there's a place to sign up for their email Listserv and you'll be notified of anything they're doing in the future.

And I'm sure that some of our other new areas will have those same opportunities in the very near future as well.

Jonathan Blum: Yes, in fact, we have other mechanisms beyond email. You know, I guess you could follow us on Twitter, correct? We're not quite live there yet but we will be – we are, OK. And we look forward to hearing back from folks regularly.

Operator: Your next comment comes from the line of (Leo Smith) from Medsource Government Solutions, your line is open.

(Leo Smith): Well thank you very much. I just heard a little – a word just a couple of speakers back, say transparency. And back in 2002 I was a consultant for HIPAA at that time and I just was thinking about the idea that these beneficiaries who find out that they're in an (ACO) and maybe they're doing, they're being taken care of by some physicians that are not necessarily in the same (ACO), when transparency comes into this, how do we make sure that they're – they've signed up to allow this to occur so that they are within the HIPAA guidelines, of privacy guidelines?

Susie Butler: We will take that information back and make sure that there is clarity in our communications about that as we go forward. Thank you, (Leo).

Operator: Again to make a comment please press star one on your telephone keypad. Your next comment comes from the line of (Bonnie Burns) from California Health Advocates, your line is open.

(Bonnie Burns): Thank you. I wanted to thank you too for holding this call today to get us all with new information. I'd like to encourage you to make sure that in all of these new systems that the consumers who use them have adequate notice of the resources that are available to them to help them navigate some of these new systems and to access the benefits that they are entitled to. That's often a gap in the kind of information that consumers have available and these new systems that are going to be difficult for some people to navigate without assistance.

Susie Butler: OK, thank you, (Bonnie).

Operator: Again, to make a comment please press star one on your telephone keypad. Your next comment comes from the line of Joseph Isaacs from United Spinal Association, your line is open.

Joseph Isaacs: Yes thank you and I'm joining the others in thanking you for putting on this conference call. I had two comments tonight. I agree with many of the

comments that have been stated, but one is in the arena of the notion of literacy, transparency and general consumer understanding. One of the things you don't hear enough about is the informal care giver, the provider of 85 percent of care, often the purchaser and the decision maker of the care.

And I think that in looking at accountable care organizations and the emphasis on not only being patient centric but family centric, or informal caregiver centric is critical as well, because literacy often drops when you're the patient, even further then it would if you were the consumer. On the other side of the equation the success of the (ACOs) or whatever will become – will depend on incenting providers to be participants.

I would encourage you to look at what seemingly is a successful project that's Medicare (inaudible) for demonstration for the New Jersey care and integration (consortium) and it's a Medicare physician hospital collaboration but I think it has a lot of good insights into the application of gainsharing and the capacity to improve performance and appreciating quality as it might be applied to the (ACO) in the future. So I would encourage you to look at that.

Susie Butler: Thank you, Joe.

Joseph Isaacs: Yes.

Operator: Again to make a comment please press star one on your telephone keypad. Your next comment comes from the line of (Carol Pattium) from (Health Affairs) your line is open.

(Carol Pattium): Hi, there, this is (Carol Pattium) from (Health Affairs), I've just got a question for you, are you looking to provide different funding compensation for patients that are in medical homes or any benefits directly tied to that and I apologize if you've already addressed this, I was a little bit late… but trying to highlight primary care in those studies a little bit more. Thank you.

Jonathan Blum: Yes of the – of the initiatives that we announced earlier, we talked about several that are focused on supporting efforts to develop and expand medical home programs.

One of those is the multi-payer primary care demonstration projects that we are doing in eight states. Another one is one that we'll be doing across a number of states with certain qualified health centers and then the third is the health home initiative for Medicaid recipients which we will be announcing and that by the way is a program, it's not a demonstration project. So states who are interested in pursuing that will be able to do that through the Medicaid – state Medicaid folks working with Federal Medicaid officials.

(Carol Pattium): And if we want to learn more about those then could we go on your innovations web page then?

Jonathan Blum: There is, yes, there is some information on the website now describing those and links to those other programs.

(Carol Pattium): Great, thank you so much.

Jonathan Blum: You bet.

Operator: And you have no further comments at this time.

Susie Butler: OK, so I want to thank everyone and I want to thank all of you who called in today for your time and your interest. I want to thank all the speakers today for their time and I want to remind you where you can go for more information and also where you can submit your feedback if you think of something after the call.

For the innovation center, go to innovations.cms.gov, and sign up for their email newsletter or their news feed, Twitter, all of that good stuff; also at the bottom of the page there's news releases and other pertinent information as it comes available; for the (ACOs) go to aco@cms.hhs.gov.

However, if you want to comment on the request for information you have until this Friday when the comments are due, December 3rd, you need to go to regulations.gov and find the November 17th Federal Register notice and submit a comment as directed in the notice. Finally for the Federal coordinated healthcare office use those initials that make an acronym, FCHCO@cms.hhs.gov to send your ideas, thoughts and comments.

Again, thanks everyone for participating today and we'll be in touch with you soon.

Operator: That concludes today's conference call.

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