Centers for Medicare & Medicaid Services

Moderator: Gil Kunken
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Operator: Good afternoon, my name is (Beth) and I will be your conference operator today. At this time I would like to welcome everyone to the Healthcare System Delivery Reform, New York region. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a comment session. If you would like to make a comment at that time simply press star then the number one on your telephone keypad. And if you would like to withdraw your comment please press the pound key. Thank you. Dr Gil Kunken you may begin your conference.

Gil Kunken: Good afternoon, I would like to thank all of you for attending today's call on Healthcare Delivery System Reform. My name is Dr. Gil Kunken and I am the Deputy Regional Administrator in the New York regional office of the centre for Medicare and Medicaid services for CMS. I will be the moderator for today's call. Our hosts for today's call are Mr. Jim Kerr, CMS Consortium Administrator for Medicare, Health Plans Operations. And Dr. Jaime Torres, Regional Director for the US Department of Health and Human Services.

Mr. Kerr is the Administrator of the Consortium for Medicare Health Plans Operations at the centre for Medicare and Medicaid Services. He supervises approximately 400 staff in CMS' 10 regional offices that provides daily oversight to over 800 contracts delivering Medicare advantage and prescription drug services to more than 26 million beneficiaries nationwide. Mr. Kerr was formally the CMS Regional Administrator in the New York office. Jim I'll turn it over to you.

Jim Kerr: Thank you Gil for that kind introduction and thank you Jaime for joining me in hosting the call today. Region 2 is very fortunate to have you guiding its operation from New York. We're also fortunate to have three very knowledgeable leaders from our CMS headquarters on the phone to speak with us today. We'll hear from Dr Mandy Cohen, Cheryl Powell and John Pilotte. And a big thank you to everyone on today's call for taking time out of your busy schedule to attend this listening session on heathcare delivery system reform.

Welcome consumers, clinicians, employers, hospitals, health systems, state representatives and healthcare experts. We appreciate you being with us here today. All of us want the highest quality health care system possible, a system that coordinates and integrate care, eliminate waste and encourages the prevention of illness. With new provision in the Affordable Care Act we have more opportunity than never before to work with both of public and private sectors to make real improvement in our nation's healthcare delivery system.

We can all agree that our current healthcare system is broken. We pay a lot of money for a system that is fragmented, disorganized and fail to meet many of the patient's needs. The problem of our healthcare system has been created by payment and delivery systems that reward care that is delivered piece by piece not care that is delivered in a seamless coordinated manner. Patients want care that is high quality, timely and efficient and they don't want to pay more than they need to for this care.

Patients want to be treated like individuals. They want their doctors to take into account their values and wishes. Healthcare professionals want to care for people, that's why they chose their careers in the first place. Everyday health care professionals work to provide the best care to their patients. They want to help others. But our current health care system often doesn't provide many patients with the care they should receive and doesn't support healthcare professionals in providing that care.

The purpose of today's listening session is to hear from you on how CMS can best undertake the important work of reforming this nation's healthcare

delivery system. The Affordable Care Act has given CMS new opportunities to improve the care delivery and payment system. We will spotlight three areas of interest. The Accountable Care Organization Shared Savings Program, the CMS Innovation Center, and the Federal Coordinated Health Care Office.

Thank you everyone for your participation here today and for your hard work to follow in the weeks, months and years ahead.

Gil Kunken: Thank you Jim. I would now like to introduce our next host Dr Jaime Torres. Dr Torres is a podiatrist and he is the regional director of a New York regional office for the U.S. Department of Health and Human Services. In this role he serves as a key representative to Secretary Sebelius throughout New Jersey, New York, Puerto Rico and the U.S. Virgin Island and working with Federal, state, local and tribal officials on a wide range of health and social service issues. Dr Torres.

Jaime Torres: Thank you very much Jim and Gil for your opening remarks and good afternoon everyone. I am pleased to know that so many of our partners in the regions are on the line this afternoon. I've had a chance to meet or speak with many of you about the implementation of the Affordable Care Act over the past six month since I was appointed as a Regional Director of HHS. We talked about how we in Region 2 share our long tradition of innovative approaches to health care delivery and how all of us all the divisions of HHS including CMS are now able to offer new support and partnership to the tools provider in the Affordable Care Act.

Today’s session is an opportunity for engagement and dialogue on some of the most significant ways in which the health care system is going to be transformed in collaboration with all of you. Know that going forward I'll continue to be available to you as the secretary senior representative in the region and will continue to work with our senior leadership team and in particular with Jim and Gil and the great CMS team we have here in our region. Gil?

Gil Kunken: Thank you Dr Torres. As you just heard from Jim, Dr Torres this is an enormous challenging and exciting opportunity for CMS. But we cannot do it alone, we need your help. Today we will hear from three leaders of CMS representing three different programs all at different stages of development. As our stake holders we are excited to engage you in the process. Dr. Mandy Cohen, Cheryl Powell and John Pilotte will be introduced in just a few minutes. But they will be speaking today about the Center for Medicare and Medicaid Innovations, the Federal Coordinated Healthcare Office and the new Accountable Care Organization Shared Savings Programs.

If you are like me the best ideas occur often after the opportunities have passed. We don't want that to happen to you. So we have mailboxes for each of these areas where you can send your thoughts and ideas. I will be reminding you of them at the end of the call but here they are now. The innovations center website www.innovations.cms.gov. At this site you can sign up for emails and be part of the Twitter alert and RSS newsfeeds. That email box will be launched shortly and we will let you know about that as well. Accountable Care Organization - acocms.hhs.gov, Federal Coordinated Healthcare Office - fchcocms.hhs.gov.

So during today's call we will be sharing information on the three important areas just mentioned. And you will have a chance to share ideas and give your thoughts and input. Your remarks will not be considered formal or official responses or remark of record. CMS will be in a listening mode. As your facilitator I may ask a clarifying question or follow up but CMS is in the role today of listening to you. Please keep your remark to two minutes or less. We like to give as many people as possible the chance to share.

I would now like to introduce our first speaker Dr. Mandy Cohen, Senior Advisor for CMS centre for Medicare and Medicaid Innovation. In her role at the innovations centre Dr Cohen works with CMS leadership to develop and implement innovative programs that will help improve and update the nation's healthcare delivery system. Prior to joining CMS, Dr Cohen an internist served as the Executive Director of Doctors for America, a physician advocacy organization working to improve the healthcare system through reform.

Dr Cohen has also served as the Deputy Director of Comprehensive Women's Health at the Department of Veteran Affairs at Washington DC where she led a major initiative to improve the delivery of primary care to women veterans. Dr Cohen continues to see patient as the Washington DC VA Medical Centre. Dr Cohen?

Mandy Cohen: Thank you so much, thank you Gil and Jim and Jaime for hosting this call and for all of you have taken a time out of your busy schedule. I know it's hard especially for the doctors, nurses, other providers and patients who are out there who have taken out of their schedule to join this call. So we really appreciate it and look forward to the dialogue.

What I'm hoping to do is to talk about the new centre for Medicare and Medicaid Innovation. And so I want to start out by echoing some of the earlier comments of understanding why a new centre was created in the Affordable Care Act and it's really a bit as we know that the delivery system that we are all in the healthcare system is broken. It's financially not sustainable and it produces outcome that are average at best. Providers like myself are unsatisfied, patients are not satisfied and we have to do better.

And under (Dr. Berwicks) leadership here at CMS, CMS as a whole working to adjust these issues of our broken healthcare system. And we've began to implement CMS' new vision to be constructive force and a trustworthy partner for continual improvement of the health and healthcare of all of Americans. And key to accomplishing this vision is going to be the transformer of our current fragmented high cost delivery system to one that delivers more seamless care experiences, a journey of health care experiences with better health outcomes and better care for patients and lowering costs in doing that through improvement.

And so that's why it's a great excitement that I tell you about the new CMS centre for innovation. It's a newly established by the Affordable Care Act and it's a new tool in a CMS toolbox and it's different from what CMS has been able to do in the past. It was charged by congress to identify and test new payment and delivery model that can ultimately save money for the system

and improve the quality of care that's delivered. And the ultimate goal is really to produce better experiences of care and better health outcomes for all of Americans. And so it's going to be in partnership with all of you on the phone out there and around the country as we create this centre as you help us identify test and ultimately spread new ways of delivering care and new ways of paying for care.

So I want to tell you little more about the centre and what makes it different. One of the things that makes it different is it's nice to have funding and some money on which to do the work we need to do and we have 10 billion dollars over the next 10 years to do this work. Second we were given some flexibilities is the regulations going forward that haven't allowed CMS in the past to be ambitious as they wanted to and now we have those abilities to wave some of those barriers.

And third once we find new model of that work and new ways to pay that save money and improve quality we actually can change policy without needing to go back to congress to change the law which can often take years and potentially not happen at all because of the political process. So we have an opportunity here to really learn as a system the best way as I said to save money and improve care and work with you to find out these ways and really change policy for across the entire centre for Medicare and Medicaid Services.

So we've started our work and I am happy to talk more through questions about what we're going to do but we essentially had our birthday our opening of our doors in November. And we've been building the centre hiring folks some great people to do their work. The acting director of the centre is Dr. Richard Gilfillan who comes to guiding our system and our system that has really been a leader in coordinating care and improving the quality of care that's delivered. And another new member of the team is Jim Hester who led the (Remont) initiative to reform their healthcare system, so we have some great leaders at the center to really start to move things forward. This month as you can tell we are doing a lot of listening, we want to know from you what are the right places for us to view model, new ways to pay for care, new ways to do better in terms of keeping people safe, keeping them healthy and then

having them stay out of the hospital and not need to go to the doctor. So looking for your ideas on that during the question period.

And then lastly we're starting our work, we have started some new initiatives that I wanted to tell you about in concert with the rest of the CMS organization. One of those projects is a multi payer medical home demonstration project and that is something where CMS is partnering with other payers of healthcare so with private health plans to allow from medical home pilots to proceed and New York is one of those states that is going to be participating in that demonstration project and we are expected for that demonstration project to touch about a thousand medical homes and serve almost 1 million Medicare beneficiaries.

Second we announced recently that with our Medicaid colleagues that there is a Medicaid health home state plan option which was also created by the affordable care meaning that states can get 90 percent federal funding for the first two years in their Medicaid program when they do the health home pilot. The next two are new work of the center for innovation, we are starting a medical home pilot demonstration in Federally Qualified Health Center, so for those of you who work or are connected to Federally Qualified Health Centers there is a new primary care medical home pilot that is going to be starting early next year and we are doing that in collaboration with the health resources and services administration.

We plan to include nearly 500 Federally qualified health centers and touch almost 200,000 patients in that pilot. And lastly the center supporting a new demonstration with the Federally Coordinated Health Care Office, those who are dually eligible for Medicare & Medicaid Services and I imagine several will talk a bit more about the solicitation that is up on our website and you can get more information about. So that's a little bit about the center, our charge, some of the new authorities that CMS now has.

Our initial work that we are doing and then lastly one more request to you out there to say, you know we can't do this alone, we ask for your partnership, we ask for you input and to join us in this endeavor in this journey really to

improve and reform the system going forward. So thank you again to our hosts for the call and to all of you for your time. Thank you.

Gil Kunken: Thank you Dr Cohen. The next speaker is Cheryl Powell. Cheryl has recently been appointed as the Deputy Director of the Federal Coordinated Healthcare office at the Center for Medicare & Medicaid Services which was established by the Affordable care Act. As a deputy director Ms Powell assists in leading the work of this office charged with more affectively integrating benefits for individuals eligible for both Medicare & Medicaid and improving coordination between the Federal government and states for dually eligible individuals.

Ms Powell has held leadership positions in the healthcare fields and both the public and private sector, prior to joining CMS Ms Powell served as a senior research analyst at the Hilltop Institute where she lead the analysis of state healthcare coverage initiative and the evaluation of healthcare services utilization in Medicaid programs. She was also the director of Medicare policy for Coventry Health Care. Cheryl?

Cheryl Powell: Thank you so much, and I'm very excited to be here and to talk with all of you little more about the Federal Coordinated Health Care Office. It was created as part of the Affordable Care Act section 2602 and to us it's clear that our job in this office is to make the care experience better for beneficiaries who are eligible for both Medicare and Medicaid. And then large part of that depends on improving the relationship between the state and the federal government as we are partners in delivering and providing care for the population.

So what we are doing is working towards seamless coordinated care system. Really there is no better opportunity to do this than for individuals who are dually eligible. There are 95 percent of duals or in fragmented fee for service systems and we spend more than of 300 billion combined annually on their care. So again we feel that this is time for delivery system and payment reform. So we have established our office and we are up and running. And currently the office is focused on two areas.

The first is program alignment. In that area we are identifying every place that Medicare and Medicaid bump up against each other. So this is administrative, regulatory and statutory misalignments and we are coming up with literally a list. The list is populated with anything and everything where these two programs are working at odds with the beneficiary having a seamless experience. So we are working to prioritizing that list and turning it around and to make it public. We see it as a transparent and living document. It would be shared continuously with stake holders so that we can continue to improve it and make sure that it really captures all of the areas where improvement is needed.

So we encourage all of you to submit your ideas to the mailbox that was mentioned at the beginning of the call and will be reiterated towards the end of the call, so please submit any ideas that you may have. This list has been developed with a lot of input from external and internal stakeholders and we will continue to perfect it. And to move forward we're going through that list and basically seeing where we can fix things, where we can make things more streamlined. Where the care and the beneficiary experience can be improved and where we can improve upon quality and cost of care provided to dual eligible individuals.

The second area that we are working on has to do with demonstrations and models. Involving new testing and innovation and new delivery system and payment models for dual eligibles. And these are models that fully integrate the Medicare and Medicaid services that recipients are eligible to receive. So it means acute care services, long term care services and support behavioral health services. It's very important there is no integration of all of these services.

We announced a few weeks ago the availability of having design- contacts of up to $1 million each up to 15 states. And that solicitation is now available, we just released that in that last few days and more information is on the innovations website. It's an opportunity for us to provide funding to states to support the design of innovative care delivery and payment models for dual eligible individuals.

So we are inviting states to use the opportunity to test new and emerging models as well as to build on existing vehicles in order to create a new person centered model that aligns the full range of acute behavioral health and long term care support and services and to improve the actual care experience and lives of the dual eligible beneficiaries. And then we are moving forward as well to partner with the innovation center to further explore and enhance other opportunities for the integration of care services and financing for dual eligibles. So I encourage all of you to make sure that we have your input and your feedback and I look forward to hearing the questions and comments on the rest of the call and any input you would like to provide towards our mail box as well. Thank you.

Gil Kunken: Thank you Cheryl. Next we will hear from John Pilotte. John is the acting director of the performance payment policy staff in CMS' Center for Medicare. John manages a staff responsible for designing and implementing Medicare value based purchasing program including the Medicare shared savings program and the physicians value based payment modifier and oversees the development of value based purchasing plan for Ambulatory surgical centers, field nursing facilities and a home health agency.

Prior to joining CMS, John was a senior consultant with Price Waterhouse Coopers health care practice and then an associate on the government relation staff of the national association of children's hospital and related institution. John?

John Pilotte: Thank you. And thank you all for taking time out of your day to join us on this open door forum, we appreciate it. Today I'd like to share with you (Dr Berwick's) vision for the Accountable Care Organizations and Medicare shared savings program and provide a brief over view of the program and pose several questions for you to consider providing comment today or through the ACO mailbox that was mentioned earlier.

Recently (Dr. Berwick) described Accountable Care Organization as a new approach to delivering care that reduces fragmented unnecessary care and excessive cost growth for Medicare fee for service beneficiaries by promoting population health management coordination of Part A and B services and

encouraging provider investment in infrastructure and redesign care processes. ACOs will promote the delivery of seamless coordinated care that promotes better health, a better patient experience and lower cost growth by putting the beneficiary and family at the center of care.

Remembering patients over time and place; attending carefully to hand offs in care, patients move along they continuum; proactively preventing illness and promoting population health especially for chronically ill beneficiaries and average population. Tracking and reporting outcomes and giving timely feedback to physicians and providers with IT infrastructure, innovating and improving continuously to achieve better health, better care and lower cost growth and expenditures towards patients' population. And investing in team based care and its overall work force.

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 which are defined in the status of physicians and practitioners and hospitals employing ACO professional. The Secretary may also include other providers and suppliers of services that are discretion.

Under the Medicare shared savings program, an ACO will accept responsibility for an aligned patient population and procedures and processes in place to promote evidence based medicine, report on quality and cost measures, coordinate care and be patient centered. Furthermore the ACO must have sufficient capacity to provide primary care services for at least 5000 aligned patients as reference in the Affordable Care Act.

The aligned patient population is the basis for establishing and updating the financial benchmark assessing quality and financial performance and the focus of ACOs effort to improve care and reduce growth in Medicare spending. ACO providers continue to be paid under the regular Medicare fee for service payment system and are eligible for shared savings if they need the quality performance standard and their spending for the aligned patient population is below as updated ACO specific benchmark. ACO will be

responsible for reporting quality measures including clinical care processes and outcome measures. Patients can give experience of care measures and utilization measures such as Ambulatory care sensitive condition.

We welcome your thoughts and comments today on the above as well as the following questions that we recently published in the request for information around the Medicare shared savings program. They are what policies or standards should we consider adopting to ensure that groups of fellow and small practice providers have the opportunity to actively participate in the Medicare shared savings program. And the ACO models that are being tested by our colleagues in the innovation center that Mandy talked about earlier.

What payment model, financing mechanisms or other systems might we consider either for the shared savings program or again as models under the innovation center to address access to capital issues or small practices. In addition to payment model what other mechanisms could be created to provide access to capital. The process of aligning beneficiaries to an ACO is important to ensure that expenditures as well as any savings achieved by the ACO are appropriately calculated and the quality performance is accurately measured.

Basically two approaches are that, one pro-affectively prior to the start of the performance period, patients could be aligned with the ACOs based on the ACO to historical performance data or electro actively at the end of each performance here based on the actual utilization of services by patients at the ACO. There are pros and cons to each approach and registering your thoughts and comments about how we should balance these two points of developing the patient alignment model for the Medicare shared savings program.

How should we assess beneficiary in care giver experience of care as part of our assessment of ACO performance. What aspects of patient's fitness are particularly important for us to consider for the shared saving program and how should we evaluate them. What quality measure should the secretary use to determine performance in the Shared Savings Program? What additional payment model should CMS consider either under the authority provided for partial capitation in the health care models or the authority under the provided

CMS under the innovation center and what are the relative advantages and disadvantages of any such alternative payment model approach.

Finally how should beneficiary communications about ACO be handled and what should be communicated to Medicare beneficiaries about the Medicare shared savings program. We look forward to your thoughts and comments around these and other issues that you may have today and again as mentioned earlier, feel free to forward your thoughts and comments to our ACO mailbox. And thank you again for taking the time out to participate today.

Gil Kunken: Thank you Dr Cohen, Cheryl and John for your presentation. We will now move into the time when CMS will listen to the good thoughts and ideas from all of you. Let me remind you once again of the ground rules as I know many of you were joining the call even as we began. It is your chance to share ideas and give your thoughts and inputs. Your remarks will not be considered formal or official responses or remarks of record. CMS will be in a listening mode.

As your facilitator, I may ask the clarifying question or a follow-up. But CMS is in the role today of listening to you. Please keep your remark to two minutes or less, we'd like to give to as many people as possible the chance to share. When you speak please let us know your name, affiliation and which area your comments are addressing. Accountable Care Organization, the Innovation Center or the Federal Coordinated Health Care Office. Operator we are now ready to open the lines for comments.

Operator: At this time I would like to remind everyone in order to make a comment 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 (Sanford Offman). Please state the name of your organization.

(Sanford Offman): Hi. I'm with the law office of (inaudible). I'm an elder law attorney, I'm also an AARP legal panel and I guess this is directed to (innovation) center I guess it would be for Dr. Cohen. Many issues which regularly comes up with my client how in nursing home is the standard by which physical therapy is ended and the way it's usually explained is that the patient is out of plateau

otherwise making no progress. Now if physical therapy is ended that also means that Medicare ended the same time.

There's been a lot of controversy about this. In fact there's a recent settled court case in a court decision in (Western) district of Pennsylvania (inaudible). It basically said that this is not the proper standard and so even if recovery or medical improvement is not possible a patient may need to go services to prevent further deterioration in the current capabilities. In other words people are allowed to deteriorate because they are not going to get better and so my question is, is this something that's going to be reviewed because it's my understanding from what I hear from different nursing homes is that this comes directly from CMS.

Mandy Cohen: Thank you for your comment. This is Mandy Cohen. So to understand what the innovation center is doing is, is really looking for new ways to pay a new models of care that allow CMS care experience to make sure that the right care is delivered at the right time for the patient. So if there are inadequacies in the current policies we want to identify them and find out what the best solution is for them so I'd say that you know we are wide open at this point in terms of what we are looking at. But again with that goal of improving quality and reducing cost for the patient. Thanks for your comment.

Operator: Next we have a question or comments from (Diane Coleman). Please state the name of your organization. Your line is open.

(Diane Coleman): Thank you. I'm with the Center for Disability Rights and Rochester New York. I'm also a member of the States commission of the (inaudible) health systems agency and a member of Adapt which is a national disability rights group that works on expanding options for in home services.

Back in 1965 when Medicaid was first setup it mandated that all states that wanted Medicaid would have to cover nursing facilities and it took about 15 years for the first waiver program to be developed. I think it would be innovative, maybe this is for Dr Cohen, but could be applicable to the other speakers as well. To kind of shift or reverse the burden of proof and have and

not require a waiver to get home care but rather a waiver to put somebody into long terms care facility.

So I'd like to see if there could be an exploration of in affect reversing the institutional bias that is prevalent in the Medicaid system at those points. Also as a person with disability myself I'm very aware and see how people are kind of put on a bit of a train if you will from a hospital or an acute episode or an injury, a stroke, whatever, towards the risk at least if not in so many cases the reality of permanent placement in the nursing facility when in fact some simple thing could prevent that. Often times things about the reality that physical layout of the home whether the bathroom door is wide enough for person who needs a mobility device whether there's a ramp into the home and so on.

But often times there aren't enough coordination with programs that can pay for that either through Medicaid which they can or in coordination with (HUD). So perhaps an innovation would be the build, better coordination with sister agencies like (HUD) to ensure that there is a diversion path or realistic derailment of a train that winds people up in permanent nursing home placement necessarily.

Mandy Cohen: Hi this is Mandy Cohen from Innovation center. Thank you so much for you comments. I think that's something both for Cheryl and myself to take back to make sure that we are coordinating those who are eligible as I said for both Medicaid and Medicare and to make sure that services are coordinated for the population to join that, that is our goal. Thank you.

Operator: Next we have a comment or question from (Natalie Gonzales). Please state the name of your organization. Your line is open.

(Natalie Gonzales): Actually this is (Chris Sparks) from the Washington State Department of Health. And this question relates to the innovative center or the center for innovation. And in the description of the projects that you were involved with. I wasn't clear whether the center is going to take ideas and kind of put them forward or if someone has an idea or an interest can may present that to

the center and work on demonstration projects or bringing that idea to solution.

And are you blocked by what I used to understand was the case with CMS demonstrations that if it dealt with a condition of participation for a hospital then congress actually had to intervene and say that they would allow demonstration of something that was, I guess it must have been in statute. But I guess what can you work with people to explore ideas and do you have a broader authority to explore ideas?

Mandy Cohen: Thanks for the question and the answer is yes to both in that. We are both putting out as you would see with the dual eligible population solicitation, both works that we are putting forward with our partners here at CMS but also interested in hearing from you on the phone where either put the places that we need to go. Certainly we are open to hearing suggestions and thoughts on where to go and how to do that and yes on the question about the regulatory requirements that has been removed for the center for innovation to allow us to do those demonstration projects and without needing congressional authority on each and every itemized project that we move forward with. So thank you.

Operator: Next we have a question or a comment from the line of (Ryan Asmas). Please state your organization, your line is open.

(Ryan Asmas): Hi I'm calling from (Mush) Capital Medical Center in Illinois. And I had a question regarding the ACO which I apologize I came in late to the call, so I hope this is an appropriate question. But with respect to the ACO development organizations I'm looking to consider whether or not to join or create an ACO. It seems to me one of the threshold questions I would want to know is, will I have the ability through CMS data to evaluate the patient population that I'm about to essentially take care of?

Namely what is the actual level of the Medicare population that would be part of my proposed ACO? And also maybe how much does my population migrate in and out of my service area if I have for example, If I'm in a fairly competitive hospital environment and I have a lot of my patients going to

competitors or moving around my service area or even snow birding down in Florida for half of the year. Is there going to ever be a way for ACOs to maybe get information in advance before they make those thresholds, determination of whether or not to join an ACO.

John Pilotte: Thank you. This is John Pilotte, thank you for that question. It's a good question, its one that we hear a lot from folks that we talk to about the need for data information about the population that ACO and the patients that they are seeing, typically the services from providers, the services the patients are receiving from providers outside, their provider organization. And we are in a process of rule making. I can't elaborate further sort of on the details around that.

I mean this is an issue we are aware of. In addition some of the issues you have laid out, there's a number that's sort of you know beneficiary protection. Patient privacy issues that we are working through as well. And I would encourage you to take a look at our notice of proposed rule making when it's put out tentatively early next year in quite the latter half off January. So I would encourage you to take a look at that and we'll be accepting comments as part of the rule making process at that point in time as well. But thank you for the question.

Operator: Your next comment or question comes from the line of (Shanti Raman). Please state the name of your organization. Your line is open. (Shanti Raman) your line is open.

(Shanti Raman): Hi. I'm on behalf of the American Diabetic Association and my question relates to the inclusion and more thoughts of the integration of the greater provider community within the ACO infrastructure which obviously includes register dietician and ingestion professionals. And sort of how CMS is providing educational tools for outreach. And more so as the reimbursement is ironed-out depending on capitation outside of care. Are there ways CMS is evaluating to determine how each provides and will receive its appropriate amount.

John Pilotte: Under the share savings program we planned, there is a future service program is laid out in the statue and provide as we continue to be paid under the normal regular Medicare fee schedules. So physician fee schedule for physician or practitioners and for those Medicare services as well and really they feel free to have the opportunity to share in savings, that it generates from better coordination of care for the patients that served and fees throughout the year and the quality of improvement and high level of quality performance.

So they feel would have discussion in terms of how shared savings generates would be distributed, but providers under the program would continue to be paid under normal Medicare fee-for- service rule.

Operator: Next we have a question or a comment from (Dias Scuffle). Please state the name of your organization. Your line is open.

(Dias Scuffle): Yes, my name is (Dias Scuffle) and I'm calling on behalf of the Institute for Puerto Rican and Hispanic Elderly. My question is related to the innovation center. And specifically I would like to ask if CMS is contemplating the possibility of running demonstration projects of just like 2 or 3 years learn and to be able to deliver in a timely manner results of the demonstration project considering the experience of the past.

Mandy Cohen: Thank you for your question, and from calling from Puerto Rico. I think we are all jealous you know in the cold.

(Dias Scuffle): No I'm not in Puerto Rico, I'm in New York City.

Mandy Cohen: Oh I'm so sorry that you are not.

(Dias Scuffle): It's OK.

Mandy Cohen: Thank you for the question. You know our focus is on making it work as rapid as possible. We want to not only seek out new ideas but build on those that we know are already working but aren't known to the rest of the system to see if they work in other population, different settings, learn from what's in each setting and to do it as quickly as possible because we know that we can't wait and we need to do this quickly as possible. So you know part of our

agenda has been to try to work as quickly as possible and to get those done. So we are going to try for outcomes on the order of months instead of years. So I hope to have some successes to talk about when we talk next in a year. Thank you.

Operator: Your next question or comment comes from the line of (Jing Truman) HCD International. You line is open.

(Jing Truman): Yes good afternoon and once again I applaud on this continual data gathering that CMS is going through. Mine is more of a comment and certainly if you have a response. And that is primarily to, it relates specifically to ACO. Just looking at some of the strategy, the communication strategy indexed the whole, maybe the whole operational strategy as it relates to adverse population or birth population and population of color-whether we are talking about providers as well as patients?

And maybe how that will be, you know the consideration which not only provide it certainly have a different set of challenges that they deal with in front of their patient population there, you know their medical practices. And so just wanting to be certain that across whether it's a key (inaudible) strategy and you know just the operational thinking that's going on just around some of that thought leadership relating to how the strategies will – population, at-risk populations diverse or speaking of the Latino, African-American just across the board.

And thinking about some of those challenges that might prevail. Should know where you were in that process and kind of if you are looking at having some special for conversation around that. And where you might, you know where some of your (inaudible) at this particular time.

John Pilotte: Thank you for the question. It's an important question and one that we are still working through. It's a multi passage as you pointed out. And you know communication to beneficiaries as well providers is something that will need to be addressed. It certainly as you know takes out different implications particularly for under served population and providers who serve large numbers of those under served population of patients. It's something that we

are working through. I would say that the statute basically talks about the monitoring of at risk patients specifically. And that's an area where we're looking at sort of processes and so forth to put in place to make sure that we address those provisions as well, particularly around avoidance of average population as well. So I think it is an area where we're working on, it is of critical importance as you mentioned across the board but particularly for under served communities and …

(Jing Truman): So even when you speak of your dual eligibles, I mean. You know that population as well, so as you've given us the websites that we can submit some of the idea and so we'll move forward and give you some of our best thoughts in terms of the experience that we've had and some successful strategies that you may want to consider.

John Pilotte: That would be great. I appreciate it.

(Jing Truman): Thank you sir.

Operator: Again if you would like to ask a question or make a comment please press star one on your telephone keypad. Our next comment comes from the line of (Dexter McKenzie) Provident Clinical, your line is open.

(Dexter McKenzie): Hi good afternoon. This question will be for John Pilotte as it related to the ACO. So the question is will the ACO in the new environment co-exist in competition with the Medicare advantage plan or are we looking at a new model to plan that strategy?

John Pilotte: No. The ACO--the accountable care organization under Medicare Shared Savings Program as the new program, it is called forth in statute and talks specifically about four specific types of providers that are eligible to participate and provide discretion for the Secretary to designate others, but the four specifically mentioned in the statute are physician groups, hospital employing physicians, joint ventures between the two and then physician networks. So it is a new program and it would be in addition to the existing fee-for-service service program as well as the existing Medicare Advantage Program. Thank you for the question.

Operator: Your next question of comment comes from the line of David Hoffman, (Wyclef Kites). Your line is open.

David Hoffman: I'd like to ask you a follow-up question to the previous questioner. I'm at a community teaching hospital in a medically under served area and we very much like to use the accountable care organization shared savings program to do something about bringing our length of stay for Medicare patients inline with our length of stay for Medicaid and other pay or patients.

The issue we faced that's really quiet affecting is we've spent the last 17 years convincing the hospital, convincing our doctors that the hospital is not allowed to enter into any sort of contractual arrangement that results in the sharing of revenue with doctors. I was wondering whether we can look for any guidance or any information flowing directly from CMS to doctors that we could facilitate so that they would be convinced that they are not running a risk of a visit from the inspector general or other enforcement authorities.

John Pilotte: The issue around labor is something that we have been looking at as part of a larger strategy as well with the FTC and DOJ around antitrust and waivers. So we had an open door forum back in October on that issue and the transcripting information is up and available on the website and so forth. I encourage you to take a look at that, but I mean this is an issue we're aware of and we're looking at it and we will be putting out a notice as well as part of the NPRM or parallel notice from our colleagues in the department and FTC and DOJ around this issue as well. So I would encourage you to take a look at the NPRM when it becomes available early next year. But it's obviously is an important issue and we are working through a number of issues that are around, the issue of waivers in general.

Your next question or comment comes from the line of (Annie Rojack Ghasler) from (Kisdale County) your line is open.

(Annie Rojack Ghasler): I'm a services coordinator. I work with elderly low income people. I see quite a number of people enrolled in Medicare and Medicaid spend down. After admission to the hospital many of them are stuck with huge hospital bills ranging from a thousand and up and sometimes it's past $10,000

which they have to pay out of pocket because the bill is used to meet their spend down. It's not over a number of months but it doesn't resolve the issue of the huge hospital bill they are stuck with.

And there is nothing at this point anywhere to help them with these bills and with the current income they are struggling and the hospitals are saying well in the past is we won't accept $10 a month. Now they are requesting a whole lot more and I see a lot of these people are on very limited income. I'm really concerned as to what's going to happen with all this in the future and as they are continue to be the crack wall, these people are falling through and not being able to make and meet.

Mandy Cohen: Hi this is Mandy Cohen from Innovation Center. I don't know if Cheryl was still with us, but I think it's an important intersection where it's a dual eligible population where can be more thoughtful about how those programs are intersecting and seeing how people transition to program. So thank you for the comment.

Operator: Your next comment or question comes from the line of (Rita Dias) Your Local Health Department. Your line is open.

(Rita Diask): Good afternoon. Thank you for taking my call. This is (Rita Dias) I'm calling you from Florida. So it is warm down here. A lot warmer than up there. Anyways I guess my quick question is as part of the health care act prevention is the key and in order to really reach us the cost what we are trying to do is to really prevent people even becoming sick and going to the hospital.

So therefore how much of the collaboration are you including with let's say (inaudible) child prevention program. Not only on the (inaudible) but high disease and so forth as well as utilizing the community health care model. The community health care model, the community health worker model which we really promote to use with the community especially the under served population. How do you consider that as well?

Mandy Cohen: Thank you for that comment. This is Mandy Cohen again from the Innovations Center and just to echo that we are partners with HHS, CDC

among them to work on these important issues because they are going to take a team effort in order to tackle them. We are going to; one of our key areas of focus is to think about how we keep the population healthy. How do we keep us all healthy and to make sure we protect our precious healthcare dollars going forward.

So we are talking right now how to best coordinate all those efforts to make sure we're moving forward and you should hear more from us in the future and on that topic and about using, you know we want to build systems that makes sense for communities. As I mentioned earlier one of our first project is fairly qualified. Health centers which I know use community health workers so we want to make sure that building systems that works for patients that work for the providers and that we'll keep those systems sustainable. So I appreciate your comments.

Operator: Your next question comes from the line of (Judith Barik), she's a consultant. Your line is open.

(Judith Barik): Hi thank you for holding the call. I have two completely unrelated questions. One is a question and one is a comment. Many of the people who are eligible for both Medicare and Medicaid are involved in long term care either institutional or community based. Have you thought about the possibility of a long term care consortium becoming ACO and the services being built and coordinated through that whether than physicians or hospital based services? And my second question which comes from my past being a CMS retiree is, many times when innovations begin the unfortunate number of cooks in the system look at it as a way of taking advantage and are you working with your new center on program integrity to make sure that you think about that and prevent that from happening as you go forward. Thank you.

Mandy Cohen: I'll let other folks comment on the long term care question about ACOs. But about making sure that we're in coordination with the new office that is helping to cut down on fraud and abuse. The answer is very much yes and in fact (piagraphy) means anything to you, (Peter Badediwho) is the head of that new office and my boss Dr Gil Kunken, Cheryl Powell, their offices are next

to each other. So I think I know they talk often and are working in tandem as we build both of the centers going forward. So thank you.

Operator: Next we have a question or a comment from the line of (Thomas Privinsky), the Office of the Ageing. Your line is open.

(Thomas Privinsky): Hi good afternoon Coleen Smith, I'm a social worker here at the office of Ageing in Orange County. And this is really a follow-up to the woman from Florida's prior question which had a preventative flavor to it and so this is a question for the innovation center. Would you consider paying dividend or lower premiums for individuals who make healthy preventative choices, such as joining a gym, doing routine screenings, seeking nutritional council, exercise, stress management and other measures which would reduce the likelihood of more cost saving medical intervention? Thank you.

Mandy Cohen: Thank you. I actually know that, that sentiment is what captured in affordable care act for employers, so those that to allow employers that utilize those types of programs to offer discounts for their employees for those programs. So I know that sentiment is very much part of the spirit of the affordable care act and so we can take that back and look in how that can work for them Medicare or Medicaid population. Thank you.

Operator. Next we have a comment or a question from the line of Edward Shannon, Hudson Headwaters. Your line is open.

(Edward Shannon): Yes, hi there. It's Triff Shannon, Hudson Headwaters, South Network which is F2IC and this is for Dr Cohen. Actually we're going to be one of the participants who are in the (inaudible) medical home pilot. So in choosing New York State we will be one of those who are looking forward to this project. Question actually, comment or question, do you envision really robust sharing of data between CMS and participants in these innovative projects and also you're hoping that CMS can help orchestrate network amongst the various groups participating in these projects.

Many Cohen: Thanks so much for the question and for participating in one of the projects and me being on the leading edge of this, so fantastic. I want to say yes to both in terms of, you know we know that data is necessary for you to

understand progress or left there of and so. You know we are working to similar issues that John Pilotte mentioned earlier in terms of providing data in the timely manner so that process improvement can go on.

And secondly we are also building infrastructure within the center to allow for lesson learned to be shared so that we can create a community that can share those lessons learned to interact with each other and to share knowledge as we move this forward. So stay tuned and I might be calling upon you to give us more suggestions on how to best build that center. So stay in touch.

Operator: Next we have a comment or a question from the line of (Gennie Vigoson). Please state the name of your organization. Your line is open.

(Gennie Vigoson): Thank you. I'm calling from the Medical Society of the County of Queens. And my question has to do with ACO's. Many of our physician members and smaller solo practice ask us very often, if it's accurate to state that a physician who is not in ACO eventually will not be able to treat fee for service beneficiaries. Is that accurate to say?

John Pilotte: You know the ACO measure (inaudible) program the new program we're launching it, I mean there is still you know, for an addition to the Medicare fee for service program which serves tens and millions of patients and you know the provider will continue to serve fee for service patient as part of for just paying Medicare in the program. So as the earlier caller mentioned there will be a number of different options available to patients to choose from and for providers to participate in as currently exist in the Medicare program.

So Medicare fee for service to Medicare advantage to new types of payment arrangement with providers and new organizational models under the share program, as well those models under the innovation center that Mandy has talked about. You know and there is even new models contemplate around partial capitation to test and develop. So you know providers will continue to be able to see patients under the Medicare fee for service program and continue to be paid under these schedules as well.

(Gennie Vigoson): Thank you.

Operator: Your next question or comment comes from the line of (Keisha Lu Simpson). Please state the name of your organization. Your line is open.

(Keisha Lu Simpson): I'm calling from the American Medical Services in Brooklyn New York. And this question is directed to John Pilotte regarding the ACO module. As many medical beneficiaries are already in Medicare advantage trend, what are the requirements or the recruitment strategies I mean to utilize and enroll in members into the ACO and how will ACO attract enrollees?

John Pilotte: Yes. Those are good questions. As I mentioned earlier ACO is our new mechanism or rewarding more organized system delivery system for improving the quality and overall efficiency care for the patients they see and serve under that program. The statue talks about assigning patients to ACO based on legalization of primary care services and so forth. And one of the areas that we are interested in is sort giving comments and thoughts that's around doing that prospectively and then, how to do that in sort of how would information between cater the beneficiary and so forth and buyers or retrospectively at the end of the year based on the actual flow of patients in the organization.

You know I think there are a couple of different approaches around this and we are looking at getting industry input and comments around it and I would encourage you to comment on that as part of the MTRM as well. I think one model that we have experienced with is under physician group practice demonstration. They basically looked at the patient population that these ten large organizations sort of during the course of the year.

And then at the end of the performance period looked at the claims experience after the patients they served in assigned patients to a physicians group in this case for books of the measuring quality, and efficiency based on the actual utilization of patients they saw during year in order to be signed and assigned to the physician group for the performance year. The physicians group had to provide the polarity of their office base care during the year.

So just basically patients continue to operate under through the normal fee for service program. Those who have had to make beneficiaries aware that they

were participating in this demonstration and new arranged with Medicare, but importantly because it's a fee for service program like the ACO program beneficiaries retain their freedom of choice and ability to choose any provider to say just wanted to see. So within that sort of guide frame that's one area where we have experienced with and we would like to get for your thoughts and comments around the use of prospectively aligning patients with provided organization constituting the ACO as well and we welcome the thoughts and comments at part of the MTRM. Thank you.

Operator: Your next question or comment comes from the line of Carleen Adams, United Rebecca Homes. Your line is open.

(Carleen Adams): My name is Carleen Adams and I'm just concerned how would the ACO benefit the duly eligible patient on home health, forwarding receiving home health care. Would this limit their services?

John Pilotte: No I should say. As I mentioned earlier patients in the Medicare fee for service program retain their freedom of choice retain their ability to choose any provider they would see. I think the area coordinating post to acute care is an important one. It's an area that I think is not done well, can lead to unnecessary re-emissions I mean so forth which would be a source of additional cost of the program and to the organization.

I think that ACO in addition to the preventive focus and chronic disease management focus and proactive prevention that we have heard a number of other callers talk about would also need to address areas around post this charge follow up and hand off in transition which were areas that are also specifically referenced in the AC – affordable care act statute for the Medicare share savings program. So I would think that you know potentially there is probably opportunities for better coordination around postage charge follow up care and particularly around coordination with care providers as part of that as well.

So I think that would be an area that we could see some really interesting redesign efforts around in improving those hand offs and reducing of avoidable re-emissions. Thank you.

(Carleen Adams): Thank you.

Operator: Your next comment or question comes from the line of (Barbara Cassius), (Cerebral Palsy) Associations. Your line is open.

(Barbara Cassius): Hi thank you very much. First I missed the mailbox that we could submit ideas for the coordination care in particular for duly eligible, so if you wouldn't mind repeating that. And then also in looking at program alignment for duly eligible, I'd ask that you request that you look at the New State Medicaid State plan amendment that excludes dual eligible from the medical home incentives and the medical home initiatives.

(Sue Kelly): Hi this is Sue Kelly. Cheryl Powell has left the call but she did ask me to take notes and relate to her the questions and comments that have been put forth. And I just want to repeat again the website Gil Kunken was going to repeat them all at the end. Gil correct me if I'm wrong, it's http, it's fchcocms. hhs. gov. And we will make particular note for Cheryl Powell of this particular point with respect to the New York State plan amendment that would exclude dual eligibles from participation and are you saying health homes.

(Barbara Cassius): Yes the medical homes. Medical home initiative.

(Sue Kelly): Medical home.

(Barbara Cassius): My understanding and correct me and if I'm wrong that you can exclude duals from health home. They affordable care act to help homes, but apparently there is no such provision in medical home incentives. And New York did exclude duals from the medical home incentives.

(Sue Kelly): OK. We will follow up with respect to that. You know I would have to note that for Cheryl and also brief her further in term of the particular state plan amendment.

(Barbara Cassius): Great, thank you very much.

(Sue Kelly): Thank you.

Operator: There are no further questions at the present time. I'll turn the call back to our presenters.

Gil Kunken: I think we have heard all of today's comments, but I would like to remind you that if you were unable to provide your comments today or if you have something you would like to share after today's call you may contact Health and Human Services and CMS by emailing us at acocms.hhs.gov and fchcocms.hhs.gov and by visiting the center's website at www.innovation.cms.gov. We would like to thank you for your partnership and your participation on today's call.

Please note that for those of you that may have missed some of the calls or if you have colleagues or friends that were unable to join us today, the presentation will be available through the Encore feature in approximately two hours after the completion of this call. The recording will be available until the end of the week. To access Encore dial 1-800-642-1687, that's 1-800-642-1687 and use the participant ID code 28948644. Again that's 28948644. Thank you and have a good afternoon.

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

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