

**Acute Care Episode Demonstration  
Applicant Teleconference**

**June 4, 2008**

Teleconference Operator: Welcome and thank you all for standing by. At this time your lines are on a listen-only mode until the question and answer segment of the call. This call is being recorded. If you do have any objections you may disconnect at this time.

I would now like to turn the call over to Natalie Highsmith. Thank you ma'am you may begin.

Natalie Highsmith: Thank you, Hope, and thank you all for joining us and welcome to the Acute Care Episode Demonstration Applicant teleconference.

Today's teleconference is open to prospective Acute Care Episode or ACE Demonstration eligible applicants as well as other interested parties including hospitals and physician groups, hospital and physician group associations, other healthcare organizations and associations, Medicare beneficiary advocacy organizations and members of the press.

Herb Kuhn, Director, I'm sorry, Deputy Administrator of the Centers for Medicare and Medicaid Services will begin with opening remarks about the

current reality of Medicare payment policy and how the ACE Demonstration will test new methods of properly aligning provider incentives to maximize quality and efficiency of care.

Afterwards Rachel Duguay, the ACE Demonstration Project Officer, will provide a detailed overview of the demonstration including requirements and guidance available for applicants and how the demonstration will benefit Medicare beneficiaries.

Finally, Dr. Jeffrey Rich, Director of the CMS Center for Medicare Management, will discuss from a cardiac surgeon's perspective the logistics of how, through a focus on quality of care, cost containment care can be achieved. The question and answer period will follow the three presentations.

In addition to these three speakers, two other CMS representatives are available to address your comments and questions. Linda Magno, she is the Director of the Medicare Demonstrations Program Group, and Mark Wynn, the Director of the Division of Payment Policy Demonstrations.

Herb Kuhn is currently serving as both Deputy Director of CMS and Acting Director of the CMS Center for Medicaid and State Operations. When he first joined CMS in March 2004, Mr. Kuhn served as Director of the Center for Medicare Management. Throughout all of his roles Mr. Kuhn considers his contributions in shifting Medicare hospital payment from resource consumption and volume...to value and results among his most important.

He was instrumental in developing and implementing diagnosis related groups that tie Medicare payment to the severity of the patient's condition. He is a nationally recognized expert on value-based purchasing and payment policy.

Prior to joining CMS. Mr. Kuhn served as the Corporate Vice President for Advocacy at Premier Incorporated, a Hospital Performance Improvement Alliance with 1,700 participating not-for-profit hospitals and health systems serving communities nationwide.

Mr. Kuhn also served for 13 years as Vice President for Federal Relations for the American Hospital Association. He began his career in public service as Legislative Director to U.S. Representative Robert Whittaker, a member of the House of Representatives, Energy and Commerce Committee Subcommittee on Health and the Environment.

I will now turn the call over to Mr. Herb Kuhn for his remarks. Herb?

Herb Kuhn: Natalie, thanks so much for that very kind introduction and thank all of you for participating on this afternoon's call. I do want to extend our apology for starting a little bit late but we had a number of people in the queue on the call so what we found already is that this subject matter is much more popular than I think we thought and we have literally hundreds of people on the line participating in today's call. So again, my apologies for being a little bit late getting started, but thank you all for participating.

I think those that have seen the original announcement for this particular demonstration recognize that this is one of an ongoing effort on our part here at CMS, and I think a larger part of what we're seeing around the country to move forward evermore in this area of value-based purchasing.

It's our attempt at CMS to continue to pivot the organization away from just paying for volume to really pay for value, and for us to continue to move from being nothing more than a passive payer of services and becoming an active

purchaser of high quality efficient healthcare. That's a big change for any organization, but certainly a significant change for CMS as we go forward.

Demonstrations are a wonderful opportunity for us to prove and test concepts and we're excited about this particular demonstration, as we get ready to go to move forward. Now Medicare pays hospitals a prospective, kind of all-inclusive amount per discharge under the current DRG system. Medicare, I think as everybody knows, pays physicians on a fee-for-service schedule and the incentive that Medicare has when you really think about the physician and hospital relationship are not aligned, therefore it appears in many cases we are encouraging additional services, not better outcomes. The system, in effect, is for all intents and purposes on auto pilot.

If patients have a complication or get duplicative or even ineffective treatment, beneficiaries and the taxpayers wind up paying more. And as we all know from what we've seen with the good work of the folks at Dartmouth and others, that more treatment is not the same as treatment that is more effective. Areas of the country that have more specialists don't necessarily have better health, in fact the reverse is often true and healthcare appears to be no better in high spending regions versus those parts of the country that spend less per capita per patient.

A recent report by the Congressional Budget Office said that as much as \$700 billion annually or 5% of GDP is spent on care that cannot be shown to improve a patient's health. So, in steps the ACE Demonstration, which is our attempt to test the premise that a system that coordinates treatment for the entire episode of care will result in fewer complications, duplicative or ineffective treatment.

It also hopes to test the premise that a single bundled payment for hospital and doctor services will simplify bill paying for patients; once patients understand what they are paying for they will become their own best advocates for better care and we hope at a lower cost.

The ACE Demonstration provides bundled payments for 28 cardiac and nine orthopedic surgical services such as coronary and artery bypass graft, valve replacement, and hip and knee replacement surgery. These were chosen because they are high cost, high volume procedures in the Medicare program, they were also chosen because quality metrics are available for them, though improvements in the delivery for these particular services can be measured effectively as we move forward in this particular demonstration.

The demo will launch in Medicare Administrative Contractor or MAC as the new organization that we have of our old carriers and physical intermediaries come together, but it'll launch in MAC jurisdiction four, and will therefore be open to physician hospital organizations in Texas, Oklahoma, New Mexico and Colorado.

We are awarding only one site per market in that region to enhance the distinction of becoming what we call a Medicare Value-Based Care Center in an individual community. The demonstration will cover up to 15 sites we hope, and include as many as 17,000 Medicare beneficiaries over all three years.

Physician hospital groups will need to submit a competitive bid applying for designation as a Value-Based Care Center and (unintelligible) the payment they expect to receive for both the Part A as well as the Part B Medicare services that are delivered during the entire episode of care.

This market-based mechanism is important because we anticipate that the increased deficiencies created by this collaboration and the physicians and the hospitals coming together and the ability of the hospitals to market themselves as a Medicare Value-Based Care Centers will help drive patients to participating hospitals for the procedures that are covered by this particular demonstration.

Applicants may also choose to set up gainsharing opportunities or programs within this particular demonstration which we all know will allow providers to distribute payments for improved quality within the provider group without being subject to anti-kickback rules.

Beneficiaries who choose to be treated by a Value-Based Care Center will share in the savings directly. This is new for demonstrations, as many who watch these and understand how the program works know. CMS will provide up to 50% of Medicare savings and payments to offset beneficiary cost-sharing obligations. Beneficiaries will receive a payment not to exceed the amount of the standard Part B premium with savings achieved through competitive bidding for this demonstration.

With the ACE Demonstration, we expect to not only show how to better coordinate in-patient care but also how to share savings between providers, beneficiaries and ultimately the Medicare program. I think as we all know we can't continue to pay more for services if we don't get what we pay for.

The ACE Demonstration reflects CMS' ongoing commitment to actively pursue the best medical care for Medicare beneficiaries through value-based purchasing on behalf of beneficiaries, tax payers and to the healthcare consumers overall to achieve better healthcare at the lowest possible cost we can.

So with that, again I apologize for the delay in getting started but again thank all of you that are participating on this call. And with that, Natalie I'll turn the call back to you.

Natalie Highsmith: Thank you Herb. Next, we will hear from Rachel Duguay.

Ms. Duguay has been with CMS since May 2002 both as an analyst working on issues such as Medicare prescription drug policy and now as a project manager for the ACE Demonstration. Prior to joining CMS, Ms. Duguay spent two years with the healthcare consulting firm The Lewin Group focusing on healthcare finance. Ms. Duguay earned a Masters of Science from the Dartmouth Health Policy Center. Rachel?

Rachel Duguay: Thank you, Natalie. The slides that I'm speaking from are on the ACE Demonstration Web page, for most people on this call, you have already visited the Web site or have the link available but if not, to locate the ACE Demonstration Web page, go to [www.CMS.HHS.GOV/demoprojectsevalrpts](http://www.CMS.HHS.GOV/demoprojectsevalrpts), select "Medicare Demonstrations" from the left hand column and finally select "Acute Care Episode Demonstrations" in the main display.

CMS vision of being a value-based purchaser of care, articulated as the right care for every person every time, is motivated by well-documented deficiencies in the quality and safety of healthcare as well as unsustainable growth in healthcare spending in the U.S. overall.

We are all familiar with the health policy and clinical practice literature spearheaded by Dartmouth's Health Policy Center regarding the lack of a relationship between available services, using hospital beds or physicians as a proxy, and health outcomes.

As the largest single payer of healthcare services in the country CMS is committed to developing as a purchaser of quality, efficient services thereby adjusting the misaligned incentives discussed earlier.

I'm now on slide 3. The ACE Demonstration is one CMS value-based purchasing initiative.

The ACE Demonstration goals are to improve quality of care through consumer and provider understanding of both price and quality information of care; to increase collaboration among providers and health systems; and to reduce Medicare payments for acute care services using market mechanisms. There have been and continue to be efforts within and outside CMS to coordinate care within hospitals, within healthcare systems, and in larger contexts in order to achieve better outcomes for patients and to reduce inefficiencies of care.

A few examples [of previous or ongoing demonstrations] include the Medicare Participating Heart Bypass Center Demonstration, which began in 1991 through CMS. Through this demonstration, participating hospitals achieved cost efficiencies through streamlined processes leading to fewer reoperations, lower readmissions, and shorter lengths of stay.

Medicare achieved savings without any decrease in the quality of care provided to beneficiaries and patients in the demonstration had lower mortality rates, were more satisfied with the quality of nursing care they received, and appreciated the simplicity of a single co-insurance payment.

The Virginia Cardiac Surgery Quality Initiative [is another example]. This is a voluntary consortium of 17 hospitals and 13 cardiac surgical practices

providing open-heart surgery in the State of Virginia. Dr. Rich will speak further about this initiative and how it relates to the ACE Demonstration later.

[Finally], the Northern New England Cardiovascular Disease Study Group is another such voluntary consortium similar to the VCSQI and was founded in 1987.

What distinguishes the ACE Demonstration from CMS' two previous bundled payment demonstrations<sup>1</sup> is that ACE expands the bundled payment concept to a broader set of inpatient orthopedic and cardiovascular procedures with the potential to include or expand to post acute services after year one of the demonstration. Also, ACE will use a competitive bidding rather than negotiated pricing approach to awarding voluntary applicants. Finally, beneficiary participants will share in Medicare savings, and CMS intends to take an active role with ACE Demonstration sites in the marketing of the demonstrations.

The Acute Care Episode Demonstration solicitation for applications period, I'm now on Slide 5, began May 15th and will last until August 15th. We have mailed the solicitation materials to all short-term, acute care, prospective payment system hospitals in the selected four state region.

The solicitation and guidance materials are also available on the ACE Demonstration Web page. Some of the materials include a guidance document in the form of pre-formatted Microsoft Excel table shells for applicants to use in fulfilling the quantitative data application requirements; the provider incentive or gainsharing program rules for use by prospective sites that are

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<sup>1</sup> The "two previous demonstrations" referenced are the Medicare Participating Heart Bypass Demonstration and the Medicare Cataract Surgery Alternate Payment Demonstration. Only the Medicare Participating Heart Bypass Demonstration was discussed during the call but information on each is included in the ACE Demonstration Solicitation for Applications.

interested in proposing such a program; the quality monitoring measures that will be used to ensure quality at sites throughout the demonstration; the terms and conditions agreement that sites must sign after selection, and a frequently asked questions document about the ACE Demonstration.

CMS' central office and regional offices have conducted extensive outreach to prospective applicants through national and local press releases as well as e-mails and phone calls to national and state hospital, medical and related healthcare associations.

CMS will provide guidance to prospective applicants during the application or solicitation phase. For example, on an as-requested basis, CMS will provide data to applicants on estimated Part A and Part B payments that would be made in the absence of the demonstration such that bundled bids are informed by actual data. Applicants should ask for this data. The Part B data, especially, will be useful because most hospitals don't have a full picture of all Part B payments related to consulting physicians' work within their hospital. The pre-formatted Microsoft Excel table shells already mentioned are another form of guidance useful in meeting application requirements. I will come back to guidance for applicants later in the presentation.

Slide 6 - Eligible applicant's are Medicare providers in either Texas, Oklahoma, New Mexico, or Colorado. CMS chose these states for administrative simplicity and funding purposes as well as to maximize the number of viable applications from prospective demonstration sites. Applicants must be physician hospital organizations.

A physician hospital organization (or PHO) may be formed for purposes of participating in the ACE Demonstration. The minimum requirements for qualifying as a PHO are: to be an affiliation of at least one physician group

and at least one hospital which routinely provide the procedures included in the demonstration; documentary evidence of an agreement between the entities comprising the PHO attesting to the ability and willingness of the partnering organizations to enter into the demonstration for the full length of the project; and a signed statement agreeing to accept the sites' own, annually-updated bundled payment amounts as payment in full for demonstration procedures.

Additionally, if multiple hospitals are part of the same PHO, the applicant must make clear which particular hospital or hospitals will be the demonstration site(s). And, applicants that show evidence of a quality committee with both hospital and physician representatives and dedicated time to overseeing this demonstration will be given preference.

Another requirement is that applicant's must have received the full quality reporting update for reporting quality measures to CMS since at least Fiscal Year 2006. To give you an idea, every year since Fiscal Year 2006, at least 95% of hospitals have received full payment updates.

Volume thresholds - demonstration applicants are required to show that they meet specific volume thresholds as per peer-reviewed medical literature for the lead orthopedic and cardiovascular procedures that are the focus, that is 100 Medicare bypass surgeries and 90 Medicare hip and knee replacements.

By limiting the demonstration to applications that meet evidence-based volume standards, CMS is emphasizing the quality component of value-based purchasing. That said, if a prospective applicant is close to you but does not meet the volume requirements, they can request to discuss the requirement with CMS. For example, if an applicant previously met the volume criteria but

in the past year it did not by a slim margin this may be a situation for an exception.

Applicants will be competitively selected. Selection will be based upon the size of the discount, percent total dollar savings, and evaluation of quality of care measures to meet the goal of value-based purchasing. This is explained and a formula for calculating discounted bids is provided in the Solicitation for Applications, Section 4.2.

CMS expects to award only one ACE Demonstration site per market where a market is defined as a metropolitan core-based statistical area. After Year 1 of the demonstration, CMS will consider expanding the demonstration to test alternative competitive bidding models such as awarding multiple sites per market area in a new geographic area.

Slide 7 - I have briefly outlined the incentives for physician hospital organizations [on this slide]. Sites have the potential to increase volume for the demonstration procedures due to a few factors including CMS' and sites Value-Based Care Center marketing campaigns, CMS' transparency work in educating referring physicians and beneficiaries about the price and quality components of value-based care, and the beneficiary financial incentive program.

The goal of the ACE Demonstration is to have physicians and hospital collaborate to make improvements in processes of care leading to both greater efficiency and greater quality. In this way, the ACE Demonstration offers opportunities for product line development for coordination of care leading to efficiency of care.

Another plus for Medicare providers is that the sites may enhance their reputation based on participation in the Medicare demonstrations. Sites will

have flexibility, through bundled payment, to use CMS payment as the providers of care deemed most appropriate. Sites will also have the option of engaging in provider incentive, or gainsharing, programs.

Gainsharing is when providers set up financial rewards for the design of clinical care processes that result in improvements in quality of care and health outcomes. The ACE Demonstration allows demonstration providers to set up gainsharing programs.

Slide 8 - applicant's will supply CMS with a competitive bid reflecting expected payment for both Part A and Part B Medicare services during selected in-patient episodes. Sites may distribute each single bundled payment as it sees fit, therefore the site, a physician hospital organization, will distribute payment to its relevant clinicians and hospital departments.

Applicants will bundle all related inpatient services for the selected procedures into an "episode of care". Each applicant should submit a bundled payment rate for each episode of care included in the demonstration at that site. Sites may submit proposals for global payments for bundled payments under the demonstration for one or both of the major procedure categories listed in Section 3.2 of the Solicitation; [for] cardiac and/or orthopedic care.

Applicants must bid on every listed Medicare severity diagnosis related group (or MS-DRG or just DRG) in the selected category. All admissions for eligible beneficiaries for DRGs in a category for which a facility is selected shall be processed under the demonstration payment rules.

Applicant bids will be provided according to the formula mentioned earlier. Basically the bids will be the regular fee-for-service amount minus a certain percentage discount left open to the demonstration applicant.

The applicable discount should be expressed as a discount off the base DRG payment amount. Disproportionate share hospital payments and indirect medical education payments should not be included in the discount calculation and will be paid as per usual prospective payment system rules. However the bids should include applicable outlier and capital payments. Again, CMS will provide data to applicants as requested on estimated Part A and Part B payments that would be made in the absence of the demonstration.

Slide 9 - the bundled bid and amount of the discount represented by the bundled bid will be compared with regular average payments to the hospital and physicians in the evaluation by CMS. The size of the percent discount will be weighted more heavily than the total gross dollar savings to Medicare. Applications will be scored, in part, on the percentage discount across all selected demonstration DRGs using a weighted average of the applicant's own historical volume.

Discounts on current Medicare rates will be given significant weight as part of the evaluation of the overall application. Also considered will be the applicant's overall global bid relative to that of other proposals received. Applicants should provide sufficiently competitive discounts to Medicare to yield meaningful savings to both beneficiaries and the Medicare programs.

Applicants must describe how the proposed discounts will be achieved as well as what process or other changes will enable their institution to offer the proposed discounts while maintaining or improving quality of care. Finally, up to 15 sites will be selected for year one of the demonstration.

Slide 10 - in this demonstration bundled payment includes Part A and Part B services provided during an inpatient stay for the selected procedure. DRGs,

the current way of paying for hospital inpatient services, is a form of bundled payment, however as certain care can be shifted outside of inpatient setting to outpatient and/or post-acute care settings, and because the DRG system does not encourage coordination between settings, CMS is testing, through the ACE Demonstration, bundling groups of services larger than what is currently bundled through the DRG system.

All physicians practicing at the demonstration hospitals whether part of the PHO (physician hospital organization) or not, will be subject to the demonstration payment provisions if they provide services to demonstration beneficiaries. The bundled payment amounts bid by demonstration applicants and agreed to by CMS will be processed by the Medicare Administrative Contractors (MACs) serving the demonstration site. Sites must accept the single bundled payment as payment in full.

Slide 11 - as part of the Acute Code Episode Demonstration, CMS will share up to 50% of the Medicare savings from bundled bids with demonstration beneficiaries to offset their Medicare cost-sharing obligations. CMS will share savings with Medicare beneficiaries in the form of a payment not to exceed the beneficiary's annual standard Part B premium amount. I can provide an example of how the beneficiaries shared savings will be calculated during the Q&A session. One finding of the Medicare Heart Bypass Demonstration was that beneficiaries appreciated the transparency of the single co-insurance bill for their in-patient stay. This will likely be true for the ACE Demonstration as well.

Slide 12 - CMS intends to take an active role in publicizing the demonstration. There are two main audiences - Medicare beneficiaries seeking care for demonstration procedures and the population of referring physicians serving those market areas.

One of the benefits of participating in the ACE Demonstration for beneficiaries is a greater understanding of the value of their healthcare through what CMS terms “transparency”.

In order to affect coordination of care, the ACE Demonstration not only uses competitive bidding for bundled payments, and provision of beneficiary financial incentives as a marketing tool, it will also offer price and quality information in formats conducive to the Medicare population and referring physicians which should encourage beneficiaries to choose Value-Based Care Centers.

CMS expects an increase in volume at participating demonstration sites due to beneficiary shared savings and through active marketing and education.

Beneficiary and referring provider outreach strategies will include updating the [www.medicare.gov](http://www.medicare.gov) Web site’s two popular tools, “Find a Doctor” and “Hospital Compare” with ACE Demonstration-specific information and data. Also, a link for further information about how beneficiaries may benefit from receiving care at participating sites will be included.

Standard media outlets, especially through CMS regional offices and provider and beneficiary partner organizations, will also be useful in reaching both beneficiaries and physicians.

Sites will be encouraged to market their unique programs and their participation as ACE Demonstration sites as well.

The site may choose to market themselves under a special designation, the term Medicare Value-Based Care Center should be used.

Slide 13, again I cannot emphasize enough the different forms of guidance available to prospective ACE Demonstration applicants. Interested applicants should request information on total Part A and Part B payments, including consultants and other non-surgeon fees. This historical specific data from CMS and its contractors will be useful in developing applicant bids for demonstration procedures.

Applicants should also use Microsoft Excel table shells available on our Web page for use in completing the application quantitative requirements, both quality measures and bids.

And if an applicant is interested in setting up a gainsharing or provider incentive program, CMS will work with the site to meet publicized rules.

Thank you for your interest in the ACE Demonstration. In closing, I'd like to remind prospective applicants to email or call with any questions regarding the application process.

You may email [acedemonstration@cms.hhs.gov](mailto:acedemonstration@cms.hhs.gov) or call 410-786-6654. Now I'll turn it over to Natalie who will introduce Dr. Rich. I'll be happy to answer your questions after the final presentation.

Natalie: Thank you Rachel. Our final presentation is from Dr. Jeffrey Rich. Dr. Rich was appointed to his position as a director of the CMS Center for Medicare Management in February 2008 by Secretary Michael Leavitt.

As the director of CMM, Dr. Rich is responsible for developing the regulations and reimbursement policies for the Medicare fee-for-service

program. He also manages the program contractors that process more than one billion claims a year and make provider payments for more than \$280 billion.

Dr. Rich was a practicing cardiothoracic surgeon at Sentara Healthcare in Norfolk Virginia for 18 years with a special interest in heart transplantation and (unintelligible).

Prior to arriving at CMS, he was the director of the heart transplantation program, the ventricular assist device program as well as the scientific director of the Sentara Cardiovascular Research Institute.

Dr. Rich's special interests include quality improvement, health care policy, and payment reform. He has served as the chair of quality improvement for cardiac services at Sentara Healthcare for the last 12 years, and is a founding member of the Virginia Cardiac Surgery Quality Initiative and Regional Quality Improvement Consortium and served as the chairman of its board of directors.

Dr. Rich also served as the board of directors of the Society of Thoracic Surgeons and chaired its task force on quality initiatives and pay-for-performance.

In addition to his roles in his professional society, he has also - he is also involved with National Quality Organization. He served as chair of the National Quality Forum Council on Research and Quality Improvement and on its board of directors and is involved as a member of the AQA alliance steering committee as well as the quality alliance steering committee.

His special interests have led him to serve on the STS workforce on health policy, reform and advocacy and help develop pay for performance programs both in the public and private sector.

He has testified three times before Congress on physician quality, gainsharing and payment reform. Dr. Rich?

Jeff Rich: Thanks, Natalie, and good afternoon everybody. Sorry you had to suffer through that introduction. I didn't realize it was going to be so extensive, but thanks for being on the call today. I know there are at least 300 participants on the call.

I don't know who they are, we didn't have a list but I know that certainly some of my colleagues are on there and I know (unintelligible name), and colleagues from the STS in particular are there so hello to you.

So, in any case I wanted to say as an introductory comment I think that since coming here I've been well received and have had an opportunity to work with Rachel and her colleagues on the design of this. I have to admit they did most of the ground work and did a wonderful job in incorporating a lot of comments and thoughts out there that exist.

They design[ed] a demo which I think is going to be sort of ground breaking in terms of our ability, and now I'm going to wear my provider hat, to actually move the whole healthcare system toward cost savings while maintaining or improving quality improvement, improving quality, excuse me.

And I think that the uniqueness of this design is that it allows shared savings between providers who work so hard to improve quality and to recognize and evaluate those patients.

[This demo] will quantify those savings and then allow savings among the providers in a way that should be well-articulated in your application.

And I think [the demonstration design] has really been responsive to a lot of the criticisms that my professional society, the STS [Society for Thoracic Surgery] and I, and my Virginia Cardiac Surgery Initiative colleagues have had about how we have sort of hit the wall in working with payment reform.

But it appears to me like a very thoughtful approach has been done and there's a lot of opportunities here and a lot of parallels<sup>2</sup> and I wanted to just highlight some of those.

I think that embedded within this - within the ACE demo - are the principles and precepts of what we attempted to do in the Virginia Cardiac Surgery Quality Initiative Demonstration<sup>3</sup>.

And I think it has to start with structure first. The structure was just getting people together voluntarily in a consortium like we did in the State of Virginia to collect data, share data, improve quality.

You have to look at all the people that touch your patients and would even include, I would imagine, post-acute care providers to some degree<sup>4</sup>. And I think that design is clearly going to be up to you.

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<sup>2</sup> There are a lot of parallels between the ACE Demonstration and the Virginia Cardiac Surgery Quality Initiative.

<sup>3</sup> During his presentation, Dr. Rich referenced the Virginia Cardiac Surgery Quality Initiative (VCSQI) and the Virginia Cardiac Surgery Quality Initiative Demonstration design. While the VCSQI has been in existence since 1996 and continues to operate, at one time there was a proposal for it to become a CMS demonstration (extending its impact beyond current operations). That is the "demonstration design" (ultimately withdrawn) to which Dr. Rich refers. We apologize for any confusion this may have caused. The parallels drawn between the ACE Demonstration design and VCSQI are real, and the ACE Demonstration was built upon many lessons learned from both the ongoing VCSQI project and VCSQI Demonstration proposal.

Obviously, in order to collaborate you need somehow to collaborate in some data. So this is going to promote and encourage the use of clinical data, it will continue to strengthen the use of the STS database.

I know that that culture is already embedded within all of us who come through our training and in our professional societies and in institutions in which we work, I think the STS database has been a phenomenal tool for us.

And I hope that this would propel the development of that in orthopedic surgery as well as in other areas of medicine, but clearly that was a sine qua non of importance and collaboration.

And each of these projects I think focuses on the belief that through quality and quality improvement and reductions of complications that we can achieve cost containment, not only in cardiac surgery but in orthopedic surgery.

And I believe that we've chosen two areas that are very easy to define the episode of care; you find you can put your arms around it; you can define it from the hospital standpoint and the provider standpoint.

It should be clear and CMS will provide you a lot of data and support in helping you define at least financially where these milestones are and entrance and exit out of your particular DRG.

It's a serious concern, because if you translate this into the broader areas in medicine, it gets very difficult. There are border zones that are hard to define where ownership is. There are white spaces where patients get lost because of

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<sup>4</sup> **Post-acute care services will not be included in the bundled payment for episodes of care in the ACE Demonstration. However, CMS will research the possibility of reconstructing (and re-bidding) the episodes to include post-acute care services after Year 1 of the demonstration.**

poor coordination of care and so hopefully that's just demonstration once defined an acute care episode in the hospital and that we learn how to drive quality improvement for them and improve efficiencies that will be able to translate into a bigger and broader perspective.

But more specifically for this, I think we're talking about reliably capturing clinical data that's sent to the STS database and the newly developed orthopedic database - which I say with a smile I don't know that it exists but I hope that this would stimulate it to exist.

And all of that is designed to realize the cost of care savings based on quality improvement tied to better patient outcomes, efficient use of resources and performance.

If you look at the VCSQI, we looked at various patient populations that would be part of the demonstration. We looked at the 'inlier' population that you're so used to taking care of and that you may feel that you've extracted all your efficiencies on.

But I can guarantee you as you go through this you'll be able to define further efficiencies and look at resource utilization and lower resource utilization through a focus on them.

But more importantly, through a focus on quality and maintaining your focus on quality, I think that's - and don't even consider applying if you think that your quality will worsen by participation in this demonstration because that will be a checkpoint you know immediately for you to be an effective participant is that you must maintain or improve quality in order to qualify to be a participant in the shared savings model. Having said that, I think there's

another population that we looked at very strongly within VCSQI and that proposal was the high risk or 'outlier' patients.

We felt that there were clearly opportunities to define that population, to look at the things that drive - that are the drivers of cost in that population - and to effectively look at the things that put the patient in that population.

We thought that [complications related to surgery] were opportunities to reduce [the] outlier population size and provide some savings.

Because remember that this demonstration will be priced out on the collection of data that you receive that will include both inlier and outlier payments for both Part A and Part B services for your historical experiences.

So there's your reference point and your baseline and from there you can work both on the patient who does - who gets through, he or she gets through an operation easily but perhaps has had some excess resource utilization or to focus on reduction both complications that drive higher utilization drive lines to stay.

And all of this is driven financially from the standpoint of a bundled payment and Rachel has already talked about that, the bundled payment was something we were quite comfortable in dealing with.

Also easy to define through the data that it is very extensive that exists here already, and we had actually had data use agreements in the past...with CMS and we were provided with more than we needed.

And it was very open and it was easy to understand and get through it.

The additional things I think that are nice here is that you'll be able - there'll be a much stronger marketing effect on beneficiaries. (Unintelligible) The agency has moved in the direction of making sure that beneficiaries are well aware of what their rights are, well aware of what their co-pays are.

And as you know, HHS and Secretary Leavitt are very focused on transparency. The Hospital Compare website and other websites out there have had a very strong push from above. And it's a good push and it's the right direction that we've been transparent about what costs are and what your co-pays are going to be.

And we think that's very important, so there will be as I read through this [ACE Demonstration Solicitation] and hear it from Rachel, a lot of good regional relationship development between the people who are participating and CMS to tend to this with you on the marketing efforts. CMS [marketing] guidelines do exist and are well written.

Transparency will be [in part] the data out on the Hospital Compare Website. We don't have a 'Physician Compare' Web site but we are the midst of thinking and talking about that, [un]related to this demonstration.

But it's certainly another motivating force within the agency. There will be a lot of work to get it done and I think that the refreshing thing about participating is that you'll develop very strong relationships with your hospitals and hospitals with their physicians.

The potential here is for the identification and sharing of savings. And I think that's an excellent opportunity because it's one of the things that has always stymied us as providers or surgeons in the hospital working to drive quality

improvement and generate reductions in complications and create savings for the hospitals which were all appropriate.

We, as providers, would like to share in those savings. Most importantly, you'll find that, through participation, you'll actually redesign properties of care, you'll redesign yourself I think.

You know it goes through every team rather than those individual components kind of fighting for a source of funding. [With the ACE Demonstration], you'll have a combined source of funding you'll have ownership in. And, there's the potential for beneficiary impact and improvement in the quality of care.

So with that I'll close, I've probably over used my time.

Natalie Highsmith: Okay, thank you Dr. Rich. Now we will move into our Q&A period. Operator I hope will give you participants instructions on how to ask a question.

Today we are focusing on answer questions from prospective ACE Demonstration applicants. When it is your turn to ask your question please remember to restate your name and what organization or provider you are representing today.

Operator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press star 1. Please unmute your phone and record your name clearly when prompt.

Your name is required to introduce your question. To withdraw your request press star 2. Again, press star 1 to ask a question. One moment please for the first question.

Our first question comes from Justin Hunter, your line is open.

Justin Hunter: Thank you operator, Justin Hunter here from HealthSouth. Rachel, Dr. Rich, Herb thanks for being on the call. I have read through the documents that have been issued in conjunction with the announcement of this demo.

And if I recall there was a statement to the effect that at least in the initial year of the demo, post acute care services associated with these procedures are not envisioned as being part of it.

But I think I heard Rachel and Dr. Rich both mention post acute care services and I want to make certain that the comments that I've heard on this call are not leading me to a different conclusion than that which I initially arrived at in reading the documents.

And that is: will post acute care services in connection with these procedures be included or not be included in the bundled payment that's envisioned?

Rachel Duguay: Thank you for your question. Post acute care services will not be included in the bundle in the initial phase of the demonstration. CMS has stated in our solicitation materials that we will consider and do research into potentially including post acute care services, both orthopedic and cardiac rehabilitation services, after year one of the demonstration.

However, if that were to occur, we would certainly open the bidding process back up again and it would be necessary to re-solicit the bids from the applicants.

Justin Hunter: Okay.

Jeff Rich: Yeah Justin, this is Jeff Rich, thanks for the question. Rachel's already answered it, but I spoke to it only because in our [VCSQI application to CMS that was ultimately retracted, post-acute care was] included.

That was a request (unintelligible) which has been withdrawn but we were actually looking at post acute care. So it was something that I've dealt with and was sensitive to, but I didn't mean to imply that it was going to be involved, nor should it be.

But I hope that answers the question.

Justin Hunter: It does indeed and thanks for the clarification.

Rachel Duguay: Okay, next question please.

Coordinator: Our next question comes from Fred Grover, your line is open.

Fred Grover: Hi, Jeff, thanks to you and Herb and Rachel for your leadership on this and the nature of the things that you're doing I just wanted to express our appreciation and we'll take a hard look at it.

Jeff Rich: Thanks, Fred. I hope you're doing well. Thanks for all your support over the years.

Fred Grover: Well, I think you know obviously this is what we had hoped to see the fruition of this type of quality improvement program built into these types of programs, so it's very rewarding to hear you present your presentation.

So, thanks again.

Jeff Rich: Sure.

Coordinator: Our next question comes from Doug Emery, your line is open.

Doug Emery: Thank you, again I'd like to reiterate the congratulations and what an exciting development this is for government policy, even though it's an experiment I think it will be very interesting to see how it plays out.

I have two questions. First has to do with the nature of the methodological analysis being applied to determine the global fees when combining Parts A and B, and the second is the logistics of actually operating it from day to day, because you're talking about probably millions of claims and being able to keep track and account for contractual rates versus actual performance.

And if there are opportunities to work with CMS, we have a Robert Wood Johnson grant right now to do precisely this thing, and we're wondering if perhaps there were opportunities to share knowledge and work with one another on these two areas.

Mark Wynn: Doug, this is Mark Wynn, nice to hear your question. In terms of the logistics issues, yes we'd like to get in touch with you in terms of the Robert Wood Johnson-sponsored processes.

We think we have solved a lot of these questions or are very open to looking for additional ideas about how to do that. In terms of the methods to calculate the base from which the discount is calculated, the Part A payment of course is relatively straight forward, those (unintelligible) know what the DRG payments for given MS DRGs.

Obviously include the outliers however, in terms of the Part B payments it gets a little more complex. We simply mean all the Part B payments for services to the included beneficiaries at the given hospitals including the surgeon's fees, the assistant for surgery, anesthesiology consultant, the whole ball of wax.

And, as Rachel pointed out in her presentation, in many cases hospitals don't have the full understanding of the full amount. But that would be the calculation that we would use to determine the base for Part B.

Doug Emery: That's great. And I hate - please don't think I'm implying that somehow you need help in all this, we're just very interested in the approach and hope that we can communicate.

Jeff Rich: This is Jeff, I mean based on my experience we've done a lot of this by hand. It was laborious. But boy, did you learn a lot. You really don't - not only about how - not only about efficiency but about who really touches your patients and all the providers that are out there.

It's very interesting process to go through and it probably could be streamlined a bit from what we did which was looking at this big Excel spreadsheet in doing it.

But I think it's clearly do-able, but you know people like yourself who have been in-house would certainly be welcome I believe.

Doug Emery: Well, that's great, thank you very much.

Coordinator: Amanda Wong, you may ask your question, with Healthcare Policy Group.

Amanda Wong: Yes, I have two questions. First of all for those physician groups and the hospitals that would create physician hospital organizations in order to submit a bid for this demonstration, could you elaborate a little bit more on what exactly constitutes a physician hospital organization?

And then second of all with respect to the submission of the bid is the bid applicable for all three years, or would there be an opportunity at the end of every year to sort of update or modify the bid? Thank you.

Rachel Duguay: I'll take your second question first. Yes, the bid would be in effect for the full three years of the demonstration. And in terms of what constitutes a physician hospital organization, CMS would require that the organization be an affiliation, documented, between at least one hospital and at least one physician group.

Mark Wynn: Rachel, let me re-ask the first question. [How will] DRG payments be updated each year?

Rachel Duguay: Yes, I'm sorry, the - well the bid is in effect for three years, and it will be updated annually according to the regular inpatient perspective payment system update, for Part A and for Part B.

I'm sorry, that was kind of a muddled response, but if prospective applicants have questions about whether or not their organization would qualify as a physician hospital organization, I encourage them to contact CMS.

Jeff Rich: Well, I think the definition [for physician hospital organization] is pretty broad. I was [thinking of it as, potentially,] a single cardiac surgical group working with a hospital.

That would be sort of basic entry-level criteria which would be very easy. I mean, there are already a lot in the provider communities out there [including] one each hospital and physician group.

Rachel Duguay: Yes.

Jeff Rich: And then I think you could go on beyond that, it could be as far as a clinic model with multi-specialty groups all being exposed at a hospital.

Rachel Duguay: Does that answer your question?

Amanda Wong: Yes, I think perhaps in the future we might return to CMS with a more specific question about the PHO.

Rachel Duguay: Okay, thank you.

Amanda Wong: Thank you.

Operator: (Kay Barlow) with Denver Cardiology Associates, you may ask your question.

(Kay Barlow): Good afternoon, how are you?

Rachel Duguay: Good, thanks.

(Kay Barlow): I have kind of a technical question and I'm sorry to do this to you, okay? But what if you have a patient that comes into the hospital and only has Part A coverage and not Part B...how would that be handled?

Rachel Duguay: Well, the patient would be considered part of the demonstration and...

Jeff Rich: That's a good question. You have to have - it was very clearly defined [in the previous VCSQI Demonstration proposal] that you have to have Part A and Part B coverage. Sorry Rachel, I...

Rachel Duguay: No thank you for jumping in there. [You're right, the beneficiary has to have both Part A and Part B to qualify as a demonstration beneficiary, otherwise, payment to that hospital for that beneficiary would not be bundled and would be according to usual IPPS rules.]

(Kay Barlow): So if that's the case and you're part of the demonstration and the patient's a Medicare recipient with Part A only, would you revert back to the hospital getting the regular DRG and the physicians getting their fee for service?

Rachel Duguay: Yes, for those patients we would.

(Kay Barlow): Okay, thank you.

Operator: Lani Berman with Goodroe Healthcare Solutions, you may ask your question.

Lani Berman: Yes, hi, good afternoon. This is Lani Berman with Goodroe Healthcare Solutions, and my question is related to the part of the application and the solicitation that talks about a set of incentives that are offered to beneficiaries and referring physicians.

It specifically talks about the two categories of in-kind services to beneficiaries and their families. And then secondly in-kind services to referring physicians. Can you share some examples of what in-kind services would look like to referring physicians please?

Rachel Duguay: I'm sorry. I'm not familiar with what you're referring to.

Lani Berman: The solicitation describes that in-kind services can be offered to referring physicians as part of the demonstration. It also talks about in-kind services to beneficiaries and their families.

So are there certain kinds of incentives that specifically under the demonstration can be offered to referring physicians that would not qualify if they were not under the demonstrations?

Linda Magno: Under the demonstration, hospitals can engage in gainsharing with their physicians, which they otherwise cannot do under the Medicare program except under very stringent guidance from the Office of the Inspector General, so that physicians - so that's part of the way in which physician-hospital organizations can achieve savings sufficient to cover the discounts that they [will have] offered [CMS].

Lani Berman: Okay, that's very helpful. So gainsharing would be the main mechanism for hospitals to offer incentives to their physicians to participate.

Linda Magno: Right.

Lani Berman: Okay, wonderful. Thank you.

Linda Magno: This demonstration cannot work without hospitals and physicians working collaboratively. If physicians are not interested, there's no demonstration to be had here.

Jeff Rich: Right, and I want to sort of keep moving all of this away from the term gainsharing because I think there's a broader concept and that's the shared savings model. Gainsharing, as I see it, it's the (unintelligible) side of sharing of savings like, you know, going to the producers or industry and trying to get big discounts.

That was clearly historically the way it was termed, and we're stuck with the term, but we're looking at shared savings. So, if you could generate savings by collaboration, then it's correct. You have to have collaborations, then you can share those savings.

I think what's imbedded in your question is whether there can be alternate ways to provide incentives for the docs. Can you do something for them; buy computers for their office or do something like that? I don't know. There are very new and clear guidelines that this will follow that are available and that are on the Web site.

And there may be even an expansion of some of those guidelines in future sort of regulations and rule-making. So we'll be very attentive to that, but I think that we will follow the - we certainly will follow the guidelines that CMS has out there posted for this.

Moderator: Okay. Next question please.

Operator: (Lester Rockwood) with Nix Health Care System. You may ask your question.

(Lester Rockwood): Yes, this is (Lester Rockwood), Nix Health Care System. I have a couple of questions. One is how will the PHO do the billing to CMS for the combined bill? Will it be on an episodic basis, each episode of care? And if so, will it be

paid promptly or will it be under the 14-day delay currently experienced by the hospital for CMS?

Rachel Duguay: Payment will be made by the case. So the hospital will be submitting their claims in a very similar way, but they'll be acting on behalf of the physician-hospital organization.

(Lester Rockwood): I would assume that the PHO would be submitting the bill since they are paying the doctor and the hospital and the hospital would not be submitting the bill to CMS.

Rachel Duguay: Correct. However, in most cases, it will likely be an administrative office of the hospital that will take charge of that process on behalf of the physician-hospital organization.

(Lester Rockwood): And in the material that talks about that, the discount will be applied to the base DRG amount and not against the disproportionate share payment, will the disproportionate share payment be paid as part of the demonstration project, or how will it be settled on the cost report? Because if it's not paid as a DRG payment on the (PS&R) from the intermediary, the percentage would not be applied and the hospital would not get the disproportionate share payment.

Rachel Duguay: The disproportionate share payment will continue as it currently is.

(Lester Rockwood): Currently is, but if a hospital is not submitting the bill, how will they get paid?

Rachel Duguay: This is a technical issue which we're working on with the Medicare Administrative Contractor which will be serving these hospitals and more

details can be made available about that as we get down to that phase of the project.

Jeff Rich: We dealt with this issue in our demonstration, too, and it was clear that disproportionate share payments would not change. We had worked out the mechanisms by which it was going to be billed accurately and paid accurately and that includes indirect and direct medical education which (unintelligible) as well.

This won't impact any of that. [The demonstration] doesn't want to penalize academic institutions or institutions that are providing certain levels of care to the community and getting disproportionate share payment.

Lester Rockwood: I'll look for the technical changes. Thank you.

Jeff Rich: All right.

Operator: Our next question is from (Joseph Dean Romero) with Surgery Specialty Hospitals of America [SSHA]. You may ask your question.

SSHA: My question was just regarding the slides that Rachel was talking about. I didn't get those and maybe I didn't go to the right Web site.

Rachel Duguay: I can email them to you if you want to email [acedemonstration@cms.hhs.gov](mailto:acedemonstration@cms.hhs.gov). I will get those to you.

SSHA: All right. Thank you.

Rachel Duguay: You're welcome.

Operator: Our next question is from (Kim Cooper) with Valley Medical Center. You may ask your question.

Kim Cooper: My question on billing has been answered previously. Thank you.

Operator: (Kristen Stewart) with Credit Suisse, you may ask your question.

(Kristen Stewart): Hi. I just wanted to say congratulations on the program. Just wondering if you guys have received any feedback from any of the [device] manufacturers on the program and, you know, what some of those concerns might be?

Rachel Duguay: I'm sorry. Right now we're trying to focus on questions from hospitals about the actual application process.

(Kristen Stewart): Okay. Apologies.

Rachel Duguay: That's okay.

Operator: (Jay Sutton) with Medalign, you may ask your question.

(Jay Sutton): Thank you. Let me start by congratulating you on how well you-all have pulled together the materials. I've been involved in a number of other applications, and you-all have really done a good job on anticipating things and providing the templates and the information.

I'd like to ask three quick questions. The first one, how can, we for a given market, get the historical Part A and Part B data that has been discussed a number of times?

Rachel Duguay: Well, you should contact me, Rachel, at the ACE Demonstration email address or my phone line is 410-786-6654, and we can discuss doing the data analyses necessary and getting you the data.

(Jay Sutton): Thank you. My second question, to your knowledge, is there going to be another OMB review after you selected the PHOs or the applicants before the program can start, like what's going on right now for the 646 and 5007?

Rachel Duguay: As far as we understand, we've received OMB approval for this demonstration.

(Jay Sutton): Excellent. My third question has to do with the gainsharing specifications that you've helpfully published. There are some DRGs that are outside of the target for this demonstration project that, for example, would involve devices from manufacturers providing the stents and the pacemakers and that kind of thing.

Can the gainsharing provisions of this upset episodes or effect care that is outside the targeted episodes for the ACE solicitation?

CMS: I'm sorry. Are these DRGs [you mention] part of the same case [with a demonstration case]?

(Jay Sutton): No. I'm speaking, for example, of some vendors that are principal suppliers of stents, of pacemakers and that kind of thing, but they also provide devices for episodes that are not included in the ACE Demonstration.

As I imagine, what gainsharing projects might look like, they might encourage vendor selection that also involves these non-ACE Demonstration project-

related episodes, so can the gainsharing program cover those non-ACE Demonstration projects episodes, as well?

CMS: We're focusing on only the DRGs in this particular demonstration. The exemptions for gainsharing, and for that matter, the other portions of the demonstration, have to do only with this demonstration.

So for example, if there's some device used in a pulmonary procedure, for example, that is outside the scope of this.

(Jay Sutton): That's very, very helpful. Thanks. And thanks again for the good work you-all have done in setting this up.

Rachel Duguay: Thank you.

Operator: (Ron Cunningham) with Bone and Joint Hospital of Oklahoma, you may ask your question.

(Ron Cunningham): If a hospital and a physician group affiliate through the PHO, their current or future Medicare patients - it's not assumed they're automatically going to become part of the program. I mean, they would have both [types of] patients, those physicians, for example, and the hospital could have patients who are still the traditional reimbursed Medicare patient and patients who participate in this program?

Does that make sense, I mean, my question?

Rachel Duguay: I'll try to answer your question. Beneficiaries who enter the demonstration sites for the specified diagnoses that the site bid on, they will be in the demonstration, unless, as we mentioned earlier, they don't have Part B or

there are some other exemptions for why the care provided to them would be paid under regular inpatient prospective payment system rules.

However, as a normal course, any beneficiary entering that hospital for the specified procedures would be part of the demonstration.

Jeff Rich: Yeah, it's pretty much designed so that you can't cherry-pick populations or try and avoid certain ones. Maybe cherry-picking isn't the right word, but anybody who comes in after care with that DRG will be under the demonstration.

(Ron Cunningham): My question really comes to - because my concern, it's more that as a hospital, we're going to have many physicians practicing here, some of whom may be participating in this affiliation and others may just be continuing on in their own individual practices.

So, I guess that's the scenario that concerns me.

Jeff Rich: I'm not sure what the concern is. You're worried that a physician in the hospital who's not treating [for example] cardiac surgical patients will somehow be swept into a demonstration design?

(Ron Cunningham): Yeah, I guess so...

Rachel Duguay: Yeah, any physician who treats the demonstration beneficiary will be - their claims will be paid through this demonstration. So whether they have an official affiliation with the PHO or are just providing a consultation as per their normal business,...it will be the responsibility of the physician-hospital organization to reimburse that physician.

(Ron Cunningham): Thank you.

Operator: (Joseph Cleveland) with Society of Thoracic Surgeons, you may ask your question.

(Joseph Cleveland): Hi, good afternoon, and thank you to the panel. Jeff, it's good to hear you again.

I guess I'm representing both the STS and also our [medical] practice here (with Fred Grover) and we certainly want to look at this, too. My question relates to the quality measures selected and they seem like the standard things.

I just want to, I guess, make sure - not make sure, but just hear that these are going to be - [are] things like sepsis and physiologic and metabolic derangement, I'm just curious, and maybe Jeff could speak to this, were these things that you looked at in the Virginia Quality Improvement Project and abstracted to this demonstration?

Jeff Rich: No - Joe, hey how are you? I'm glad to hear your voice.

No, I think, you know, when I looked at that, we talked about it and I kind of beat Rachel up a little bit about it over [some of the quality measures]. She's laughing here. What they did when they wrote [the Solicitation is] they pulled in a lot of the language that you see in coding, coding language, like metabolic derangement and things like that, but I think for your demonstration, and you can correct me if I'm wrong, you need to define what you want to measure<sup>5</sup>.

(Joseph Cleveland): Okay.

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<sup>5</sup> The quality measures that must be reported at the time of application and during the demonstration are listed and described in detail on the ACE Demonstration Web page.

Great. Thanks again for your work. It's a very appealing project.

Operator: (Chris Dukes) with Paris Regional Medical Center, you may ask your question.

(Chris Dukes): Yes. Actually it's (Chris Dukes), but...Two questions, one, in terms of reviewing this material, I'd say that there's going to be 15 sites and basically it's metropolitan statistical areas, but I think that there was also a provision in there for rural hospitals that fall into this category.

And I guess my question is thinking of most rural hospitals that would have cardiac programs, they may not meet all of those volume criteria, so is that a potential exception for the rural-based hospitals, the fact that they are rural?

Rachel Duguay: Well, we do have the volume thresholds there for a reason, as I mentioned. We do want to ensure that the hospital is performing at a level of quality necessary to operate this demonstration and - but also, as I mentioned, we are open, if a hospital wants to come forward and present their data, we may be able to make exceptions on the volume thresholds. But I can't say, you know, across the board that there will be an exception for rural [providers].

(Chris Dukes): Okay. The second question really goes back to something that was asked earlier and I kind of heard a different question than what was answered. And it had to do with physicians that may or may not be participating in the PHO but may have staff privileges.

And the way that I heard that question is, for example, if you had 15 orthopedic surgeons and 15 of them said, yes, we want to participate in this, or maybe the hospital said we don't want [one or a few particular surgeon(s) involved in the demonstration PHO] because we know that you're not going

to do anything to improve quality or gain efficiency, and those guys either select themselves out or the hospital selects them out, but if they have a patient that they see either through their obligations for call on the hospital's ER panel, or through their own private practice, are those billed as demonstration patients or are they excluded?

And I understand, you know, that we want to have cooperation of the physicians, unfortunately, that's not always the case.

Mark Wynn: Yes, all of the patients who meet those demonstration criteria, ...and go to [a demonstration] hospital, ...are included in the demonstration. It's up to the hospital and the PHO to assure that all of the physicians and all of the care adheres to the quality standards and so forth that's included in their application.

And, perhaps some physicians refuse to sign up as part of the PHO...I hope that wouldn't happen, but if that did happen, I would assume that they either have to reach an agreement with that physician, for example, paying fee for service.

(Chris Dukes): Or a smaller fee for service if the physicians don't want to cooperate in the first place.

Mark Wynn: Well, I think that's up to the hospital. I mean...

(Chris Dukes): I mean obviously there's incentives in there for rewarding, you know, demonstrated improvements in quality and efficiency. That's a component of this. So I would imagine if you had a physician that didn't want to participate in the first place and he wasn't doing anything to improve your quality, his payments might go down.

Rachel Duguay: If [a physician who is outside of the PHO] does want to receive payment for his/her services [to demonstration beneficiaries], they do have to go through the physician-hospital organization. Physicians may still submit claims, and in fact, we ask that they continue to do that; however, they will be processed as no-pay claims. And they will be kept for record-keeping purposes so that we can evaluate the amount and also cost of services being provided through what we would consider the “normal” Part B channel [of services] under the demonstration

However, they will not be paid [under] Part B. They will be paid through the bundled payments that the physician-hospital organization receive.

Jeff Rich: I think I may further expand on your example. If you’re, say, a community hospital who has an orthopedic surgeon who doesn’t routinely practice electively there but is only covering for emergencies on Friday nights because of staff coverage obligations, and he does or she does an emergency operation, how would that work?

Well, it would work because this is beneficiary-driven and the patient comes with a DRG. If [the DRG] falls under this, then the hospital, the PHO, would be obligated to pay that ad hoc physician or that person whatever they have agreed to within the PHO.

Does that clarify it a little bit more? I think what you’re talking about are physicians, though, on staff who are generally a problem, and...

(Chris Duke): Right.

Jeff Rich: And you’re trying to decide what the heck to do with these guys.

(Chris Duke): Just to give you a perfect example, we got both an orthopedic program and a cardiac program and we have been very successful with all of our orthopods in standardizing on implantable devices and therefore getting some significant savings from the vendor, all with the exception of one of our orthopedic surgeons who refuses to use that vendor.

So, you know, if we did the orthopedic program, and he's included, we already know that he's going to screw up our data.

Rachel Duguay: He would have to come to the table before the demonstration and you would have to all agree about how it will [work].

(Chris Duke): So I guess the real question is from the hospital's perspective, with orthopedic surgeons and cardiovascular surgeons it's an all or none kind of situation. They all have to be on board, otherwise, the results of the demonstration project are not going to be anywhere near where anybody wants them to be.

Operator: Our next question is from (Zach Maley) with Rocky Mountain Heart Association. You may ask your question.

(Zach Maley): Hi, yes. You may have hit on this already, but the bundled payment that you've been discussing was supposedly going to be applied to 28 cardiac services; I've heard you hit on valve procedures and bypass, would cardiac defibrillator implants and cardiac pacemaker procedures and also percutaneous cardiovascular procedures be included in that?

Rachel Duguay: Yes, they are and the full list of DRGs is in the solicitation.

(Zach Maley): Okay, thank you.

Rachel Duguay: I can send those to you if you'd like to email the ACE Demonstration email address.

(Zach Maley): Okay.

Jeff Rich: I want to sort of indulge in that because when I spoke, I spoke a lot about cardiac...

Operator: (Unintelligible) with Mediline, you may ask your...

Natalie Highsmith: I'm sorry. Dr. Rich was trying to address a question, operator.

Operator: Oh, I apologize.

Jeff Rich: I keep speaking [about] cardiac surgery cases, but in our original demonstration design, it also included cardiology DRGs; tests, percutaneous intervention, angioplasty and now, it would obviously include stenting now. But at the time we wrote it, it didn't. So yeah, there was a full array than just cardiac surgery, and I think, Rachel, you've already discussed, there are 26, you said, of cardiac?

Rachel Duguay: Twenty-eight.

Jeff Rich: Twenty-eight.

Natalie Highsmith: Okay, Hope, we're going to take our final question.

Operator: Okay. I apologize for interrupting [earlier]. (Bridget Turitin) with Medalign. You may ask your question.

(Bridget Turitin): Hi, thank you very much. My name is (Bridget Turitin). I am with Medalign. We're a consulting organization that helps hospitals with applications and have a couple of questions. First, [the Solicitation] talks about expansion [of the demonstration]. Do you want expansion ideas as part of the application, such as, you know, the post acute care or other related DRGs, those kinds of things?

Rachel Duguay: Not at this point. I think demonstration sites should focus on the current design of the demonstration.

(Bridget Turitin): Okay, and second quick question is do you have a goal for turnaround time? On the last couple of gainsharing programs, it has been relatively long from when applications get turned in until you are selected as a site. Do you have goals as to August 15th deadline when you hope to have these up and running?

Rachel Duguay: The goal is to have site selection in October and to have demonstration sites up and running as of January 1st of 2009.

(Bridget Turitin): Terrific. Thank you very much.

Rachel Duguay: Thank you. I thank you so much for the interest today. I'm sorry we left [the caller] a couple of callers back, dangling. There was a little confusion on our end, but if you do have further questions, please feel free to contact me at [acedemonstration@cms.hhs.gov](mailto:acedemonstration@cms.hhs.gov) and I will get your question to the appropriate person.

Again, thank you so much for your participation today.

Natalie Highsmith: Hope, can you tell us how many people joined us on the phone?

Operator: Yes, one moment please. [There were over 500 callers on today's call.]

This does conclude today's conference. You may now disconnect.

END