

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
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2:00 p.m. ET

Operator: Good afternoon. My name is (Steve) and I will be your conference operator today. At this time I would like to welcome everyone to the advance payment initiative special open door forum.

All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be an opportunity for comments. If you would like to make a comment, during that time, simply press star then the number one on your telephone keypad. If you would like to withdrawal your comment, press the pound key.

I would now like to turn the call over to Ms. Barbara Cebuhar. Please go ahead.

Barbara Cebuhar: Thank you very much for everyone being on the call today. My name is Barbara Cebuhar and I work in the office of Public Engagement here at CMS. We're here to discuss some exciting new options for a whole range of providers across the healthcare spectrum that are considering being a part of accountable care organizations.

Accountable care organizations are one of the most innovative tools provided by the Affordable Care Act that will help us create a healthcare delivery system that is sustainable over the long term.

Today we're discussing a new initiative from the CMS Innovations Center, the Advanced Payment Initiative. I'm joined today by Dr. Mandy Cohen and Sean Cavanaugh from the Innovation Center to provide an overview and an

opportunity for us to hear from you about what you might need to make this a successful venture for you and your organization.

This call is not for press. It's for stakeholders only. The encore recording of this call will be available about three or four hours after the completion of the call, until June the 17, at midnight. And the way you access it is you call 1-800-642-1687 and ask for call number 71725238.

If you have comments, after this call ends, you can always send them to an e-mail address here at CMS. It's advpayaco@cms.hhs.gov. That's advpayaco@cms.hhs.gov.

I would like to now turn the call over to Dr. Cohen. Mandy go ahead please.

Mandy Cohen: Great. Thanks Barb. And thank you to everyone who has joined the call today. Again, my name is Mandy Cohen. I'm the director of stakeholder engagement for the Innovation Center. And I'm glad you joined us today to help us shape one of the new initiatives in the Innovation Center, the advance payment initiative for ACOs entering the Medicare Shared Savings Program.

And we know that the path towards sustainability cannot be through cutting care or slimming down coverage. It has to be achieved through improving care. And we think ACOs is a perfect example about how we can get to a more sustainable healthcare system. The idea behind ACOs, as many of you know on the phone, is to encourage and support physicians, hospitals and other providers, to lower costs by providing better quality of care, and to reward them for successful by allowing them to share in the resulting savings.

Two months ago CMS published its initial proposal on how to implement ACOs through the Medicare Shared Savings Program. That public comment period closed last week. This call will not be focused on the Medicare Shared Savings Program and those initial regulations.

We will be focusing, however, on an initiative that the Innovation Center is considering to compliment the Medicare Shared Savings Program. And this program would be for those new ACOs entering the Medicare Shared Savings

Program, to test whether and how prepaying a portion of those future shared savings could increase participation in the Medicare Shared Savings Program.

So, as I said, we won't be taking comments on the Medicare Shared Savings Program today but we will want your comments on how an advance payment initiative may be shaped to compliment the Medicare Shared Savings Program. CMS is now going through the comments on the Medicare Shared Savings Program so we can modify and improve that proposal into the final rule going forward.

So the Innovation Center staff is here with me today. Sean Cavanaugh is here as well as others to listen to your comments and potentially ask any other questions.

Just to give you a little more background on the Advance Payment Initiative, CMS and the Innovation Center are committed to developing initiatives that meet the three part aim that Dr. Berwick has laid out for CMS, of better healthcare, better health and reduced cost of improvement.

And we know, like I said, one part of that effort is through accountable care organizations. But we also realize that organizations interested in becoming ACOs have different needs and have different levels of experience with coordinating care across settings.

The Advance Payment Initiative is in response to providers who have expressed concern about their lack of ready access to capital needed to invest in the infrastructure and staff for care coordination in transforming their organizations into accountable care organizations.

In response to that concern, of their lack of ready access to capital, the Innovation Center is considering, as I said, this Advance Payment Initiative for those ACOs entering the Medicare Shared Savings Program to test whether and how prepaying a portion of those future shared savings could increase participation in the Medicare Shared Savings Program.

And now we need your help to shape and design an affective program that would complement the Medicare Shared Savings Program. Some of the

potential parameters that we have put out for public comment include things like under the proposed initiative eligible organizations could receive an advance on their shared savings and could be expected to earn back advanced payment in monthly payments for each of their aligned Medicare beneficiaries.

Another potential provision: ACOs would need to provide a plan for how they would use those up front funds to build care coordination capabilities and investing their infrastructure. Lastly, those advance payments could – would potentially be recouped through the ACOs earned shared savings at the end of a performance period.

So those are the very high level parameters in which we've shaped this initial initiative, but really this is an opportunity for us to hear from you about if we were to move forward with this program of advanced payment, for those ACOs entering the Medicare Shared Savings Program, how should we develop that program, what are the parameters that we need to be considering, how should those payment structures work, and what other concerns and feedback might you have.

So we are mostly going to be in listening mode today, and looking forward to your comments. We may ask you to clarify, give us more detail or thoughts, but really this is going to be us listening.

If you aren't able to get your comment in on the call today, and you would like to submit it by e-mail, again Barb gave the e-mail address. It's advpayaco@cms.hhs.gov. And you can feel free to submit by e-mail up until June the 17, of this year.

And then if you have questions about any of our other initiatives that the Innovation Center is doing around accountable care organizations, we also recently released a Pioneer ACO model of which we answered many, many detailed questions on an open door forum last week.

You can go to our website and hear a recording and read a transcript from that open door forum on our website. The Innovation Center website is [www.innovations](http://www.innovations.cms.gov), with "s", [.cms.gov](http://www.innovations.cms.gov). That's [innovations.cms.gov](http://www.innovations.cms.gov).

And again you can read more about our Pioneer ACO model and get a transcript of the open door forum that answered questions about that program.

And lastly, one other (plug) for one of our other ACO programs, we are also offering free learning sessions for those new, emerging or established ACOs that want to learn more about the fundamentals of improved care coordination, and building some infrastructure for becoming a successful ACO.

Those sessions are free, and our first session is in Minneapolis next week, June 20 to 22. Again, you can visit the Innovation Center website to learn more. There will be recurring sessions that will be the same information given again in September, October and November. So if you're not able to join us in Minneapolis next week, look forward to those future sessions.

OK, without further ado, I'm going to turn the call over to you who are on the phone to give us some feedback and help us shape and design the Advance Payment Initiative for ACOs entering the Medicare Shared Savings Program.

So, operator, I turn it back over to you.

Operator: At this time I would like to remind everyone, if you would like to make a comment, you may do so by pressing star then the number one on your telephone keypad. We'll pause for a moment to compile the list of comments. And, as a reminder, it's pound if you would like to withdrawal your comment.

Again, as a reminder, if you would like to make a comment, please press star then one on your telephone keypad.

And your first comment comes from the line of Mary Jacobsen from Colorado Hand. Your line is open.

Mary Jacobsen: I think I pushed that by error.

Operator: Your next...

(Inaudible)

Operator: Your next comment comes from the line of (Rama Duchuru), from Silicon Software. Your line is open.

(Rama Duchuru): Hi. My name is (Rama Duchuru) with Silicon. Thank you for inviting me to participate in this comment. We are currently in the process of forming an ACO in the Tampa Bay.

Lately we are bringing in an (effort) (inaudible) with our (inaudible) to small primary care physicians, and given the proposed rules that are in place, waiting for comments to be finalized, we believe that still we are in a very unique position to deliver value, a complete quality (issue) model such as fee to our hospital as well as the (inaudible) but we lack in financial resources.

And if we are given access to a good amount of advanced payment we'd be able to deliver quality of care. And I am making a statement based on the feedback that we have been receiving from the physician members that we have been collaborating.

Sean Cavanaugh: Thank you for that comment. Can you give us some examples of what you could use the advanced payment for?

(Rama Duchuru): One of the things is probably to create a leadership team, in terms of bringing clinicians and company (inaudible) and also support on healthcare a lot, and more importantly bringing somebody with IT experience.

So we need to create management and leaders conception that would require compensation of (inaudible) over the time period before the (inaudible) kicks in. And also, we have been constantly talking to healthcare IT departments and we have made good progress in terms of presenting the concept. And we are confident that we are targeting (inaudible) a way that we can deliver the value.

And as it (inaudible) while we are pursuing proposals we would like to request some enlistment in the capital where (inaudible) to small participants, like us, we are not in a position to fund that kind of capital investment.

Sean Cavanaugh: Thank you very much for your comments.

Operator: Your next comment comes from the line of Donna Wildes from Mercy Medical Center. Your line is open.

Donna Wildes: Hi. I'm sorry, this isn't really a comment, and it's – I know it's not in regards to the advanced pay. It's more in the application. I have a question and I was just hoping you can direct me to where I'd need to go.

There are two things on the application. One is section five of the data use agreement, and it's asking for specific file names. And it says that if you – if there are no one that you can contact a CMS representative, but I'm not sure of where to go for that representative.

Mandy Cohen: Sure. Donna, if you don't mind, we have an e-mail inbox that's manned by some of the staff that's listening right now, if you want to send your question to pioneeraco@cms.hhs.gov, we can point you in the right direction with the application questions for the Pioneer ACO.

So it's pioneeraco@cms.hhs.gov and someone will get back to you today.

Donna Wildes: OK. So pioneeraco@cms.hhs.gov.

Mandy Cohen: Correct.

Donna Wildes: OK.

Mandy Cohen: Thanks.

Donna Wildes: All right, thank you.

Operator: Your next comment comes from the line of Dr. (Venetia) with the American Health Alliance. Your line is now open. Dr. (Venetia), your line is now open.

Howard Haft: So – yes, this is Dr. Howard Haft with Shah Associates. And the question is, in terms of prepayment, if that can be considered so that it's done on a per member per month basis based on the attributed patients, the advanced knowledge of the attributed patients, and then distributed in a lump sum in

advance at the beginning of each year to adequately capitalize the organization.

Mandy Cohen: Thanks for your comment. May I clarify what you were just saying right now? So you're – the idea was to base the scale of the payment on per member per month, but you would prefer it at – in one lump sum up front.

Howard Haft: Exactly, yes. So there's no – that a lot of the cost, or fixed cost, in establishing this kind of organization and be able to capitalize that at the onset would be a great advantage in terms of being able to put in place in advance the processes you would need to be able to take adequate care of the patient.

Mandy Cohen: Thank you.

Operator: Your next comment comes from the line of Jim Kane with the Central Maine Medical Center. Your line is now open.

Jim Kane: Well thank you very much. This is Jim Kane from Central Maine Medical Center. I had a similar comment or question regarding the monthly per member per month advanced payments.

Is there a minimum dollar amount on that per member per month, or a maximum dollar amount that CMS is comfortable with? The reason I ask this question is if there are say 5,000 enrollees in the shared savings model, a payment of a \$1 or \$2 per month is 10,000 a month, maybe 120,000 a year. That is not really enough money if you're going to invest in infrastructure – IT infrastructure or higher care managers to help manage that population. Thank you.

Mandy Cohen: Thanks Jim for that comment. And may I ask if you could follow up and say what is a dollar threshold that you think would satisfy your need to do that infrastructure investment?

Jim Kane: I would think something around 20 percent of the total spend for the enrollee would be appropriate.

Mandy Cohen: Thank you.

Operator: Your next comment comes from the line of Terri Goldman with the Home Health Depot. Your line is now open.

Terri Goldman: Thanks very much. We were wondering how is the benchmark set that the cost savings is calculated against. Is that on a per patient basis or does that – does that go – kind of based on more of a demographic basis? So is it tracking like one person you know from age 70 and then they turn 71 and you're looking at the difference in the – in the cost of care, or is it – is it more broad than that?

Sean Cavanaugh: I apologize. The purpose of this call is to talk about advanced payment. We will – I will tell you though in the next few weeks we will be posting the technical specifications, for those calculations you're asking about, on our website.

So I would stay tuned to our website at innovations.cms.gov.

Mandy Cohen: So to clarify, I think Sean is referring to specifications around the Pioneer ACO model. And I just wanted to make sure we're distinguishing between the Pioneer ACO model and then the Medicare Shared Savings Program, because the Advance Payment Initiative, that we're discussing today on the call, is how we could potentially link advanced payments to the Medicare Shared Savings Program and not the Pioneer ACO model.

Sean Cavanaugh: Thank you Mandy. And the specifications for the shared savings program are in the NPRM, the notice proposed rule making.

Operator: Again, if you would like to make a comment, you may do so by pressing star then one your touchtone telephone keypad. If you would like to withdrawal your comment, please press the pound key.

And your next comment comes from the line of (Dan Valley) with (Berrick) Solutions. Your line is open.

(Dan Valley): Thank you. My question relates to the IT infrastructure cost that potentially could be shared across both the MSSP model and with other commercial or Medicare advantage payers. Many of the infrastructure costs that we would

be incurring would be share across those. And I'm wondering if there's a principal or a philosophy as to how you would go about handling those types of situations.

Sean Cavanaugh: I think what we would like to do is know more about how you – the mechanism which you would share them – first of all, your estimate of what the costs necessary are and your ability to share them proportionately across payers, and how you propose to do that.

So, if through our e-mail address or on this call, or any other means, you can help us understand that better, we would appreciate it.

Operator: And your next comment comes from the line of Ivan Reyes from Florida Accountable Care Services. Your line is now open.

Ivan Reyes: The question is is there a possibility of an advance payment along with a monthly cap rate that you have determined from PMPM payments, and is there any thought on that?

Mandy Cohen: Thanks for the question. And think – just to repeat back, so the question is are we considering something where we do an advance payment where there's an upfront lump fee as well as an ongoing monthly payment. Is that the question?

(Inaudible)

Mandy Cohen: And I think for us, again, if you could be more specific about helping us understand what the funds would be used up front versus the ongoing monthly fee, and how those costs and the spend would look..

Ivan Reyes: So let me – let me interject here. First of all, on this advanced initiative, are we looking at 5,000 members or are we looking at the 15,000 member project?

Mandy Cohen: So we're looking at the 5,000 one in terms of the Medicare Shared Savings Program.

Ivan Reyes: All right, so based on the 5,000 what we're looking at are their hybrid model where a percentage of the shared savings – of the expected shared savings at the end would actually be probably like (inaudible) 20 percent. In addition to that, a six month PMPM, from their expenditures, which will go into IT infrastructure, which happens to be their high cost piece of the whole project for the clinical integration HI.

Mandy Cohen: OK, great. So to repeat back to – you're saying that the upfront cost would be for IT and then the ongoing monthly payment you would envision investing in...

Male: The infrastructure.

Ivan Reyes: The infrastructure. The clinical integration piece.

Mandy Cohen: OK. Thank you.

Operator: As a reminder, if you'd like to make a comment, please press star then one on your telephone keypad. And you have another comment from the line of (Rama Duchuru) from Silicon Software. Your line is open.

(Rama Duchuru): Thank you very much. This is (Rama Duchuru) with Silicon Software again. I would like to emphasize, with regard to the advanced payment two different issues where in if the (PP3 issue) is making an application, they should be given more emphasis and more monies as a part of advanced payment, given that the other issue was they are quite rich in terms of the financial resources in compared to relative terms such as hospital ACOs or specialty ACOs.

And in the last six to nine months we have been working on the numbers and we are in a good shape to make an application but – we are able to compete to deliver value but the specialist ACOs and the hospital ACOs, they're able to move forward because they already infrastructure in place. They are able to put the resources in placed, but there is where we are lacking in financial resources.

But we are able to assemble quite a number of primary care physicians. So given this research and the study we have been conducting we would like to

emphasis that (PP3 issue) has to be given more emphasis for the advanced payment. Thank you.

Sean Cavanaugh: Thank you. If there's any of that research in any of the findings or calculations that you've done, that you feel comfortable sharing with us, we'd be grateful to receive them.

(Rama Duchuru): Yes. Again, this is a (viable) discussion. I think this is well understood in the marketplace where there are five models that have start out in the proposed regulations, but you know if you do look at on the (inaudible) on the low (inaudible) (area) and (PP3 issue) it is primarily an effort of independent physician practices.

Certainly though it is very clear that you know we need more help, you know, to make it happen. And we are in a very unique position to deliver value and to meet the object of (inaudible) as opposed to operating models where they would be (inaudible) to deliver value at the same time they have an intention to maintain their volumes given their method of business.

Sean Cavanaugh: Thank you for your comments.

Operator: Your next comment comes from the line of Sharon Cheng with Strategic Healthcare. Your line is now open.

Sharon Cheng: Thank you very much. At the – at the top of the call one of the issues that you introduced was whether or not plans – ACOs would have to submit plans for how to use the funds. I think what you're – what you're pondering a little bit with that question is whether that would be a separate application for the advanced payment program in addition to the application for becoming an ACO.

And I would suggest – from my conversations with a number of organizations that are contemplating being an ACO, on the smaller end, they already see the application as being a fairly comprehensive and a bit of a list in terms of getting all that information together.

And in that – in that application they will be required to discuss how they will be patient centered, how they will promote evidence based medicine, their plans for using data from CMS internally and for external quality reporting.

In thinking about the application to become a Medicare Shared Savings Program ACO, I think a lot of the information you'd want about how those funds are going to be used will really already be covered in that original application.

So I guess I would suggest if you would like to increase the value of the incentive of the advanced payment ACO, the process for enrolling in it should be minimal, if not maybe even a deeming process; if you get through the ACO application process you could be deemed to have applied for the advanced payment ACO.

I think streamlining that part of the process will increase the effectiveness of the advanced payment program and enhancing the uptake for the Medicare shared savings ACO.

Mandy Cohen: Thanks Sharon. That's very helpful. And if you – not necessarily on this call – have further thoughts – or anyone on the call further thoughts on other barriers that might be keeping folks from participating in the program, particularly the Advance Payment Initiative piece, that would be very helpful to share so that we can do our best to streamline that process.

Sharon Cheng: Thanks so much.

Operator: And your next comment comes from the line of Terri Brown, Attorney. Your line is open.

Terri Brown: OK. Thank you for taking the comments. I represent a group of physicians in integrated practices in IPAs. And what we are struggling with is how ACO management will be funded both at the front end and on an ongoing basis.

And the second thing we're struggling with is funding of reinsurance or stop loss premiums as an element of risk barring. And obviously front end advanced payment of the cost of integrating the networks to meet your ACO

standards, utilization, case management and member care improvement costs, are capital barriers to the individual practices and to the physicians contemplating entering into an ACO arrangement. So that's how we would propose to use front end payment, or advance payment.

The second part of the question is whether you're contemplating paying administrative costs in this range of \$10 to \$20 per member per month as part of – or similar to a capitation model, and whether those costs are potentially front ended. Thank you.

Sean Cavanaugh: Just to be clear, for this program to go forward, the payments would not be specifically for specific costs. They would be advance payments of future shared savings. We would be interested in knowing – and the purpose of this call is to learn the things that organizations need to spend that money on in advance.

And you listed management, reinsurance premiums and care management upfront costs, which we appreciate. Can you tell me more about the administrative structure you think that the ACO needs that would need advance funding?

Terri Brown: Well the experience in Medicare advantage is that the care and feeding of the network generates and costs roughly \$10 to \$20 per member per month in administrative costs. And we're expecting to have that some burden.

It has to come from somewhere and if it doesn't come in the course of the run out, it has to be front ended as capital by the physicians. And I don't expect that that's going to happen.

Sean Cavanaugh: Thanks for that information.

Operator: Again, if you'd like to make a comment, please press star then one on your telephone keypad. And your next comment comes from the line of Kirsten Sloan with the National Partnership for Women and Families. Your line is now open.

Kirsten Sloan: Thank you. Hi Mandy and Sean. Thank you for holding this call. The original ACO reg for the Medicare Shared Savings Program did a very good job of identifying some specific patient center criteria.

And if we are going to move towards some advanced payment to attract some other entities into the ACO program, we would want to see that – make sure that a portion of that advanced funding is used to make sure that the care management element of an ACO is up and running as quickly as possible so that we can make sure that those eight patient center criteria, that we're identified in the reg, are really on the – on the agenda of an ACO as something they want to achieve as quickly as possible.

Mandy Cohen: Thanks Kirsten for those comments.

Operator: Again, if you'd like to ask – make a comment, please press star then one on your telephone keypad. We'll pause for a moment to see if there are any further comments.

Mandy Cohen: Operator, while folks are considering other comments they might have for us, if I might delineate a few of the questions that we think we're trying to answer here. Obviously we're thinking about the scope and scale of this program in terms of how we would think about the amount of money, the timing, what – obviously we'd focus a lot on what those funds would be spent on so that we can get a better sense of how much advance pay payment would be helpful for organizations going forward.

And I think that that's been very helpful for us if you also have a sense of in terms of which organizations, who might be in the Medicare Shared Savings Program, would you like to see benefit from this, how would – how would you hope that CMS would go about deciding who would be able to participate and who would not.

And some of those answers to those questions will be very helpful for our staff.

Operator: Your next comment comes from the line of Keith Pugliese from Brown and Toland Physicians. Your line is now open.

Keith Pugliese: Hi. Thank you. It's Keith Pugliese, Brown and Toland Physicians. So I just want to step back a second. You know first of all we applaud CMS for proposing an Advance Payment Initiative.

You know philosophically the hope is that we move the entire industry from a (single) serviced base for Medicare all govern programs commercial payers. And so the Advance Payment Initiative is a really great impedance for many organizations out there to focus on putting together systems and processes in place.

What I'm concerned about is the notion of potential recruitment that the advanced payment would be based on potential shared savings. If a new developing ACO were to receive advance payment but, let's say you know through their performance year, maybe they're not able to make all quality thresholds, and that could result in possibly having to have their advance payment recouped back to CMS.

You know that concern can either prevent an – a potential ACO from developing into an ACO or could have serious economic ramifications for that organization. So is it possible to consider advance payment based on the certain percentage of beat the service reimbursement and a prospective sense, in a PMPM?

So, for example, if it's a physician organization that's developing as an ACO, do a percentage PMPM based on part B forecasted expenditures, or if it's a hospital ACO that's developing, base it on a certain percentage PMPM on – go forward on a – on a hospital services.

But not tie it to shared savings, but just have that advance capital available to the organization so that they could start expending it on putting systems and structures together to support health – integrated delivery systems, health (I) teams and achieving clinical integration. Thank you.

Sean Cavanaugh: Thank you. Can I ask a follow up question, just so I understand your comment? Are you saying the advanced payment, if we do them, should not

be recovered under any circumstances, should be recovered only if there's earned shared savings...

Keith Pugliese: I'm putting under any circumstances, that if it's a percentage of what otherwise would be the overall fee for service reinvent – of reimbursement for services rendered, do it that way, give it – give new developing ACOs a chance at putting things together.

And it's a sort of proactive investment for ACO development in the nation but it – at the end of the day it shouldn't be higher dollars spent by the – by the government because it should all wash out if it's just a percentage of the base fee for service payment, is what I'm thinking about.

Sean Cavanaugh: Thank you for your comment.

Keith Pugliese: Thanks

Mandy Cohen: Thanks Keith.

Operator: Your next comment comes from Ken Lalime from Connecticut State Medical IPA. Your line is open.

Ken Lalime: Hi. This is Ken Lalime from the Connecticut State Medical Society IPA. Can you hear me?

Mandy Cohen: Go ahead Ken.

Ken Lalime: OK, great. I appreciate all the comments that have been made prior, especially the last one. I do think there's an opportunity here for some of the front end payment not to be returned. I think that's a very small portion that would probably be going to primary care physicians.

But the calculations that we've made estimate somewhere in the four to five percent range of the total spend. You break out into a couple of different areas. First is the ton of fixed expenses that we see, and we would probably need those funded probably six months ahead of the initial start date of a – of a program.

And those expenses would be for the defined medical director executive that is needed to be put in place, as well as some of these data analytics and the development thereof that would be needed to deliver the transfer of data into information back to the practices.

Half that, the other set of fixed expenses include the technology, things along the line of registries; what we're looking at here is a – that we're an IPA and they're independent practices, certainly not in the same technology infrastructure. And health information exchange in most communities is a bit far away at the moment of reality of actually sharing discreet data on a regular basis.

So we believe that those are some fixed costs, probably in a range of one percent. We see the admin ones as we're moving towards the total of about one and a half percent. And those are on – I'm using that estimate on a 10,000 life block of patients.

The variable – the largest variable cost that we see is in care coordination. We have estimated that we'll need about two care coordinators for every 1,000 to 1,500 members that are in that population. So we've estimated that cost to be somewhere in the one and a half to two percent range.

So those – adding all that up, we're talking about a four to five percent total amount. Again, a very small portion of that not being part of the potential recruitment. The one that concerns us though, as we speak with the physicians, that if this type of a model did go forward and there was recruitment regardless of actual creation of those savings, that the entity would end up potentially having to pay some of those infrastructure development costs that we didn't have. And that's again to the line of credit issues.

So we would – we would want to see a program that was actually helping to build the infrastructure and would be in place for a longer period of time. One worry that we have is a three year commitment right now that about starts turning some ROI based on some of these costs that we see going forward but that, after three years, we don't really know what that system's going to look

like and certainly the benchmarks will be changed at that point and additional shared savings might not be available to offset any upfront payments that might come forward.

So I know that the – a variety of things in there but I think we've somewhat defined fairly concretely some of the areas and expenses that we see needed to be fronted. Thank you.

Mandy Cohen: Thanks Ken. That was very helpful. And if there's any additional information and calculations that you wanted to share with us on paper and directly with our staff, again, feel free to e-mail us to the advpayaco@cms.hhs.gov. So, thanks again.

Ken Lalime: I'd be glad to do that.

Operator: Your next comment comes from the line of Elizabeth Baldwin with the MaineGeneral Health. Your line is open.

Elizabeth Baldwin: Thank you. Thanks for much for hosting this call. I agree – we, as an organization, agree with many of the comments that have already been made. And I would just add that one of the biggest concerns we have about the shared saving program is the length of time considering an advanced payment would be an investment, or a return on investment, may actually take longer than three years.

And the exclusion of organizations that don't meet the savings targets, within those three years, would continue to be a (prohibit) factor in some of those smaller organizations to make – engage in this even with an advanced payment model.

So I would urge you to consider extending the program length of time beyond three years to give an opportunity to actually achieve those savings.

Mandy Cohen: Thank you.

Operator: Your next comment comes from the line of (Jennifer Seedan) from (Bon Secours) Medical Group. Your line is open.

(Jennifer Seedan): Yes. Thank you for hosting this call today, as many have echoed. We – my prospective and comments are answering a couple of your questions about what types of organizations are interested in this and what are some of the major issues you're facing.

So the prior caller was from an ITA, and even those of us from large integrated delivery systems with multiple hospitals, home care, long term care and large medical groups within our portfolios, are still going to have substantial infrastructure costs around building out the care management structure that's needed, the documentation systems within the EMRs to communicate affectively and provide the seamless continuity of care, as well as the informatics infrastructure that will be needed to support the analytics needed to go at risk for some of these things.

So I just wanted to make sure that that was acknowledged, that even the larger organizations will still have those upfront costs as well, and also would like to see the longer horizons as far as the return on investments for those.

Mandy Cohen: Thanks (Jen).

(Jennifer Seeden): Thank you.

Operator: As a reminder, if you would like to make a comment, you may do so by pressing star then one on your telephone keypad. And press the pound key if you'd like to withdrawal your comment.

And your next comment comes from the line of Emma Dolan from Integrated – The Integrated Health Association. Your line is open.

Emma Dolan: Hi. This is Emma Dolan from the Integrated Healthcare Association in Oakland, California. We run a statewide pay for performance program for HMO providers. And we've been running this program since 2003, and data from the last several years of our program has indicated a correlation between socioeconomic status of an area and provider performance.

And we've noted that provider organizations that are located in lower SES geographies have poor performance outcomes than those in higher SES regions.

And these providers have indicated to us that, because they have high portions of Medicaid and uninsured patients, they're not able to obtain favorable commercial contract payment rates and, as a result, they receive lower overall compensation and have less capacity to invest in the things that they would need to start an ACO.

So our comments are specifically on who you would want to prioritize in a program, like the Advanced Payment Program, and we think that you would want to take into account, amongst other things, both the socioeconomic characteristics of the census tract in which an ACO operates and the care mix, specifically what percent of the ACOs patients are covered by Medicare and Medicaid.

Sean Cavanaugh: Thank you for those comments. Either now or later, if you have specific suggestions over what kind of pair mix you're talking about, or what characteristically the socioeconomic status, we'd appreciate hearing those.

Emma Dolan: Yes. We've prepared a letter that we'll e-mail to you later in the week.

Sean Cavanaugh: Thank you very much.

Operator: Your next comment comes from the line of Terri Brown, Attorney. Your line is open.

Terri Brown: Thank you. I wanted to focus a little bit on the element of recoupment, which I didn't get to in my earlier comment. If you're laying out funds as advanced payment, it's against the shared saving bonus.

And another element of our concern is how you're computing that bonus. As we understand the way things now stand, assigned patients from prior years are not necessarily the payments for the ACO performance in the target years. And variations and cost and savings can be distorted either positively or negatively, particularly down here in Houston.

And the question is whether a better way of comparison might not be to compare actual use of the beneficiaries, who were treated by the ACO physicians in a year, compared to the average Medicare costs in the same area. And use that as your benchmark should there be either a cost shared savings or in the element of recoupment. Thank you.

Mandy Cohen: Thanks Terri.

Operator: Again, if you'd like to make a comment, please press star then the number one on your telephone keypad. And you have another comment from the line of (Rama Duchuru) from Silicon Software. Your line is open.

(Rama Duchuru): Thank you very much. I did not get to this comment in my previous call. We have been studying Medicare Advantage because most of our primary care physicians in Tampa have been sort of using Medicare Advantage members in the last six to 10 years, and that program has been very successful.

And, given the Advanced Shared Savings Program in place, we believe that (inaudible) start acting as payers and, thereby, we would like to present to CMS, with regard to the cash flow coming in from CMS to Medicare Advantage plan, to (AP), to primary care physician, what if the money flow come in from CMS to the – directly to the ACO, to primary care physicians and at the high level the Medicare Advantage plan it might not be right, they are taking like 18 percent.

The idea is depending on the size of the (AP) and the location of the (APA), they are taking anywhere from three to 10 percent. So there is already a cost being incurred by CMS to an extent of, you know, 20 to 35 percent, and that money should be given in the (inaudible) payment to the PCP (inaudible) because the advantage program is the basis on which CMS should build advanced payment for shared savings programs.

And in the advantage program PCPs have been experiencing in service and their beneficiaries for several years, and that experience should be recognized and that experience should be placed in the ACO model that is being proposed.

So my comment here is basically why CMS has not part in the previous proposal or in the previous discussion in terms of enunciating this money, like 20 to 25 percent of the money with PCP led ACOs.

Sean Cavanaugh: Thank you for your comment. We will certainly consider what you said as we develop any possible programs.

Operator: Again, if you'd like to make a comment, please press star then one on your telephone keypad. We'll pause for a moment to see if there are any further comments.

And there appears to be no further comments. I'll turn it back over.

Mandy Cohen: Great. Thank you so much operator. And I just wanted to thank everyone again for joining us on the call today. For those of you who, after this, have other comment you'd like to submit to us, again, the e-mail address is advpayaco@cms.hhs.gov.

And you can find out more information about everything that this Innovation Center is up to in terms of all of its ACO programs and other work at innovations.cms.gov. Right on their homepage you can get information both about the accelerated development learning session in Minneapolis, that you can attend for free – actually you can attend as a webcast next Monday, Tuesday, Wednesday. On the website you can find more information if you want to make comments about the advanced payment, if you're interested in applying for our ACO pioneer model.

So, a lot of information there, and I hope you visit our website to get more information. Again, thank you for taking the time today. The comments were excellent and will really help us shape a better program going forward as we consider this initiative.

And again, if there are more comments, you have until June 17 to get them to us as we move forward.

So, thanks again and have a good rest of the day.

Operator: Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

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