

**Centers for Medicare & Medicaid Services**

**Moderator: Rhonda Hunter**  
**December 16, 2010**  
**12:00 p.m. CT**

Operator: Good afternoon. My name is (Sarah) and I will be your conference operator today. At this time, I would like to welcome everyone to the Healthcare System Delivery Reform Region for Atlanta Conference Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a comment session. If you wish to comment at that time, simply press star then the number one on your telephone keypad. And to withdraw your comment, please press the pound key.

I would now like to turn the call over to Mr. Renard Murray. Mr. Murray, you may begin your conference.

Renard Murray: Thank you very much, (Sarah). I appreciate your help. Good afternoon everyone. I would like to thank of you for attending today's call on Healthcare Delivery System Reforms and for taking time out of your very, very busy schedules to attend this listening session. As (Sarah) said, my name is Renard Murray and I am the regional administrator for the Centers for Medicare & Medicaid Services regional offices in Atlanta and in Dallas. I will be monitoring today's call. I would like to begin by introducing the guest speakers for today's call and to tell you a little bit about them at a later point. On the call with me today is Dr. Mandy Cohen, John Pilotte who is the Acting Director for Performance Payment Policy, Ms. Sharon Donovan who is Director of Division of Program Alignments, and our regional director for U.S. Department of Health and Human Services is here with me, Mr. Anton Gunn.

I am responsible for some affairs with the Centers for Medicare & Medicaid Services in the Atlanta and Dallas regional office. As the (CMS) spokesperson, I oversee the external affairs activities for the 13 states within those two regions. I want to say to you welcome consumers, welcome clinicians, employers, hospitals, health systems, state representatives, healthcare experts, and a number of other disciplines. You are all welcome and we're glad to have you here with us today.

All of us want the highest quality healthcare system possible. A system that coordinates and integrates care, eliminates waste, and encourages the prevention of illness. With new provisions in the Affordable Care Act, we have more opportunities than ever before to work with both public and private sectors to make real improvements in our nation's healthcare delivery systems. I'm sure that you can agree with me that our current healthcare system is broken. We pay a lot of money for a system that's fragmented. It is disorganized and fails to meet the many patients' needs. The problem is our healthcare system has been created by payments and delivery systems that reward care that's delivered by piece by piece not care that's delivered in a seamless, coordinated manner. We know that there are two things that patients want.

The patients want care that's high quality, timely, and efficient, and they don't want to pay more than they need to for this care. Patients also want to be treated like individuals. They want their doctors to take care of them in a successful manner and to account for the values in which that they have in their own treatment. As healthcare professionals, we want to care for those people. That's why we chose our careers in the first place. Everyday healthcare professionals work to provide the best care to their patients. We want to help others as well as to make sure that our system is operating functionally. But our healthcare system at present doesn't provide many patients with the care they should receive and doesn't support healthcare professionals in providing that care.

The purpose of today's listening session is to hear from you, from many of you, on how (CMS) can then undertake the important work of reforming this nation's healthcare delivery system going forward. The Affordable Care Act

has given CMS new opportunities to improve the care delivery and payment systems. Today, we will spotlight three of those areas of interest and those are the Accountable Care Organization Shared Savings Program, the CMS Innovation Center, and the Federal Coordinated Healthcare Office.

Again, I want to say thank you everyone for your participation, for being here today, and for the hard work that you'll be doing with us in the following weeks, months, and years ahead.

So as you've heard this is an enormous challenging and exciting opportunity for CMS but we cannot do it alone. We'll need your help to kind of move forward. Today, you will hear from three special guests from CMS in charge of those three different programs that I mentioned earlier, and they're all at different stages of development. So your comments are crucial to us at this point. As our stakeholders, we're excited to engage you in the processes. Dr. Mandy Cohen, Ms. Sharon Donovan, and Mr. John Pilotte will be introduced in a few minutes but they will be speaking today about the new Accountable Care Organization, the Shared Savings Program, the Centers for Medicare & Medicaid Innovation, and the Federal Coordinated Health Care Office.

If you're like me, the best ideas occur often after the opportunity has passed. We really don't want that happen to you today. So we have mailboxes for each of these areas where you can send your thoughts and ideas even after the call is done. And we will be reminding you of those at the end of the call but let me give them to you now just in case any of have to leave before we end the call. The innovation center's website is [www.innovations.cms.gov](http://www.innovations.cms.gov). Again, [www.innovations.cms.gov](http://www.innovations.cms.gov). At this time, you can sign up for e-mails and be part of a twitter alert and RSS news feed system that allows you to have the most up-to-date information. The Accountable Care Organization is [aco@cms.hhs.gov](mailto:aco@cms.hhs.gov). That will allow you to comment on the federal register. And then also the Federal Coordinated Healthcare office comments can be sent to [fchco@cms.hhs.gov](mailto:fchco@cms.hhs.gov).

And so during today's call, we'll be sharing information on those three important areas as mentioned and you will have a chance to share those ideas and give your thoughts and input on how we can shape this up. Your remarks

will be considered formal. Our official responses are remarks of records. CMS will be listening intently to kind of hear your comments. And as your facilitator, I along with Dr. (Rick Wild) who is the chief medical officer here may ask a question to clarify what your responses are or follow-up. But CMS will be in the listening mode today. So please your keep your remarks to about 2 minutes or less and we would like to give as many people as possible chance to share.

So with that in mind, I would like to now introduce our first speaker, Dr. Mandy Cohen. She is an internist and senior adviser for the Centers for Medicare & Medicaid Innovation in Washington D.C. Prior to joining CMS, Dr. Cohen served as the Executive Director of Doctors for America. It is a physician advocacy organization working to improve the healthcare systems to a reform. Dr. Cohen has also served as the Deputy Director of Comprehensive Women Health of the Department of Veterans Affairs in Washington D.C. where she led a major initiative to improve the delivery of primary care for women veterans. She also continues to see patients at the Washington D.C. VA Medical Center and received her medical degree from Yale University and Masters of Public Health from Harvard and trained in internal medicine at Mass General Hospital. So, Dr. Cohen.

Dr. Mandy Cohen: Thank you so much Renard and (Rick) and thank you to all of you who have joined the call today. I heard the weather in Atlanta is a bit icy, so I hope everyone is safe on the road getting home today. But thank you for taking the time on your busy schedule to hear a bit about what CMS is doing as a whole to address the problems we know exist in our delivery system. We know and Renard outlined them beautifully about, you know, unfortunately, we're working in a broken system but CMS is really trying to address this and we've been given a lot of tools with the Affordable Care Act, the new health reform law, to address these problems in our delivery system.

Under Dr. Berwick's leadership, we began to implement the new CMS vision which is to be a constructive force and a trustworthy partner for continuing improvement of health and healthcare for all Americans and that might be something new that you haven't heard from CMS in the past. And key to accomplishing that CMS vision is going to be to transform from our current

fragmented and high cost delivery system to one that delivers the most care which provides better health, better care for our patients at lower cost.

I want to tell you a little bit more where I work, which is the CMS Innovation Center. One of those tools in the toolbox at CMS that was established because of the Affordable Care Act. The Center for Innovation was created and charged with identifying and testing new pair and payment models to improve the health and reduce cost in the system. We are just beginning our process here at the Innovation Center in setting up how we're going to go about living up to that charge given to us by the statute. We're ultimately looking to partner with all of you to take the great ideas that we know are out there and learn from them and ultimately scale new care and payment models that improve and sustain the Medicare and Medicaid programs for all of our beneficiaries and ultimately change the health system at large and that's going to mean improving care and reducing cost from millions of patients seen most in communities.

I want to tell you a little bit about why the Innovation Center is unique and different from what CMS has been able to do before. First, it was given funding to be able to do some of this work. It was given \$10 billion over the next ten years to do this work of identifying and testing new payment and care delivery models. Secondly, it was given some new flexibility and removing some regulatory barriers that let us do our work quicker and faster as we go forward and trying new and bolder things that we haven't been able to try here at CMS before. And then lastly, the center has the ability to say if we find a model that both reduces cost and improve quality that we're able to take that model and actually change the policy of CMS without needing to go back and actually get congressional approval for that change. So the Secretary can change CMS policy directly and that's a new flexibility that has never been afforded to CMS, and I think that tells you that, you know, Congress has wanted the CMS to have the ability to learn and to really make improvements as quickly as possible.

As approach our work we want to be very transparent and really want to collaborate at all points, which is why we kicked off our work with these calls. We have a lot of these sessions. With this call we nearly complete either one

of these calls or a session in person in nearly every region in the country and we heard amazing ideas and look forward to even more from you today. So we are stating our work by just listening, to hearing your thoughts on how we should go about our work, what are the ideas that we should highlight and focus on. Second, we are also just building the Center. My boss, Dr. Richard Gilfillan, is the acting director of the center. He came to us from Geisinger Health Plan. We just hired Jim Hester, who came from Vermont who was leading the large reform effort up there, so great folks who are bringing their passion and energy to CMS to really try to make a new change.

And then lastly, we are actually starting our work, all of CMS is, with a few specific pilot projects that I just wanted to highlight for you today. The first one is a multipayer medical home demonstration project. This is a demonstration project where CMS as a payer for care joined with already existing medical home pilots in eight states. The states are Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota, and we're joining to those payers to provide improved primary care to 1 million Medicare beneficiary lives with improvement in the coordination, the quality, all at reduced cost for those in that pilot. Secondly, we're working with our partners at Medicaid to release the Medicaid Health Home State Plan Option.

This is also created by the Affordable Care Act. And it provides funding for states up to 90 percent federal funding for those states that use the Medicaid Health Home pilot program, so opportunities for states to take the lead in providing more coordinated care for their Medicaid beneficiaries. Third, the Center for Innovation is moving forward with the medical home demonstration project in federally qualified health centers. So for those of you who worked in FQHCs or had patients that were seen there, there is going to be a new medical home pilot in those settings and it is hopefully going to touch 500 federally qualified health centers which are going to support about 200,000 patients.

And then lastly, Cheryl will talk a little bit more about this but the Center is also supporting a new demonstration for those who are both dually eligible for

Medicare and Medicaid making sure that their care is better integrated and coordinated.

So, we've opened our doors. We're listening for new and great ideas and looking forward to your comments. We started our work and look forward to your partnership in the future. We can't do this alone. CMS can't do it alone. And again, we need your energy and passion and your ideas going forward. We look forward to hearing those in the call today and in the future. So thank you very much.

Renard Murray: Thank you Dr. Cohen. Those were some great comments and we appreciate your leadership and guidance with the new Centers for Medicare & Medicaid Innovation and we look forward to the comments from our audience here.

Next, we're going to hear from Ms. Sharon Donovan. Ms. Donovan has served as the Director of the Division of Program Alignment in CMS Federal Coordinated Healthcare Office since October 2010. Prior to that, she served for six years in CMS Medicare Enrollment and Appeals Group with a focus on low-income beneficiaries, access to enrollment in the Medicare Part D Prescription Drug Benefit. From 2001 to 2004, she worked in the Centers for Medicaid State Operations and the Medicaid Managed Care Waivers and Demonstration area. Sharon started her career with CMS at the Seattle Regional Office in 1998. From 1990 to 1998, she worked for Montana Medicaid developing and implementing managed care plans and programs. Sharon has a wealth of experience. Welcome Sharon.

Sharon Donovan: Thank you so much Renard and thank you everyone for taking the time to join us to hear about the exciting new efforts of CMS.

I am going to talk specifically about the Federal Coordinated Health Care Office which is created under the Affordable Care Act specifically Section 2602. Our job is to make the care experience better for beneficiaries who are eligible for both Medicare and Medicaid. In large part, that depends on improving the relationship between states and federal government as the key partners in delivering and providing care for this population. We are working towards a more coordinated care system and there is no better opportunity to

do this since these are individuals who are dually eligible. Over 95 percent of dual eligibles are in the fragmented fee for service system and we spent upwards of \$300 billion combined annually on their care. Especially for this population, this is the time for delivery system and payment reform.

We've established our office and we're up and running, and currently our office is focusing on two areas. The first is program alignment. In that area, we're identifying every place in which the Medicaid and Medicare programs bump up against each other. These included administrative, regulatory and statutory misalignments. We're coming up with literally a list and the list is populated with anything and everything where these two programs worked at odds as beneficiary having a seamless experience of care. We've been prioritizing that list and turning it around and making it very public. It will be a transparent, living document that will be shared continuously with stakeholders so we can continue to add to it and to improve it. We encourage you to submit any ideas through our e-mail box mentioned at the beginning of the call and that we'll repeat again at the end of the call. We've developed a list of lots of input so far from external and internal stakeholders and we look forward to continuing to perfect this.

The second area that we're working on is the area of demonstrations including those mentioned by Mandy just a minute ago. This involved testing and innovating new delivery systems and payment models for dual eligibles. These are models that have fully integrated Medicare and Medicaid services that these recipients are eligible to receive, so this means acute care services, primary care services, long-term care and support and services, behavioral health benefits. It is very important that there is an integration of all the services in a single point of delivery.

We'll be working first with states in the demonstration area. We announced a few weeks ago that we'd be making design contracts available and in fact last Friday, December 10, we released the solicitation for states to apply for planning contracts. And we're partnering with the Innovation Center to further explore and enhance other opportunities to the integration of care, services, and financing for dually eligible as well. And we really encourage you

to make sure we have all of your input and feedback and look forward to hearing from everyone on the rest of the call.

With that Renard, I'll give it back to you.

Renard Murray: Thank you so much. I appreciate your comments and your leadership in that area as well. Our next special guest is John Pilotte. John Pilotte is the Acting Director of the Performance Payment Policy Staff in the Centers for Medicare at the Centers for Medicare and Medicaid Services. John manages the staff responsible for designing and implementing Medicare value base purchasing programs including the Medicare Shared Savings program and the (Physicians) Value-Based Payment Modifier.

John oversees the development of value-based purchasing plans for Ambulatory Surgical Centers, skilled nursing facilities, and home health agencies. Prior to joining CMS, John was the Director of the Division of Payment Policy Demonstration in the Office of Research Development and Information and he was also the Senior Consultant with Price Waterhouse Coopers Healthcare Practice and an associate of the government relation staff of the National Association of Children's Hospitals and Related Institution. John holds a Masters in Health Policy and Management from John Hopkins University and a Bachelor of Science from Indiana University. Welcome John.

John Pilotte: Thank you and thank you all for taking the time out of your day to participate in this open-door forum. We look forward to your thoughts.

I would like to share with you today Dr. Berwick's vision for the Accountable Care Organization, provide a brief overview of the Medicare Shared Savings program, and post several questions for you to consider providing comment today and through our ACO mailbox at [aco@cms.hhs.gov](mailto:aco@cms.hhs.gov). Recently, Dr. Berwick described Accountable Care Organization as a new approach to delivering care that reduces fragmented unnecessary care and excessive cost growth for Medicare fee for service beneficiaries by promoting population health management, coordination of Part A and B services and encouraging provider investment and infrastructure and redesign care processes.

ACO will promote the delivery of seamless, coordinated care that promotes better health, a better patient experience, and lower cost growth by putting the beneficiary and family at the center of care, remembering patients over time and place, attending carefully to hand off in care as patient transition along the continuum of care, proactively preventing illnesses and promoting population health especially for chronically-ill beneficiaries and other at-risk populations, tracking and reporting outcomes and giving timely feedback to providers, innovating and improving approaches to achieving better health, better care, and lower growth in expenditures for its patient population, and continually investing in team-based care and its provider work force.

As called for in the Affordable Care Act, existing and newly formed organizations are eligible to apply to participate in the Medicare Shared Savings program including group practice arrangements, physician networks, joint ventures, and partnerships of hospitals and ACO professionals which are defined as physicians and practitioners, and hospital employing ACO professionals. The secretary may also include other providers and suppliers of services at her discretion.

Under the Medicare Shared Savings program, an ACO will accept responsibility for an aligned patient population and put procedures and processes in place to promote evidence based medicines to put on quality and cost measures, coordinate care, and be patient centered. Furthermore, the ACO must have sufficient provider capacity to provide primary care services for at least 5000 aligned patients. The aligned patient population is the basis for establishing and updating the financial benchmark affecting quality and financial performance and the focus of ACOs efforts to improve care or reduce growth in Medicare spending. ACO providers continue to be paid under regular Medicare fee for service payment systems and are eligible for Shares Savings if they meet the quality of performance standards and they're spending for their overall total Medicare spending for their aligned patient population is below the ACOs specific updated benchmark. ACOs will be responsible for reporting quality measures including clinical care processes and outcome measures, patient and caregiver experience of care, and will be responsible for outcome measures such as ambulatory care sensitive condition admissions or admissions around the ambulatory care sensitive conditions.

We welcome your thoughts and comments today on the above as well as the following questions that we recently announced and request for information and while the formal comment period is close, we would be interested in your thoughts and comments today and we encourage you to submit those to the mailbox as I mentioned previously as well if you have thoughts on these after the call.

The first question relates to how should beneficiary communications about ACO be handled and why it should be communicated to Medicare beneficiaries about the Medicare Served Savings Program and their providers who may be participating in Accountable Care Organization.

The second question is what policies or standards should we consider adopting to ensure the group (inaudible) small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models being tested by and planned by our colleagues in the Innovation Center?

The third question is what payment model, financing mechanisms, or other systems we might consider either for the Shared Savings programs or as models under the Innovation Center to address access to capital issues for small practices. In addition to payments models, what other mechanisms could be created to provide access to capital especially for small practices and similar practice physicians?

The process of aligning beneficiaries I mentioned earlier is important to ensure that expenditures as well as any savings achieved by the ACO are appropriately calculated and the quality performance is accurately measured. Some argued that it is necessary to attribute beneficiaries before the start of the performance period so the ACO can target care coordination strategies to those beneficiaries who is costing quality information will be used to assess the ACOs performance. Others argues the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are aligned to based upon the services they receive from the ACO providers during the performance period. Our question

relates to how should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings program and the ACO models tested by the Center for Innovation.

The next question is how should we assess beneficiary and caregiver experience of care as part of our overall assessment of ACO performance. I would point out that this is an area that's also specifically mentioned in statute as well?

The next question is what aspect of the patient's (inaudible) are particularly important for us to consider for the Shared Savings program and the ACO should meet in order to be eligible from the program and how should we evaluate them.

The next question relates to what quality measures should the secretary use to determine performance in the Shared Savings program?

And finally, what additional payment models should CMS consider either under the (authority) provided for partial capitation and alternative models under the Medicare Shared Savings program authorizing statute or the authority under the Center for Innovation and particularly what are the relative advantages and disadvantages of any such alternative payment models.

Thank you again for participating. This is rather a lengthy list of questions but again we look forward to your thoughts and comments on these today as well as any thoughts and comments you may have after the call. I encourage you to submit them to our ACO mailbox. Thank you again.

Renard Murray: Thank you very much John. We appreciate your comments. And also Mandy and Sharon, thank you so very much for such a detailed explanation and overview about the areas that you're responsible for as well. So now, we're going to move in to the time when CMS will listen to the deep thoughts and ideas from all of you (inaudible) that based on the comments that you heard from John, Sharon, and Mandy. You got some things that you want to share with us.

So let me remind you once again of the format as I know many of you were possibly joining the call as we're in the midst of it. So today is your chance to share with us ideas and give your thoughts and inputs and your remarks as I mentioned earlier will not going to be considered formal or our official responses on. (Inaudible) remarks on record but we will be in the listening mode to kind of understand what you're recommending to us. As a facilitator, I may ask the qualifying question or Dr. (Wild) may ask a clarifying question or follow-up, but CMS is in the road (inaudible) listening to you.

I asked if you could please keep your comments and remarks to not more than 2 minutes because we would like to give as many people if possible an opportunity to provide the chance to share their information. And I will also add one additional thing that when you speak please let us know your name, your affiliation, and the area which your comments are directing for instance, the Accountable Care Organization, the Innovation Center, or the Coordinated Health Care Office.

So with that in mind, (Sarah), I am going to open it up for comments if you would please.

Operator: If you wish to make a comment at this time, please press Star then the number one on your telephone keypad.

We will pause for just a moment to compile the comments roster.

And your first question or comment comes from the line of (Alyson Silvers) from Village Care. Your line is open.

(Alyson Silvers): Hi. I have two questions if can fit it in. The first is for the Innovation Center. Would you welcome even small scale ideas or are you looking for things that would have enough of a scale that it can be fully replicated. And my second question is just a quick one for the ACO role out. Is there a way to perhaps to more formally create a role for long-term care in aging service providers?

Dr. Mandy Cohen: Thanks (Alyson). This is Mandy from – I hear a lot of background noise. Thank you so much for the question and I wanted to say first we welcome small-scale ideas and we definitely do. We know that we are looking to learn

lessons in all different aspects of care and we didn't go into the details of how we're structuring but we know that there are many innovations on the small scale to learn from and we're looking for those as well as the big payment change projects that we're also thinking about. So, thank you.

John Pilotte: And this is John. I would just add on your question about ACO. We would just add that the statute that I have talked about with the ACO would be accountable for the total Medicare expenditures for the (aligned) patient populations though specifically total Part A and Part B on Medicare expenditures for those patients that are aligned to it and really regardless of what are those services that are provided within or outside the organization. So to the extent that patients aligned, the organization is utilizing long-term services that are covered under Medicare but particularly the services that might be provided in the skilled nursing facility or nursing homes for Part B services. You know, those would encapsulate the Medicare portion of those services for those institutions and those patients.

Renard Murray: (Alyson), thank you so much for your question and John and Mandy for the explanation in terms of what the question is centered around. (Sarah), with that in mind, we'll take the next question please.

Operator: Your next question or comment comes from the line of (Nicole Bulbo) from the National Association of School Nurses. Your line is open.

(Nicole Bulbo): Thank you very much for taking my comment. I guess this goes towards the Innovation Center. We just put out the plea to consider recognizing the hidden healthcare system that's happening in our schools. The number of children that are having multiple chronic diseases managed as well as health promotion activities that are going on and the reimbursement is literally nonexistent.

Dr. Mandy Cohen: Thanks Nicole. This is Mandy Cohen. I very much appreciate you bring up the point and you know we are looking for the innovative and different care settings in which people are already getting their care. So thank you for bringing that to our attention. I will bring that back to the rest of the team.

Renard Murray: Thanks Nicole. That was a great comment. (Sarah), next comment please.

Operator: Your next comment comes from the line of (Rebecca Miller) from the University of Kansas Medical Center. Your line is open.

(Rebecca Miller): Hi. I was wondering has CMS, has any program of the CMS addressing assessing duplicate testing payments (inaudible) such as what CMS did with (inaudible) and has any data been collected to address this issue?

John Pilotte: I'm sorry. I didn't hear the first part of the question. It is kind of (inaudible) now.

(Rebecca Miller): Has any CMS program addressed assessing duplicate testing payments of the (inaudible) such as what CMS does with the (inaudible) and has any data been collected to address this issue?

Renard Murray: In duplicate testing that surround our B services or ...

(Rebecca Miller): Well, just any duplicate testing such as, you know, when someone comes into say a small town hospital or rural hospital and they have a CAT scan done and I'm thinking just simply objective testing, blood test, and then they go to a large hospital because they have to get transferred there and they do the exact same test even they knew and even on the same day or even with something even more costly such as heart catheterization.

Dr. (Rick Wild): Rebecca, this is Dr. (Rick Wild) and I am the Regional Chief Medical Officer and many of our initiatives are going to be addressing that very issue. One of them in particular of course is our electronic health records incentive initiative through coordination of information and transmission of information. We hope very much to reduce the need to perform unnecessary test or duplicate test because there is lack of data. And certainly, the EHR incentive program that we're rolling out for hospitals and physicians should go along way. And then of course I'm sure John would mention that the Accountable Care Organization as well would address that. That's an issue really that's addressed by almost all of our programs to achieve better care and more efficient care.

Renard Murray: And so (Rebecca), you were asking possibly that we include in the comments that we consider that as we're looking at the Federal Coordinated Health Care Office and the things that we're doing, is that correct?

(Rebecca Miller): Correct.

Renard Murray: OK. Wonderful. We thank you so much. That's great comment. We appreciate it.

(Rebecca Miller): Absolutely.

Renard Murray: Thanks for joining the call today. (Sarah), next call and the comment please.

Operator: Your next question or comment comes from the line of (Michael Latin) from (Chance Healthcare). Your line is open.

(Michael Latin): Thank you very much. And (inaudible) I am driving in the middle of somewhere in Florida. My question is about ACO and Innovation Center. Were they spending a thought about doing combined projects between the ACO development and the potential Innovation Centers with respect to payment to physicians and trying to shift the (per dimes) who pay more for primary care versus the procedural specialty care.

John Pilotte: Yes. I would say – this is John. I will let Mandy jump in as well around some of the medical (inaudible) and I just want to comment on but I mean we work very close with our colleagues in the Innovation Center. There are a lot of opportunities to align things (quickly) as we look at, you know, now only standing up the Medicare Shared Savings program but testing those of alternative payment models such as partial capitation and other risk oriented models under statute. So the answer is yes and we will continue to do that as we roll our and develop both programs and initiatives.

Dr. Many Cohen: This is Mandy from the Innovation Center side. we definitely are looking at other types of payment models and structures of care settings in order to do just that to make sure that we're finding the things that work that save us money and improve quality and so we know an investment in primary care is going to be part of that equation and learning what are the right pieces that we

need to be investing in that actually reduce cost for this (inaudible) improved quality for everyone. And then again to echo what John said about our teams working in tandem and coordinating on efforts, so learning lesson as they develop their programs that are going to be translated for the Innovation Center and making sure our work is complementary.

(Michael Latin): OK. Can I ask a follow-up question?

Renard Murray: Yes sir, please.

(Michael Latin): How do you envision the ACOs working either in collaboration with or maybe in competing against Medicare advantage firms?

John Pilotte: Well, I would – the Medicare Shared Savings program is a fee for service program. So it is focusing on Medicare beneficiaries that are in the fee for service program now and providers have the opportunities to come or join Accountable Care Organization that will better coordinate care. And if they're successful in improving the quality and overall efficiency of care, they're eligible for Shared Savings. So you know, I look at it and it is really sort of an outgrowth of Medicare fee for service and you know the Medicare advantage program is a fully capitated program and where beneficiaries elect to enroll in those plans and so forth. So I think it is another for the complimentary program that surrounds out the sort of Medicare Part A and Part B program.

(Michael Latin): Very good. Thank you very much.

Renard Murray: OK. Michael, thank you for your question and thanks for joining us as you drive to Florida there. (Sarah), next comment please.

Operator: Again, if you would like to ask a question or make a comment, please press star and then the number one on your telephone keypad.

And your next comment comes from the line of (Marty Lucia) from Miami-Dade Country Wide Planning. Your line is open.

Renard Murray: (Marty), are you there?

Operator: (Marty Lucia), your line is open.

Renard Murray: We're not getting him (Sarah). If you can just move to the next comment please.

Operator: There are no further questions or comments. Thank you.

Renard Murray: OK. At this point, then we're going to take a shift and move over to Mr. Anton Gunn who is here with us. He is our Regional Director for the Department of Health and Human Services. And Anton is going to provide us with some remarks and then we'll come back and just check one more time to see if there are any additional comments before we close the call. So Anton, thanks for joining us.

Anton Gunn: Thank you very much, Renard. Thank you for having me here and thank you for the opportunity. This is actually the highlight of my day to participate in this call to really hear what we can do to keep moving in a positive direction in terms of lowering cost in healthcare and improving quality. I think that's what we all are here to do, and we can't do it alone individually. It is going to take more than just CMS trying to do this but it is going to take many of the folks that we heard on the phone helping us and working together so we all can move in the right direction on that.

I am also very appreciative of a guest that we have on the line, our leaders in HHS, for helping us with this whole process. Dr. Cohen, we thank you so very much. Sharon Donovan, we thank you. And John Pilotte, we thank you so, so much for what you bring to the table and your commitment to all being focused on this task of how do we reform our delivery system and make it better for the people that we all serve.

I would love to see if there are any more comments on the line because otherwise I want to really give people the opportunity that if you have friends, neighbors, colleagues that you work with around the country and around the region who could not be with us on the call but still would like to ask questions and provide comments to us, we want to offer you that opportunity to continue to provide those comments and questions. Again, I want to repeat the e-mail address that you heard earlier from John and that's

aco@cms.hhs.gov. It is where you can submit your comments and information to us as well as another e-mail address, fchco@cms.hhs.gov. I will repeat those again for anybody that's still listening aco@cms.hhs.gov and fchco@cms.hhs.gov. And of course, you can always visit the Innovation Centers website which is www.innovations.cms.gov. These are all opportunities for you to continue to give us comments and input on the direction that we go and we're all excited about the direction that we're going in and of course we want to go there with the constituents and people that we work with in healthcare every single day.

So with that, I am going to hold the line now and turn it back over to Renard to see if there are any other comments for us on this call.

Renard Murray: Thank you very much Anton for joining us today and we appreciate the leadership that you provide to the Department of Health and Human Services.

(Sarah), are there any other comments that are in queue?

Operator: You have a comment from (Greg Masters) from Preferred House Ventures. Your line is open.

(Greg Masters): Thank you so much for this (inaudible) to be open to public input. My question is do you envision eligibility for alternative practice models like that's called direct practice membership model, primary care, perhaps some (quarters) concierge medicine, being eligible for ACO consideration?

John Pilotte: Yes. Thanks for the question. I think the fact that you talked about (inaudible) for providers based organizations that are eligible for the program specifically group practice arrangements, physician networks, hospital employing ACO professionals, in this case physicians and practitioners, and joint ventures and partnerships of hospitals and ACO professional. So I would look toward that in our Noticed for Proposed Rule Making which should be out in the latter half of January for guidance on eligible organizations and eligibility requirement for the program. But it is sort of based in sort of the existing towards the Medicare Part A and Part B providers to participate in the program. Thank you.

Renard Murray: Greg, thank you so much for those comments and that question. That was some really great remark that you made. (Sarah), at this point, do we have any other comments?

Operator: Your next question or comment comes from the line of (Catherine Montoya) from the Leadership Conference on Civil and Human Rights. Your line is open.

(Catherine Montoya): Great. Hi. Thanks for having this call. It is very helpful for us down in the South to be able to hear from CMS about the next step coming down the pipe in the course of the next year. I just wanted to add a couple of comments. One is that we're hopeful that consumers and patients be at the table and be involved in all the aspects of the (inaudible) to inform, the design, the implementation, and the assessment. I think that getting consumers engaged earlier in the process and throughout the process helps with the roll out and kind of reduces any type of backlash that might occur further down the road.

We're hopeful that any new models that kind of target and serve the highest risk and highest (cost) population first and I think it includes making sure that there is (inaudible) coordination and that everything is done in a team approach for consumers. And then I think the last thing that we're hopeful is that there'll be little accountability built into the new models so that we can ensure that there is real quality improvement in patient protection with these new models of care. I think that it is easier than other new models.

It should be accountable for both quality and cost and there should be good performance measures and meaningful performance threshold both for individual and kind about the group system level. So those are my comments. Thanks.

Renard Murray: Catherine, thanks for those comments. And it kind of build on what John had mentioned earlier about how we would engage consumers. Could you expound a little bit more in terms of what you think that might look like if you were to kind of have it in a perfect world?

(Catherine Montoya): In terms of the accountability or the bringing consumers to the table?

Renard Murray: In terms of bringing consumers to the table.

(Catherine Montoya): OK. I think there are a few things. I think that we should encourage strong patient protection that include kind of transparency category I would say, you know, the beneficiary should be notified when they have been attributed to an ECO and be made aware that their provider may have new financial incentives to limit their care and that I think is important to more beneficiaries, you know, on the front end rather than on the back end.

I think in terms of network adequacy, making sure that ACOs have a network of healthcare providers that meet the needs of enrolled patients including kind of high risk, high cost population. And then I think that appeal process is nearly critical and including making sure the patients have access to not just an internal appeal process but an external appeal process.

And hopefully, you know, what would be great is that if consumers and (inaudible) were a part of those free buckets of work during the design of them where at least an opportunity to comment on them (inaudible) when it is not necessarily super formal but rather an opportunity to have real dialogue with CMS on a process or an idea as it relates to help transcend the network adequacy before it kind of get – I feel like once we get to the rule making state, it is extremely formal and you'll lose the ability to have a really honest and candid dialogue about what might be best for consumers and patients.

Renard Murray: Thank you for that clarification. I know you have some (nuggets) hidden in that comment that you have made also. We appreciate it. Thank you so much for the remarks.

(Catherine Montoya): Thanks.

John Pilotte: I would just add actually one thing if I could is that in the (inaudible) talk about that in the quality of performance standards must be met before the ACO would be eligible for any Shared Savings so that quality is very prominent there. As I mentioned earlier, it does mention a number of areas but it also indicates that, you know, the secretary should look to continually improve and set improved performance under the (inaudible) as well. So it is

not static overtime but I appreciate those comments and specific suggestions around that as well. Thank you.

Dr. Mandy Cohen: This is Mandy Cohen again from the Innovation Center side. Thanks Catherine for bringing up those points and we certainly as we move forward are embedding in our processes to make sure that consumers are at the table from the beginning. You know, when we think about where we started all of our comments which is a place that we know we are looking to – we know that the system is being financially unsustainable as it is now. We are looking to, you know, reduce cost and that was troubled by your comment and saying that by reducing cost we're going to limit the care that patients are going to have access to.

But what we really saying is not that they're getting limited in any way but we are removing some of the waste that's in the system already and making sure that we are coordinated in actually improving quality while we're reducing cost. So I want to make sure that we are building systems that very much protect patients and consumers as we do it and we're going to need your help to make sure we we're able to do that in the best way possible. So thank you.

(Catherine Montoya): Am I still live?

Renard Murray: Yes. You are.

(Catherine Montoya): Oh OK. I really appreciate those comments and I think to that point I think and we all know perception is often times different than intention and so I think just related to your last point that if there are ways to get this information out in front of consumer advocates, the groups, and other patient protection organization that would be able to kind of dispel some of those (inaudible) to arrive throughout this process, I think that through our wide advantage. So just to put that on the table as well.

Dr. Mandy Cohen: Thank you so much and we will call upon you and we hope to help us in that process. Thank you.

Renard Murray: Thank you so much Catherine. (Sarah), next comment please.

Operator: Your next comment comes from the line of (Gerry Wheeler) from Tennessee. Your line is open.

(Gerry Wheeler): Thank you for having me on this call today. I'm just a case worker and I have enjoyed everything that has been said today. Usually, I don't have very many problems unless patients that are not aware of how they might appeal their Medicare claims and whatever but I think it is beneficial – I have taken some notes so I think this will help in my case especially in the first of the year.

Renard Murray: Thank you so much for being on the call (Gerry) and for all the work that you do with case work. We really appreciate you.

(Gerry Wheeler): All right.

Renard Murray: (Sarah), next comment please.

Operator: Your next comment comes from the line of (Catherine Reese) from the Florida Coalition for School-based Healthcare. Your line is open.

(Catherine Reese): We are interested in know what steps have been taken to include school-based health centers as essential community providers in the health benefit exchange Section 1311 C1C requires the secretary to include providers that serve predominantly low-income medically underserved individuals and the centers are key piece of the healthcare safety net for nearly 2 million people. We're interested in knowing how school-based health centers will be included in that definition. So many of our students do not get any other healthcare other than what they received in the school-based health centers.

Renard Murray: Catherine, thank you for those comments and the reference as well that kind of show where are you coming from with that, and we appreciate that and we're definitely make sure that we got that part of it included in the process. John, Mandy, any comments on that?

Dr. Mandy Cohen: Just to thank you from us. We're definitely going to take that back to the rest of the team and Nicole's earlier comment about school nurses and the type. Thank you very much.

Renard Murray: Catherine, thank you for joining us. (Sarah), other comments?

Operator: And your next comment comes from the line of (Marty Lucia) from the Miami-Dade County Wide Planning. Your line is open.

(Janet Perkins): Hello. This is (Janet Perkins) from the office of County Wide Healthcare Planning. Our team is involved with an innovative model utilizing local Medicaid funds to enable (adult) above 133 but below 250 percent of poverty to purchase low-cost but comprehensive market-based insurance. The reason I am bring this up and we have presented to the Center on Innovations is to encourage you as you provide incentive funds for new models before the healthcare reform goes into full operations in 2014 to look at other ways you can bring people using Medicaid funds into a covered status. We encourage you to not only follow what we're doing and learn from our experiences but should you be interested in expanding on these kinds of models consider providing incentives to create this kind of pilot initiative.

Renard Murray: That's a great comment Janet. We'd definitely take that into advisement. Is any resource that you have that's already in process that you are doing down in Florida that you could provide to us that would kind of give us some information about that?

(Janet Perkins): We would be delighted to provide you the presentation and our initial findings. Our premium assistance program has been in effect now for about three months. We went live in September 11 using funds that are part of the state's Medicaid waiver, the section that enables funding of pilot initiatives for premium assistance. We are the only program in the state using a licensed insurance product and we very closely (inaudible) actually we did it before. The information was out on the exchanges. We very much closely paralleled the population that the exchanges will provide premium assistance for. So we are most delighted to share that information with what could be a learning laboratory as Medicaid looks at ways to maximize the resources under healthcare reform.

Renard Murray: Thank you. We do look forward to that presentation. We would love to see it. If you could share it with us at the e-mail address that we provided earlier, that would be fantastic.

(Janet Perkins): Thank you very much.

Renard Murray: Thank you for joining the call. (Sarah), next comment please.

Operator: And your last comment comes from the (Inaudible) from Preferred Health Ventures. Your line is open.

Male: Thanks again. My question is I'm not in your region but I am listening in because this appeared of the listening sessions that I am aware of, this is the one that was more of a call-in format. So for those of us perhaps not region specific might get some consideration for having another one of these sessions more globally that might leverage some social medial participation as well. For instance, I might be tweeting about this and I am posting a comment using a (hash deck) CMS 10 and there are some conversation on Tweeter and I don't know if any of these people are actually taking the time to call in but obviously there is a lot of interest in what you're doing and this is one viable method for gaining grounds to reach granular input of people who are just general participants in healthcare as well as those who run the provider and payers side.

Renard Murray: We appreciate that comment and we have had two national calls already that we invited (inaudible) country and as Mandy mentioned earlier, we're going around the country doing this in each one of the regions and I am not sure what the plan is going forward. I am going to have to ask Mandy or John if they could provide some comments on this but we may have others that I am not really aware about at this point. But nonetheless, even if you don't live in region, in the Atlanta region, we do appreciate your comment and appreciate you being on the call and the recommendations that we have of these national calls that provides individuals opportunities to share their ideas. Mandy, John, any other comments?

Dr. Mandy Cohen: No. Just to say thank you and yes this is our first call and multiple sessions that we've been having. We did have two national open door calls.

We've had either a call or an in-person meeting in all ten regions across the country but as I said, this is only the first step and you will hear much more especially from the Innovation Center as we continue our work and we move along with different projects. And we look forward to using social media more in the future and appreciate your participation today. Thanks.

Male: Thank you.

Renard Murray: (Sarah), other comments?

Operator: There are no further comments. Thank you.

Renard Murray: OK. I want to say thank you all so much for taking time out of your very, very busy schedules. I know it is the holiday season that's upon us. We want to also say thank you so much to John, to Mandy, and to Sharon for providing us with the overview on the information about their wonderful work they have been doing in their centers but most of all I want to say thank you to all of you because the information that you share with us today is going to be valuable for us moving forward and we appreciate those ideas, those thoughts, those questions that you provided to us as well as your remarks.

I want to remind you again that we do have mailboxes set up so that where in the event as Anton mentioned you have neighbors, friends, or whoever that were not able to join us, they can provide us their comments via e-mail that we can make sure that we take a look at those and consider those as well. Let me give you those e-mail addresses one more time just in case. As Anton mentioned the first one is [aco@cms.hhs.gov](mailto:aco@cms.hhs.gov). The next one is [fchco@cms.hhs.gov](mailto:fchco@cms.hhs.gov). The last one is [innovations.cms.gov](mailto:innovations.cms.gov). As I mentioned earlier, we appreciate all of your time today and your comments and your remarks. We hope that you all have a great holiday season and we look forward to talking with you soon. Thank you.

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

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