THE REGION 10 DEPARTMENT OF

HEALTH AND HUMAN SERVICES (HHS)

AND

THE CENTERS FOR MEDICARE AND

MEDICAID SERVICES (CMS)

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Medicare Shared Savings Program Accountable

Care Organization Listening Session

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APRIL 28, 2011

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Hilton Seattle Airport & Conference Center
Crystal Ballroom A & B
17620 International Boulevard
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Co-hosted by HHS Regional Director Susan Johnson and CMS Regional Administrator John Hammarlund

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Adjourn

1 P-R-O-C-E-E-D-I-N-G-S

2 9:31 a.m.

3 MR. HAMMARLUND: If you don't
4 mind taking your seats we're going to go ahead
5 and get started. Okay.

6 Good morning everybody, thank you
7 so much for being here. My name is John
8 Hammarlund, I am the Regional Administrator
9 for the Centers for Medicare and Medicaid
10 Services based here in Seattle, that's Region
11 10. We cover the states of Washington,
12 Oregon, Alaska and Idaho and it is my great
13 pleasure to welcome you today to this
14 important listening session on the Medicare
15 Shared Savings Program and CMS's recent
16 regulations regarding accountable care
17 organizations.

18 We have people here in the room;
19 we're delighted you came to be with us in
20 person. We also have about 140 people on the
21 telephone and later on when we go into our
22 question and answer period we're going to take
23 questions from the audience here and we're

1 going to take questions from the ceiling where
2 the operator is residing, where there are lots
3 of folks also on the phone.
4 We are really excited and
5 delighted to have with us today the CMS Deputy
6 Administrator and also the Center for Medicare
7 Director, and that's Mr. Jonathan Blum. And
8 before I introduce Jon and tell you a little
9 bit more about the purpose and the mechanics
10 of today's listening session it's my great
11 pleasure to introduce my co-host, Susan
12 Johnson, the Regional Director of HHS who will
13 provide us with opening remarks.
14 Susan, as many of you know, was
15 appointed by President Obama to be the
16 regional director of HHS and she is Secretary
17 Sibelius's primary representative and key
18 liaison to constituencies in this region. She
19 works with federal, state, local and tribal
20 officials on a wide range of health and social
21 service issues that are part of the HHS
22 portfolio.
23 For 12 years prior to this job she

1 was the regional health administrator and
2 director of the King County Health Action
3 Plan, and before that Susan was a member of
4 the Washington State Health Care Policy Board
5 and prior to that she was a governmental
6 relations director for Service Employees
7 International Union. And my favorite part of
8 Susan's bio is that she's also an avid fly
9 fisher, angler, and she and I share that
10 hobby. So please welcome Susan Johnson.
11 (Applause)
12 MS. JOHNSON: Thanks John. Any
13 other fly fishing people in the room or in the
14 area? Oh good. All right. Somebody's waving.
15 We'll all have to get together later on.
16 Thank you for your kind
17 introduction. It's great to work with you in
18 all of our work together with HHS. Great to
19 have you here Jon and thank all of you in the
20 room for coming to share your energy around
21 the finally released regulations for ACOs. I
22 know they've been long awaited and highly
23 anticipated and I've been meeting with many

1 about your feelings at first blush on the
2 rules and regulations in draft form and I know
3 you have some very strong and important
4 feelings and thoughts and concerns and ideas
5 to share today.
6 I think we're all here and I
7 especially highlight our region because we've
8 been working on improving quality health
9 systems and care for individuals, the triple
10 aim, as Don Berwick would say, for years
11 especially in Washington State and Oregon as
12 we continue to move ahead.
13 So I know we have the highest
14 goals in mind for achieving those ends, and
15 input on the draft regulations will be ever so
16 important as we keep those goals in mind to
17 improve the structures that can go forward
18 with us to improve the health systems that we
19 have now.
20 It is my great privilege to work
21 in the region, representing this
22 administration and the Secretary and although
23 I've met with many of you there are many of

1 you I have not yet met with so please invite
2 me to your events, make sure I have your ear
3 and you have mine as issues come up. I do go
4 back to Washington, D.C. about every three
5 months and carry back the high level concerns
6 that you share with me to make sure that unmet
7 needs do not continue.
8 So with that I just want to thank
9 you again for your energy and your thoughtful
10 review of these regulations and your input
11 today as we strive to improve the health of
12 all of our citizens. So thank you for all of
13 those in the room and thank you for those in
14 the air who are spending your time with us
15 today and now back to John.
16 MR. HAMMARLUND: Thanks so much
17 Susan. We've invited quite a great group of
18 folks here today who answered the call to
19 either come here to the hotel or to join us by
20 phone. We've got consumers, clinicians,
21 employers, hospitals, health systems, health
22 care experts, all of you are part of the
23 dialogue, the important dialogue that we're

1 going to have today and we appreciate your
2 taking time out of your busy schedules to be
3 with us today and to learn about the proposed
4 rule which is designed to help doctors,
5 hospitals and other health care providers
6 provide a better coordinate care for Medicare
7 patients through ACOs.
8 The proposed rule as you know was
9 promulgated by the Department of Health and
10 Human Services on March 31st and it, along
11 with corollary Office of Inspector General
12 notice and other federal agencies notices is
13 posted on our web site as well as on the
14 Federal Registers and you can find fact sheets
15 about the proposed rule on the healthcare.gov
16 web site. We also have some fact sheets at
17 the back of the room where you entered in.
18 HHS also announces it's going to
19 hold a series of open door forums and
20 listening sessions during the comment period
21 to help the public understand what CMS is
22 proposing to do and to ensure that the public
23 understands how to participate in the formal

1 comment process. So this today is one of
2 those listening sessions.
3 Accountable Care Organizations are
4 designed to create incentives for health care
5 providers to work together to treat an
6 individual patient across care settings,
7 including doctors' offices, hospitals and
8 long-term care facilities.
9 The Medicare Shared Savings
10 Program will reward ACOs that improve or
11 deliver high quality care and lower growth in
12 health care costs while putting patients
13 first. Patient and provider participation in
14 an ACO, of course, is purely voluntary.
15 Now the comment period for our
16 rule ends on Monday, June 6th so you have
17 until then to get your comments to us.
18 You may submit comments in one of
19 four ways that are outlined in the notice of
20 proposed rule making; electronically, by
21 regular mail, by express or overnight mail or
22 by hand or courier and unfortunately because
23 of staff and research limitations we cannot

1 accept faxed comments.
2 Now I want to distinguish today's
3 dialogue from the formal comment process. The
4 session today is not the forum for submitting
5 formal comments on the proposed rule. We want
6 to have today a community dialogue with you
7 and after we've given you a thumbnail sketch
8 of the proposal then we'll have a chance to
9 hear and answer your questions.
10 The comments you offer us today
11 are going to be an important part of the
12 conversation and will certainly go into our
13 subconscious but they do not substitute for
14 formal comments which you have to submit to us
15 electronically, by regular mail or by courier.
16 Today's conversation is, however,
17 very useful for us and I think for the
18 collective thinking of the health care
19 community that's assembled in this room and on
20 the phone.
21 When you do submit formal comments
22 to us, and I hope each of you does, please
23 take advantage of the opportunity to teach us.

1 The most effective comment you can write is
2 one that tells us with specificity how a
3 proposal would impact your ability to serve
4 patients. Please don't just point out
5 problems but offer us solutions or
6 alternatives.
7 There are many places in the
8 preamble, and those of you who have read it
9 will notice this, where we say we considered
10 doing X, and we considered doing Y. We
11 decided to go with X in this proposal and
12 we're interested in knowing what you think
13 about it and whether you think we should go
14 with Y. That's your opportunity to let us know
15 your preferences and we can reflect much
16 better on analysis and suggestions for change
17 than we can mere anecdotes. So please we
18 appreciate your deliberate and thoughtful
19 approach to the comment writing and we look
20 forward to receiving your comments. We do
21 take them into account -- and we will -- as we
22 write the final rule which will be issued
23 later this year.

1 Okay. Back to today's meeting
2 again. We have lots of information for you
3 and Jon is going to share some information
4 about the regulations and set the table for
5 you.
6 After that we're going to go into
7 listening mode, we ask that you please raise
8 your hand. We'll get a microphone to you, you
9 can announce your name and your organization
10 and if you have a distinctive name please
11 spell it for us; that would be helpful. We'll
12 go with comments from the room here and we’ll
13 go with comments on the telephone as well.
14 And now it gives me great pleasure
15 to welcome to Seattle and introduce Jonathan
16 Blum, Deputy Administrator of CMS and the
17 Director for the Center for Medicare. John is
18 responsible for overseeing the regulation and
19 payment of Medicare fee for service
20 providers, privately administered health plans
21 and the Medicare Prescription Drug program.
22 He's got the entire Medicare portfolio.
23 The benefits pay for health care

1 for approximately 45 million elderly and
2 disabled Americans with an annual budget in
3 the hundreds of billions of dollars.
4 Over the course of his career Jon
5 has become an expert in the gamut of CMS
6 programs, he's served as an adviser to the
7 Senate Finance Committee members and its
8 current chairman, Senator Max Baucus, where he
9 worked on the prescription drug and the
10 Medicare Advantage policies during the
11 development of the Medicare Modernization Act.
12 He's focused on Medicare as a
13 program analyst at the White House Office of
14 Management and Budget, and prior to joining
15 CMS, Jonathan was the vice president of
16 Avalere Health overseeing its Medicaid and
17 long-term care practice. He also served on
18 the Obama-Biden transition team. He holds a
19 Master's Degree from the Kennedy School of
20 Government and a BA from the University of
21 Pennsylvania and he is a delight to have at
22 CMS. Please welcome to Jonathan Blum.
23 (Applause)

1 MR. BLUM: Thank you, John, for
2 the very kind introduction and thank you
3 everyone for coming out today to listen and to
4 provide feedback on the proposed ACO rule. And
5 when CMS does this presentation we always have
6 four or five different agencies folks standing
7 with us. This rule is just not produced by
8 CMS but we've had other partner agencies with
9 us; the anti-trust agencies, the IRS to think
10 about changes in tax policy, the Inspector
11 General's Office. So this is not just a CMS
12 effort but this is a comprehensive federal
13 government proposal to provide a new
14 opportunity for health care providers,
15 physicians to interact with the Medicare fee
16 for service program. And from my perspective
17 this was by far the most complicated, the most
18 challenging, the most complex rule that I've
19 had experience working on.
20 We are trying to do a number of
21 different things across the country. The ACO
22 rule is not a demonstration, not a pilot, but
23 a permanent part to the Medicare fee-for-

1 service program and our challenge at CMS is to
2 define rules and to define payment processes
3 that just don't apply to one part of the
4 country but the entire part of the country
5 and, given how different health care is
6 delivered and provided across the country,
7 that provides very tough challenges for CMS.
8 And as John mentioned, we face a
9 couple of dozen very difficult decisions about
10 how to set the benchmark, how to set
11 assignments, how to set the payment
12 reconciliation and, as John indicated, we
13 didn't always know the best answer until we
14 said there's a couple of options we're
15 considering. We threw out our best idea given
16 all the different tensions that CMS faced but
17 we understand there are different views.
18 I've already heard a lot of kind of
19 informal feedback and I think some might say
20 disappointment in some of our proposals but
21 hopefully now that you've read through the
22 preamble that we are very open, we are very
23 interested to other points of view and that's

1 the spirit at this conversation.
2 What I hope to do mostly is to
3 listen, to take feedback. This is not the
4 formal comment process but this is a kind of
5 listening session and, as John indicated, in
6 order for CMS to respond we have to have the
7 comments in writing.
8 But I thought what I would do is
9 just kind of talk for 15 or 20 minutes, give
10 the highlights of the proposal to frame the
11 discussion, to frame the conversation and I
12 hope that we have some feedback, some dialogue
13 that we can all take back to CMS, kind of
14 partner agencies, but that also we can help to
15 explain some of the thinking that was behind
16 the proposed rule and some of the principles
17 that we followed with developing the rule.
18 So real quickly what I hope to do
19 is just talk about the background to the
20 Shared Savings Program, what the law says CMS
21 shall create, who is eligible through our
22 proposal to be an ACO, the different payment
23 tracks we have proposed.

1 We have proposed two payment
2 tracks for an ACO to enter. How we propose to
3 assign beneficiaries to an ACO. I think one
4 important distinction about the ACO program is
5 this is part of the traditional fee-for-
6 service program and the law requires that
7 beneficiaries in the fee-for-services program
8 be able to see any participating physician,
9 hospital that participates within Medicare.
10 And our challenge is to create a
11 more integrated system of care within that
12 freedom of choice. This is not the private
13 side of Medicare where we have a locked-in
14 network, this is fee-for-service Medicare, and
15 that was one of the greatest struggles to how
16 CMS has to develop this program, that it is
17 part of fee-for-service but we have some
18 thoughts to how we assign beneficiaries to an
19 ACO.
20 I'll talk a little bit about the
21 quality framework that is probably the most
22 aggressive and far-reaching quality framework
23 that CMS has contemplated. We have heard

1 already that it's challenging for providers
2 and so we're happy to talk about that, then
3 beneficiary notification provisions and then
4 lastly the anti-trust process.
5 I'm from CMS, I'm not an anti-
6 trust lawyer, we do a very high level
7 description but real detailed questions will
8 need be referred back to our anti-trust
9 agencies.
10 So just going into the background
11 of the ACO program. This program was
12 authorized under Section 3022 of the
13 Affordable Care Act and I think from the
14 congressional perspective the goal really is
15 to think about ways to improve the overall
16 quality of care and also to lower the costs by
17 encouraging physicians and other health care
18 professionals to work more closely together.
19 This is a program, which means
20 that it's eligible for any entity throughout
21 the country, throughout the fee-for-service
22 program. This is not a pilot, this is not a
23 demonstration, this is not a negotiated type

1 contract with CMS but it is a program which
2 means by law we have to set consistent
3 requirements throughout the country.
4 ACOs are eligible to share in
5 savings that they achieve and we define what
6 savings means according to a defined
7 benchmark, and the law requires that CMS
8 establishes a program by January 1, 2012. But
9 again this is not the only year for ACOs to
10 participate, this would be a process that
11 occurs every year through our proposal where
12 ACOs will have the opportunity to sign a
13 three-year agreement starting on January 1,
14 2012 but for those organizations that choose
15 to come in 2013, 2014, that is very much
16 permissible.
17 As John mentioned, we issued a
18 proposed rule March 31st, and we are
19 soliciting comments through June 6th and again
20 we'll listen very carefully and do our best to
21 respond to those written comments.
22 So according to our proposal, what
23 is an ACO? Well, first is that it's a

1 separate legal entity that is recognized by
2 state law and that is a group of health care
3 professionals, providers that are working
4 together to better coordinate care, that are
5 investing in improvement system changes to
6 improve the overall coordination of care, to
7 improve the overall patient experience, that
8 have agreed to be accountable for both the
9 cost, the quality and the overall care that is
10 provided to Medicare fee-for-service
11 beneficiaries.
12 This is not just the care that the
13 professional directly provides but the entire
14 Part A, Part B benefit that is provided by the
15 Medicare fee-for-service program. And also
16 that has processes that establish their
17 governance throughout the ACO organization.
18 So who is eligible to become an
19 ACO? Well really through our framework we
20 don't want to dictate a kind of one size fits
21 all model. Our notion is that an ACO can be
22 different kinds of organizations. The law
23 requires that the fundamental one constant

1 throughout any ACO organization is that they
2 have a primary care physician base that can
3 serve 5,000 beneficiaries.
4 The 5,000 beneficiaries was stated
5 in law, we don't have any flexibility to lower
6 it but that is the kind of one fundamental
7 nature that's true for any ACO organization
8 that participates that it has the 5,000
9 primary care base that it can serve.
10 Our hope is that we have
11 organizations that come in that are different
12 kinds of organizations, that are group
13 physician practices, physicians working and
14 coming together for the first time to be a
15 kind of integrated delivery system.
16 Hospitals working with physicians,
17 hospitals that are employing physicians. And
18 our hope and our notion is that we have lots
19 of different kinds of organizations coming
20 into the program but it's not a one size fits
21 all model, that it's not a defined provider
22 network but the notion is that it's a primary
23 care physician base that can serve 5,000 or

1 more beneficiaries. But our framework is
2 flexibility in the design of the overall
3 structure that can participate.
4 We have proposed, and I think
5 based upon pre-input, pre-feedback, a 2-track
6 approach. The law provides CMS flexibility
7 how to structure the payment model and while
8 the base law talks about shared savings,
9 meaning one-sided risk meaning that the
10 organization produces savings, they can share
11 in savings, but the law also provides a
12 framework that says that CMS can develop other
13 payment models.
14 We have heard pre-input from
15 provider organizations, from academics, from
16 outside experts that says that if we create a
17 payment model that has a two-sided risk
18 infrastructure, meaning that the organization
19 faces up side but also faces down side, that
20 will produce a greater dynamic for quality
21 improvement and cost savings.
22 But we also understand that for
23 lots of organizations that are new to this

1 model that are trying to participate for the
2 first time, that we need an easier on-ramp to
3 allow organizations to come in. And we have
4 proposed a 2-track approach that says for
5 those organizations who are new, who are
6 coming at this for the first time, they can
7 come into the program for two years with one
8 sided up side risk only before they transition
9 to two-sided risk in year three.
10 For those organizations who are
11 more experienced that want a different
12 financial model, that want to face greater up
13 side potential, they can come in from year one
14 with a two-sided risk approach meaning there's
15 both shared savings and shared losses. But by
16 the second contract period, after the first
17 three year period, all organizations to our
18 proposal would face a two-sided risk.
19 And what we're trying to
20 accomplish is to balance the tension between
21 creating a stronger incentive, stronger
22 dynamic for greater quality improvement and
23 for greater savings but also to allow

1 organizations that are new to have a two-year
2 on-ramp to that two-sided financial
3 relationship.
4 We have proposed to assign benefit
5 shares to an ACO through a retrospective
6 process. This was probably one of the most
7 difficult decisions that CMS faced and again
8 this is proposed. But we felt that the goal
9 of the ACO program is to focus on population
10 health, is to focus on the entire population
11 that is served by the organization rather than
12 those beneficiaries who are formally assigned
13 to the ACO.
14 The way the CMS proposal works is
15 based upon the plurality of primary care
16 services, CMS will assign beneficiaries to an
17 ACO. The proposal says that we do it after
18 the fact, after the year is out. How do we
19 then determine which beneficiaries should be
20 assigned to that ACO?
21 We've heard different pros and
22 cons for different directions. Many
23 organizations have said that in order for this

model to work the organizations need to know up front who the patients are that are assigned to the ACO. But the other side of the argument says the ACO program is about population health, but the entire population not just the beneficiaries who are formally assigned to the ACO.

In order to balance the tension what CMS has proposed is to say we'll assign beneficiaries retrospectively but provide data on those beneficiaries who are likely to be assigned up front to address the concern that some organizations have to know and to understand.

Now, for the first time, what we’re saying is that we're going to provide claims level information, Part A, Part B and Part D prospectively to the organization on the beneficiaries who are likely to be assigned.

It's a whole new relationship, whole new opportunity, whole new experience that we're providing ACO organizations. It's

1 up front claims level information to be
2 provided as fast and as frequently to address
3 the concerns that ACOs need the information up
4 front but at the same time we want not to
5 create the incentive for only the care
6 interventions, the care models, to focus on
7 those beneficiaries who are assigned. And I'm
8 sure we'll have lots of dialogue about that
9 later this morning.
10 We have proposed a very aggressive
11 quality measurement and performance framework.
12 We have proposed that ACOs report on 65
13 quality measures that are separated within
14 five domains: patient care-giver experience,
15 care coordination, patient safety, preventive
16 risk, at-risk population and frail elderly
17 health measures.
18 Those organizations that score
19 higher will be eligible for greater savings
20 really with the relationship being that the
21 higher the quality, the higher the
22 performance, the greater the up side
23 potential.

1 We tried our best to align these
2 measures with the current PQRS, our physician
3 reporting measures that are in place. We also
4 tried to align the measures the best we could
5 with the requirement for meaningful use which
6 has two purposes; the first purpose being that
7 with that kind of simplification those
8 organizations that are participating with the
9 meaningful use HITECH regulations are
10 incentive payments, the goal is to really
11 provide integration, provide a kind of
12 seamless process.
13 But, second, that to align those
14 measures to encourage participants to
15 participate with the meaningful use measures
16 creates revenue opportunity because it creates
17 the opportunity to participate within the
18 incentive payments through the HITECH process
19 which provides funding for infrastructure to
20 achieve and to meet this quality framework.
21 So it's a two part goal. One to
22 align, to ensure that our programs are
23 coordinated but second is to provide added

1 revenue base to comply and to meet these
2 requirements.
3 We've heard a lot of input from
4 the consumer community, from the beneficiary
5 community whether beneficiaries should be
6 notified that their physician is participating
7 within an ACO. And, again, this is part of
8 the traditional fee-for-service program,
9 beneficiaries aren't locked into a provider
10 network, they still have their full rights for
11 freedom of choice, and so one could argue that
12 this whole model should be seamless to
13 beneficiaries.
14 This is assignment after the fact;
15 this is about reconciliation of payments. The
16 beneficiary's relationship should hopefully be
17 stronger with his or her physician so the care
18 should hopefully be improved if the ACO
19 program is working. But you could argue that
20 from the beneficiary's perspective there's not
21 a need for notification.
22 We've heard a lot of concern from
23 the consumer community, the beneficiaries'

1 community that said well this may be changing
2 how care is delivered. Beneficiaries have the
3 right to know that his or her physician is
4 facing different incentives.
5 Also, we are sharing for the first
6 time in a confidential way Part A, Part B,
7 Part D claims information with physicians
8 which we felt beneficiaries have the right to
9 know that the program will be sharing that
10 data.
11 So what our proposal says is that
12 physicians who are participating within the
13 ACO would have to notify their patients in a
14 standardized format that he or she is
15 participating within an ACO but provide the
16 beneficiary the opportunity to opt out to the
17 data sharing requirements given the very
18 sensitive nature and the very strong concerns
19 regarding patient privacy.
20 Beneficiaries really, because this
21 is still part of the fee-for-service program,
22 can't opt out of an ACO similar to how they
23 can opt out of a health plan type

1 relationship. So we have heard concerns,
2 'Well this proposal doesn't give the
3 beneficiary the right to opt out of the ACO.'
4 But in order to balance all these competing
5 tensions we felt that it was important for
6 beneficiaries to be notified but also have the
7 opportunity to opt out, not opt in to the data
8 sharing requirements.
9 And, lastly, I just want to spend
10 a few minutes talking about the anti-trust
11 review process. Again, this is not a CMS
12 proposal but the anti-trust agencies, the
13 Department of Justice and the Federal Trade
14 Commission put out a joint policy statement to
15 provide guidance to what kinds of
16 organizations would trigger an anti-trust
17 review.
18 And the way I understand the
19 framework, what it says is that for those
20 organizations that are existing the anti-trust
21 review process doesn't apply, but for those
22 organizations that are coming together for the
23 first time, that are consolidating or that are

1 forming a new organization for the first time,
2 that's when the anti-trust agencies become
3 concerned.
4 And they've divided up their
5 framework into kind of a 3-part category. For
6 those organizations that have market share for
7 defined services that are less than 30 percent
8 with a real exception, there is no anti-trust
9 concern. The organization should feel
10 confident that there's no concern from the
11 anti-trust organizations.
12 Taken to the other extreme, for
13 those organizations that have a greater than
14 50 percent share, there is going to be an
15 anti-trust concern, kind of anti-trust review.
16 And so what our proposal says is
17 that CMS will require any organization that
18 triggers this greater than 50 percent
19 threshold that they will be entitled to an
20 expedited review by one of the anti-trust
21 agencies before they can become a CMS ACO.
22 And there's this category in the
23 middle of greater than 30 percent less than 50

1 percent, whether the ACO application would
2 still be entitled to an expedited review if
3 the organization would like to play it safe.
4 But if they follow good market conducts, as
5 defined by the anti-trust agency, they should
6 be able to proceed without that review.
7 But again I'm not an anti-trust
8 lawyer and will have to defer any questions to
9 our anti-trust agencies but, hopefully, that
10 gives an indication to the overall framework
11 policy statement that was proposed.
12 So I will stop there and be happy
13 to open it up. I can sort of sense from the
14 audience there's some concerns, there's some
15 questions. We're really here to kind of open
16 it up and take any questions and to take any
17 feedback and to be able to be responsive the
18 best we can. So we'll go into the Q and A.
19 MR. HAMMARLUND: Thank you very
20 much, Jon. All right. Well as promised we
21 are now going to go into listening mode, we're
22 going to be listening for your comments as
23 well as your questions and hope to have

1 answers.
2 I'm going to invite another CMS
3 colleague, Ms. Jennifer Magyar, up to the
4 front of the room so she can participate in
5 this session. Thank you Jennifer.
6 And, again, what we're going to do
7 is we're going to take your questions and
8 comments. If you're here in this room raise
9 your hand or otherwise notify us that you'd
10 like to speak and we will get a hand-held
11 microphone to you. And again please let us
12 know your name and the organization you
13 represent and if you have a distinctive name
14 we'd really appreciate it if you could spell
15 it out for us.
16 And also we're going to go the
17 phone and get questions from there. And in
18 just a moment I'm going to engage with our
19 operator, Catherine, because I want to make
20 sure she gives instructions to people on the
21 phone as to how they access us too.
22 I just want to note again that
23 this is a listening session for us. It is not

1 a substitute for formal notice and comment.
2 Your comments and questions, however, are
3 going to be transcribed and we appreciate
4 Terry being here today and in a few weeks they
5 will be posted up on the web site so you can
6 see how the dialogue went.
7 All right. Catherine, I want to
8 now engage you and have you explain to the
9 callers on the phone how they can comment or
10 ask a question.
11 Thanks a lot Catherine, and
12 meanwhile we're going to go ahead and take a
13 couple of questions out of the room first and
14 then we will re-engage with the telephone
15 line. As you can see, they're here loud and
16 clear, the telephone callers. All right. Any
17 questions or comments here in the room. All
18 right. We'll get a microphone to you.
19 DR. YEN: Okay. My question is
20 what has CMS devised in terms of engaging
21 beneficiaries to be part of an ACO? It seems
22 like there is no incentive and maybe there's a
23 perception that if a beneficiary participates

1 in an ACO that the savings are going to
2 benefit someone other than themselves.
3 MR. BLUM: Well again going back
4 to what the ACO program is and how it's
5 designed by law, this is still part of the
6 fee-for-service program and beneficiaries are
7 not locked into the ACO. So we do not see
8 this as a beneficiary choice model, you know,
9 kind of similar to our health plan model where
10 beneficiaries choose a health plan. For those
11 beneficiaries, the 80 percent or so on average
12 across the country who are in the fee-for-
13 service program they would still navigate the
14 health care delivery system the same way they
15 do today.
16 Now the way that our proposal
17 works is that the physician is the one
18 participating within an ACO. And so the hope
19 is and the arguments that we've heard and what
20 kind of the ACO program is based upon is that
21 there's a better care experience to patients
22 who want to have a much stronger relationship
23 with his or her physician, that care is

1 coordinated, that care is integrated for the
2 beneficiaries not locking into an ACO
3 organization.
4 Now for CMS that presents some
5 very challenging communication prospects. On
6 the one hand, we want beneficiaries to be
7 having a stronger and more engaged
8 relationship with their ACO organization, with
9 their primary care physician. That's the
10 whole argument, the whole premise behind the
11 ACO model.
12 But legally and not similar to the
13 Medicare Advantage Program, beneficiaries
14 aren't locked into the ACO program. So we're
15 hoping that the beneficiary experiences,
16 better care, better coordinated care, a much
17 stronger relationship with his or her
18 physician, but it's not the beneficiary's
19 choosing or enrolling or locking himself into
20 an ACO organization because legally the fee-
21 for-service program still applies and all of
22 the provider choice, provider freedom laws and
23 regulations still apply.

1 Now we believe that beneficiaries
2 should have the right to know and to be
3 notified but it's not the enrollment kind of
4 model that's similar for our practice in
5 Medicare. Did that answer your question?
6 DR. YEN: A bit. I think on the
7 one side, I'm a provider by the way, my name
8 is Dr. Tony Yen, I'm from Evergreen Health
9 Care.
10 But if I was a beneficiary I would
11 think to myself well what are the benefits for
12 me other than what you mentioned. And would I
13 question the provider who are delivering care
14 to me that well if they didn't order that MRI,
15 for example, is that because they're being
16 incentivized to order that MRI or is that
17 really better for me?
18 MR. BLUM: Yes. We've heard
19 that challenge and some have suggested well
20 maybe there could be a different co-pay
21 relationship or what have you but really the
22 ACO program legally, structurally and kind of
23 fundamentally is based upon the premise of a

1 better care coordination model for the
2 beneficiary, a stronger relationship with his
3 or her physician to hopefully provide the
4 beneficiary trust that the care will be
5 improved going to an ACO participating
6 physician.
7 But, at the same time, CMS legally
8 will have to communicate to beneficiaries that
9 you still have the right, you still have the
10 opportunity to navigate the health care
11 delivery system consistent with the fee-for-
12 service rule so it creates tensions. But our
13 hope is that there's a stronger beneficiary
14 connection to the physician to build a
15 relationship that I think you're trying to
16 describe.
17 MR. HAMMARLUND: Thank you so
18 much for your question, and I'm going to take
19 one more from the room here and I'm going to
20 do a better job of making sure you identify
21 yourselves. Go ahead.
22 MR. DAVID: I'm Lloyd David, I'm
23 a CEO for the Poly Clinic which is a multi

1 specialty group in Seattle, about 60 primary
2 care physicians and about 25,000 Medicare
3 beneficiaries and we've engaged in shared
4 savings contracts in the commercial basis and
5 we've been at risk for Medicare Advantage. So
6 we were actually looking forward to this
7 opportunity.
8 A couple of things I would share
9 with you. I was at the American Medical Group
10 Association meeting two weeks ago, the annual
11 conference, and in a group of about 40 CEOs
12 there were five who thought that they would
13 participate based on the regulations as they
14 were written.
15 There are three things I would
16 point out about the program. I would
17 reinforce the issue of patient engagement for
18 those of us who were here in the 90s when
19 patients worried that somehow their doctor was
20 doing something that wasn't in their interest.
21 We completely believe in transparency, every
22 patient should know that their physician
23 participates.

1 But the more the patients can feel
2 engaged with their provider, we think the
3 better the program will go.
4 And two other issues that I would
5 call to your attention. One is the issue of
6 patient severity. We've learned that it takes
7 quite a bit of work to accurately capture the
8 clinical state of a patient and our
9 understanding is the regulations today don't
10 allow for improved documentation of that
11 clinical status or to recognize increases in
12 the severity of a patient population.
13 And frankly, without the ability
14 to have severity adequately measured and our
15 payments adjusted for that, I just feel it's
16 way too risky to participate.
17 And then, finally, we would like
18 to be sure that our benchmark, the standard
19 against which we're judged, is our community
20 performance and not our own historical
21 performance. If you have already have better
22 than average performance in your community it
23 makes is extremely difficult to see the

1 opportunity to succeed. And obviously, as
2 with most people, we would like the threshold
3 to be able to earn savings to be something
4 that gives us a greater chance of success.
5 My last comment would be, given
6 all of the concerns, we really hope that
7 Medicare Advantage stays a strong and viable
8 program. We think that's an important element
9 to have out there.
10 MR. BLUM: All very helpful
11 suggestions and not ones that we haven't heard
12 before.
13 I want to follow up on a couple of
14 things that you said. The last one about the
15 MA program absolutely, we are very much
16 committed to making sure that program is
17 strong. We have the 5-star quality system
18 which hopefully shows our intent similar to
19 what we're trying to do for the fee-for-
20 service Medicare program, the same goals and
21 aspirations that we have for the MA program.
22 I expect the MA program to grow
23 but still we need to ensure that the fee-for-

1 service program, given that that's the
2 dominant part right now for the program
3 nationwide, we need to make sure that the fee-
4 for-service program be as strong and also is
5 focused on quality improvement and overall
6 patient experience.
7 I guess going to your first
8 question and then going to the gentleman's
9 question too. What would you recommend, and
10 again this is listening not formal comment,
11 but to kind of create a stronger patient-- I
12 think what you're both suggesting is creating
13 an even stronger way to ensure the beneficiary
14 is, and I don't want to use the term "locked
15 in," but you know has a stronger relationship
16 to the ACO.
17 So do you have any suggestions
18 that would say here's a better way to ensure
19 the patient is thinking about the ACO
20 organization?
21 MR. DAVID: Well, I have two
22 thoughts and these are really preliminary.
23 The first is I understand the patient advocacy

1 concern about people not getting locked in and
2 having secrets but, at the same time, this
3 ought to be affirmed to patients as something
4 that would be good for them as opposed to
5 something we want to be sure you know about it
6 so you can get out of it.
7 So I think for CMS to be clear to
8 members, to their enrollees that this is a
9 positive thing.
10 MR. BLUM: Absolutely. I think
11 too that I ought to make clear that our
12 communication plan for beneficiaries will have
13 language in the handbook that beneficiaries
14 receive every year.
15 But our hope and our goal is to
16 communicate to beneficiaries that the ACO
17 program is not about cost savings, it's not
18 about care reduction, but it's about stronger,
19 better care coordination, stronger
20 relationship with the health care delivery
21 system, higher quality that will lead to lower
22 overall costs. And that's going to be our
23 primary message.

1 MR. DAVID: So the other thing
2 we've begun to talk about and again this is
3 really preliminary, is some version of an
4 economic incentive to choose, whether that's a
5 differential co-insurance requirement offered
6 by CMS. We can't figure out a way that you
7 can actually share the savings with a member
8 but provide some inducement for people to see
9 this could be good for me as well.
10 MR. BLUM: We'll look forward to
11 your written comments.
12 MR. DAVID: All right. Thank
13 you.
14 MR. HAMMARLUND: Thank you,
15 Lloyd. As I mentioned, we have about 140
16 people on the phone so I'm going to now turn
17 it over to Catherine and Catherine why don't
18 we take the first three people in your queue
19 for questions or comments.
20 OPERATOR: Okay. Our first
21 question is from Lance Hinekist. Go ahead,
22 your line is open.
23 MR. HINEKIST: Thank you. This

1 is Lance Hinekist from the Washington State
2 Medical Association. I'm sorry I cannot be
3 there in person but I had a consult later this
4 morning.
5 I would simply like to emphasize
6 all the points that have been made,
7 particularly the points around beneficiary
8 assignment and Lloyd's two comments around the
9 need for risk adjustment and the need for a
10 better benchmark. We will be reflecting
11 those in our comments that come in June.
12 I have two sort of technical
13 questions that I'd like to pose. The first is
14 regarding the use of plurality of charges for
15 assigning patients. Will there be a floor on
16 that plurality? In other words, if the number
17 gets too small it becomes meaningless.
18 MR. BLUM: No. How the rules are
19 now set up is that it's an absolute plurality,
20 whether it's 5 percent, 50 percent, 75
21 percent, but there's no floor what plurality
22 means to our definition.
23 And what we're trying to create is

1 a way based upon a preponderance of primary
2 care services or charges that are provided for
3 a given year, and beneficiaries that don't use
4 the health care system throughout the year
5 some beneficiaries won't be assigned.
6 But again going back to the
7 statutory construct, going back to the
8 statutory framework, this is about a kind of
9 assignment process based upon primary care
10 services. So we felt that the best way to
11 think about this is plurality not majority or
12 not you know greater than 50 percent, but
13 that's our current proposal.
14 MR. HINEKIST: Well, we will be
15 submitting comments on that because at some
16 point as the number gets smaller it really
17 becomes pretty meaningless. And we don't
18 think it needs to be a majority but you may
19 want to consider setting a floor of 25 or even
20 10 percent just to prevent really silly
21 assignments.
22 And then my second question
23 regards the equity issues or really the lack

1 of equity issues in how savings and losses
2 will be shared. The way the proposed regs are
3 written currently, depending on the quality
4 score for an ACO, they can share in between
5 zero and an upper threshold of 65 percent of
6 the savings.
7 But, given the formula you're
8 proposing, again, based on the quality scores,
9 they're required to share between 35 and 100
10 percent of the loss. And this seems to be
11 inequitable and I'm wondering if you would
12 comment on the rationale for that.
13 MR. BLUM: Well, I think we were
14 trying to create a framework that would
15 provide greater rewards for organizations that
16 score higher on the quality performance
17 scores. We have certainly heard concerns both
18 about the kind of up side financial prospects
19 and the down side and really you know this is
20 a judgment call by CMS.
21 We understand that there are
22 different perspectives, we're hoping to get
23 feedback, we're hoping to get your perspective

1 of whether or not our proposal works from a
2 business perspective, works from a financial
3 perspective and I expect we'll get a lot of
4 feedback on that.
5 But really we were trying to
6 create a framework to incent quality
7 performance, to incent organizations to work
8 with federal qualified health centers and
9 they're ultimately, based upon analysis,
10 they're ultimately our best judgment. But we
11 understand that there are other very good
12 points of view.
13 We're learning about how to do
14 this for the first time and we're going to
15 need feedback about what makes sense from a
16 business perspective and that's part of the
17 reason why we're here today.
18 MR. HINEKIST: Well, we will
19 certainly be providing feedback on that. It
20 seems like an easy fix but would be to change
21 your formula to be .65 minus the quality score
22 so you'd have equal sharing of risk and equal
23 sharing of losses.

1 And I will rejoin the queue. I'll
2 let some other people go now.
3 MR. HAMMARLUND: Thanks very much
4 for your question. Catherine, we'll take the
5 next caller.
6 OPERATOR: I have no further
7 questions at this time.
8 MR. HAMMARLUND: All right. Let
9 me see if there's some other folks in the room
10 who have a question and we may be then
11 circling back to our caller who was just on.
12 Please be sure to identify yourself.
13 DR. TRONOLONE: My name is Mike
14 Tronolone and I'm the Chief Medical Officer at
15 the Poly Clinic and I'd like to offer two
16 comments that are basically high level
17 comments about what I think you should use
18 when you sort of look at the comments that
19 people are making about specifics of the
20 regulations. Okay?
21 So one I think, and Lloyd sort of
22 alluded to this, is thinking about it from
23 provider perspective ways that you could

1 reduce the business risk. And I'll give two
2 specific examples.
3 When we contracted for similar
4 kinds of shared savings programs in the
5 commercial market we got a chance to look at
6 the data before we committed to contracting
7 and it allowed us to feel confident that we in
8 fact did have control over these patients in a
9 sense that they came to us regularly and we
10 could really actually make an impact like
11 that. And that gave us the confidence to sort
12 of move forward into a new way of thinking
13 about how we would do the contract. So that
14 would be sort of a specific around the idea
15 about reducing the business risk.
16 The other one that I think could
17 be specific about reducing the business risk
18 is that given the data sort of moving forward
19 that the ability to stop at some point prior
20 to incurring a loss because some of our
21 organizations, as has been mentioned we do
22 really well with Medicare Advantage like that
23 and this just might not be right for us like

1 that.

2 And I think that there's going to

3 be people that are not going to jump into this

4 just because the business risk is too high to

5 even begin to start.

6 The second thing is around

7 regulation. I’m all for regulating around

8 anti-trust, okay, and for regulating to make

9 sure that beneficiaries that their rights are

10 upheld and all of these other things, okay.

11 But I think that you have to draw the line at

12 regulating delivery system innovation. We

13 have to be free as providers to think about

14 changes that we would make in the delivery

15 system, okay, that could achieve the outcomes

16 that we're both looking for.

17 So for instance like that it would

18 be a bad regulation if every communication we

19 wanted to send to our patient had to have CMS

20 approval like that. So a new strain of flu is

21 out, we're on top of it like that, we're

22 ready, we want to get people in, we want to

23 get them immunized, we shouldn't have to say,

1 "Mother, may I?"
2 MR. BLUM: I think that's a
3 helpful suggestion. Our goal and our
4 principle going into developing the proposed
5 rule was not to dictate and not to regulate
6 care interventions and delivery reforms.
7 We learned from the PGP
8 demonstration that each organization that
9 participated had their own mechanism and their
10 own way and their own system changes that were
11 implemented to improve quality. And so our
12 principle was not to regulate, not to dictate
13 the specific changes to care delivery.
14 We wanted to set out a quality
15 framework that was high, we wanted to set
16 beneficiary protections that were consistent
17 with the law and consistent with overall CMS
18 principles. The unintended things that we did
19 that would, you know, interrupt organizations
20 making changes that they know best better than
21 CMS, that's what we need to hear.
22 And we've heard a lot about the
23 beneficiary standardized materials. Our goal

1 is to make sure that beneficiaries are
2 communicated with in a consistent way that
3 says it's not about either trying to cherry
4 pick beneficiaries or to kind of cream skim,
5 which is no one's intent I know, but that's
6 sort of the unintended consequences that have
7 happened in the past. But we're not about
8 preventing organizations to communicate, you
9 know, it's time to get your flu vaccine.
10 So if there's ways that we can
11 balance that then we're all open to those
12 kinds of comments.
13 MR. HAMMARLUND: All right,
14 thanks. Let's go back to the phone lines.
15 Catherine, has somebody joined the queue that
16 would like to make a comment or ask a
17 question?
18 OPERATOR: Mr. Hinekist has
19 called back in, would you like to take that?
20 MR. HAMMARLUND: Absolutely.
21 MR. HINEKIST: I'm back. Two
22 additional questions. One, we really applaud
23 the willingness of the CMS to share the data

1 on the anticipated beneficiaries that are
2 going to be assigned to an ACO. We think that
3 will be very helpful.
4 But we do have some concerns
5 around the time delays between when the
6 services are actually delivered and when that
7 data can actually reach the ACO, particularly
8 for services for a beneficiary that are not
9 being delivered by the ACO so they wouldn't
10 know about them until they actually got the
11 data.
12 Do you have any sense of what the
13 time lag would be between a service and when
14 you can anticipate giving that data to the
15 ACO?
16 MR. BLUM: Well it's a hard
17 question to answer precisely because currently
18 within the fee-for-service construct, and I
19 forget the precise time lines, but both
20 hospitals, physicians and other providers have
21 a period of time where they have to submit a
22 claim.
23 So whatever data that CMS does

1 provide organizations, we're dependent upon
2 those claims being submitted to our carriers
3 for processing.
4 Our goal is to provide frequent
5 data. I think that our proposal says
6 quarterly. But we're dependent on how fast
7 physicians, how fast hospitals, how fast other
8 providers submit data and probably with our
9 Part D data there's a much more kind of a real
10 time notion given that those transactions tend
11 to happen very, very quickly.
12 But other medical claims, our goal
13 is provide that kind of as real time as
14 possible but we know that CMS real time
15 doesn't mean 30 days, doesn't mean the kind of
16 transaction timetables that we have on the
17 Part D prescription drug side. But again
18 we're dependent upon when physicians, when
19 hospitals submit claims. So our goal is to do
20 the best we can but we're dependent upon
21 others to submit claims timely.
22 MR. HINEKIST: Thank you. And
23 then the second question is as you know Region

1 10 has a lot of rural areas and I'm wondering
2 if you can at least briefly explain the
3 provisions that are being made for community
4 access, or excuse me critical access hospitals
5 and also rural health centers and FQHCs to get
6 them involved.
7 When you went through your
8 presentation you didn't touch on that and I
9 think it would be helpful to have that
10 explanation.
11 MS. MAGYAR: Sure. Thank you for
12 your comment. Right now as written in the
13 proposed rule, FQHCs and RHCs don't have the
14 ability to be an independent ACO but in effect
15 they can become part of one in participation
16 with another group.
17 So we will be working through
18 Region 10 in our outreach and education
19 efforts to make sure that that's clearly
20 illustrated. We have that message out there
21 and specifically to work with those FQHCs and
22 RHCs in this Region to notify them.
23 And for the critical access

1 hospitals we have to think about Method 1 and
2 Method 2 billing here. For Method 1 billing,
3 the critical access hospitals would not be
4 participating as primary, it's going to be
5 under Method 2. So we have to look at
6 reasonable costs associated with that and,
7 again, that will be another big part of our
8 outreach and education efforts associated with
9 that to all those critical access hospitals
10 in this Region.
11 MR. HINEKIST: Thank you.
12 MR. HAMMARLUND: Catherine, has
13 anybody else joined the queue on the phones?
14 OPERATOR: I have no further
15 questions.
16 MR. HAMMARLUND: Okay. Well
17 we'll let their shyness subside and meanwhile
18 take a few more questions here from the room.
19 Yes?
20 MR. MARSALLI: Good morning, Bob
21 Marsalli with the Northwest Regional Primary
22 Care Association here in Seattle.
23 Why aren't FQHCs and rural health

1 centers able to be ACOs?
2 MR. HAMMARLUND: Go ahead
3 Jennifer.
4 MS. MAGYAR: You know, a lot of
5 it is going to stem back to what I think Jon
6 was saying earlier when we talked about this
7 being a Medicare fee-for-service program so
8 when we look at the data behind FQHCs and RHCs
9 typically we're looking it's not always under
10 the traditional fee-for-service schedule
11 billing. So that's a component of it.
12 ?Something similar that we saw in
13 the HITECH under the EHR incentive programs so
14 that's one of the reasons, you know, I don't
15 want to speculate on all of them here in front
16 of you but I'm happy to have a conversation
17 with you further but we'll certainly work
18 with, again, all the FQHCs and RHCs in this
19 Region to explain that.
20 MR. BLUM: My understanding is as
21 we improve the FQHC payment system and start
22 the direct billing mechanism, that over time
23 we can have FQHCs become the primary part of

1 the ACO.

2 We're just sort of in a world for
3 the next several years where CMS doesn't
4 collect that data so we're trying to get
5 around it through incentive payments where we
6 want to encourage ACOs to include FQHCs as
7 part of their primary care network.

8 We're limited currently with the
9 data and that will change over time but 2012
10 we're not there yet.

11 MR. MARSALLI: Yes. And just
12 lastly, it's unfortunate because as you know
13 FQHCS have been revolutionizing the delivery
14 of primary care now for at least five to seven
15 years, many of them in the forefront of the
16 so-called primary care patient centered
17 medical home movement which is all about
18 improving quality at reduced cost with robust
19 data available through very sophisticated
20 electronic health records systems that are now
21 in many cases fully adopted and meeting this
22 criteria so I would hope that thinking could
23 be expanded. Thank you.

1 MR. HAMMARLUND: Thank you. All
2 right. Any other questions or comments from
3 the room?
4 MS. THOMAS: My name is Cheyenne
5 Thomas, I'm with Northwest Health Services in
6 Spokane, Washington and I just have a
7 clarification question.
8 So the difference between the
9 participants versus the provider/suppliers is
10 that the participants are who you will use to
11 assign the beneficiaries and they must be
12 present in a large enough sum to gather the
13 5,000 required beneficiaries versus the
14 provider/suppliers can also be part of the
15 entity, they just won't have beneficiaries
16 assigned? Is that correct?
17 MR. BLUM: Yes, I think that's a
18 good way of thinking about it. The way I
19 think about it is there's an ACO organization
20 that is comprised of the entities that are
21 going to be sharing savings in a shared
22 governance perspective. But for assignment
23 purposes, how we assign Medicare beneficiaries

1 to the ACO it's based upon those who are
2 providing primary care services, you know,
3 critical access, Method 2 billing, primary
4 care physician. There's an assignment process
5 versus the organization for a shared savings
6 kind of sharing purpose and a shared
7 governance purpose.
8 MS. THOMAS: Okay. Thank you.
9 MR. HAMMARLUND: Catherine, how
10 about those folks on the phone? Any other
11 questions or comments?
12 OPERATOR: Yes, we have another
13 question from Trent Green. Go ahead sir.
14 MR. HEWITT: Hi there, this is
15 Cory Hewitt sitting in with Trent Green, we're
16 from Legacy Health.
17 We have a question about the
18 benchmark again and about how the benchmark
19 will be set, specifically if there's going to
20 be regional adjustments to that or is it going
21 to use a national per capita expenditure to
22 make those benchmarks?
23 MR. BLUM: So here's the way that

1 I think about it is that the ACO program
2 nationwide you know given that we have such
3 different cost trends and kind of cost
4 relationships across the country, the ACO
5 program tries to balance those tensions in a
6 couple of different ways.
7 First is that it sets the
8 benchmark based upon the local experience, and
9 that's a comparison point. But the growth
10 rate, how those benchmarks are going to
11 increase are based upon the overall national
12 per capita change. So you know Congress sets
13 a balance and the CMS proposal sets a balance
14 between kind of providing encouragement for
15 organizations to participate in a low cost and
16 very efficient parts of the country but also
17 to provide incentives to provide within the
18 high cost areas of the country.
19 And that's the way that we're
20 balancing that tension is to set the benchmark
21 based upon local experience but to grow it
22 each year based upon the national per capita
23 that for low cost areas of the country, for

1 example, that will provide hopefully a more
2 healthy increase but at the same time that
3 will dampen the increases for the high cost
4 parts of the country.
5 So we're trying to balance
6 competing tensions between how to set a
7 national payment policy you know given that we
8 have much different cost relationships
9 throughout the country.
10 MR. HAMMARLUND: Do we have any
11 other questions or comments from the room
12 here? Catherine, how about on the phones?
13 OPERATOR: I have no further
14 questions.
15 MR. HAMMARLUND: All right. Well
16 we're going to do one more look here. Going
17 once?
18 MS. GROVER: I'm Linda Grover,
19 I'm the Director of Corporate Services for
20 Kline Galland Center and we have a skilled
21 nursing facility in the Seward Park area.
22 My question is I'm not
23 understanding about the assigning of the

1 beneficiaries. Can you explain a little bit
2 about how that would happen? Is it that the
3 beneficiary would express interest in joining
4 an ACO and then you would assign them? Are
5 they assigning themselves? Could you explain
6 how that works?
7 MR. BLUM: Sure. I think it goes
8 back to the earlier questions. For the ACO
9 program, to our proposal the beneficiary is
10 not making an active choice. He or she is,
11 you know, navigating the Medicare fee-for-
12 service program the same way that he or she
13 does today. She sees a physician, she needs a
14 hospital, based upon that physician's
15 recommendations but there's no form that a
16 beneficiary would fill out that would say I
17 want to be in an ACO.
18 Now hopefully if this program
19 works to our collective goals, that there is a
20 better care coordination experience, better
21 care transition experience, a stronger
22 relationship with the beneficiary's physician
23 but the beneficiary is not making an active

1 choice to say that I want to be in an ACO.
2 Hopefully, he or she is saying
3 that I want to see a physician that's
4 participating in an ACO to create that
5 stronger relationship.
6 The assignment process will be
7 behind the scenes, after the fact. CMS will
8 look at claims data to assess how a
9 beneficiary is navigating primary care
10 services and, based upon the plurality of
11 primary care services, which physician did the
12 beneficiary see most often in the given year,
13 that will be the assignment process.
14 But to a beneficiary perspective
15 this is going to be a seamless assignment
16 process but we do believe that the beneficiary
17 has the right to know that his or her
18 physician participates in an ACO which caused
19 us to propose the kind of disclosure process.
20 But the assignment process is not the
21 beneficiary signing a form or indicating to
22 CMS or to the Medicare program that they want
23 to be in an ACO. It's the physician who is the

1 participant.

2 MR. DAVID: Lloyd David. Could

3 you just speak to the thinking about the

4 severity documentation in the draft

5 regulations?

6 MR. BLUM: I want to give you

7 sort of my experience based upon the MA

8 program, based upon the PGP demonstration. In

9 the MA program, as you know, we see rises in

10 documentation occurring. When you provide

11 incentives to plans or entities to code they

12 do it. It's not fraudulent, it's just a

13 natural way of operating. But from a

14 government perspective, from a budget

15 perspective, that raises costs. And so in the

16 MA program we've had to make adjustments, you

17 know, bringing down the payments due to those

18 documentation and coding increases.

19 In the hospital PPS environment we

20 have proposed very significant payment

21 reductions based upon coding and documentation

22 increases.

23 What we're trying to accomplish

1 with our proposal, we're going to adjust for
2 risk but we're not going to pay for those
3 documentation coding trend increases. That's
4 the payment philosophy.
5 Now that takes away the incentive
6 to code accurately but from a
7 budgetary/government perspective that takes
8 away some of our financial risk from the
9 government side. But that's a tension because
10 we want to create a payment environment that
11 is fair and that provides incentives to take
12 on high cost patients.
13 This is an area that I know we'll
14 get lots of comments on but if you can take it
15 from the government perspective, from the
16 trust fund perspective, this is a cost to the
17 program.
18 Now if you look at the PGP
19 demonstration some have argued that when you
20 adjust for the coding changes the savings that
21 were achieved go away, so we're very mindful
22 that this program has to both raise quality to
23 create a good business proposition for

1 entities to participate but at the same time
2 protect the trust funds. And that's how we're
3 balancing those competing tensions but I know
4 this is going to be an area for comment, so
5 that's the thinking behind the proposal.
6 MR. HAMMARLUND: Anybody else in
7 this room? Catherine, one more try with the
8 phone lines.
9 OPERATOR: I have a question from
10 Donna Milands. Go ahead, your line is open.
11 MS. MILANDS: My question is a
12 beneficiary related question. If a patient has
13 been assigned to a critical access hospital
14 with a primary care facility and then requires
15 hospitalization, is there going to be any
16 penalty to the beneficiary or any disincentive
17 for that patient or will the patient
18 experience more of a cost if they choose to go
19 to a different facility for their
20 hospitalization?
21 MR. BLUM: No. The beneficiary
22 still has the right and the opportunity,
23 without financial penalty, to use any hospital

1 that participates in the Medicare program. So
2 the notion here is that we're trying to create
3 stronger ties but there is no financial
4 penalty or no financial disincentive to the
5 beneficiary to not use a hospital that's part
6 of an ACO organization.
7 MS. MILANDS: And then the second
8 part of that is would the ACO be affected with
9 lower scores?
10 MR. BLUM: Well, I think the hope
11 of the ACO program is that the total spend by
12 the beneficiary in the course of a year for
13 Part A and Part B medical services is reduced.
14 So there's an overall trend factor to consider
15 so the ACO has an incentive to coordinate and
16 to manage and to ensure that beneficiaries
17 have very good experiences when they do go to
18 the hospital. So there is financial incentive
19 on the ACO but not on the beneficiary.
20 But there's no gatekeeper type
21 mechanism that the ACO could prevent the
22 beneficiary from navigating the health care
23 system how he or she does today.

1 MS. MILANDS: Thank you.
2 MR. HAMMARLUND: Thank you.
3 Catherine, anybody else on the phone
4 OPERATOR: We do have a question
5 from Henry Chen. Go ahead your line is open.
6 DR. CHEN: Yes, Henry Chen. I'm
7 an internist and I'm representing an
8 association of the Chinese community; an
9 organization from New York City. And there's
10 two questions, two comments.
11 One, the benchmarks set in the
12 proposed rule, we feel that it's really
13 penalized the good performance from our past
14 experience and we have reached under 75
15 percent so we are in a good performance
16 group. So with the benchmark setting in this
17 criteria then we are penalized for that good
18 performance.
19 We propose that the benchmarks
20 should be set in a regional, either by city,
21 by state or by whatever the region, and that's
22 fair for everybody to compete in that
23 benchmark.

1 The second question our comment is
2 from the proposed rule we see that they allow
3 75 to 150 ACOs but we feel that many of the
4 physicians or hospitals or other entities
5 already formed an ACO with a legal entity. So
6 what we would like to see is an ACO with the
7 legal entity in which more than 5,000 Medicare
8 beneficiaries should be allowed and should be
9 given the certification or should be given the
10 construct to start an ACO, because we have
11 spent so much effort and time and money to
12 build an ACO, especially the one we have in
13 New York City right now. We raised more than
14 $1.5 million and 200 participants so we are
15 really into this field.
16 And they lost. They only allow
17 seven ACOs and how do they count along with
18 the CMS proposed rule from 75 to 150 and also
19 even with the proposed rule up to 150 it is
20 still not enough for whoever is interested and
21 whoever is able to do this ACO. And I'd like
22 to see any comment from CMS.
23 MR. HAMMARLUND: Thank you.

1 Before we do that can I just ask you to again
2 let us know your name and how it's spelled?
3 DR. CHEN: Henry Chen. C-h-e-n.
4 I'm an internist in New York City.
5 MR. HAMMARLUND: Great. Thank
6 you very much.
7 DR. CHEN: Our organization is
8 the Chinese community, an organization that
9 was legally formed under New York general
10 corporation law.
11 MR. BLUM: Sir, I think I don't
12 follow what your specific question is. Are
13 you trying to understand better the financial
14 model that we're proposing or is it a more
15 specific question?
16 DR. CHEN: A specific question.
17 One question is benchmarks and we'd like to
18 see the benchmark should be set as a regional
19 benchmark not seeing the ACO as one.
20 And the second, the ACO we would
21 like to see if any ACO with the legal entity
22 with more than 5,000 Medicare beneficiaries
23 should be given the construct to start as an

1 ACO.

2 MR. BLUM: Sir, I think your
3 question says can an organization with less
4 than 5,000 beneficiaries participate and the
5 statute prohibits that. We have to use the
6 5,000 as the base. And we've heard comments
7 that that should be lower but we're really
8 locked into it to a statutory construct.

9 And then to your question about
10 could the benchmark be set more on a regional
11 level than on a specific level to that ACO,
12 and again that's an area that we're taking
13 comments on. We have put our proposal out
14 but we expect that to be part of the comment
15 process and really can't comment until we go
16 into the final rule process.

17 MR. HAMMARLUND: So we look
18 forward to your comment on that. All right.
19 We're going to have to bring this to a close
20 pretty soon. Is there anybody else in this
21 room that would like to make a comment or ask
22 a question? Going once? Twice? Catherine,
23 anybody else on the phone?

1 OPERATOR: I do have another
2 question.
3 MR. HAMMARLUND: All right.
4 We'll take this and this will close out our
5 session today.
6 OPERATOR: Okay. It comes from
7 Beth Roder. Go ahead your line is open.
8 MS. RODER: Yes. I'm wondering
9 how with the measurement of the patient
10 experience and increased coordination how are
11 you going to balance those things for patients
12 who are used to being able to self direct and
13 not utilize primary care, etc.? As I
14 understand the ACO model it will be more
15 primary care based. And so how are you going
16 to measure for the changes in how the
17 beneficiaries' perception of their quality has
18 changed? Feeling more restricted possibly and
19 those kinds of things, the very reasons why
20 people don't enroll in Medicare Advantage,
21 etc.
22 MR. BLUM: Sure. Well that's a
23 very good question and that is part of our

1 overall quality metric proposal. And one
2 reaction that we're getting is your quality
3 framework is really, you know, far reaching
4 and a lot more aggressive than we have ever
5 seen by CMS before.
6 But on the other hand, we're also
7 trying to gauge and trying to assess and
8 trying to measure that patient experience.
9 And what the law and the framework really has
10 created with the ACO program is a patient-
11 centric organization and so that has led us to
12 think about the quality framework as being one
13 based upon patient outcome and patient
14 experience taking into account surveys of
15 patient care.
16 And this is not just true in the
17 ACO programs; we're also trying to develop
18 high quality frameworks for the MA program,
19 Medicare Advantage, for hospitals for dialysis
20 services, much more focused on the patient
21 experience, the patient outcome than simply
22 the process of care.
23 So take a look, please, at our

1 proposed framework for quality assessment. We
2 have tried our best to incorporate that
3 patient experience but again going back to the
4 overall notion of framework and the kind of
5 statutory authorization, the ACO program to
6 our minds is really a different patient-
7 centric model.
8 MR. HAMMARLUND: Thanks so much
9 for your questions. Catherine, can you tell
10 us how many folks we had on the phone today
11 joining us?
12 OPERATOR: Sure. Just one
13 moment. One hundred and four.
14 MR. HAMMARLUND: One hundred and
15 four. Quite a crowd, including New York City
16 so that just shows you how virtual we are.
17 I want to thank you all very, very
18 much for coming today and being part of this
19 dialogue. We've received some great questions
20 and some great comments and we really
21 appreciate your input.
22 Please do comment formally in
23 writing and your deadline again is Monday,

1 June 6th. We look forward to you giving us
2 your knowledge and interest.
3 I want to do a few thank yous. I
4 understand that we have some representatives
5 from Senator Murray's office as well as
6 Representative Inslee's office so we're
7 delighted you could join us today. Thank you
8 very much.
9 Secondly, I want to again thanks
10 Jennifer Magyar, my colleague from the Seattle
11 office, for helping us. I want to thank my
12 co-host, Susan Johnson and all of my staff
13 here in CMS Seattle who helped put on this
14 session today. Most kudos go to you for
15 taking time out of your busy day to join us.
16 We really appreciate it.
17 And finally let's give one more
18 hand to Mr. Jonathan Blum from Washington,
19 D.C. Thank all very much for coming and enjoy
20 your day.
21 (Applause)
22 (Whereupon, the Listening Session
23 of the Medicare Shared Savings Program

1 Accountable Care Organization having been
2 concluded, went off the record at 10:55 a.m.)