MEDICARE SHARED SAVINGS PROGRAM
PROPOSED RULE OVERVIEW
NATIONAL PROVIDER TELECONFERENCE
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Operator: Welcome to the Medicare Shared Savings Program Proposed Rule Overview National Provider Teleconference. All lines will remain in a listen only mode until the question and answer sessions

Today's conference call is being recorded and transcribed. If anyone has any objections you may disconnect at this time. Thank you for participating in today's call. I will turn the conference call over to Ms. Leah Nguyen. Ms. Nguyen, you may begin.

Leah Nguyen: Thank you, Sarah.

Hello. I'm Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to the Medicare Shared Savings Program Proposed Rule Overview National Provider Teleconference.

On March 31st, 2011 the Centers for Medicare & Medicaid Services released a notice of proposed rule making for the Medicare Shared Savings Program: Accountable Care Organizations, as established under the Affordable Care Act.

Under the proposed rule, eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or joining an Accountable Care Organization, also called an ACO. The public comment period on this proposed rule closes on June 6, 2011.

CMS has hosted a series of teleconferences and listening sessions during the comment period to help the public understand how CMS is proposing to administer the programs and to ensure that the public understands how to participate in the formal comment process.

During this national providers teleconference, CMS subject matter experts will give an overview of the shared savings program proposed rule and will respond to questions following the presentations.

Please note that this call is being transcribed, and a written transcript will be posted to the CMS teleconference and events section of the Shared Savings Program website at www.cms.gov/SharedSavingsProgram within a week.

You'll also find on the shared savings program website links to the proposed rule, various fact sheets that discuss the proposed rule, and transcripts of three proposed rule teleconferences held during this 60-day comment period. There will not be an audio replay of this teleconference.

It is important to understand that this teleconference is not the forum to submit formal comments on the proposed rule. You may submit comments in one of four ways that are outlined in the notice of proposed rule making - electronically at www.regulations.gov, by regular mail, by express or overnight mail, and by hand or courier. The proposed rule provides specific details on submitting your comments. Due to staff and resource limitations, we cannot accept comments by fax.

Formal comments on the proposed rule will be accepted for 60 days, ending on close of business Monday, June 6, 2011. CMS will respond to all comments in a final rule to be issued later this year.

Without further delay, I would like to introduce our presenter for today, Dr. Terri Postma. Dr. Postma is a neurologist, who currently serves as Medical Officer and Advisor in the Center for Medicare at CMS. Before joining CMS, she completed a public policy fellowship with the Senate Finance Committee during the healthcare reform debate.

Following the fellowship, Dr. Postma came to CMS, where she advises senior leadership on policy issues related to Medicare's payment system and quality initiatives, particularly value-based purchasing initiatives such as the Medicare Shared Savings Program, resulting from passage of the Affordable Care Act.

And, now, it is my pleasure to turn the call over to Dr. Terri Postma.

Proposed Rule Overview

Dr. Terri Postma: Great. Thank you. Hi, everyone. Thanks for joining us today. I've been asked to give a brief overview of several aspects of the Medicare Shared

Savings Program proposal. What I'd like to do is give an overview of several aspects of how the law directs us to implement the Shared Savings Program. And then, I'm going to highlight some areas where we have discretion and what we've proposed. And, what we're hoping that you'll submit formal comments on.

The Medicare Shared Savings Program was mandated last year as part of the Affordable Care Act. It's in section 3022. It establishes a voluntary program that incentivizes Medicare providers and suppliers to form what are known as Accountable Care Organizations or ACOs in order to improve the quality and efficiency of care delivered to Medicare fee-for-service beneficiaries.

This provision must be established by CMS no later than January 1st, 2012. On March 31st as was mentioned, we displayed a Notice of Proposed Rule Making containing proposed policies to implement the Shared Savings Program, and we're looking forward to receiving public comments on it.

Details on how to submit comments are located in the proposal itself. And, as was mentioned, one of the ways that the public can submit comments is through www.regulations.gov. And, comments are due by June 6.

Additional information, including a link to the proposed rule, fact sheets, and links to notices concurrently released by the antitrust agencies, IRS and OIG can be found at www.cms.gov/sharedsavingsprogram.

As many of you may know, the concept of ACOs grew out of the Dartmouth Atlas Project work on geographic variations in cost and quality. MedPAC featured the concept in its June 2009 report to Congress. And during the development of this healthcare reform provision, Congress drew from these expert sources as well as from the Physician Group Practice Demonstration or PGP Demonstration Project at CMS.

The PGP Demonstration showed promise as a model for improving the quality of care delivered to a Medicare fee-for-service population, while controlling growth and expenditures. In the first four years of the demonstration, all 10

PGP participants demonstrated quality improvement in measure modules. And six of the 10 groups received $78 million in savings.

Now, anyone who's been involved in our healthcare system, whether as a provider, a patient, or the family member of a patient, knows that our healthcare system is fragmented. It's developed in pieces. A hospital over there. A Clinic over here. And it's developed really without conscious or well-designed connections between those pieces. Fragmentation of payments, particularly fee-for-service payments, reinforces that fragmented care.

The Shared Savings Program is a new approach to the delivery of healthcare aimed at reducing that fragmentation, improving population health, and lowering overall healthcare expenditures by promoting accountability for the care of a Medicare fee-for-service population, improving coordination for services provided under Medicare Parts A and B, and encouraging investment in infrastructure and redesign care processes.

Participants in the Medicare Shared Savings program would continue to receive fee-for-service payments. But, the way that they've organized or the group that they've organized in would be rewarded each year with an incentive payment for demonstrating high quality and efficient care delivery.

It should be emphasized that this is not a managed care program. This program is designed to provide an incentive for providers of fee-for-service care to improve the quality and efficiency of care delivery to a fee-for-service Medicare population.

Now, the law states that an ACO must be a legal entity and must be a group of healthcare providers and suppliers that work to manage and coordinate care for Medicare fee-for-service beneficiaries. The ACO must agree to be held accountable for the quality, cost, and overall care for Medicare beneficiaries who are assigned to it.

They must also encourage investment and infrastructure and redesign coordinated care processes for high quality and efficient service delivery. The

law further states these providers and suppliers must have a mechanism for shared governance.

Now, the law also requires an ACO to meet several eligibility requirements in addition to the ones that I just mentioned. The proposal explores each of these. And we made proposals around how to verify that ACOs meet each of these criteria and are seeking comment on them. By law, the ACOs must meet these eligibility criteria.

ACOs must have a formal legal structure to receive and distribute payments. ACOs must have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries. The ACOs must agree to participate in the program for a period of three years. An ACO must have a leadership and management structure that includes clinical and administrative systems. The ACO must define processes to promote evidence-based medicine, report quality and cost measures, and coordinate care. And, an ACO must demonstrate that it meets patient centeredness criteria.

I'm going to take a minute and review each of those requirements that are in law and what we've proposed.

We proposed that the legal entity must be recognized under state law, having a taxpayer ID that can receive Shared Savings payments and distribute them to the participants. We proposed that the mechanism for shared governance be in the form of a governing body, which is provider based. That is, it would be comprised of, at least 75 percent Medicare enrolled providers and suppliers and include a beneficiary representative.

The governing body would make the decisions for the ACO, such as how best to redesign care processes among the participants, how best to coordinate care, and how best to share savings among the participants.

The law says that the ACO must have enough primary care physicians sufficient to care for and to assign at least 5,000 fee-for-service beneficiaries. This is a really important criterion, and I'll go into more detail on this a little later.

Clinical integration is also an important part of the ACO. And something we worked closely on with the FTC and DOJ. Clinical integration is something that mitigates concerns that an ACO is behaving anti-competitively. The law states the ACO must have clinical and administrative systems in place.

So what we've proposed is that clinical integration would be demonstrated by having an experienced executive team whose focus is quality improvement, clinical management by a local senior level medical director, and financial or human investment in the performance and success of the ACO.

As I mentioned earlier, the law also states the ACO must define processes to do certain things, such as promote evidence-based medicine, report quality and cost measures, and coordinate care. So, what we've proposed is that the ACO tell us on its application how it will be doing those things.

The law also states the ACO must meet patient-centeredness criteria as defined by the secretary. We drew from the Institute of Medicine and the National Partnership for Women and Families to propose a set of patient-centeredness criteria, emphasizing such things as provider and patient communication and patient engagement, patient involvement and governance, use of individualized care plans, internal monitoring and reporting for continual improvement, and community stakeholder collaborations.

We proposed that existing and newly formed organizations would be eligible to participate in the program. But they must meet all the other eligibility criteria. The ACO entities could include ACO professionals, as defined by the law - MDs, DOs, NPs, PAs, or clinical nurse specialists in combination with each other or in combination with hospitals.

CMS has also proposed to use secretarial discretion afforded by the law to expand that list of eligible entities to include all other Medicare enrolled providers and suppliers who would join with ACOs professionals to form an ACO.

Other eligibility requirements, the important ones that I mentioned before, which is having enough primary care physicians sufficient to care for and assign at least 5,000 fee-for-service beneficiaries.

While we've proposed that any Medicare enrolled providers-suppliers are invited to participate, the Medicare enrolled groups that form an ACO and apply for the program must have a primary care physician core sufficient to assign at least 5,000 fee-for-service beneficiaries.

We have proposed that method II critical access hospitals that bill for physician primary care services might be able to comprise the primary care core. ACOs would also be incentivized to include Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) as participants through a higher potential sharing rate. And we're seeking comments on all those proposals.

We proposed that ACOs may choose to participate in one of two tracks, both of which would be for the statutorily required three-year period. The first track would be comprised of two years of one-sided shared savings with a transition in the third year to two-sided performance-based risk where ACOs would share in both potential savings and losses, if there are any. The second track would be the three years. But all three years would be under two-sided performance-based risk, where the ACO would share in both savings and losses, if there were any. At the end of the three-year agreement period, the ACO would have the opportunity to continue in the program for another three years. But it must be under that second track, the two-sided model of performance-based risk.

We believe this proposal provides an on-ramp or entry point for organizations to gain experience under the one-sided model in track one with shared savings before transitioning to a performance-based risk model. Additionally, we believe that track two, the two-sided performance-based risk model, provides the opportunity for groups to take on performance-based risk immediately in exchange for a higher reward.

In the one-sided model under the first track, we proposed that an ACO can earn up to 52.5 percent in savings, depending on quality performance and whether or not the ACO includes FQHCs or RHCs. In the two-sided model, the second track, we proposed that ACOs can earn up to 65 percent in savings depending on quality performance and whether or not the ACO included an FQHC or RHC.

As we talked about before, the ACO must become willing to become accountable for the Medicare fee-for-service population assigned to it. Again, unlike a managed-care setting, fee-for-service beneficiaries retain their freedom to choose any practitioner they wish to see, regardless of whether that practitioner is participating in the ACO or not. Because of this, when we refer to assignment, what we're really talking about is the operational necessity of defining a population unique to the ACO for purposes of determining whether the ACO has met the standards necessary to receive an incentive payment for improving the quality and efficiency of care delivery.

Beneficiary assignment is the basis for establishing and updating the financial benchmark, quality measurement and performance, and the focus of the ACO's efforts to achieve what our administrator, Dr. Don Berwick talks about the three-part aim – better care for individuals, better health for populations, and lower growth in expenditures.

We've proposed to assign beneficiaries in a similar fashion to the way in which beneficiaries were assigned the PGP Demonstration. That is we've proposed to assign beneficiaries retrospectively based on the plurality of allowed charges. Unlike the PGP Demonstration, we've proposed that beneficiary assignment be based on services rendered by primary care physicians defined as internal medicine, geriatric medicine, general practice, and family practice.

In the proposed rule, we discussed alternatives to this proposal such as the two-step method of assignment. First, on the basis of primary care physician as described above. And then, second, on the basis of all provider types for beneficiaries who lack a connection to a primary care physician. We're seeking comment on this proposal.

Many stakeholders have expressed preference for prospective assignment of beneficiaries. They've told us it's important for them to understand who their patient population is so that they can proactively redesign care processes that make sense for improving the quality and efficiency of care delivery for those patients.

While prospective assignment makes a lot of sense in the managed care world, where beneficiaries choose to be locked into a network, the Medicare Shared Savings Program is focused on the fee-for-service population. We've expressed concerns in the proposal that prospective assignment may unintentionally place limits on fee-for-service care or cause the ACO to create care processes for a select group of individuals, rather than standardizing care processes for all patients. Moreover, when pressed, providers have told us that they really want to be held accountable for who they actually cared for during the course of the year, rather than risk being held accountable for beneficiaries that may ultimately choose, during the course of that year, to receive care elsewhere.

With these things in mind, we're proposing to assign patients retrospectively based on where they chose to receive the plurality of their primary care services. If they chose to receive a plurality of their services by providers participating in the ACO, they would become part of a population assigned to that ACO.

But - in response to the stakeholder concerns that we heard, and in order to assist ACOs to proactively redesign care processes that make sense for their population , we're also proposing to provide the ACO with certain data at the start of the agreement period. These data would be in the form of an aggregate report of beneficiary characteristics and utilization derived from the fee-for-service population cared for by the ACO during the three-year benchmark period. Additionally, upon request, the names of those beneficiaries used to derive the benchmark would be shared with the ACO.

This is sort of hybrid approach that we've proposed. And we believe this hybrid approach creates an incentive for ACOs to standardize care processes

and treat all Medicare fee-for-service patients the same, while also aiding ACOs in understanding their patient populations and proactively redesigning care processes for them. And also holding ACOs accountable for who they actually saw during the course of the year.

We've proposed that providers participating in the program be required to notify their patients that they are participating. Beneficiaries would also receive general information about the Shared Savings Program from CMS. The information would make clear that there are no changes to their benefits or their rights under fee-for-service to choose their providers. We've also proposed that in the course of data sharing with the ACO that we share, on a monthly basis, beneficiary identifiable claims data.So what we've proposed along those lines is that beneficiaries be given the opportunity to decline to have their data shared with the ACO. Regarding quality measures and performance, according to statute, without meeting both the quality standard and achieving lower growth in expenditures, the ACO will not share in savings.

The statute also directs us to evaluate the ACO on such measures as patient experience of care, utilization, process, and outcomes. We therefore propose 65 measures to form the quality performance standards. Measures would be collected in several ways: by a claim, posing no additional burden on the ACO; by a survey; and with the GPRO tool used in the PGP Demonstration and in PQRS.

We proposed five domains for these quality measures: first, patient caregiver experience of care; second, care coordination; third, patient safety; fourth, preventive health; and, fifth, at risk and frail elderly health.

We proposed measures that align with other CMS initiatives, such as Physician Quality Reporting System (PQRS) and the EHR Incentive Programs. We've also proposed that regardless of whether the ACO has successfully met the quality standard and regardless of whether the ACO shares in savings, if the ACO reports fully on these proposed measures, eligible professionals would qualify the PQRS bonus if they participate in an ACO that fully reports measures through the Shared Savings Program. The

PQRS bonus would be separate payment. It would not be deducted from any share in savings.

In response to stakeholder concerns, we work closely with FTC and DOJ to develop an application process that would ensure applicants would be able to meet the three year commitment, required by statute. The antitrust policy statement published by FTC and DOJ concurrently with the ACO proposed rule, outlines and solicits comment on proposed Safe Harbors related to the creation and operation of the ACOs and applies to collaborations formed after the passage of the Affordable Care Act on March 23, 2010.

A key component to the antitrust policy statement is the primary service area, (PSA) calculation for percent share for common services. ACOs must calculate PSAs as part of the application process. PSA calculations indicate whether an ACO applicant must undergo expedited antitrust review as part of the application process.

ACOs undergoing antitrust review must have a letter of approval from an antitrust agency before entering an agreement with CMS. That would apply to ACOs with a calculated PSA share greater than 50 percent. ACOs with a PSA share of 30 to 50 percent may also request an expedited review. Or, they may agree to comply with good market conduct principles or do neither, but run the risk of antitrust agencies scrutiny in the future.

ACOs with PSA shares of less than 30 percent would meet what the policy statement describes as the antitrust agency safety zone and no review would be necessary as part of the application process. Additionally, as described in the antitrust policy statement, any ACO that meets a rural exception would qualify for the safety zone.

Iin addition to the statement of antitrust enforcement policy by FTC and DOJ, there were a number of other notices issued concurrently with our proposed rule. There was a notice of tax guidance on ACOs by the IRS. And, also, a joint CMS and OIG publication with comment period regarding possible waivers of the Civil Monetary Penalties Law, anti-kickback statute, and the

physician self-referral prohibition with respect to certain specific circumstances of the Social Security Act.

We heard a number of public concerns about the interaction between the Shared Savings Program and those three specific laws. CMS is committed to harmonizing fraud and abuse laws with the Shared Savings Program. Congress provided the secretary with a tool to address this tension created by these statutes, which is a waiver authority within this law.

Sections 3021, which deals with demonstration pilots and programs under the Innovation Center, and section 3022, the Medicare Shared Savings Program, expressly authorizes the secretary to waive the fraud and abuse laws as necessary in order for these programs to be successful and for participation in them.

CMS and OIG attempted to propose uniform waivers across applicable laws. We recognize that these laws are different and therefore, waivers would be structured differently. Both CMS and OIG intend to apply waivers uniformly to all eligible participants. These waivers would last as long as the agreement with CMS is in place. The waiver would apply to any ACO or its participants, providers, or suppliers that have entered into a Shared Savings Program agreement with CMS.

ACOs, ACO participants, and ACO providers and suppliers are required to comply with the agreement, statute, and implementing regs. CMS is particularly interested ensuring the ACOs comply with patient and program safeguards, while receiving the benefits of the waiver.

I'm going to go through each of those three laws and give you a little bit of background on what the laws are and then what the proposed waiver says. So the first one is the self-referral law, also known as the Stark Law. The Stark Law prohibits physicians from referring Medicare patients for certain designated health services, including hospital services, to entities with which they have a financial relationship.

CMS is responsible for the Stark Law policy. There are many exceptions with very technical requirements. An arrangement must fit fully into an exception in order to avoid liability. Entities cannot bill Medicare for improperly referred services under the Stark Law.

The proposed Stark Law waiver would apply only to shared savings distributions made by CMS to the ACO under the Medicare Shared Savings Program. The proposal would waive all Stark liability for distributions to or among ACO participants, ACO providers and suppliers, or members of those categories who were part of an ACO when savings were earned.

The proposal would also waive Stark liability for distributions to other individuals or entities for activities necessary for and directly related to the ACO's participation in and activities under the Medicare Shared Savings Program. These proposed waivers do not intend to protect other payments to physicians outside the ACO but some of those would fit into existing exceptions.

Second, the anti-kickback statute law. The anti-kickback statute is an intent-based criminal law that, broadly speaking, prohibits the purposeful buying and selling of any federal healthcare program business. There are a number of existing voluntary Safe Harbors that protect some arrangements. OIG is responsible for creating this policy.

Both the Stark Law and the anti-kickback statute were enacted in order to combat over utilization and improper steering of patients in the context of a fee-for-service payment system that rewards volume. In the joint proposal of waivers this is generally designated to parallel the Stark waiver.

We've proposed to waive the anti-kickback statute related to several distributions. Distributions of shared savings to or among ACO participants, ACO providers or suppliers, or members of those categories who are part of an ACO when savings were earned. We've also proposed to waive the anti-kickback statute related to distributions of shared savings to other individuals or entities for activities necessary for and directly related to the ACOs participation in and activities under the Medicare Shared Savings Programs.

Finally, if a financial relationship is necessary for an ACO's participation in the Shared Savings Program and if that financial relationship fully complies with the Stark Law exception, then it will also comply with kickback. That has not always been the case. So this waiver brings Stark and anti-kickback laws in line with each other.

Third, Civil Monetary Penalty or "gain sharing". One of the provisions of the Civil Monetary Penalty Law prohibits hospitals from paying physicians to reduce or limit services to hospital patients under the physicians' care. This is different from the Stark Law and the anti-kickback statute because it arises in the context of the DRG payment system. Civil penalties are up to $2,000 per patient for these covered services.

The OIG is responsible for creating this particular policy. All of these laws operate on the general principle that medical decision making can best be protected by removing temptations to make decisions based on financial interest.

In our joint proposal, the "gain sharing" provisions of the CMP law are waived for distributions of Medicare Shared Savings Program shared savings payments where the hospital and physician are each ACO participants, or providers and suppliers, or where ACO participants or providers and suppliers during the year in which shared savings were actually earned. We've also proposed waiving distributions for shared savings payments where the payments are not made knowingly to induce limitation or reduction of medically-necessary services.

And, finally, gain sharing CMP has also waived as to financial relationships between ACO participants and-or ACO providers and suppliers that fully comply with an exception to the physician self-referral law.

CMS and OIG received other public comment requesting that we consider broader or differently targeted waivers. We're looking forward to comments that provide detailed responses to our solicitations. And we're particularly interested in specific descriptions of planned or proposed ACO models.

Solicitations broadly fall into several categories: Remuneration directly related to startup costs or investment costs; non-shared savings financial arrangements either between or among ACO participants and/or providers and suppliers, or with outside entities,for example, care management fees and the provision of EHR systems; arrangements with private payors; and the scope, safeguards, and duration of waivers; finally, the two-sided risk model.

Please do send in specific comments. Some of those relate to Medicare Shared Savings Program and some relate to the Innovation Center initiatives. And, I want to go into that for just a minute before we open it up to questions.

Congress created the Innovation Center under the Affordable Care Act, giving the center the authority and direction to test innovative payments and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those who get Medicare, Medicaid, or CHIP benefits.

The Innovation Center recently announced three initiatives related to the Medicare Shared Savings Program. First, the Innovation Center will be testing other ACO payment models, such as partial capitation, with experienced organizations. Lessons learned from these demonstration and pilot projects will inform future development of the Medicare Shared Savings programs.

Second, in response to stakeholder concerns regarding startup costs for participation in the Shared Savings Program, the Innovation Center is seeking feedback on the possibility of an advanced payment for certain participants who lack ready access to capital needed to invest in infrastructure and staff for care coordination.

Finally, the Innovation Center has also announced a series of accelerated development learning sessions, designed to provide executives from existing and emerging ACOs with the opportunity to learn about essential ACO functions and ways to build capacity needed to achieve better care, better health, and lower expenditures through integrated care models.

With that, I'll turn it back over to our moderator, and we'll open it up for questions.

Leah Nguyen: Thank you, Dr. Postma. Before we begin the question and answer session, our CMS subject matter expert will begin by addressing the most frequently asked questions that we received through the online registration for this teleconference.

I will now turn the call over to Tricia Rogers, Acting Deputy Director of the Performance-Based Payment Policy Staff here at CMS.

Frequently Asked Questions

Tricia Rogers: Thanks, Leah. We've received a number of questions around the role of providers and suppliers who are excluded from the statutory definition of ACO professionals – those defined as physicians, NPs, PAs, and CNS, and hospitals defined as acute care hospitals under the IPPS. But we recognized that providers and suppliers across the healthcare continuum play an important role in improving the health and coordination of care of Medicare beneficiaries. So we have used secretarial discretion afforded by the statute to propose the expansion of the definition of an ACO participant to include any Medicare enrolled provider or supplier who may participate independently or by joining with other Medicare enrolled providers and suppliers as long as all other eligibility criteria are met. This could include, for example, healthcare professionals such as visiting nurses and entities such as long-term care facilities and home health agencies and SNF.

Another question, related to the first, a number registrants for this call are seeking clarification on the role of providers and suppliers in ACOs when they are not the basis for beneficiary assignment - such as specialists, FQHCs, and RHCs.

According the statute, assignment can be based only on a physician. As proposed, we would base assignment on MDs and DOs providing primary care services. Specifically, those with specialties of general practice, internal medicine, family practice, or geriatric medicine. We are seeking comment on

a step-wise approach to beneficiary assignment that includes identifying specialists who are providing primary care services to patients who are not seeing any other primary care professional.

As proposed federally qualified health centers (FQHCs) or rural health clinics (RHCs) cannot independently form an ACO, but will be a valued partner. And an ACO may receive increased savings for including FQHCs and RHCs in the ACO partnership. We currently lack the requisite data elements in the claims and payment system to enable us to determine beneficiary assignment during the performance year, as well as for determining the statutory three-year benchmark based on FQHCs and RHCs.

A third concern we heard from the call's registrants pertains to the attractiveness of the program to entities that are in low-cost areas or low-cost providers. Some consider the proposed shared savings methodology advantageous to providers in low-cost areas or low-cost providers because the benchmark will be updated annually by the projected absolute amount of growth in the national per capita Medicare Parts A and B expenditures.

Another question we received was about the availability of financial assistance for providers needing to establish electronic health records, and a related issue around the ability of smaller, independent practices to participate in an ACO. A week ago, and as Terri mentioned, the Center for Medicare and Medicaid Innovation released information seeking comment on the idea of the advanced payment initiative that gives certain ACOs participating in the Shared Savings Program access to the shared savings upfront, helping them make the infrastructure and staff investment crucial to successfully coordinating and improving care.

We have links on our Shared Savings website to the innovation website, or you can go directly at http://innovation.cms.gov for more details.

We also received a number of questions about the final rule, such as the timeline for publishing and how the final rule maybe different than what is proposed. The final rule will reflect suggestions provided in comments received. As you heard from Terri, we are seeking comment on numerous

issues and we encourage submission of substantive comments before the June 6 deadline. We will consider all official comments and issue a final rule later this year.

And then one last item, there were numerous questions on where to find descriptive information about the program. And I think Leah and Terri mentioned that our proposed regulation was published in the Federal Register on April 7. It was made public on March 31st. The Federal Register website is www.regulations.gov where you're able to see the proposed rule in its entirety. And, we have information and fact sheets available on our Shared Savings website at www.cms.gov/sharedsavingsprogram. And again, there are links to the Innovation Center from that website.

That is the overview of the questions we received. I might not have answered your specific question, but you got the general idea of the most frequently asked questions.

So with that, I'll turn it back over to Leah.

Question and Answer Session

Leah Nguyen: Thank you, Tricia. We will now move on to the question and answer session. As a reminder, we will not be taking official comments on the proposed rule today. Please refer to the proposed rule for instruction on submitting official comments.

Before we begin, I would like to remind everyone that this call is being transcribed. While asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we will only take one question per participant.

All right, Sarah. You may open the line for questions.

Operator: We will now open the lines for our question and answer session.

To ask a question, press star, followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question. And pick up your handset before asking your question to ensure clarity.

Please note your line will remain open during the time you are asking your question. Anything you say or any background noise will be heard in the conference. And, just one moment, while we compile the Q&A roster.

Your first question comes from the line of Trudy Overbay. Your line is open.

Trudy Overbay: Hi, this is Trudy Overbay with Smith County Ambulance Service. I was wondering how this was going to impact ambulance services. If we were going to be part of the organization, or if we would continue to provide services as we do now?

Terri Postma: Hi, Trudy. This is Terri. Thanks for your question. If ambulance services are Medicare enrolled providers or suppliers they may act as participants in the ACOs. So they would have to join together with other groups though because they don't provide primary care services required for eligibility. But, they could join with other providers and suppliers that can help meet that primary care core. So, in that way, they are welcome. We've proposed that any Medicare enrolled provider, supplier can participate.

As for payment structure, this program is designed to maintain the regular fee-for-service payment structure. So any ACO participant, any Medicare enrolled provider or supplier that participates would continue to receive the fee-for-service payment. But, at the end, those providers that have joined together to form the ACO will be assessed on a yearly basis. And if they've met the quality performance standards and they've reduced per capita cost for the fee-for service population assigned to them, then they would be able to share back in some of those savings as a lump sum incentive payment.

Operator: And your next question comes from the line of Travis Ansel. Your line is open.

Travis Ansel: Yes, hi. This is Travis Ansel with Healthcare Strategy Group in Louisville, Kentucky. My question was about the opt-out clause. I mean assuming that the ACOs are going to operate as they're defined and the regulations as

they're directed. If track one has losses in its first two years, but exercises the 60-day opt-out clause for years three, are they going to be responsible for those losses? Are they going to have to pay those losses after they opt-out?

Terri Postma: I think what you might be referring to is what we've proposed around sharing individual beneficiary identifiable data where we've said that the beneficiary will be given the opportunity to decline to have that data shared with the ACO. That's the only opt-out that I can think of that we talked about in the proposal.

Travis Ansel: I'm sorry. I thought it was in the regulations that there was a 60-day opt-out clause for any ACO that had joined the Medicare program for the three years.

Terri Postma: We've conferred a bit. And we think that maybe are you referring to the 25 percent withhold of shared savings?

Travis Ansel: No, I'm not. I've read through the regulations, but I don't remember which page it was on. But, there's a 60-day clause that allows an ACO to opt-out of the Medicare Shared Savings Program, but with 60-day notice. So I'm saying if they were in track one ,where they're non-risk bearing for the first two years, if October 31st of the second year, they've generated losses rather than savings, do they have the ability to opt-out before year three where they become risk-bearing? And, if so, are they responsible for those losses they've accrued during the first two years?

Terri Postma: One of the things we've proposed is that because the law states that as a condition of participation, as its eligibility requirement, is that the ACO participate for a minimum three-year period. What we've proposed is that if the ACO breaks that agreement that before the three-year period is up, and the ACO may do that. We can't prevent an ACO from breaking that agreement. However, if the ACO does break that agreement, then the 25 percent withhold that we've proposed would be retained by CMS because the ACO did not fulfill their agreement.

That might be - I think that's what you might be talking about. We proposed the 25 percent withhold to help offset any potential losses that might occur in

that third year. If there are no losses and the ACO continues to share in savings, that 25 percent withhold would be returned to the ACO upon the completion of the third year.

But, you know, like I said, since it is a condition of eligibility to participate for three years, if the ACO terminates the agreement before the three years is up then they would forfeit that 25 percent withhold.

Travis Ansel: And if they've never generated savings during the term of the agreement then there would essentially be no penalty for breaking the agreement?

Terri Postma: Yes, there is no withhold if there are no savings.

Travis Ansel: OK. Fantastic. Thank you.

Terri Postma: Yes, but they'd still be responsible for losses.

Operator: Your next question comes from the line of Julie Scurrick. Your line is open.

(Julie Scurrick): Hi, this is Julie Scurrick from ProStep. My understanding is that as a participant we would need to choose one ACO per tax ID. How would this be accomplished if we operate in several states?

Terri Postma: Yes. That's a good question, Julie. Thanks.

One of the things that we've put in the proposal and, of course, we're seeking comment on all these things. And we really would like your specific comments on them. One thing we proposed regarding the Tax ID is that we proposed to define ACO participants as their Medicare enrolled tax ID. This is really an operational necessity because we need to be assigning beneficiaries and that sort of thing. We need to know who's participating. So the Medicare enrolled tax IDs would, as part of the application, tell us who they are. And then, the Medicare enrolled tax IDs that are participating, upon whom assignment is based, would have to be exclusive to a single ACO. And the reason for this is because assignment is based on those tax IDs. We need that patient population to be unique to a single ACO. So a tax ID that's participating in two ACOs and assignments based on them, we can't tell,

which ACO really gets the shared savings payment for improving the quality and reducing the expenditures for those beneficiaries. And that's why we've proposed that those tax IDs upon which assignment is based must be exclusive to a single ACO. Tax IDs upon whom assignment is not based, however, are free to participate in several ACOS.

Julie Scurrick: Could you explain the difference between the two versus assignment and non-assignment?

Terri Postma: Sure. So we've made a number of proposals around how to assign fee-for-service beneficiaries. As I mentioned before, the law says that we have to assign on the basis of primary care services rendered by primary care physicians. And so we've proposed a number of CPT or E&M codes, office-based codes that would define primary care services and those services that rendered by primary care physicians, whichwe've defined to be geriatric medicine, internal medicine, family medicine, and general practice. Then when we see those claims come in and it's a plurality of services have been rendered for a particular beneficiary within those ACO providers, that beneficiary would become assigned.

And so we look at the claims that are sent in by these Medicare enrolled tax IDs. So if Medicare enrolled tax IDs have those primary care physicians practicing in them, providing those primary care services, they would be counted toward that plurality of services rendered to the Medicare fee-for-service beneficiary.

That's why those Medicare enrolled TINs or tax IDs that we're using to assign beneficiaries. And it would be primarily the ones who are billing for primary care services rendered by primary care physicians. Those are the ones that would have to be exclusive to a single ACO.

Operator: Your next question comes from the line of John Van Dyke. Your line is open.

(John Van Dyke): Hi, John Van Dyke with Hospice Caring from Wisconsin. Can an ACO participate in a community-based care transition demonstration as well?

Terri Postma: Hi, John. Thanks for that question.

When we draft up the final based on comments we hear, we're going to try to make it as clear as possible. And I think what you're referring to is that there's a section of a law that says that folks who are participating in certain other shared savings programs, or models, or demos cannot also participate in the Medicare Shared Savings Program. And, specifically, the law talks about the Independence At Home Act. It talks about the Center for Medicare or the Innovation Center demos, such as the one I mentioned with the pioneer model that they've proposed. That would be a duplicate. And the third one is the physician group practice demonstration. If groups are participating in a PGP demo extension, they would not also be able to participate in the Medicare Shared Savings Program.

And so, it would apply to any program or demonstration that involves Medicare fee-for-service beneficiaries. It would be those providers that would not also be able to participate in this shared savings program.

And the reason for that is that, I believe that was put in the law because they didn't want CMS to be paying out additional incentives or multiple incentive payments for the same fee-for-service population. So, the care transitions is one that we do not think would be a duplicate, but we're seeking comments on what you all think may be duplicates, or may not be duplicates. And we'll make that very clear in the final.

Operator: Your next question comes from the line of Kristi Knox. Your line is open.

Kristi Knox: Hi, this is Kristi Knox. I'm in Michigan, Gynecologic Oncology. My question, obviously, is referenced subspecialist. We've looked at this quite a bit. And it seems everything is very focused on primary care, as are most of the parameters for measuring quality. So my question is, are you expecting subspecialists with a very narrow area of care, in our case cancer, to be an active part of these ACOs? Or, are we waiting to see how our definitive parameters for measurement would be delineated for the date?

Terry Postma: Thanks, for that question, Kristi. You know, this program is very primary care focused because that's one of the eligibility requirements for that primary care core. So by necessity, all ACOs are going to have to have that primary care core. However, I think this is a really great opportunity for subspecialists, for hospitals, for other Medicare enrolled providers and suppliers to be involved in this process.

For example, we can't assign on the basis of a hospital because a hospital doesn't provide primary care services, the acute care hospital. But, hospitals are a very important part of the delivery system, as are subspecialists. And so I would think that a group of providers and suppliers in a particular region that think they might want to participate, I would think that it would be beneficial to have a hospital in their system or to have subspecialists in their system, or maybe a pharmacy. You know, all these provider types, all Medicare enrolled providers and suppliers have an obligation and a part to play in the delivery system for fee-for-service beneficiaries.

For example, care coordination between transitions, between different settings: transitions from the hospital to the primary care provider; from the primary care provider who refers out to a subspecialist and back again. Those transitions are really important, and that's where the ACO can make a big difference in care coordination.

To the extent that all these providers and suppliers are on board and are participating in the ACO, I think it improves the chances of success in improving the quality of care for those fee-for-service beneficiaries and for reducing growth in expenditures.

Even though there's a focus on measures for the primary care, and one of the reasons that we did that was because we know that primary care core will be a part of every single ACO. But, we didn't want to be prescriptive. We want to leave a lot of flexibility to various regions to determine how best to organize, get together based their populations and what makes sense to their regions.

You might have an ACO with a hospital in one place. You might have an ACO without a hospital in another place. Or, you might have an ACO with a

pharmacy in one place and not in another, or a subspecialist in one place and not in another. We've left that determination up to the ACOs to figure out what makes sense for them and for their region.

I hope that helps.

Kristi Knox: It does. I mean the concern that there is on both sides. And we've been meeting on reference ACOs is for the primary care physician since gynecologic oncology can be an expensive part of care with the surgery and the chemotherapy. Their concern is whether that will raise their cost. And then, obviously, on our side we're concerned is – if the primary care say we won't have any control over - won't do things to do the cost savings and we could all be on the line for more money. So it's a little bit concerning for subspecialists, that's all.

Terri Postma: Well, we'd really appreciate your specific comments on that.

Kristi Knox: OK. We'll do that. Thanks.

Terri Postma: Thank you.

Operator: Your next question comes from the line of Michael Fox. Your line is open.

Michael Fox: Hi, thank you. This is Mike Fox of Dean Health Plan in Madison, Wisconsin. I just want to know as far as the benchmark, the fee-for-service benchmark, if you have people in your service area or your ACO area that are members of a 1876 or cost plan where the plan is paying primary for Part B. It is only secondary for Part A. Is it just Part B that would be included in the benchmarking under fee-for-service? Or would both be excluded or both included?

Terri Postma: Thanks, Michael, for that question. This is a provision that's designed around the fee-for-service purchase population and for Parts A and B, for Medicare beneficiaries that are enrolled in traditional fee-for-service. So I think what you're talking about is beneficiaries that are enrolled in Medicare Advantage.

Michael Fox: Right. But under costs we are - the plans are not primary on A. They're just the secondary payer under A, so that the hospitals are paid. They're paid by CMS. They're paid fee-for-service.

Terri Postma: Right. But this would be for beneficiaries that are enrolled in traditional fee-for-service - A and B.

Michael Fox: So none of that experience would be included in the benchmark, neither in-patient or out-patient?

Terri Postma: No, those beneficiaries would not be assigned.

Michael Fox: OK. Thank you.

Operator: And your next question comes from the line of Chris Acevedo. Your line is open.

Chris Acevedo: Hi, this is Chris Acevedo with Acevedo Consulting. My question really deals more with the thought process behind not defining an ACO from a patient perspective and only holding the provider accountable. If providers can really only control what they're doing, so if the patient is going to providers that are outside of the ACO, I'm just wondering why CMS would not consider having the patients even opt-in to only receiving care through an ACO.

Terri Postma: Thanks for that question, Chris. I think really what that gets down to is that this provision is designed for Medicare fee-for-service beneficiaries. And under fee-for-service they have a choice about what providers to see.

One of the things though that we do discuss in the proposal is under patient centeredness is that relationship and getting beneficiaries engaged in their care through, for example, individualized care plans, through the patient experience for care survey, through other patient engagement mechanisms. And that – so that's part of the eligibility requirements.

We are seeking comment on that. And to the extent that we can help facilitate that patient engagement. Any specific suggestions you have along those lines we're open to hearing that.

Chris Acevedo: But you're saying that you're open to suggestions on how a provider may engage patients to perhaps stay within inside the ACO but not open to comment on whether or not you would modify the model to require patients to receive their care through an ACO, and maybe have to opt-out after a certain period of time, correct?

Terri Postma: Well, we're happy to take that comment. But, we have to follow what the law tells us to follow. And the law is in a traditional fee-for-service setting. So, there's no impact on beneficiary benefits under fee-for-service or their rights to choose their provider.

Operator: Your next question comes from the line of Carmilla Knockweinen. Your line is open.

Carmilla Knockweinen: Hi. I was trying to take notes as the introduction and the comments were being made. Is there going to be any type of summary document or bullet points that explain the five parameters, and the two tracks, and all of the definitions that you gave today?

Terri Postma: Yes. Thanks, Carmilla. It's a lot of information to cram into 30 minutes, and I can imagine your hands are cramped at this point. I'd like to refer you to our Website at www.cms.gov/sharedsavingsprogram . We've got a ton of information on that site. There's a link to the proposal itself. There's a link to a number of fact sheets, which distill a lot of this information. And, you can look there for some good bullets. And then, additionally, there are links to the concurrently-released notices, the joint notice by CMS and OIG that I mentioned earlier, the FTC and DOJ statement proposed policy statement, and then also the link to the IRS concurrent statement.

Carmilla Knockweinen: I was on that site, and I did look because I was on it while the phone call was going on just to see if there was a document for today. I really do appreciate the way you organized the thoughts of the call because I am now going to report back on this call, and I didn't get everything. I would have to go probably all of those places to find pieces that I missed. Is there anyway that you could maybe post your bullets from today?

Terri Postma: To make things really easy for you, we're going to be posting a transcript of this call.

Operator: And, again, if you would like to ask a question, please press star, then the number one on your telephone keypad. And, your next question comes from the line of Deb Brady. Your line is open.

Debbie Brady: Hi, my name is Debbie. And I'm calling from Hematology Oncology Associates. And, I work for a specialty office right now, but I've worked both on the hospital end and the physician end. And, here's my questions. It's two parts. Can a hospital start its own ACO? And if so, can they pick and choose who joins the ACO?

Terri Postma: Thanks, Debbie. So first, can a hospital start an ACO? Sure. A hospital can as long as the hospital can meet the requirements. So one of the things that the law talks about is a hospital who employs ACO professionals. And the ACO professionals in the law are whom assignments based on, particularly those primary care physicians. So it's possible that an ACO could be an ACO – or a hospital could be an ACO by itself if it meets those eligibility requirements and has that primary care core. Or, a hospital could reach out to other Medicare enrolled providers and suppliers in the area and see who else is interested in starting an ACO with them.

Debbie Brady: OK. So that's my first question. The second question was could a hospital pick and choose who joins the ACO? So let's say I'm with a specialty and the hospital has an ACO and they already have a physician for that specialty, does that just knock my physician out of the ballpark? I mean, how do we compete in that environment - that specialist?

Terri Postma: Not just the hospital, but any Medicare enrolled provider or supplier can pick and choose who they'd like to invite to join with them to create an ACO to participate in the program.

Debbie Brady: But can the hospitals - I guess my question is going back to the hospitals. Can they pick and choose who join? Let's say that my physician would be interested in joining the ACO. Can I call one of the hospitals that they use

and say, “I’d like to join your ACO?” And can they turn me down or at that point, would they - I mean what is the criteria?

Terri Postma: We’ve really maintained a lot of flexibility in the proposal for groups to join in a way that they prefer and that makes sense to them. So we haven’t placed any restrictions or any requirements on who must be present within an ACO., so it really is up to the providers and suppliers in the region.

I would say if you feel like your hospital is starting an ACO and they don’t want you for whatever reason to join, you’re free to join with other providers and suppliers in the region to form another ACO.

Debbie Brad: OK. Thank you.

Operator: Your next question comes from the line of Frank Floyd. Your line is open.

Frank Floyd: Dr. Frank Floyd, United Health Services Binghamton, New York. My question just getting started on the process. How do you do an assessment to determine where you would fall under your savings and payments methodology to help determine which one of the risk categories you might want to enroll in? Or, whether you even want to enter the program?

Terri Postma: Thanks, Frank.

One of the things you might want to consider is the Innovation Center Accelerated Development Learning Sessions. Anybody who is thinking of starting an ACO or who might already be participating in an ACO is welcome to look into these sessions. They are designed specifically for existing or emerging ACOs. For the opportunity to learn about essential ACO functions and the ways to build the capacity that are needed to function under the shared savings model.

That can be found at the Innovation Center Web site, or there’s a link on www.cms.gov/sharedsavingsprogram to the Innovation Center site.You might want to look into those Accelerated Development Learning Sessions.

Frank Floyd: Thank you.

Terri Postma: And those will be starting soon.

Operator: And your next question comes from the line of Dianna Serber.

Dianna Serber: Thank you. This is Dianna Serber with FHS Consultants in Oakland, California. My question is regarding FQHC beneficiaries who receive the plurality of their primary care at an FQHC or an RHC, but those patients will not be assigned to an ACO because of the data issues. How will the shared savings attributable to those patients be accounted for in the program?

Terri Postma: That's a great question, Dianna. You know, we really struggled over this question, and we go into a fair amount of detail in the proposal about the difficulties of meeting the statute and the way the statute tells us to assign beneficiaries. And as you mentioned, it's just a difference in how billing is done. FQHCs and RHCs don't bill fee-for-service, but we recognize them as an important part of the delivery system. What we've proposed is that we want to have those FQHCS and RHCs involved in the ACOs. So we proposed to give the ACOs a higher sharing rate for including FQHCs and RHCs.

Even though their beneficiaries may not be counted in the assignment, we still recognize that they're an important part of the delivery system structure, and we wanted to provide an incentive to ACOs for including them. We're hoping that at some point in the future we may be able to assign beneficiaries on the basis of primary care services rendered by FQHCs and RHCs, but we were not able to legally find a way to do that this time around.

But we are seeking comments, so thanks for that question.

Dianna Serber: I have one follow-up question to that.

Terri Postma: Sure.

(Dianna Serber): How is the increased shared savings determined for FQHC participation?

Terri Postma: Well, I think we've proposed that if within that fee-for-service assignment pool that gets assigned to the ACO. If a certain percentage of those

beneficiaries have had at least one visit to an RHC and FQHC that the ACO would receive a higher share in savings.

And we're seeking comment on that. We worked real closely with HRSA on this particular point. But, if there are other ways that make more sense to FQHCs and RHCs, we'd like to hear that. We want to do the best we can to make this provision make sense for FQHC and RHC participation and also for the beneficiaries that receive their services there.

Dianna Serber: Thank you.

Operator: Your next question comes from the line of Margaret West. Your line is open.

Dee Rogers: Hi, this is Dee Rogers, representing Margaret West, Magnolia Ridge Medical Center, Magnolia, Arkansas. After listening to several of the comments, I have one question. Hospitals cannot become an ACO unless they, from what I understand, employ enough primary care physicians that qualify to meet the 5,000 beneficiary requirement, right? Or they could reach out and gather enough providers for that?

Terri Postma: Yes, an acute care hospital in and of itself wouldn't be able to qualify on its own because one of the eligibility requirements is the assignment of fee-for-service beneficiaries on the basis of primary care services received by primary care professionals. So the hospitals would have to either employ those professionals or they would have join with other primary care physicians in the area to form that primary care core and meet the eligibility requirement.

Dee Rogers: OK. I guess by reviewing the governance you would determine who is. OK. So, now, converse of that then, a hospital could be a member of multiple ACOs?

Terri Postma: Yes, that's correct.

Dee Rogers: OK. And I just had one comment. Somebody mentioned earlier with the facility that called in asking for a provider to call in and asking if a hospital or provider could pick or choose if it was a hospital that formed an ACO. And I'm a quality nurse. I'm the director of quality at my facility. I would guess

that would be a good incentive for hospitals that know the performance of the physicians that might want to join them in an ACO in their facility.

And if they want to lead up that ACO that they might use that as a screening tool, especially with the quality indicators that I'm reading in this Federal Register. Because if you're going to lead up an ACO as a hospital and you've got those physicians working with you and you know what their track records are already, I would not invite somebody that's going to ruin your track record. Just a comment.

And my other question my pharmacist asked. And it was from the oncologist perspective. Are pharmaceutical companies going to be asked to decrease their cost to us because I could see that point where they might now invite specialists in because that cost is not going to change a whole lot.

Terri Postma: Well, the law requires us to calculate costs for the total care of beneficiaries under Parts A and B. So Part Dpharmacy services would not be included.

Dee Rogers: OK. That's true. OK. Thank you.

Operator: And your next question comes from the line of Matt Anderson. Your line is open.

Matt Anderson: Hello. This is Matt Anderson with the Minnesota Hospital Association. One of the questions that we have is here in Minnesota - you may find this surprising, but during the winter months, we have some residents who like to go to other parts of the country. And, when they are in those other parts of the country sometimes they need healthcare. They're there for several months. Is there any way that CMS will account for or somehow modify the attribution method or the cost calculations for residents who are not in their primary service area of the ACO for significant periods of the year?

Terri Postma: Thanks for that question. We've heard a lot of folks ask that particular question. And I think this is one of the challenges of the fee-for-service population and improving the quality of care for them in reducing expenditures in this particular population.

I think it represents an opportunity for coordination of care with the providers that they might see during the winter. And the other thing is a lot of the PGP Demonstrations were actually in the North. Wisconsin, Marshfield Clinic. There is University of Michigan, Dartmouth, Park Nicolet - a lot of Northern states that experience a lot of snowbird kind of activity within their fee-for-service population.

You know, the one thing I would say is that the way we proposed to develop the benchmark is that it's by looking back at fee-for-service beneficiaries who would have been assigned to that particular group of providers and suppliers, so a lot of those costs are already taken into account in the benchmark.

Going forward, the ACO is really assessed on the basis of how they do going forward and assessed against their own individualized benchmark for their typical fee-for-service population. But otherwise a lot of those PGPs that were in the North, Marsh Dale Clinic and the University of Michigan faculty group practice earned a lot of savings and proved the quality of those – of those fee-for-service patients. And they face some of the same challenges.

But it's not an insurmountable challenge. We'd love your comments though on that particular point. Thank you.

Operator: Your next question comes from the line of Colin Ward. Your line is open.

Colin Ward): Yes, this Colin Ward from GMBC in Baltimore. I'm just wondering as providers in the marketplace may be slow to warm up to the notion of accountable care and shared savings. How will the regulations allow independent providers to join existing ACOs once the ACO has already enrolled in the program?

Terri Postma: Great, Colin, thanks for that question. We'd really appreciate your comments on that particular issue. What we've proposed is that those Medicare enrolled taxpayer IDs or TINs that have agreed to participate for three years and that have signed the agreement with us, as part of the process of the application they potentially have to go through an antitrust review and that's for PSA shares of greater than 50 percent.

What we've proposed is that during that three-year period, there'd be no additions to the Medicare enrolled TINs that join. And part of that is because if they had other Medicare enrolled TINs join them it changes the antitrust review, or they'd have to go or undergo an additional antitrust review or potentially go through one when they hadn't before. And if, for whatever reasons, there's a problem as we talked about with that other caller, the expectation is that that agreement would be for a three year period.

If they allow other Medicare enrolled TINs to join them during that three year agreement, they would have to undergo an antitrust review. The antitrust reviewers might say, "We're concerned that this represents some anti-competitive potential," and not give them the green light to go ahead. In which case, they would have to dissolve and face the potential forfeiture of that 25 percent withhold of shared savings that they already earned.

That's one reason that we proposed that during the course of the year, the Medicare enrolled TINs that applied at the beginning would not be allowed to add during the course of the year. They may add and subtract providers within those TINs, that's fine. But the Medicare enrolled TINs that initially joined, we have proposed that they not add during the course of the 3-year agreement.

Now, after the three year period is up the ACO may decide that they want to continue in the program. At that point, they may have additional Medicare enrolled providers (TINs) that are interested at that point in joining them. And so, then they could join and go through the application and review process and start another three year period.

I hope that helps. And we are seeking comment on that. Mainly, we want to find a way to protect the ACOs that have already initiated an agreement.

Leah Nguyen: Unfortunately, that is all the time we have for questions today. We would like to thank everyone for participating in the Medicare Shared Savings Program Proposed Rule Overview National Provider Teleconference.

A written transcript of today's call will be posted to the CMS teleconference and events section of the Shared Savings Program Web site at www.cms.gov/sharesavingsprogram within a week.

As a reminder you will also find on the website links to fact sheets that discuss the proposed rules, copies of previous proposed rule teleconference transcripts, and a link to the proposed rule. The comment period for the proposed rule ends June 6. Please see the proposed rule for details on submitting comments.

I would like to thank our speakers for today. Dr. Terri Postma and Tricia Rogers for their participation. Have a great day everyone.

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

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