

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
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Operator: Good afternoon, ladies and gentlemen, my name is (Shawn) and I will be your conference operator today. At this time, I would like to welcome everyone to the Pioneer ACO Special Open Door Forum Conference Call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. To withdraw your question, you may press the pound key. Thank you.

Ms. Barbara Cebuhar of CBS, CMS, excuse me. You may begin your conference call.

Barbara Cebuhar: Good afternoon, everyone. My name is Barbara Cebuhar. I'm with the CMS Office of Public Engagement. Thank you for everyone being with us on the call today.

We're here to discuss some exciting new options for a whole range of providers across the health care spectrums that are considering being a part of accountable care organizations. Accountable care organizations are one of the most innovative tools provided by the Affordable Care Act that will help us create a health care delivery system that is sustainable over the long term.

Today, we're discussing a new initiative from the CMS Innovation Center, the Pioneer ACO Model. I'm joined by Dr. Mai Pham and Dr. Mandy Cohen from the Innovation Center to provide us overview and answer your questions about the Pioneer ACO model.

I just want to make sure that folks know that this is not a press call. This is for stakeholders only and also that the Encore recording of this call will be available about three or four hours after the conclusion of this call. So, that means about 5:30 Eastern Time. And you can access it by dialing 1-800-642-1687 and asking for call number 70961782. If you have questions after this call ends, you may send them to pioneeraco@cms.hhs.gov. That's pioneeraco@cms.hhs.gov.

I'll now turn the call over to Dr. Pham and Dr. Cohen.

Mandy Cohen: OK. Thank you, Barb. Hi, everyone. My name is Dr. Mandy Cohen. I'm the director of Stakeholder Engagement for the Innovation Center. And we just wanted to welcome you all to the call today and thank you for taking the time and of your busy schedule to join us.

We're going to be reviewing the Innovation Center's new Pioneer ACO model, the request for applications that was announced just few weeks ago, and go through any questions you might have. I think we all know that the path towards a sustainable health care system can't be through cutting care or slitting down coverage. It has to be through improving care. And we can achieve better care, better health, and lower cost by putting patients at the center of our health care system. And we believe Accountable Care Organizations or ACO's is the perfect example of how we can get there.

About two months ago, CMS published its initial proposed rules on how to implement ACO. And the public comment period for that rule, the Medicare Shared Savings Program closed yesterday. This call will not be addressing the Medicare Shared Savings Program; rather, it's to discuss the Innovation Center's new model, the Pioneer ACO model.

This model will offer an accelerated pathway performing an ACO to providers, who are already ahead of the pack in terms of coordinating care even before those new regulations for the Medicare Shared Savings Program go into effect. So, again, we'll only be focusing our comments today on the Pioneer ACO model and answering questions about that request for application.

The comment period for the proposed rule did close yesterday. And we are currently going through their comments. And are sure to have a stronger final rule later this year as a result of your comments and feedbacks. So, thank you for those of you who did submit comments to that rule.

So, now, I'm joined by Dr. Mai Pham and by Sean Cavanaugh who are here to provide some additional background on the Pioneer ACO model and to answer your questions.

But, before I turn the call over, I just wanted to highlight one other offering from the CMS Innovation Center around ACO and that's a learning opportunity that's important to providers around the country who want to learn some fundamental skills about how to build an ACO. This is an opportunity to learn from experts around the country who have been doing integrated care. Participation in this session won't have a factor in your selection of participation in any of the CMS ACO programs, but are incredibly rich resource and free for you to take advantage of.

Our first session is in Minneapolis, June 20th to 22nd. There will be three additional sessions, September, October, and November of this year. So, please check back with the Innovation Center Website www.innovations.cms.gov for additional updates on that.

And so, with that, I would just turn the call over to Dr. Mai Pham.

Mai Pham: Thanks very much, Mandy. And thank you for joining us. I wanted to start off, before we describe, give you an overview of the Pioneer ACO model, to announce that we are going to push back the deadlines for the letter of intent and the application. We have heard loud and clear from many provider organizations that they would appreciate more time to put together the organizational backing, that they need to do this, and also to put together a strong – an application as possible.

So, the new due dates are – for the letter of intent, June 30th and for the application itself, August 19th. So, a two-week extension on the letter of intent and a month extension on the application.

So, I wanted to start by explaining the context for the Pioneer ACO model. That it is part of the unified CMS strategy for ACOs that acknowledges and wants to leverage the fact that provider organizations are starting from different starting point with different levels of experience and appetite for managing risk. The Pioneer ACO model is designed for the more advance organizations that has experience in delivering care across setting for defined population of patients as well as managing financial risk.

The goal is to compliment the Shared Savings Program to the Pioneer Model as well as to inform future changes to Shared Savings Program. Some key features of the Pioneer Model that we would like you to take away are that there is a longer participation agreement period. The agreement lasts for a minimum of three years. But CMS and Pioneer ACOs can jointly decide to extend that agreement up to a maximum of five years.

There is greater financial gain in terms of higher risk and higher reward for Pioneer ACOs as compared to the Shared Savings Program. And, in particular, the payment arrangement includes a transition away from fee for service and towards population-based payment starting in the third year.

We also will expect Pioneer ACOs to engage with their other payers such as private health plans or Medicaid state agencies to enter similar outcome-based arrangement such that, by the end of the second year of the Pioneer model, the majority of ACOs total revenues will be committed to these types of contract.

We have a more flexible approach towards beneficiary alignment. We are allowing the option of either prospective or retrospective alignment. The procedures that are outlined in the RFA are consistent with prospective alignment for simplicity. An ACO that are interested in retrospective alignment, we would work with.

Finally, an over arching aspect in the Pioneer Model is a posture of flexibility towards the unique needs of individual organizations working in individual communities. We offer flexibility in the payment arrangements both in the core model that's described in the RFA. And we are actively soliciting suggestions from applicants for an alternative payment arrangement. We will

synthesize those suggestions and distill them down to one or two. And, again, offer those with limited options around some of the key parameters.

I wanted to just repeat for those who might have missed the earlier announcement that we are pushing back the deadline for the letter of intent to June 30th and the application to August 19th to give providers more time to put together a strong application.

Another point of clarification is that we understand that there are some people who have difficulty understanding how to fill out the data use agreement. And we've now added instructions for doing this on the CMMI Website. Those organizations that have already completed the DUA and submitted their LOI do not need to submit a revised version.

And, with that, I wanted to turn it back to Barb and open up the discussion for comments and questions.

Barbara Cebuhar: (Shawn), its Barb. If we could please go ahead and tell people how to queue up to ask their question, I'd be grateful. Thank you.

Operator: At this time, I would like to remind everyone that in order to ask a question or make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (Sara Smith) from (Tech Mannington). Your line is now open.

(Sara Smith): Hi. Thank you. I was just wondering will the letter of intent, after they are submitted, will they be made public online.

Mai Pham: That's a very good question. The letters of intent will not be made public. I did just want to also iterate, the letters of intent are nonbinding. They are required for planning purposes, but they are nonbinding.

(Sara Smith): Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from the line of Jennifer Jackman from Monarch HealthCare. Your line is now open.

Jennifer Jackman: Thank you. On the request for application, there is a section regarding summarizing expenditure and quality performance data for other purchase or contracts that you're in and it just says summarize it to date. How far back would you like the information to go?

Mai Pham: I think it need not be extensive. I think recent history is what we're after. So, we would like to – I understand that especially in California some provider groups have extensive experience with these types of arrangement. So, what we would find most useful is recent data. So, I would say within the past three to five years.

Jennifer Jackman: Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from the line of Nayan Shah from American Health. Your line is now open.

Nayan Shah: Hi. This is Nayan Shah from American Health Alliance. The question is, since the letter of intent date has been postponed and if the intent is that Medicare Shared Savings Program we need to apply for that also, will there be any conflict.

Mandy Cohen: There should not be any conflict. Our timelines are constructed so that organizations should know how they fared in the Pioneer application process before they have to decide about participation in the Shared Savings Programs.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from the line of (Jane Alwalker) from the Association of American Colleges. Your line is now open.

Karen Fisher: Hi this is actually Karen Fisher. And I have two questions. I'm wondering if you could expand a little bit on the Pioneer ACO program. You emphasized

the word group of primary care providers when you talked about beneficiary alignment. And can you tell us a little bit more about what you're thinking is when you talk about a group of primary care provider?

And then, secondly, can you expand a little bit more about the performance expenditure comparisons and the growth rates. And you talked about using national growth rate for match cohorts and national reference population and could you just walk that through a little bit for us?

Mai Pham: Sure. Why don't I take the first one and ask Sean to take – Sean Cavanaugh to take the second one. So, when we conduct alignment, what we will do is we will flag all of the NPIs for primary care providers within an ACO applicant organization. We will similarly flag – apply a joint flag to groups of primary care provider NPIs that are affiliated with other ACO applicant or other TINs, other tax identification numbers that might not be ACO applicants.

And then the alignment algorithm essentially rank orders those groups of NPIs and ask which group of NPIs billed for the plurality meaning the greatest amount of the primary care evaluation and management allowed charges for that beneficiary. And whichever group of NPIs wins – “wins” in that alignment competition is the group that the beneficiary will be aligned with.

I just want to make sure that that was clear, Karen, before we move on to your second question.

Karen Fisher: Yes. Thank you.

Mai Pham: OK.

Sean Cavanaugh: On the second, I have two answers. The first is that the specifications – the detailed specifications of how the base expenditures are calculated, how they're trended forward to create an expenditure target will be available publicly in the coming weeks.

Mai Pham: Within the next month.

Sean Cavanaugh: Within the next month. So, there a fair amount of detail that goes into it that applicants should be familiar with. So, we will make the specifications available.

I will give you a high level description right now. Mai just described how the beneficiaries are aligned. Once a group of beneficiaries have been aligned with an ACO, we will look back at the actual expenditures on behalf of those beneficiaries for the prior three years weighing the most recent year more heavily and then trend them forward to the current year. That will create the baseline expenditure.

Now, that group of beneficiaries has unique characteristics in that, one, they live through the prior three years and they had an evaluation and management visit and other criteria. But in the coming year, the performance year, some of the beneficiaries may die, some will age. So, you have a unique characteristics in the base year and the performance year. So, when we develop the appropriate trend factor to set the expenditure target, we need to look at the national cohort that has those same criteria.

So, we'll create a cohort from national beneficiaries who also lived through the prior three years, had an E&M visit, and met the other criteria. And we'll see what their history was from the base year to the performance year adjusted for age and sex and other appropriate characteristics. And that will be the trend factor that we applied to develop the expenditure target.

Again, it's fairly straightforward in concept. There are some details that everybody needs to know. We will make those available.

Karen Fisher: OK.

Mai Pham: OK. Some of those details if I could just take that description down one more level is to explain that we will be developing those growth rates for national reference cohort by specific age and sex strata. So, we're using up to 12 age strata, very fine demarcations, gender. We might well adjust for other characteristics such as race.

So, what we are trying to do is to account for the factors that ACO does not have control over. But in a step and what you should take away is that the best predictor of what the beneficiaries' cost will be in the coming year is what the beneficiaries' actual cost was in the prior year. And that's our starting point.

Karen Fisher: (Inaudible) just two follow-ups. One is when you talk about the national cohort, are you talking about all Medicare fee for service beneficiaries or you're going to create a national cohort based out of ACO beneficiaries?

Mai Pham: All national beneficiaries.

Sean Cavanaugh: Who could have been aligned with an ACO but not necessarily were aligned with an ACO.

Karen Fisher: Got you. Who have the (ATM) visit, but may not necessarily be with an ACO.

Sean Cavanaugh: Exactly.

Mai Pham: Exactly.

Karen Fisher: And, secondly, are you going to do a severity adjustment with the national cohort or not necessarily?

Mai Pham: Right. So, the reason that we are using the beneficiary's actual expenditures is that that is a stronger predictor than applying a severity adjustment on top of a geographic or other average.

Karen Fisher: OK. Thank you.

Barbara Cebuhar: Thank you, Karen. (Shawn), our next question, please.

Operator: Yes, ma'am. Your next question comes from the line of (John Ulversliv) from IDA. Your line is now open.

(John Ulversliv): Hi. My question is – I must have missed something here. But where do I go to get the letter of intent and the application form?

Mandy Cohen: Sorry. Thanks, John. If you go to the Innovation Center Website at [www.innovations](http://www.innovations.cms.gov) – with an S – [.cms.gov](http://www.innovations.cms.gov), there's a link right off of the homepage that says Pioneer ACO Model. That will take you to the request for application. That has the full description of the program we're talking about now as well as the letter of intent and instruction for submitting both the letter of intent and the application. So, again, that's www.innovations.cms.gov.

(John Ulversliv): Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from the line of (Allen Osmond) from Memorial (Eye). Your line is now open.

(Allen Osmond): Good afternoon. I had experience in the '90s with Managed Care in California and, now, represent a specialist group. And I'm interested in knowing – understanding the first question of the LOIs will not be published. When applications are submitted, will those be published?

Mandy Cohen: Our intent is not to publish the applications because there is information submitted in those applications that will be considered confidential by both the applicant organization and by us.

(Allen Osmond): I understand that part. Would a list of the applicants be available?

Mandy Cohen: (Allen), we're going to have to follow-up and find out based on our contracting properties and the legal parameters around that about whether we can share that information, but we will make that – we will let you know the answer to that question in the future.

(Allen Osmond): OK, great. Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from the line of (Jeff Squire) from New Haven. Your line is now open.

(Jeff Squire): I have a question. In reading the information in the background, the FTC regulations will be followed. And if you need an expedited review, if your PSA is over 50 percent will – how will you council that in this shortened timeframe?

Mandy Cohen: I believe that what the RFA states is that we will prioritize applications on some organizations that do not require a full review from FTC/DOJ.

(Jeff Squire): Thank you.

Barbara Cebuhar: Does that answer your question, (Jeff)?

(Jeff Squire): Yes. It does.

Barbara Cebuhar: Thank you. Our next question, please.

Operator: Your next question comes from the line of Barbara Giloth from Advocate Health Care. Your line is now open.

Barbara Giloth: Thank you. I had a question about something you mentioned in the introduction. You said there was going to be a posture of flexibility in payment arrangements. And you were actively asking for other options per payment. I was unclear whether those would then be able to be addressed within this RFP period or whether that would be responded to later.

Mandy Cohen: The point of asking for these suggestions is so that we can do the actuarial modeling on our end during the selection process. And then offer up to the selected Pioneer ACOs an alternative payment arrangement that we believe best meets what we are hearing from the marketplace, that the marketplace wants and will generate savings for the Medicare Trust fund that we would offer up those additional options before the participation agreements are signed.

Barbara Giloth: OK. Thank you very much.

Barbara Cebuhar: Thank you, Ms. Giloth. Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of (David Oakley) from (Manatt) Montefiore. Your line is now open.

(David Oakley): Hi. In the RFA, it refers to demonstration of financial resources to accept the risk. It mentions letters of credit, but it also specifically says or other devices. Certainly, in many states, in order to demonstrate where was all do except financial risk, one of the common devices is the simple financial guarantee agreement from the provider to the HMO or, in this case, the CMS. Can you give us any elaboration of what you're thinking about in terms of what acceptable alternatives would be and/or, you know, how the financial documentation review would progress?

Sean Cavanaugh: Thank you for that question. It's an area we spent a lot of time thinking about. And the reason it's not explicit in the RFA is we very much wanted to hear from applicants what is going on in the marketplace and by state regulators. So, we would be interested in hearing what you've, what Montefiore has done with its commercial payers and what's required under New York State law. And we would take that information and work with you to find what would be acceptable for the Medicare Program.

(David Oakley): Thank you.

Barbara Cebuhar: Thank you, Mr. (Oakley). Our next question, please, (Shawn)?

Operator: Yes, ma'am. Your next question comes from the line of (Judy Chester) from New York City Health. Your line is now open.

(Judy Chester): Hello. I'm just going to ask you to repeat the new deadline date.

Mandy Cohen: Sure. The letter of intent is now due June 30th and the application is now due August 19th.

(Judy Chester): Thank you.

Barbara Cebuhar: Thank you, (Ms. Chester). Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of Jay Cohen from Monarch Health Care. Your line is now open.

Jay Cohen: Hi, Mandy and Sean. How are you doing today? I just – I first wanted to commend you and the entire Innovation Center team for taking a great step in advancing the ACO notion with the RFA as it was put out. Our question is, with the delay in the initial deadline, does that push back the rest of the timelines in the program or is it still your intent and desire to try to get Pioneer ACO launched as quickly as you had laid out before.

Mandy Cohen: I believe that the RFA, Jay, states that we are aiming for third or fourth quarter of 2011. We are obviously not going to – we're obviously going to try not place Pioneer's in the position of finding out that they've been selected one day and then having the performance period begin the next week. So, we will work hard to make sure that there is a comfortable and constructive interval between those.

Barbara Cebuhar: Thank you, Mr. Cohen. Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of (Alexandra Garcia). Please state your organization. Your line is now open.

(Mr. Garcia), if your line is on mute, please un-mute.

(Alexandra): Hi. I'm sorry. My name is (Alexandra) from (Estevez and Garcia) in New Jersey. I have actually a very, very basic question, you know, hearing all these high level questions. And I'm almost embarrassed. But, in looking at the RFA, it's unclear – and actually you gave a little bit of a hint I think in your opening statements where you said that the Pioneer ACO program is really geared for those that are already ahead of the pack when it comes to I guess innovative thinking or other payment arrangements.

And I wanted to know if you would – if you envisioned completely new groupings or new corporate structures or government structures being able to apply for this in their letter of intent, which require that it already all be established or could a plan be set forth in the letter of intent. Or do you – are you really looking for people that are already been working together, put it that way?

Mandy Cohen: I think that we don't have explicit expectations for whether the single entity is new or not. But what we would be looking for in the application and is outlined in the selection criteria is a history of strong working relationship and demonstrated experience in terms of population care management and management of financial risk. Those are the important criteria not so much when the entity was created.

(Alexandra): Thank you. That's very helpful.

Barbara Cebuhar: Thank you, (Ms. Garcia). Our next question, please, (Shawn).

Operator: Your next question comes from the line of (Vic Stanley) from Florida Accountable Services. Your line is now open.

(Vic Stanley): Real quickly. The question would be can – can a – can the ACO be directed specifically by a cardiology group or does it require the affiliation between a cardiology group and a primary care doctor?

Male: And the follow-up, can ACO be focused on one single disease grouping or does it have to be a multispecialty and a multi-disease grouping?

Mandy Cohen: We are agnostic with respect to the provider's composition of an ACO. But I need to remind you that the beneficiary alignment algorithm first prioritizes assignment to primary care providers. There is a secondary step should benefit – should those beneficiaries, some of them, not have had a great number of primary care services delivered during the baseline period. In that second step, we would then assign them – align them to certain eligible specialist.

We are agnostic with respect to what conditions the ACO should focus, on but the expenditure calculations and the construct for accountability here is for the total cost of care. And the quality performance metric and patient experience metric will also be focused on the total beneficiary experience.

Barbara Cebuhar: Thank you very much. Our next question, please, (Shawn).

- Operator: Yes, ma'am. Your next question comes from the line of Michael James. Please state your organization. Your line is now open.
- Michael James: Thank you. This is Michael James from Genesys PHO in Flint, Michigan. My question was leading to the quality measures. In your statement, you said you're going to rely upon the final reg under the ACO for quality measures. Is there any thought about rolling out of those 65 over three years similar to what we did for the primary care group model or you would still anticipate full compliance within the first year.
- Mandy Cohen: All right. I'm very sorry. It's a very reasonable question, but because the commentary has closed on the NCRM, I can't comment on the Shared Savings Program directly.
- Michael James: OK. How would you ...
- Mandy Cohen: But I will – but I will take the opportunity to say that we understand that our reliance on certain parameters within the final rule does introduce an element of uncertainty for applicants. And we're sensitive to that. So, I just wanted to reiterate for those who didn't – who weren't aware that, even if an organization submits an application to the Pioneer Model and is accepted and begins the program that they have until January of 2012 to withdraw after the final ruling is published, if they decide that the parameters that would apply to the Pioneer model are not acceptable.
- Michael James: Thank you.
- Barbara Cebuhar: Thank you, Mr. James. Our next question, please, (Shawn).
- Operator: Ma'am, your next question comes from the line of (Susan Rutgers) from (Florida) Medical Service. Your line is now open.
- (Susan Wilger): Hi. I'm assuming you mean me; the name is (Susan Wilger). Anyway, my question has to do with the provider mix. It says that providers need to be exclusively affiliated with one ACO. And I'm curious – well, oftentimes in very rural or frontier areas, you do have providers that, you know, provide services at differently locations which could be geographically quite distant

from each other. So, how would that apply to say providers that you're using for telehealth purposes and how would that provide to your specialist?

Mandy Cohen: Well, to clarify, the RFA says that we expect primary care physician to affiliate exclusively with one ACO across the Shared Savings Program and the Pioneer model. What that does not mean is that that provider need only practice in one practice site because an ACO is a single entity that where the providers have jointly agreed to take on accountability for population of patients.

The providers may practice at however many sites they deem appropriate. But if they want to be a part of an ACO program, they need to decide which organization they are going to affiliate with for purposes of expenditure calculations and quality performance measurement. That is the guide.

In terms of specialist, the RFA also explicitly states that we do not expect specialist to necessarily be exclusively affiliated with one ACO.

(Susan Wilger): OK. Thanks for the clarification.

Mandy Cohen: And I just wanted to emphasize that the reason the distinction between primary care providers and specialist in this regard is that we believe a strong primary care foundation is the core of care coordination. And so, it does not make sense to us that a primary care physician would want to be affiliated with more than one ACO.

Barbara Cebuhar: Thank you for your comments. Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of Henry Chung from Montefiore Medical. Your line is now open.

Henry Chung: Hi. Thanks very much. Henry Chung from Montefiore Medical Center. I want to go back to the issue about primary attribution and beneficiary alignment. It's clear that you are going to allow some specialist to be included, if patients have less than 10 percent of E&M visits related to primary care physicians. I guess one question I have is how you determine that given that we have internist in particular, but other specialties as well who

are double boarded and are providing some mixture of primary care as well as specialty services as a specialist.

Mandy Cohen: So, Henry, we're going to use the provider specialty code that is in Medicare databases. And I can reassure that, in independent research, we found that there is over 95 percent agreement between that specialty code and the self-reported primary specialty of the physician, which was based on physician survey data.

So, while cardiologist might well provide primary care services, we have to draw the line somewhere because those are not coded as such in claims. And that's the distinction that we're going to make.

Henry Chung: That's very helpful. Can I have brief and related follow-up? Given the number of initiative that CMMI may be rolling out over the next few months, the question is could an institution apply for say Pioneer, but also continue to take advantage of other initiatives that are not related to the ACO category for example the FQHC demo that was recently released. Is there any exclusions that an institution needs to worry about in terms of taking advantage of these initiatives?

Mandy Cohen: We definitely don't want that concern about what might be coming around the corner to be a barrier to participation. We strongly encourage organizations to evaluate each model as it becomes available on its own merit with regard to how good a match it is for them. If there comes along a model that the organizations believe are a better match for them or that we and they believe would work well in consort together, we would bend over backwards to make that work.

Sean Cavanaugh: The one caveat I would add is that, in case where both programs involve shared savings, there would not be a shared savings allowed twice for the same beneficiary, for the same set (shared).

Henry Chung: That's crystal clear. Thank you so much.

Barbara Cebuhar: Thank you. Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of Keith Pugliese from Brown & Toland Physicians. Your line is now open.

Keith Pugliese: Hi. Thank you. I really appreciated the information on calculation of expenditures. I think that was Sean Cavanaugh who spoke. I'm wondering if you could give a little more detail with special focus on end-of-life care. As you know, end-of-life costs are very high. You know a significant factor for Medicare beneficiaries.

So, in the first – the prior three years, if there is no end-of-life services yet needed and you draw up some kind of calculations, during the performance year that the beneficiary gets sicker and sicker and then there's end of life care, how does that get factored in because that could be a significant financial concern for an ACO. Thank you.

Sean Cavanaugh: Thank you for the question and actually an excellent question. And we spend a lot of time trying to make sure our calculations take into account that very factor. The short answer to your question is our primary means of adjusting for that is this national cohort approach. As you point out, the population that will be aligned will be people who survived for three years, so who did not receive end-of-life care and yet in the performance year some subset of them may die and have expensive periods because of that.

We will compare – we will – excuse me. We will establish an appropriate rate of growth for the ACOs based on the national cohorts, who have the same characteristics. Meaning the national cohort will not be all fee-for-service beneficiaries, but it will be those who live during the three-year base period, so who did not have end-of-life care that time, but who had the potential and some of whom did die in the performance year.

So, you would expect the similar trajectory of lower cost because of, no doubt, to some growth because of expensive periods involving death. So, that's the primary mechanism. As Mai Pham indicated earlier on the call, in addition to that rate of growth, we are adjusting by age categories, sex categories and we're considering other appropriate adjustment. The purpose is to recognize

that there will more expenses and different expenses in the performance year than in the base years.

Keith Pugliese: Thank you very much.

Barbara Cebuhar: Thank you for your comment and your question. Our next question, please, (Shawn).

Operator: Your next question comes from the line of (Jack Summers) from Community Care. Your line is now open.

(Jack Summers): Thank you. Two questions. One, the SSM, when it came out recognized that even within that model, it was a very aggressive approach. And they we're wondering about the January 1st deadline perhaps even extending it to July 1st. When the Pioneer model came out, it was more aggressive suggesting a start up in the fourth quarter of 2011. With the adjustment to the LOI and app dates, is there some adjustment in when roll out will be?

Mandy Cohen: As I've stated before, we purposely left ourselves some flexibility in the RFA by referring to the third and fourth quarter of 2011. And we are going to see how the process goes for application and selection.

I just want to reiterate, I don't – I can't give you a concrete answer to that because we're, right now, standing by what is in the RFA. But I can promise that we are committed to not – we are committed to giving selected Pioneer ACOs a comfortable time period during which – after selection, during which they can begin to ramp up for the first performance period.

(Jack Summers): Thank you. (Inaudible) ...

Barbara Cebuhar: Thanks for your comment. Our next question, please, (Shawn).

Operator: Your next question comes from the line of (Alex Islam). Please state your organization. Your line is now open.

(Alex Islam): Hi. I'm calling from the New York State Department of Health. And I was just wondering the rationale behind comparing the ACOs baseline to a national reference population.

Mai Pham: So, one of the things that the Innovation Center test was doing is testing new service delivery and payments model in order to inform future Medicare policy. And, in this particular case, we have an opportunity to inform future changes to this year's Saving Program.

One of those alternative approaches is novel benchmark methods. And one of the reasons to test the method that we are is that traditional benchmark calculations – basically take a geographic or population average expenditure and then adjusts that base on beneficiary's diagnostic code and risk index. And what happens when one does that is that questions arise about providers up coding HTCs force and then there's countervailing pressures to limit that potential up coding with lots of questions about the validity on either side.

What we were hoping to do is to develop a method that avoid a lot of that dissention and disagreements by finding a method that tries to adjust for the exogenous factors, the factors about the beneficiary's expenditures that the ACO ...

Barbara Cebuhar: Mai, are you on the line?

Operator: Excuse me, Ms. Cohen, if you're still connected, if your line is on mute, please un-mute.

Male: Do we have a dial ...

Operator: Ms. Cohen, if your line on mute, please un-mute. Excuse me, Ms. Cebuhar; it appears that of Ms. Cohen has dropped. One moment, please, while we attempt to reestablish it.

Barbara Cebuhar: Thank you very much. I appreciate everybody's patience as we deal with technical difficulties. Thank you.

Operator: Excuse me. The line of Ms. Cohen has been returned to the conference.

Barbara Cebuhar: Thank you.

Mai Pham: I apologize, we – our line dropped for some reason. And Sean Cavanaugh was in the middle of giving additional information on the last question.

Sean Cavanaugh: Yes. I was just going to supplement the answer that Mai gave which is, as she indicated, we test new payment delivery system models. And in the particular case of the Pioneer ACO, what we hope to do is develop lessons for the Shared Savings Program in future generations of the Shared Savings Program. And as you know, there's a national reference rate of growth in statute used for the Shared Savings Program.

So, while we're not using that formula per say, we're actually – we've tweaked it somewhat. We didn't want to go too far our field from what's been in the statute for that. But we did want to do something somewhat different.

(Alex Islam): Thank you.

Barbara Cebuhar: Thank you. (Shawn), our next question, please.

Operator: Yes, ma'am. Your next question comes from the line of Emily Brower from Atrius Health. Your line is now open.

Emily Brower: Hi. I wanted to ask about the state and objective of moving towards population-based payment specifically in the third year of the program and for some clarification. It looks like in the example that's described in the documentation and particular used in Appendix B is really more about partial cap or cash flow payment for services that are expected to be billed by the ACO and there's still a settlement for total cost or total population-based payment at the end of the period. Is that correct?

Mandy Cohen: Emily, you're correct on that interpretation. And we, in fact, tried to slide that in the RFA in the text by saying that this was a deliberate attempt at giving providers more revenue flexibility and that it did not change the risk profile going from year two to year three. However, I want to emphasize that we very much want to see suggestions for an alternative constructions of the payment arrangement from applicants and that can include different constructions of the population-based payment.

Emily Brower: Thanks. If I may ask a second question, which is about – someone touched on earlier, which is relationship with other programs? We may have a small subset of patients that would be in a 3026 of community-based care transitions program. I'm wondering, since that's not explicitly a Shared Savings Program, if there's any conflict with the Pioneer ACO Program.

Mandy Cohen: If there is not a Shared Savings component, we would encourage you to participate in both.

Emily Brower: Thank you.

Barbara Cebuhar: Thank you. Our next question, please, (Shawn).

Operator: Yes, ma'am. Your next question comes from the line of Karl Kovacs. Please state your organization. Your line is now open.

Karl Kovacs: Thank you. This is Karl Kovacs from the Michigan Bureau of Community Mental Health Services. And I was wondering what's your thoughts were regarding the role of public mental health within the ACO program. And the second question I have is how do you see health plans participating in the Pioneer ACO? Thank you.

Mai Pham: Regarding your first question, if you look through the application and selection criteria for Pioneers, you will see that we explicitly will favor applicants that has active working collaborations with community-based organizations including mental health care providers.

With regards to your second question, I'm sorry. Could you remind me what that – role of health plans. We are looking for a provider organization to be the primary applicants to the Pioneer model. However, we fully expect that some applicants – some applicant organizations will be co-owned with a health plan. And that – that may have disadvantages and advantages. And the application allows applicants to describe those pros and cons to us.

Karl Kovacs: Great. Thank you very much.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Yes, Ma'am. Your next question comes from the line of Stephen Rosenthal from Montefiore. Your line is now open.

Stephen Rosenthal: Hi, Steve Rosenthal. Two quick questions. One is you have mentioned earlier that organizations perhaps whose PSA was greater than 50 would fall to the back of the line. Is that what you implied?

And the other question is, are you asking for letters of support as part of the application. It wasn't clear in the RFA.

Hello?

Barbara Cebuhar: Dr. Pham? If you hold, just one moment, please.

Operator: Ms. Cohen, if your line is on mute, please un-mute.

Stephen Rosenthal: They're on mute.

Operator: Ma'am, it appears that the line of Ms. Cohen has temporarily dropped once again. Please stay on the line while we attempt to make another connection.

Barbara Cebuhar: I'm so sorry for the technical difficulties. We are very grateful for your patience. Thank you.

Operator: Excuse me, the line of Ms. Cohen has been returned to the conference.

Mandy Cohen: We apologize. We're really not trying to run away. So, Stephen, I believe you ...

Stephen Rosenthal: Should I repeat the question?

Mandy Cohen: Yes, please.

Stephen Rosenthal: OK. The first question was you have mentioned earlier about the PSAs in excess of perhaps 50 percent that they would be prioritize to the end of the list. Is that what you implied?

And the other question is there is no place in the application it appears for letters of support being requested. Was that your intent? Or would you like some letters of support sent in with the application and how would that be accomplished?

Mandy Cohen: So, on your first question, Stephen, the FTC/DOJ guidelines apply only to organizations formed after March 20th, 2010. I'm not sure what your situation is. But organizations that were established before then do not have to worry about these boundaries.

And the answer to your second question, we are not explicitly prioritizing letters of support other than from the applicant's other purchasers with regards to their other outcome-based contact. But you decide what stuff to put into the application. We've tried to give you parameters for the things that we're going to be looking at in terms of selection criteria.

Stephen Rosenthal: And so, that would be consistent and, perhaps, with the attachments.

Mandy Cohen: Yes.

Stephen Rosenthal: Thank you.

Barbara Cebuhar: Thank you. Our next question, please, (Shawn).

Operator: And your next question comes from the line of Jay Johnson from the Wenatchee Valley Medical Center. Your line is now open.

Jay Johnson: Yes. Thank you. Could you maybe just give a high level view sort of the summary of financial incentives of comparing low – historic low cost areas with the goals of the trend line and so on and so forth? Could you just kind of walk everyone through that because I read it a few times and I wasn't exactly clear on which – where you're going with that?

Sean Cavanaugh: Are you talking about whether or not an ACO was offered to your extension?

Jay Johnson: No. I'm just talking about succeeding in the program.

Sean Cavanaugh: Yes. OK. Well, as we've discussed earlier in the call, the base year cost are established based on the actual cost of the aligned beneficiary. So, that has no regional discussions in it. The data are what they are. Where the issue you're raising comes into play is when we trend that forward from the baseline to an expenditure target. And as we indicated on the call, we'll be using the national cohort who has similar characteristics as far as (alignability) in the base period.

Some observers have noted that using that national rate of growth provides a built-in benefit for areas that are low cost today. This is a feature that was in the proposal for the Shared Savings Program to just use the dollar increase in the national growth rate. We proposed to use a blend; 50 percent of the dollar increase in the national rate of growth and 50 percent of the percentage increase. We feel this will mitigate some of those effects.

We actually have noticed though that – we're still testing whether in fact the variations from area to area and in fact the variations from where we're likely to get ACOs are as great as some have speculated. But to – the short answer to your question is, is some observers have noted that low-cost areas might be somewhat advantaged in the formula and higher-cost areas disadvantage. We're still running data to see the degree whether that's a meaningful difference.

Jay Johnson: Well, then is that – so, are you working against the trend then?

Sean Cavanaugh: Correct. So, your base is the actual expenditures that your aligned beneficiaries had in the prior three years trended to the current period. And what your expenditure target – the target yield you're trying to meet (be) will be based on a – as I said a 50/50 – high breed of the national rate of growth for the coming year. So ...

Mai Pham: And with absolute dollar equivalent.

Sean Cavanaugh: Yes. So, 50 percent of it will be the percentage increase in national rate of growth, 50 percent will be the dollar increase in the average national rate of growth.

Jay Johnson: So, you have no advantage if you've been in the historic low-cost area or no disadvantage, if you've been, say, (Dave) county.

Sean Cavanaugh: I would say some observers have noted that you would have some advantage for historically being in a low-cost area because the rate of growth is not from a low-cost area. It's from the national average.

Jay Johnson: Well, if I could have a second question on page eight, it talks about minimum average, annual savings amounts no greater than 5 percent in ACOs and states that the lowest Medicare expenditure levels ...

Sean Cavanaugh: Yes. So, that ...

Jay Johnson: These are less than – is that backwards or am I backwards?

Mai Pham: No. That – that's correct English. It is a lot of double negatives. And we can explain – we can walk through that for you.

So, that is a somewhat different issue. That is not to do with trending your baseline to your benchmark, but rather asking a question at the end of year two have you performed sufficiently well that we feel comfortable shifting you to population-based payment. And to make that assessment, we just want to take the average of your savings performance in years one and two.

And what that paragraph is saying is that, if you are in the lowest-cost state, then that minimum average of your two years performance will be 5 percent. And then, if you're in the highest-cost state, that minimum average performance will be 1 percent. And it will vary continuously in between depending on the historical expenditure levels on your state.

We have done analyses on these minimum, and based on our projections of the likely performance of ACOs in different types of geographic regions, we believe that this is an equitable approach to allow everyone roughly equal opportunity to get to population-based payment.

Jay Johnson: So, if you're in a low-cost area, then the bar is 5 percent. And, if you're in a high-cost area, it's 1 percent.

Mai Pham: That's correct. However, if you're in a low-cost area, you're starting ahead of the game already because we are using the national reference population not a regional reference population.

Jay Johnson: Yes, but the gentleman said earlier it was a trend. That you win by ...

Mai Pham: That's right.

Jay Johnson: Beating the trend.

Mai Pham: That's right.

Jay Johnson: So, the ...

Mai Pham: So, low-cost areas also happen to be the low trend areas.

Sean Cavanaugh: Typically.

Mai Pham: Typically.

Male: OK, (inaudible) ...

Barbara Cebuhar: Thank you.

Mai Pham: So, the way – the way I would summarize this is that observers have noted that the Shared Savings Program formula, which applies a strict absolute dollar increase greatly advantages providers in low-cost areas. And what I would say is that the Pioneer model somewhat less so, but still advantages providers in low-cost areas.

Jay Johnson: OK. Thank you very much.

Barbara Cebuhar: Thank you, Mr. Johnson. Our next question, please, (Shawn).

Operator: Your next question comes from the line of Tammy Workman from Ohio State University Medical Center. Your line is now open.

Christopher Ellison: Hello. This is Chris Ellison representing Ohio State University Medical Center. We had two questions. First, are in terms of determination of

expenditures for the beneficiaries in our base year are direct medical education and indirect medical education expenses determined and added into that or are they excluded?

Mai Pham: We will include all Part A and B expenditures. So, IME will be included, but not GME.

Sean Cavanaugh: Yes. It's not that they're A and B – all claims-based expenditures.

Mai Pham: Sorry. All claims ...

Sean Cavanaugh: (Inaudible) parts A and B.

Christopher Ellison: And the second question is a follow-up, I think, to one of the other questions, are we permitted a flexibility to construct our own payment structure.

Mai Pham: You are certainly encouraged to do that and to submit some of you're suggestions. However, I want to emphasize that ultimately, for the Pioneer participation agreement, we will be offering a menu, if you will, but a limited menu. Because we want to emphasize that we want to hear from applicants what alternative arrangements should look like, but we do not to distill them and synthesize them down to a manageable one or two with variations within each.

Because at the end of the day, the Innovation Center has to produce an evaluation for Congress and for the Administration, and that requires having enough consistency across participants that we can actually draw a firm conclusion.

Christopher Ellison: Yes. We understand that. And just to follow-up, in the Pioneer ACO, would advanced payment model be something that you might consider.

Mai Pham: I would slowly encourage you to fully leverage the opportunity to submit suggestions on – comprehensive suggestions on alternative payment arrangements. And the more concrete and specific you are particularly if you

provide justifications, the better opportunities we have to give responses to them.

Christopher Ellison: Thank you.

Barbara Cebuhar: Thank you. Our next question, please.

Operator: Yes, ma'am. Once again, just a friendly reminder that, in order to ask a question or make a comment, please press star then the number one on your telephone keypad.

Your next question comes from the line of (Deborah Doberman) from American Universal. Your line is now open.

(Deborah Doberman): Yes. We actually had two questions related to provider participation. What is the methodology anticipated for terminating a provider with or without cause? And then, also related to that – how would we limit providers from participating in more than one ACO from the primary care physician?

Mai Pham: So, can I just ask for clarification, when you said terminate provider, did you mean individual providers or did you mean an entire ACO?

(Deborah Doberman): Individual providers, who are not performing to the quality standard.

Mai Pham: And you are asking what's the condition for the ACO to be allowed to do that or for CMS to?

(Deborah Doberman): For the ACO, (if you).

Mai Pham: I think that is within the ACOs governing per view to make those decisions. And that is not a level of micromanagement that CMS would get involved in.

(Deborah Doberman): To make sure, (I think) please restate that.

Mai Pham: That whether or not to continue affiliation with the individual provider is really up to the ACOs governing body and not for CMS to lay guidelines for with the exception of program integrity guidelines, right. So that we will be monitoring providers and organizations just as Medicare normally does for

any breaches of laws and regulations. And so, those are the only conditions under which we would intervene in those affiliations. Otherwise, it's really up to the ACO. The other question ...

Sean Cavanaugh: I would add two things to Mai's answer. One is, since each provider we use as for the alignment and establishment of the baseline and the expenditure target, you can terminate from the ACO during the year, but those beneficiaries will stay – and those expenses will stay in the calculation for that year. They could be updated in a subsequent year.

And, also, we would be interested in whether when you terminate a particular provider whether that has any effect on the minimum number of aligned beneficiaries that you're required to maintain.

Mai Pham: Right. And I just wanted to clarify also that while these applicants will be submitting complete list of NPIs and TINs for their affiliated providers and member organizations, we would ask (its) Pioneer ACOs to resubmit updated list of those identifiers at the beginning of each year in order to conduct alignment.

Your other question was regarding exclusive affiliation with an ACO and how would we enforce it. Because we have the NPIs, we would be able to flag a provider once that provider has been affiliated – linked with a specific ACO. And that provider will then – essentially, we will have an alert for – if that NPI shows up on another ACOs list of affiliation.

(Deborah Doberman): And then would CMS notify the ACO in that instance as we have providers who are unfortunately being courted by multiple ACOs and they – one ACO may not know that the provider has signed up with another.

Mai Pham: We will bare that news and then we will remove ourselves from the conversation. (Inaudible).

(Deborah Doberman): OK, thanks.

Barbara Cebuhar: Thank you. (Shawn), our next question, please.

Operator: Yes, ma'am. Your next question comes from the line of (Jack Summers) from Community Care. Your line is now open.

(Jack Summers): We have put – I have two questions. The first one, we appreciate the flexibility on payment methodology in the – you said that you want ideas from the plans and from participants. The first question is can we do that prior to year three, as the flexibility time wise as well as methodology.

And the second question is around the 15,000 beneficiary limit, is that set in stone?

Mai Pham: Regarding your first question – yes, I should clarify. The alternative payment arrangement suggestions that applicants submit can address the entire rank of the Pioneer Model, so not just in year three. It can include different parameters for years one through five.

(Jack Summers): So, if we want global cap – global cap out of the gate, we can ask for that?

Mai Pham: You are welcome to ask for that.

(Jack Summers): We're going to ask for it.

Mai Pham: Regarding your second question, the 15,000 beneficiary threshold is rather firm except for rural ACOs. We're not going to quiver with 14,975. However, we did take that threshold for a reason. And that's because we made an assessment about the level of financial risk that we were exposing providers to. And beyond – at 15,000, roughly 15,000 beneficiaries, the risk pool become such that estimates of risk are actually much more stable.

(Jack Summers): Thank you very much. We appreciate it.

Barbara Cebuhar: Hey, (Shawn), our next question, please.

Operator: Your next question comes from the line of Jennifer Jackman from Monarch Health Care. Your line is now open.

Jennifer Jackman: Thank you. I just wanted to follow-up on the clarification that was given to the other woman about primary care providers and if they switch or courted

by other ACOs. I understand that, if you terminate a provider, the members be aligned with you for the purpose of calculations of the expenditures. But, if the primary care provider actually switches to another ACO, what happens to their aligned beneficiaries?

Mai Pham: They stay with you.

Jennifer Jackman: For the whole period or just until the?

Mai Pham: For that performance year.

Jennifer Jackman: For that performance year. Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Again, star one to ask a question or make a comment. Your next question comes from the line of Marni Bussell from Iowa Medicaid. Your line is now open.

Marni Bussell: Yes, thank you. My question is, from CMS' perspective, do you a conflict to attribute a Medicare member to both the Pioneer ACO organization and, let's say, a Medicare – medical home or health home program.

Mai Pham: I'll just reiterate that what we – we encourage providers to participate in multiple teamwork care, care coordination models. What we cannot do is to pay out shared savings more than once for a specific beneficiary. So, we will be reconciling beneficiary alignment list on our end across programs that have a shared savings component.

Marni Bussell: So, I'm not familiar with all of the dual projects that Medicare is participating from the health home perspective, but do you consider those shared savings if they are – take care of coordination payments?

Mai Pham: So, the care coordination payments themselves do not constitute shared savings. If they are netted out of shared savings at the end, then they are shared savings at the end. My understanding is that some of the health home pilots have a shared savings component and some of them don't.

Marni Bussell: Yes. Thank you very much.

Barbara Cebuhar: (Shawn), our next question, please.

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

Keith Pugliese: Thank you. My additional question is would you consider population-based reimbursement equivalent to an outcomes-based contract. Does population-based reimbursement fulfill the request for applications focus on the ACO having multiple payer contracts and the majority of revenues being outcomes-based?

Mai Pham: It could contribute to that 50 percent criterion, if the company by substantial quality and patient experience incentives or standards.

Keith Pugliese: OK. Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Again, star one to ask a question or make a comment. Your next question comes from the line of David Durbin from SSM Health Care. Your line is now open.

David Durbin: Thank you. Could you repeat the 800 number and the call number for those who may want to listen to this a second time?

Barbara Cebuhar: Sure. It's 1-800-642-1687. And the pass code is 70961792. And that will be available at about 5:30 Eastern Standard Time – Eastern Daylight Time, sorry.

David Durbin: Thank you very much.

Operator: Excuse me, Ms. Cebuhar. Pardon the interruption. The pass code is actually 70961782.

Barbara Cebuhar: Sorry about that.

Operator: That's quite all right. Your next question comes from the line of Dr. Gary Wainer from Chicago Health Systems. Your line is now open.

Gary Wainer: Hi. Thank you. Under question 13, the second bullet, there's a request for documents or agreements relating to the ability of the ACO participant to compete with the ACO. It goes on to describe some other information that's needed, which seems to run contrary to the exclusivity notion of PCPs and ACO. I was wondering if you can comment on that.

Mai Pham: I'm not sure I understand the question.

Gary Wainer: The bullet says the requesting documents or agreements relating to the ability of the ACO participant to compete with the ACO. That is because the ACO participant is not exclusive to the ACO either individually or through other ACOs or entities. And again, I'm not understanding it well, but it seems like it runs contrary to the notion of a PCP being assigned with a single ACO as you can (see).

Mai Pham: I believe that you're referring to text – speaking about specialist members of the ACO. And specialists are not required to be exclusively affiliated with one ACO.

Gary Wainer: OK. But that's not what the question asked in the applications.

Mai Pham: I think that if you just start from the top of the FTC/DOJ section of the application – for example, when it comes to calculating market shares at the zip code level, they are much focused on specialty services.

Gary Wainer: So, that second bullet is in reference to specialist then.

Mai Pham: That is my understanding.

Gary Wainer: OK. Thank you.

Barbara Cebuhar: (Shawn), our next question, please.

Operator: Your next question comes from a participant whose information is not yet transcribed. Please state your name and your organization. Your line is now open.

Chandresh Saraiya: Hello.

Barbara Cebuhar: Yes. Go ahead, please.

Chandresh Saraiya: Yes. This is Dr. Saraiya from Florida Medical Clinic. Sorry that the information didn't come through. The question is, when CMS decides to give the population-based payment to the physician in the year three and onwards, is it inclusive – is it for primary care physicians and the specialist both? And how will that information be determined?

Mai Pham: The population-based payments will be made to ACO not to individual providers. The individual providers that are members of the ACO would receive 50 percent of their fee-for-service reimbursements. And it would be up to the ACO to determine how to allocate the remainder that would be in the population-based a payment. So, it is not by provider. It is for patients at the level of the ACO.

Chandresh Saraiya: So, it is the – to clarify, the population-based payment will be in the form of a lump sum payment for all time Medicare specialty and party, et cetera, all combined. Is that correct?

Mai Pham: It would be – it would be for all services for that particular population, yes. Paid as a ...

Chandresh Saraiya: OK, OK.

Mai Pham: Per beneficiary per month amount.

Chandresh Saraiya: Got it, OK. I understand now. OK.

Barbara Cebuhar: Thank you, Dr. Saraiya. Our next question, please.

Operator: Again, star one to ask a question or make a comment. Your next question comes from the line of Jay Johnson from the Wenatchee Valley Medical Center. Your line is now open.

Jay Johnson: On page 20, item number C, governance structure that talks about the composition of the governing bodies is reflective of member groups of providers and suppliers that form the ACO including meaningful representation from consumer advocates and patients. Most professional services groups are governed by state law in regard to who can be on the Board and that covers most group practices. I think, you know, particularly in Washington State. But that seems to go contrary to many State laws. Could you comment?

Mai Pham: Sure. So, I believe that that section is the RFA. If you look not at the application, but at the RFA where we talk about governance structure requirements, we state that there is an exception for extenuating circumstances such as legal restrictions on the composition of the governing body. We just ask that you fully document that for us.

Jay Johnson: OK. Well, thank you.

Mai Pham: But I want to emphasize that, all things considered; we will highly prioritize organizations that are committed to involving the patients and consumers in their governance.

Jay Johnson: Well, but, again, you're dealing with State legislatures on that. But I understand your point.

Barbara Cebuhar: Thank you for your comment, Mr. Johnson. Our next question, please.

Operator: Again, star one to ask a question or make a comment.

Barbara Cebuhar: OK.

Operator: And there are no further questions in the queue at this time. I'll turn the call back to – excuse me, just as I said that, a question came in from the line of Carmela Dunford from North Shore Long. Your line is now open.

Carmela Dunford: Hello. I'm calling from North Shore Long Island Jewish Health System. And our question is how the eligible patients in our primary care physician practices. Can we count patients who are long-term resident in a skilled nursing facility?

Mai Pham: If they had eligible evaluation and in management services, then yes.

Carmela Dunford: OK.

Barbara Cebuhar: (Shawn), do we have any more questions?

Operator: Your next question in the queue comes from the line of Elizabeth Flashner. Please state your organization. Your line is now open.

Elizabeth Flashner: (Hi), for Health Policy Research and Ethnicity at George Mason University. I'm just wondering can a primary care physician serve and part of an ACO and then see patients who are not part of the ACO like that are non-Medicare at all.

Mai Pham: Absolutely.

Elizabeth Flashner: I mean private.

Mai Pham: Yes, absolutely. We should emphasize that the Medical ACO models on offer do not involve beneficiary enrollment or lock in. They do not involve gatekeeping or pre-authorization. It is traditional Medicare. And we fully expect that ACOs will see some patients that are not aligned with them. We also respect that some aligned patients – some patients who have been aligned with an ACO will also see other providers at times.

Elizabeth Flashner: Thank you.

Barbara Cebuhar: Our next question, if we have one.

Operator: There are no further questions in the queue at this time.

Mai Pham: Sorry, but I just wanted to repeat for everyone on the line that if you think of additional questions, if you need follow up on specific issues, please send

them to us, the Pioneer question inbox, which is pioneeraco@cms.hhs.gov.
And we have a pretty good track record of rapid turnaround.

The Innovation center Website has many of the documents that have been referenced today.

Sean Cavanaugh: Yes.

Mai Pham: And that address is [www.innovations](http://www.innovations.cms.gov) – with an S – [.cms.gov](http://www.innovations.cms.gov).

Barbara Cebuhar: I want to thank everybody for joining today's call. I also want to make sure that folks know the 800 number for the Encore call in case there was somebody that needs to listen to it. It will be available by 5:30 Eastern time. And you can go 1-800-642-1687 and ask for call number 70961782. That's 70961782.

I don't hear any other questions yet. (Shawn), I think that we can probably go ahead and disconnect – encourage folks to disconnect.

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

END