

THE BROOKINGS INSTITUTION

ACHIEVING BETTER CARE AT LOWER COSTS  
THROUGH ACCOUNTABLE CARE ORGANIZATIONS

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**Welcome:**

MARK McCLELLAN  
Director, Engelberg Center for Health Care Reform  
The Brookings Institution

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DONALD BERWICK  
Administrator, Centers for Medicare & Medicaid Services

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**Presentation: Educating Consumers:**

DEBRA NESS  
President, National Partnership for Women and Families

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ELLIOTT FISHER, Moderator  
Director, Center for Population Health  
The Dartmouth Institute for Health Policy & Clinical Practice

DEBRA NESS  
President, National Partnership for Women and Families

FRANCIS J. CROSSON  
Associate Executive Director, The Permanente Group, Inc.

JOHN ROTHER  
Director of Legislation and Public Policy,  
Government Relations and Advocacy, AARP

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MARK McCLELLAN  
Director, Engelberg Center for Health Care Reform  
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Guest Scholar, Engelberg Center for Health Care Reform  
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**Panel:**

MARK McCLELLAN, Moderator  
Director, Engelberg Center for Health Care Reform  
The Brookings Institution

JOHN GOODMAN  
President and Chief Executive Officer  
National Center for Policy Analysis

GENE LINDSEY  
President and Chief Executive Officer, Atrius Health

ED CYMERYS  
Chief Actuary, Blue Shield of California

JOHN BERTKO  
Guest Scholar, Engelberg Center for Health Care Reform  
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**Next Steps:**

ELLIOTT FISHER  
Director, Center for Population Health  
The Dartmouth Institute for Health Policy & Clinical Practice

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## P R O C E E D I N G S

MR. McCLELLAN: Good morning, everyone. I'd like to ask everyone who's not in a seat yet to take one. We do still have a few around the room. And I'd like to welcome you on behalf of the Brookings Engelberg Center for Health Care Reform and the Dartmouth Institute to today's event on achieving better care at a lower cost through Accountable Care Organizations.

The Engelberg Center and The Dartmouth Institute for Health Policy & Clinical Practice are very enthusiastic about convening this event today. I'm Mark McClellan. I'm the director of the Engelberg Center for Health Care Reform here at Brookings and the co-director with Elliott Fisher of the Brookings-Dartmouth ACO Learning Network.

We're meeting today at a very critical time for health care reform and we're also meeting today on a very challenging day from a weather standpoint, so I really appreciate all of you braving the weather not only to get here, but to get here on time. Special thanks to all of our panelists who have come from all over the country -- Northeast, West, Midwest, everywhere -- to be here. And I also want to welcome the many people who couldn't be here in person and are joining us by webcast today.

Unfortunately, Nancy-Ann DeParle is not going to be able to join us due to some urgent matters related to the situation in the Middle East and her new duties as deputy chief of staff. But regardless of the

weather and the other logistical issues, the urgency of the issues that we are discussing here today remain, so we're very glad to convene this timely discussion today.

You all know that most of the public attention around health care reform has understandably been focused on issues of coverage expansions and their costs, and mandates and constitutional challenges, and things like that. Those are certainly very important issues.

But at the same time, Medicare and states and private payers and businesses and health care organizations, consumer groups, others are all taking many new steps to try to reform the way that health care is delivered, to reduce costs while improving health. And that's what I think of as real health care reform. And today we're focusing on a critical aspect of real health care reform: the next steps in the implementation of Accountable Care Organizations, ACOs.

The idea behind ACOs, as I think many people know at this point, is common to many kinds of health care reforms: paying more for better care at a lower cost, but not doing so in a way that's too disruptive to current payment systems and the current methods for delivering much-needed care. ACOs are coordinated networks of providers with shared responsibility for delivering better care at a lower cost and they're accountable for that. They're accountable for that. It's built into the reporting and the payment systems for the organization.

The aim behind all of this is to reward value instead of

volume and intensity by making providers eligible to share in the savings that result if they are able to take steps that reduce overall health care costs while maintaining or improving quality of care. ACOs are intended to provide better support for things that doctors that I talk to every day say we don't do well in our health care system today: coordination and integration of care, investments in important kinds of health information technology, and a wide range of other approaches that get to that bottom-line goal of better health and lower costs. The idea is to provide more payments for these kinds of services in return for more accountability, not just for volume and intensity, but for what we really want: better care and lower costs.

And something I think is important to note, and we're going to talk a lot about today, these ideas are being implemented now. They're being implemented in some Medicare demonstration programs, like the Physicians Group Practice Program, and the multi-payer Medicare health care quality demonstrations in Indianapolis and North Carolina. They're being implemented, as you'll hear, in the private sector and state programs around the country.

So, what we want to do today is get practical; as Deb Ness said get concrete. What we're learning from these private plans in states and Medicare demos, what are they telling us about what can and can't be done effectively in terms of ACO-types of reforms? What are some other steps that share the same goals as ACOs: paying more for better care,

not just more care or more complications; partial and full capitation plans; medical homes; IT payments? There are a wide range of other reforms. How can these all be related to be sources of synergy to get to better care and lower costs?

Now, the Engelberg Center here at Brookings and The Dartmouth Institute have been collaborating for some time to provide tools and guidance and support to put accountable care as I've just been describing it into practice to support better care at a lower cost, working collaboratively with providers and consumers and other groups in both the public and private sectors. We're supporting the implementation of five pilot ACOs for commercially insured populations right now. We've also started the second year of our expanded ACO Learning Network, which is supporting over 80 organizations around the country through the technical and practical details of the ACO implementation process. And along with our Learning Network and our pilot sites, we're also leading some more advanced ACO implementation groups, building and conducting ACO evaluations and surveys, and helping to develop and align on accurate, reliable, meaningful performance measures, timely performance measures as well as providing a number of other analytical resources.

One of those resources is coming out today, so we're very pleased to announce the release of the Brookings-Dartmouth ACO Toolkit. This toolkit, which is now available online at [acolearningnetwork.org](http://acolearningnetwork.org) is about 200 pages of comprehensive ACO implementation guidance based

on firsthand experience of people who are working now on programs like this, a wide range of collaborators on this overall effort. You all should have received a sheet in your packet with some more information on the toolkit, along with the agenda for today's event.

Now, today, we're bringing together -- this is one more step in this process -- bringing together experts, policymakers, a number of the organizations that have been implementing ACOs and reforms that relate to ACOs from around the country to continue this work and this discussion. We're going to focus, again, in some practical depth, we're going to try to get concrete, on a couple of critical implementation issues in particular.

One of those very important issues is how to effectively engage consumers in the implementation of accountable care. That'll be the focus of the first part of the morning. And the second is on the providers' side, how do we support the movement of ACOs to more accountability? How do we actually do this in practice, taking account of all the ideas, all the concepts, all the theoretical concerns? How do we really make that practical and real to make sure that we're having the right kind of impact from these reforms?

So, we're going to be hearing from two sets of panelists that are going to be exploring both of these critical issues. We're going to lead off each panel with some framing remarks to provide an overview and, hopefully, get the discussion going, again, around these concrete and

practical next steps. After the opening remarks, Elliott Fisher and I are going to help to moderate a discussion among the panelists. I don't think they really need us as moderators very much. These are all experts on both the big picture and the practical steps in their own right. We're going to go into some more detail.

We're then going to have a little bit of time at the end of each panel for questions and brief comments from all of you. So, looking ahead to that, there are going to be a couple of roaming mics attached to some of our staff in the audience who will come around to you. So, when we get to that part of each session, if you've got a comment to make or a question to ask just raise your hand and we'll try to get in as many as we can as quickly as possible.

As I mentioned before, this event is coming at a critical time. The goal of engaging consumers, making sure there are strong incentives in place to encourage accountability and to get to better care are essential if we're going to transform our health care system. Officials at the Centers for Medicare & Medicaid Services are currently working on regulations for implementing ACOs in 2012 -- that is less than a year from now, Don, as you know -- under Medicare provisions that are going to help encourage this transformation as well as implementing a number of innovative pilots related to extending the ideas of accountable care through the new Centers for Medicare & Medicaid Innovation.

Leading these efforts is Dr. Don Berwick, the administrator



for the Centers for Medicare & Medicaid Services, CMS. Dr. Berwick has an extensive professional history of working on ways to improve population health and improve care delivery while reducing costs, the triple aim. And for him, just like for our meeting today, this isn't just about theory. It's about getting into health care systems and changing health care delivery, changing financing, changing policies that support all that, all at the same time.

Before he became the leader of CMS, Dr. Berwick was president and chief executive officer of the Institute for Health Care Improvement. He was also a clinical professor of pediatrics and health care policy at Harvard Medical School, and a professor of health policy and management at the School of Public Health.

Don, it is great to have you with us today to kick off this event. Thank you. (Applause)

DR. BERWICK: Thanks, Mark. Thanks for your leadership and Brookings' leadership in helping us think through the health care system that we want to progress in our country. It's a constant source of ideas and inspiration to me and I want to personally thank Mark for his ongoing mentorship. He's a great counselor.

You've got a busy day ahead and I don't want to take too much time, but I thought I would just set the stage a little bit, at Mark's request, about where we are in the ACO world from the point of view of CMS, and to share a little bit about my thinking and those of my

colleagues at CMS about the principles that underlie this expedition that we're on. I'm going to do it by zooming out first to CMS as an agency -- that's the part of this story that I now know better and better -- while the work you're all doing plays out in parallel and, hopefully, in synchrony. I'm going to show you the overall CMS strategy that was launched a couple of weeks ago within the agency and then position the ACO work within that and give you some idea of how this fits into the bigger picture of the kind of work that we would like to do on behalf of our beneficiaries.

Upon my arrival at CMS, now seven months ago, I began a series of conversations throughout the organization around our nature. And it was always my intent and has been widely embraced now the idea that CMS is more than a payer, more than an insurance organization, but rather a steward and partner in American health care for making our health care system better. And so the vision statement that now guides our agency and our strategy is this: that CMS is a major force and a trustworthy partner for the continual improvement of health and health care for all Americans. That's the overarching rubric.

It's a carefully phrased, carefully constructed vision and done in dialogue with my many wonderful colleagues there. "A major force" implies an agency that's proactive. We want to actually help cause the change in synergy with you.

"A trustworthy partner" means we cannot do it alone. The kind of vision that Mark was just laying out for an ACO, let alone for the

health care system as a whole, is no longer in any single party's hands. We're going to do this together or not at all. And, therefore, the agency, to my mind, has to be a very, very trustworthy partner, breaking down barriers between the public and private sector so we can work very well together on common journeys.

"Continual improvement" means to get out of the check-off mentality, get out of the concept that minima or check -- just doing good enough is good enough. It isn't. The demands, the social needs in health care are simply too dire for us to think that way and we're really going to be in a journey of continual improvement or we can't meet the social need.

"Health and health care" is a sleeper. It's a very important issue. Scientifically, as you know, only 10 percent of the variation in health status is attributable to health care. The rest is either genetic or circumstantial. It has to do with the risks in society, behavioral choices, the causes of illness. And I think any party now in American health care that is serious about achieving better care at lower costs, which is what we're serious about, is really going to have to engage the issue of health and health production, not just health care production, more authentically. For CMS, that puts us in a partnership with other agencies. CDC, the assistant secretary for health, and others are actually more the lead agencies for health improvement, but I'm trying to orient us altogether in CMS toward the production of better health, not just health care.

And "all Americans," it just means that if we're going to work

hard to try to improve care for the hundred million beneficiaries in Medicare and Medicaid, and now the 30 million people that will end up being helped through the Office of Consumer Information and Insurance Oversight, it's the whole system in play. We're going to have to do this together in partnership with a whole system so all Americans now count, of course.

I brought my prior thinking about the three-part aim -- we now call it NCMS -- as the overarching definition of what continual improvement is. Continual improvement in performance means three things at once that Mark referred to: better care for individuals really contemplated by the Institute of Medicine "Crossing the Quality Chasm" report -- safe, effective, patient-centered, timely, efficient, equitable care; better health, that's what I just talked about in terms of upstream causes of illness; and lower costs through improvement. Here is a matter of great public debate and discourse. Do we mean lower costs through withholding care? We do not. This has to do with achieving lower costs through the improvement of the care system. And I bring to my work at CMS enormous confidence that through imagination, invention, innovation we can and we will discover ways to give care that are far better for people without withholding anything at all that people want and need through the redesign and care systems. This is the CMS aim.

Just to give you a little peak managerially inside, this is what we're working on right now. The agency itself is large and complex and

wonderful to deal with, but like all organizations we have cultural challenges. There are ways we have to be in order to be effective trying to help health care become what it can be. And so these are the five values, operating values, within the organization that I'm working on very hard with my colleagues. This is linked now to performance pay for senior staff and we're going to metricize it this year. And these five characteristics, just to give you a peak, are very important, I think, to setting a stage for our ability to help the way I think CMS can help.

Boundary-lessness, breaking down barriers within the agency between Medicare and Medicaid, between measurement functions and surveillance functions, and so on; getting out of siloed thinking, much as health care has to do and much as ACOs should be. Speed and agility has to do with moving with the pace of social need. Unconditional teamwork is the idea of sharing resources at a time when resources are constrained. Valuing innovation is willingness to take risks and, indeed, to fail sometimes en route to better care. And customer focus means an organization that's sensitive to the people who depend on it and judges its own quality in terms of how the people we're trying to help view us: beneficiaries, providers of care, and others.

We could spend a lot of time on these, but I wanted to lay out to you my general approach managerially is that values are the underpinnings to excellence. And I think the same will be true in ACOs, frankly. I once heard someone say when values are strong, rules are

unnecessary. When values are weak, rules are insufficient. And I think working on the values structure of our agency as we would hope health care will do is an important thing to be explicit about.

Our strategic areas of focus. There are about, I think, 16 or 17 goals now on our map of strategy for 2011. They fall in these four buckets, and you'll see ACOs emerge in a minute from this framework.

The first is internal. I like Gandhi's famous quote that you must be the change you wish to see in the world, and I think that's true. And as I just said about values in CMS, I think it's true of our operation as well. If we want health care to be seamless, CMS has to be seamless. If we want health care to be agile, we have to be agile. If we want health care to be responsive to the people it serves, we have to do so. If we want health care to be simple and elegant, we have to be that way. And so there's a set of operational characteristics which would bore you for me to get perhaps into detail, but it has to do with how we work, simplifying our rules and procedures everywhere we possibly can; working really hard on the capacity of our own workforce, the 4,500 people who work there, to improve their work just as I would hope health care capacity for improving care can advance. So that's Area 1.

Area 2 goes back to the IOM "Chasm" report, those six dimensions: safe, effective, patient-centered, timely, efficient, equitable care. It's trying to organize a lot of CMS work around the needs of particular individual groups in care. Probably the flagship here is patient

safety. It's 10 or 11 years since the Institute of Medicine report, "To Err is Human." We don't have a lot of evidence of progress on safety systemically. We do in pieces, but not systemically. And so there's -- one example of a goal area under Area 2 is to work really hard on now making what I'm seeing internally as to bring excellence to scale. If we know how to eliminate infections in some places, let's try to do it everywhere. If we know how to make pressure sores go down by 95 percent someplace, let's do it everywhere. And there's a series of aims I think it's time for us to share at quite a large level nationally and there's no resistance to this. And I think you will see this year play out perhaps the largest effort in patient safety our country's ever seen.

Another area in care for individuals is the amazing possibilities for dual eligibles with a new center for duals. It's got a longer and more complex name, but headed by Melanie Bella, a fantastic leader. We can pick up the needs of these 9.2 million Americans. They explain 40 percent of Medicare costs at a time when Medicare costs are a serious issue, and their quality isn't what it should be. We estimate 100,000 duals are actually in integrated care out of the 9.2 million, and so that's another area in improving care for individuals.

The third is what we're talking about here today, if I finally get to it, and that is the concept of integrated care. I think it's the flagship. I think if I had to really come down to one area where our work intensively could help deliver on social need it is this area, producing integrated

experiences. I'll come back to that in a minute.

And our fourth theory is prevention. We're going to be doing quite a bit of work this year on cardiovascular disease and prevention of heart attack and stroke in concert with CDC and others, and working on disparities. I'm working now with our new office, the office soon to be set up for minority health within our agency, picking a few areas of disparity and concentrating on that.

But let's go back to Area 3. That's what we're here to talk about, integration of care.

There is actually a flight -- a fleet of innovation fronts under the Affordable Care Act, all of which have to do with creating journeys for people instead of fragments. That's what people need. I'm always returning to the patient in my mind as a guidepost. And several times in the past month I've talked about a patient; I hope I won't bore you by repeating it if you were at some recent talks I've given. But it's a kid that I saw, oh, 20 years ago named Kevin. I wrote about him a number of years ago, but he's come back very much to my mind. He was 15 years old when I saw him. Kevin was a -- well -- he was doing well, but he was chronically ill. He had a short bowel syndrome due to resection of intestine as an infant. He'd been in and out of the hospital 30 or 40 times.

When I was teaching in the children's hospital my habit was to get together with the medical students and the residents and ask them to show me a patient who'd been in the hospital for a while and I dared



them to show me a patient who had not had a complication of care. I say I offered these underage students a case of wine if they ever successfully did that, but I never paid off. (Laughter)

So Kevin was such a case. We went to his bedside and I said to Kevin, you've been here a lot. What could be better? What could we do better?

And he said nothing, you're just great. All patients tend to say that right at the start. We're very grateful and you're doing a good job for us.

And I said, no, Kevin, I really mean it. You've been here a lot. Tell us what we could do better.

And he said nothing, I just told you.

I said, Kevin, write down what we could do better. So -- I said three things.

So, he wrote out a piece of paper which I kept for a while and then lost. And if you find it, return it to me, please. Kevin wrote three things on the paper that I distinctly remember.

The first thing he said was please tell me what you're going to do to me before you do it. He was asking for anticipation. He wanted a plan. Kevin wanted to be on a journey, not in little pieces.

The second he said was this, he said I've got 10 doctors and 20 nurses and 30 tests. He said you're all wonderful. Could you please talk with each other? That's what he wrote on the paper, please talk with

each other. He wanted us to be a team. It was too complex the journey he was on for this to be done in pieces.

And the third thing he said was I've been in the hospital 30 times. I actually know more about my illness than most of you do and I certainly know more about my life than you do. He wrote on the paper please ask me what I think.

I kept that for a long time because I think he was telling us our job. He was saying plan ahead, be a team, and put me in charge, give me power. And to me, when I go back to ACOs or bundled payment or medical homes and I try to understand what we're doing, I just keep thinking about that kid and kids -- people like him. That's what Area 3 is, that's creating journeys.

Now, the law has given us this vocabulary thanks to leaders in the room, the Accountable Care Organizations, one of several options: bundled payment, medical homes, health homes, Accountable Care Organizations. What do we imagine here?

We don't imagine, I don't imagine, the status quo repackaged. And I guess my biggest concern about ACOs might be that, that if we get it wrong that's what will have happened. We'll have taken the status quo delivery system that doesn't serve Kevin well -- today's Kevins -- and put it under a new name, and that can't -- that won't be success. That isn't meeting the social need. Not better care, better health and lower costs through improvement. I'm viewing the Accountable Care

Organization, I hope, as new care, a new care design created, as Mark said, in a very unusual context: a context of open choice, fee-for-service payment, and the absence really of restrictions, which is a very bold idea and an important idea. And if we do that well, Kevin will be well-served and so will our current financial crisis in health care. If we do it poorly, it'll be the status quo renamed.

The principles that would underlie this redesign are several. These are my own words. They're not in the law and they're not necessarily what will emerge. But first, it will put the patient and the family at the center. It will honor preferences and values and backgrounds and resources and skills at the individual level and will engage people in shared decisions about their diagnostic and therapeutic options. This will be centered around the patient, not around the care delivery.

It will have a memory. Amnesia is a real problem in health care. When Kevin says please talk to each other, he also means remember me. He means keep the data information together. Teamwork will now become paramount in the ACO, I imagine. Patients won't have to repeat their stories. They won't have to tell people to talk to each other. That'll happen automatically because now the dynamics and the incentives are in place for people to be a team, which I think they want to be.

The third is that handoffs will matter. That's related to that. A patient's journey through the system and we hand them off, and it's the

handoffs where things tend to go wrong. It's these boundary places. The concept of the ACO would be to create a seamlessness that is real for the people who don't -- who need us not to drop the baton. Make a plan, said Kevin. You know, tell me what you're going to do before you do it to me. That involves crafting pathways together.

It will have to respect resources. Better care, better health, and lower costs through improvement, all three will matter and we need agencies, agents, stewards in American health care to understand that resource management is health care, also. And the focus there is not on withholding care. It's on reducing waste. And so becoming sensitive to the nature of waste -- wasted time, wasted effort, wasted materials, wasted supply, wasted information, wasted ideas, wasted spirit -- and making sure that every step adds value is good for Kevin and good for meeting the social need. And an ACO, to my mind, is a place cognizant of that.

And then it will reinvest where investment counts. We now invest in volume and throughput. The ACO will invest in value and outcome, which means resources are moved to where they're needed. And so if there's a need for a focus on anticipation, resources will go to anticipation. If there's a need for focus on pattern recognition, resources will go there. If there's a need for care at home, resources will go home. And the ability to move resources around in a cooperative mode is key to the concept.

That will, by the way, have a big impact on one important agenda, which is the avoidance of unnecessary and harmful readmissions. When we drop the ball and things go wrong, people end up back in the hospital, not at home where they want to be. That involves proactivity. It means not waiting for things to happen, but preventing things upstream. That allows proactive clinical management with reminder and advice, keeping people healthy, keeping people aware, reaching out and telling you it's time for your test or your checkup, making sure that people know how to get what they need when they need it.

And all of this will depend on data richness, something Elliott and Mark have been stressing so eloquently in their work. We need daylight. And an ACO, properly constructed, will be able to measure and manage what's important for the patient over time and space, tracking outcomes, knowing how things are going over time and space, and transparency's relevant. The lights need to be on.

The status quo won't do it, and so we're going to somehow need an ACO economy interested in innovating, finding the better way. And there are so many options now in American health care for better ways. I'm particularly intrigued with the modern telemedicine technologies. The more I look at them, the more promise they seem to have in being able to innovate in that space. It would help all the patients we want to help.

Electronic health records will need to be key, and so will

search. I think an ACO, in my mind, would be a place that scans. We want to do better for people with short bowel syndrome. Who does the best? We want to do people for people with arthritis. Who does the best? For duals, who does the best? And that ability to scan and know is related to transparency, openness in data.

And it has to attend to its workforce. I continue to believe personally that pride and joy in work are the foundation for effective work in any industry, but they're clearly the foundation in health care. A health care workforce -- doctors, nurses, technicians, therapists, managers -- who are not joyous about their ability and capacity to help people, can't help people, not the way they really could if they could discover the pride in their work. And so I think workforce development now comes back on the screen, I hope, for the ACO, and that applies to everybody that works in health care.

As we do this, underlying this, of course, are sort of policy aims. I don't have a cogent summary, but to make this happen right, more and more we're aware that things -- certain touchstones need to be nurtured or whatever. That's a mixed metaphor. Touchstones need to be touched, I guess. (Laughter)

I think that concept of better care, better health, and lower costs through improvement is a touchstone. It means that authenticity with the ACO means simultaneous pursuit of those three, at least as a collective.

Pluralism and sponsorship matters. It's really clear if you hear the feedback, and we've been all over the country -- listening sessions, dialogues, hours and hours, days and days spent trying to hear what people are telling us -- and they're saying -- really what they're saying is give me a shot. I want in. A small group practice, a small hospital, large hospital, teaching hospital, a specialist -- everyone kind of wants to be able to play. And I think the policy framework here will create doors, opportunities for people to participate from different sites. That means an ACO won't be one thing. It'll be a collection of models, all of which share in common this core of -- that I just referred to.

We'll have to honor guidance issues, like antitrust matters, stewardship, beneficiary protections, and so on have to be (inaudible). And if we're going to use the financial mechanisms of reward for success, we will have to make sure that we know success. And that means quality measurement, quality metrics, assessment of the patient's status is the balancing measure to anything we do on shared savings or gain sharing. That's the safety terrain. We lose sight of that at our risk, at the patient's risk.

Now, I'm in a little bit of an awkward moment, aren't I? The Notice of Proposed Rulemaking isn't out yet. It will be out very soon, but I can't tell you what's in it yet because I guess I'm not supposed to, but you'll see it soon. And then there'll be a comment period, which I hope you'll all take seriously. But, of course, you know, there are issues that

we're going to have to parse as we engage in this expedition toward appropriate and helpful, integrated care.

What will risk look like? Shared savings only?

Upside/downside? Partial cap? Full cap? What would work? For whom? Who could play under each of those different conditions? And what would happen?

Beneficiary protection, avoiding cherry-picking. The ACO as written in the law preserves choice. Very important idea, protecting the ability of the patient to be powerful.

Patient attribution, will it be retrospective? Prospective?

How will we know who's in or out of the issue? This is not managed care. This is not Medicare Advantage. You don't sign up or this. You're attributed, and how to do that is a tough issue.

Measurement. How many measurements? Of what type?

What's the balance between process and outcome measurement?

Measurement capacity: the tougher the measurements get, the fewer that may be able to play, and finding that sweet spot where we're measuring enough to know and protect the beneficiary, and yet measuring with enough personally that we're not excluding people with complexity.

Privacy and data sharing. What can be shared, what not?

The ACO's going to want to know a lot about the people that are in it. What can they know about those people? Is it okay with those people for them to know it? Getting the privacy issues correct is going to be tough.



Generating capital. If it's not the status quo repackaged, then there's investment and change. Well, who can invest? Maybe large hospitals can invest. What about a small practice? How are we going to find the investment opportunity to create the pathway? Will there be enough security to invest? Is this going to go away in two years and it's not worth going through the trouble of the change?

The antitrust stark issues. We have to maintain integrity of markets and market forces, and not let monopolistic behaviors emerge.

And then there's this other very interesting and fun area, what I would call accelerated models. The 3022 rule, the core NPRM, will be a core model. It'll be what many, many can play with. But we all know there are places out there ready to surge ahead to a completely different level of integration because they've been there already or they're en route. And wouldn't it be nice if we could make space for a vanguard who could move ahead of the pack and teach us all where to go? Maybe the Innovation Center, the Center for Medicare & Medicaid Innovation, can be a home for that kind of pioneering element on our behalf, on everyone's behalf, not specially entitled players, but our scouts. And that's another issue and possibility that lies there.

The core to me is authenticity. As I say, I think there will be parties out there who wish to take advantage of the law and the vocabulary to re-label what they already do and repackage the status quo. I don't think that will be enough, not at scale. We're going to have to find a

way to deliver care better, and that means change. And the question will be, looking forward as we migrate into this terrain, it seems to be is, are you really in the game? Do you really want to provide better care for Kevin at lower costs through improvement? Or are you simply taking what you already knew and calling it something new because that's the game today? That's the question I think we'll be facing case-by-case and probably altogether.

Thank you again for your leadership and the chance to share these ideas with you. And I look forward to what's coming out of the rest of the day.

(Applause)

MR. FISHER: Gosh, what an inspirational beginning to our morning. Thank you very much, Don. I can't imagine a better vision for all of us really, although we may not be able to be a major force, each of us, we all could be a force and a trustworthy partner for continual improvement of the health and health care of the American people. I think it's not a bad model -- we're not as big as CMS, all of us, but we each can contribute in our way.

For those of you who don't know me, I'm Elliot Fisher. I'm from Dartmouth, and I'd like to add my welcome to you all. We have a wonderful morning ahead of us. Don has done an incredible bit of work outlining where we hope to go or where we could go with the ACO Program. As CMS advances its agenda, and our aim for this morning is really to help get concrete about some specific examples of places around

the country that are doing this and focus, as Mark said in the introduction on two specific areas; the notion of consumer engagement, beneficiary protection, how do we make this work from the consumer and patient's point of view, and in the second panel really about the accountability model, the financial issues.

So, our first panel really focuses on this challenge of engaging consumers, and how we successfully partner with consumers and patients. While I do the introductions, I'd like to ask our panel members to join me up here, and I'll introduce them as they come up. And those of you who want to jump up the high step can step up there. The others who want to walk around are welcome to.

So, to my immediate right is Debra Ness, president of the National Partnership for Women and Families. Debra will be giving about a 15-minute introduction and overview to sort of frame our discussion as a panel.

And then to her immediate right and my further right is John Rother, director of Legislation and Public Policy and Government Relations and Advocacy for the AARP, familiar to you all, I'm sure.

And off far to the right in right field there is Jay Crosson, who is associate executive director for the Permanente Medical Group, really running one of the large models in health care that we all think of as what many of us see as the key elements of what an accountable care organization could be.

So, with that, I'd really like to ask Debra to step and make some introductory framing remarks, and then I'll get my (inaudible).

MS. NESS: Great. Hello, everybody. It's always a challenge to follow Don Berwick. I am wearing two hats today, National Partnership for Women and Families is my home, but, also, the National Partnership for Women and Families is the hub of something called the Campaign for Better Care, which is a coalition of consumer organizations, now more than 160 organizations strong, that is really dedicated to engaging in this discussion around how we make our delivery system work better.

So, the goals of ACOs, as Don just laid out, better care, better health, lower costs are shared by consumers. There is no question about that, but we're having today's conversation because we're all excruciatingly aware of the fact that if we don't do this right, rather than consumer buy-in, we could very easily end up with consumer backlash. So, I'm going to start by saying the first step we have to take is probably going to require a major paradigm shift in our health care system, and that is the idea that consumers and patients have to be at the table every step of the way as we try to recreate and reshape our health care system. That means at the policy level, that means at the design, that means at the implementation, at the governance, at the assessment, at the dissemination, and in the intermediary and education role.

That may sound like a tall order, but I believe that there are

already places in this country that are doing it and reaping the benefits of doing so. And I want to also make the distinction you'll hear me use the term consumers and patients. When I say "patients," I mean patients and family caregivers, but I also want to say that there is a distinction between consumer advocates and patients, and we need both at the table. They are distinct players, and they are both critically important. Consumer advocates are folks who understand how to advocate, who can speak for a broad group of patients, who are sophisticated players, who can sit at the tables and go toe to toe with their counterpart stakeholders. Patients are folks who are seeing care up close and personal. They have information about what's working and what isn't. That's not available to clinicians and staff, that only they can deliver, and it's their experience that we need to learn from.

And this is not really a terribly difficult concept to understand. If you just think about the physician community, I often sit at tables with the head of the American College of Physicians or the head of the AMA, and I often hear folks say but you know what, we need some real-world practitioners at this table, too. So, it's the same thing for patients and consumer advocates. Both have to be at the table. And to do that, I think we have to bust through some pretty entrenched myths in the system.

First, this idea that if we just build it right, they will come. We've tried that before. It didn't work very well. Even the best of intentions, the best of ideas, if consumers aren't part of it, if they're not

part of shaping it, if they don't understand it, we've learned that they can't necessarily be expected to embrace it.

And I'll just give one quick example. Medical home, I know from my conversations with patients that the concepts of the medical home were extremely resonant and attractive, but find me a patient that likes the term medical home. And I think if patients had been at the table when the concept of medical home was in development, we probably never would have called it a medical home.

Another thing I want to say is that education and social marketing campaigns are not the same as consumer engagement. It's sort of like giving Mikey a bowl of spinach with whipped cream on top and saying eat this, you're going to like it, and hoping that he doesn't notice the green stuff underneath the whipped cream.

Most important, I want to say that patient satisfaction is most people's minds today still seems like something nice, but necessarily essential. People still don't understand that the patients themselves when they tell us what they want and need are actually telling us the very things that will help them adhere to and achieve the better clinical health outcomes that we want them to achieve. And there's now ample research showing that patient experience surveys, for example, are related to greater adherence, better clinical outcomes, lower malpractice risk, higher satisfaction on the part of clinicians, and more energized staff and clinicians.

It's like the story Don just told us about Kevin. Kevin put his finger right on it. The things he said, I don't know how many years ago, are the things that patients still say they want the most. They want their docs to talk to each other, they want coordination, they want communication, they want to be a part of their care planning, they want to be able to anticipate. They have a lot to teach us, and those very things that they want are things that will help us get to better clinical outcomes.

My fourth myth is that docs know what patients want. Often, they do, but not always, and I would urge folks to take a look at some research that's being done by a woman named Karen Sepucha up at Mass General, who's actually looking at the disconnect between what doctors think that their patients want and it's important to them in treatment versus what patients say that they want, and it's stunning to see how diametrically opposite sometimes those two things are. The doctors tend to focus on outcomes and survival rates. The patients tend to want to know more about side effects and risks and quality of life.

And then the final myth I think we need to get through is that patients always want everything. Now, I know all about the more is better mindset and how problematic that is, but consistently there's research showing that docs underestimate the influence that they have over their patients' decision-making, and we also know from shared decision-making research that when patients are presented with their options, they don't necessarily want everything. In fact, they're often more conservative than

their docs.

So, we need to break through those myths if we're going to get to what I think is the number one thing we need to do to build a model that works for patients and that patients embrace, and that is we have to have consumers and patients at the table every step of the way, but there are three other things I want to touch on. One is that we have to build these models right from the get-go so that the first taste of them isn't a sour taste that turns people off, which means we have to build them with the things in them that patients say that they want, and we have to build them in a way that really engage patients.

The second thing I'm going to talk about is that we need real accountability, and that accountability needs to be to real patient-centric metrics so that we know that at the end of the day, we are getting achievements and improvements that matter to patients.

And then, finally, we need to not be afraid to build in the core patient protections that patients are telling us they want. We need to build trust, and if we're building better models of care, people will come. So, we cannot be afraid to build in those protections.

So, starting with building it right, right from the get-go, one of things that I'm very concerned about is that as we build ACOs, that we keep in mind that we need to make sure they have the capacity to serve the highest-risk and highest-cost patients. That means that they have to be built with the capability to do comprehensive, team-based primary care,



care management, care that is sometimes home and community-based. There needs to be a continuum of care. I worry that we are putting so much focus on what the right legal structure is, what the right financial mechanisms are that we will forget that if you put together a bunch of providers who don't today know how to provide that intensive care management for those most complex patients, they're not going to somehow suddenly know it better when they're grouped together in an ACO.

So, what are the tools? What are the ways in which we're going to make sure that we build that primary care capacity? And for many of the patients that we have to serve if we want to bring down costs, and let's just think about it for a second, the 20 percent of Medicare patients that are two-thirds of the spend generally have at least 5 multiple chronic conditions, they tend to see what, 14, 15 different doctors, make 30, 35 visits a year, have 50 different prescriptions. Sometimes they really need home-based care if we want to keep them out of the ER, if we want to keep them from being unnecessarily put in the hospital, if we want to make sure that they're not being readmitted within 30 days. How are we going to build that care continuum?

We know that there are models out there, models like independence at home programs, models like the PACE Program. The VA, maybe one of the most mature models of an ACO out there made a decision back in 2006 to do home-based primary care in 140 sites. Their

home care costs went up 400 percent, but their overall spend on those patients went down 24 percent, and it become the most highly-rated clinical service that the VA presented. And there are examples of that over and over again.

In order to build this continuum and this primary care capacity, there's going to need to be some adequate investment, as Don said, in helping practices achieve this capability, and it's going to mean probably that there needs to be some kind of risk-adjusted payment based on complexity of patients.

The other thing to building these models right is making sure that we build in the right kinds of patient and family engagement right from the get-go, and I'm going to quickly run through a list and hope that we can have more conversation about these as part of the Q&A. Things like individual assessment and care planning and setting individualized goals. Things like giving people self management support when they have chronic conditions. Things like shared decision-making tools. Things like linking people to the appropriate community-based services that can help them take advantage of the health care and stay healthier and live independently. And then I want to say that there are things, there are certain patient experience tools that we already have available to us, things like John Wasson's *How's Your Health Tool*, which are ways of combining getting feedback from patients, with engaging them in care, and creating a tool that the patient and the physician can come together and

engage around. We have these tools already at our fingertips. We need to use them.

And, finally, I want to talk about the idea of patient and family counsels. They're being built in now to some medical homes. If any of you are familiar with this very exciting initiative in Camden, New Jersey, a Medicaid ACO initiative in Camden, New Jersey. You'll know that part of the governance of that initiative requires two voting consumers from community-based organizations as part of the process of governing that ACO and community-based involvement in how the shared savings get put back into improving care in the communities. So, engaging consumers and helping to advise and design.

At the hospital level, we're seeing similar things, patient counsels, we're seeing hospitals that are saying we're no longer doing rounds in the hallway. We're going to do them in the patient room with the patients and the families at the bedside. We're going to involve patients and shift changes. There are lots of ways we can engaged patients as we go along.

Accountability is my second point. Accountability means strong measures to tell us whether or not we're getting where we want to go, and if there's one takeaway from my comments today, it's that at the top of the list of accountability measures should be patient experience measures. Only patients through their experience of care and through telling us about their outcomes, their functional status will be able to tell us

whether or not ACOs are making care better for them. And that should be a sine qua non right from the beginning. We have the tools. They may not be perfect, but we can start using them. And I hope that eventually we get to a place of having a cap survey, for example, that is specific to ACOUs.

You all know the other kinds of measures we need. We need measures of outcomes and functional status and coordination and costs and appropriateness of use and safety for sure. Are we also going to make sure that ACOs comport with meaningful use criteria? If we want information at the fingertips, if we want to be able to use HIT to help engage patients, we need to. And are we eventually going to get to a place where we have measures of whether or not ACOs are actually engaging patients? Are they using shared decision-making? Are they doing individualized care planning? Are they linking patients to community services that can help them? Are they creating patient and family counsels? Those are the kinds of measures that will tell us down the road whether we're really engaging patients.

And, finally, whatever measures we use, we need to from the get-go build the capacity to stratify those measures by race, ethnicity, language, gender, disabilities, socioeconomic status because we need to be able to monitor the impact of ACOs on different populations and make sure we've addressing and reducing, not exacerbating disparities.

My final section is on patient protections, and I know this is

an area that makes people (inaudible). CMS has been very clear that patients are not going to get locked in, which is one of the biggest fears that patients have, the loss of choice of provider, being locked into a network that's inadequate. But we are strong proponents of full transparency, which has to mean also prospective assignment. Patients have the right to know how their care is going to change. Patients have the right to know whether or not there are financial incentives that might affect the kinds of care recommendations that their providers make to them, and how else are we going to engage patients if they don't know and they're not really full partners in this.

And we need to make sure that patients have transparent quality and cost information if we want them to make better decisions. So, full transparency, prospective assignment I think are critical patient protections. Flexibility, not lock in. Adequate networks, and the creation of some kind of an ombuds or appeals process is essential. Patients need to know there is some place they can go if they feel that they're not getting the care that they should or that their provider is recommending care that's not necessarily in their best interest. Where do they go? They need to know there's a safety valve, there's an opportunity for a second opinion, there's an opportunity if they have a certain kind of condition to go to the best place in the country to get the care that they need.

And, finally, patients deserve a return on the savings, and how that's done, there are lots of different ways, but in that Camden, New

Jersey, example I gave you, there's a requirement that the way that those savings are spent in the ACO have to include community input, and in a recent experience in that project, they went back to one of the areas they were serving and they had a conversation with residents in a very large project that was responsible for much of the spend in the health care services, and they said okay, we have this much money and here's a range of things we can do with it, and what do you think we should do with it? And they voted to put a nurse practitioner in that project, which we'll see. Will probably end up being the decision, but we'll see. But they had a say and they own it; they own that project.

So, one of the areas that I get asked a lot is how do you notify patients if you want full transparency and prospective assignment? What are the best ways to notify patients? I'm going to put a three-pronged approach on the table. I think number one, the ACO needs to notify people in a way that describes what's going to change, what the benefits are, and what the protections and responsibilities of beneficiaries are. I think that piece probably has to be standardized and approached by CMS, but I think most of the rest of it probably has to be unique to the ACO since there's going to be a lot of variation. I think CMS has a role in notifying beneficiaries. I think they need to put out information that will lay out what are the benefits, what people can expect, what are the protections, what are the rights, what are the responsibilities?

And, finally, the best way for patients to learn and hear about

ACOs and what it can do for them would be through individual conversation with their trusted physician. And if we want to get to that level, then we need support for the physicians so that they know how to deliver that information in an effective way and how to engage patients in that conversation.

And, finally, whatever we do on the notification front, I hope we focus group it and we test it with real consumers and patients because we've learned that we speak a language that doesn't necessarily resonate outside our policy circles, and we can't keep making that mistake.

So, with that, I hope I've provoked some ideas for conversation. Thank you very much. (Applause)

MR. FISHER: Very good. Debra, thank you. So, Debra, thank you very, very much. That was wonderful. You laid out a number of challenges.

Let me first come to Jay. A lot of specific requests of care organizations, and essentially these ACOs to be. What are your perspectives on what we just heard and what we should be doing?

MR. CROSSON: Well, thanks, Elliot. First of all, I'd like to say you mentioned Kaiser Permanente as an example of an ACO, and I think that's correct, although I have to say we actually had a meeting last week internally to discuss whether we should say we're an ACO or not, and we haven't figured that out yet. But we did sort of decide that we'd kind of wait to see how this whole thing turns out.

MR. FISHER: Right. (Laughter) And that's fair. Oh, and to be fair, I would call you a proto ACO.

MR. CROSSON: Oh, okay. Well, thank you. Thank you.

MR. FISHER: And we need a little more transparency and accountability in the context of this discussion.

MR. CROSSON: Right. The other point I wanted to make is I'm going to talk a little bit about engagement in an ACO. Consumer engagement in an ACO. I think there's another topic here that we're going to probably need to talk about, and that's consumer engagement on ACOs. And what I mean is what comes first? As Debra talked a little bit of a medical home, and we did a survey in a project that you know about of consumer attitudes towards different words, and we used medical home, and, as Debra said, people don't like it, and the comment we got back, which I remember from one participant was oh, I know what a medical home is.

MR. FISHER: Nursing home?

MR. CROSSON: Yes. First, you go to a medical home, then you go to a nursing home, then you go to a funeral home.

MR. FISHER: Right. (Laughter)

MR. CROSSON: So, I hope we can do a little better with ACOs.

MR. FISHER: I'm not sure.

MR. CROSSON: I did want to talk a little bit about a couple



of points here, and I think Debra mentioned a couple of them, at least with respect to our own organization. And the first thing is governance because I do think it makes a difference when you're running an organization who's running it and what decisions they're making and whether those decisions that they're making apply to them as individuals and to their families. And that's something that we've tried to stick to. So, with respect to our health plan or hospital organization where we have a board of community individuals, these are mostly community leaders, former CEOs of corporations and the like, those individuals expect for a few who have moved subsequently out of area, those individuals receive their health care from Kaiser Permanente, as do all of our physicians and all of our employees and all of their family members. So, in a sense, the people who govern our organization and the people who deliver care within our organization are all consumers. And our belief is that, in the end, that makes a bit of difference in terms of the direction of policies.

I want to talk a little bit about the issue of continuity and coordination. A number of surveys, including the one I mentioned earlier and I know Debra had this also in the paper that she's written recently, emphasize at least the perspective of consumers about the importance of the physician-patient relationship. In our organization, I'm talking here about Kaiser Permanente in general, but primarily in northern California, where I have practiced and worked for over 30 years, the notion of an ACO or an organization making the investment to make sure that that

relationship is strong is vitally important, particularly in a large organization that can be viewed as impersonal. So, we work very hard on linking members, if they're new, we call them members, new patients to physicians. We now have 98 percent, at any given time prevalence of 98 percent linkage between an individual patient and a primary care physician. Mostly primary care physicians.

That takes a lot of work. We do outreach at least 3 times over the first 60-day period, and then we have a Web Site for every single one of our physicians, which is available to our patients so that they can access and see a picture of and read information about every one of our physicians, and they're free, of course, to move at any time from one physician to the other.

The third thing I'd like to talk a little about, what Meredith Rosenthal called recently in an article in the *New England Journal* between-visit care. And that's predicated on the notion that most health care is delivered in doctor office visits. Now that's going to change. I think we know that. But the whole issue of engaging the consumer in self-management is often as much about what goes on in the doctor's office or in the hospital as it is what goes on between those two things, and organizing that systematically now increasingly through the use of technology is extremely important.

So, we have with our clinical information system and the interactive capability that we've developed the ability for our patients to

see their laboratory values the instant that they're finished. So, the instant that they are finished in the laboratory, the laboratory computer hooks up to the Internet accessibility to our patients and they see the lab results sometimes even before the physicians. Same thing with medications, not only the medications they're on, but the advice from the physician about how to use them. And we have invested highly recently in the ability of our patients to directly contact physicians by e-mail. So, we have e-mail your doctor and all of our members who have e-mail capability can send a message to their physician any time of night or day. This is above and beyond emergency care and urgent care, which is available 7-by-24, but to get to that individual physician by e-mail, we now have that available. The majority of answers come within 24 hours, and we're well over 90 percent within 48 hours. So, that's a level of -- I mean, you can think of that as well, maybe this is impersonal, right? An e-mail. But I'll tell you for busy people, they just love it, the ability to connect with the physician and get an answer in a relatively short period of time to questions small and large is extremely important and connects, as Debra was saying earlier, the real needs of the person to the mind of the physician or nurse practitioner or whoever's taking care of that person.

And this is doable. We do this in the rest of our lives. I mean, the surprise is that you can't do this for the most part with your own physician.

And the final point I'd just like to make is about

accountability. Again, as Debra said, exceptionally important. The patient experience is the key to this. How do we do that? For our physicians, every quarter at least 100 survey questionnaires are sent out to patients who were seen within 48 hours of the time they were seen, by e-mail or by regular mail. Now, you think about that. We have 7,000 physicians in our medical group in northern California. That's 700,000 questionnaires sent out every 3 months. We get response rates between 40 and 75 percent. It has questions not just about the care by the physician, but the nurses, the staff, everything with respect to that office visit, and we use that information, that experience rating for the physician as the key measure of reward for that physician, mostly in terms of recognition by peers, as well as substantial reward over the career of that physician.

That's a tremendous investment in time and energy, but the physicians see not only the scores, but they see the written comments from patients, and they see that every three months.

So, those are just a couple of practical issues about one organization that may or may not be an ACO, but has been around for a long time and has tried through investment and through technology to connect the consumer, in this context the patient, more closely to the system.

MR. FISHER: That's great. Thank you.

John, great to have you with us. What's your perspective from where you sit looking across the scope of what's happening to all -- I

guess everyone in the room must be a member, right? I mean.

(Laughter) Not quite. There are a few young people up front here. But most of us are your members, as well.

MR. ROTHER: Welcome members and future members.

(Laughter) I'd like to start off by thanking you and Mark for the leadership that you brought to this whole issue. I don't think we'd be -- not only wouldn't be here today, but the whole movement wouldn't be nearly as far along without it. And I'd also like to recognize the extraordinary leadership that Don Berwick has brought to our public programs and we are fortunate to have that.

I think Debra really covered most of the issues. I'm going to just emphasize a few, and I'm going to refer to an extraordinary article that many of you may have seen in the *New Yorker* by Dr. Gawande just a couple of weeks ago called "Hot Spotters," and if you haven't seen it, I certainly recommend it because it's a more in depth treatment of some of the concepts we're talking about here. So, I'd start off by saying that what we are talking about is culture change, and culture change is changes in behavior on both sides of the relationship. It's a change in behavior by the treating team, but it's also a change in behavior by the patient and the patient's family, and I want to lift up Debra's phrase of patient and family as a key concept here. We're not just talking about one-to-one relationship, but multiple interactions.

So, the key to making this all work is trust, and then the goal

of that trusting relationship is a change in behavior. Now, it doesn't have to be the physician. I think one of the things that we've learned in Geisinger some of the other plans that have moved this along is that it's often other people in the office who are the keys, whether it's a nurse, a social worker, or something like a community kind of health coach who's infrequent contact with a person -- now, to change behavior, to change the behavior of the treating system and the behavior of the patient, particularly those with multiple chronic illnesses, where most of the money goes, is not a matter just of information. Information is crucial, it's the basis of shared decision-making, but you're not going to get a change of behavior without the patient understanding what the benefits and risks are and why that change in behavior is a necessary or good thing.

And, so, shared decision-making based on trust is absolutely the key to this whole concept going forward. So, I think that that's probably the most difficult thing. It's not so much a matter of organizational design as it is finding the right people to deliver the care, and I think that not all doctors are going to be able to do this. We have to acknowledge that to really be committed, as Don said, you have to have the right attitudes, and this is going to be a process of sorting through who can actually rise to this challenge of a relationship based on trust, a change in behavior, a team approach, and then, of course, being accountable for the results.

I think there's great promise in accountable care. I think the

examples we've seen in different places around the country are quite promising, but it does take kind of extraordinary leadership. It doesn't just happen because of the change in financial incentives. It does take a real commitment to the culture change.

So, are patients and their families ready for this? I think the people who are the most ready are the highest users of the system. They are consistently the most critical of their health care, as the people who are in the hospital a lot, those with multiple chronic diseases, those who fully experience the fragmented system that is so characteristic of much of American health care so that they are open to this, but they need to be full partners in a new approach, and that partnership, again, based on trust, based on full disclosure and information, based on shared decision-making, and based on a holistic commitment to a patient-centered approach, where you're not just looking at the medical encounter, but you have to look at the patient's entire situation, their family situation, their living situation if you're going to focus on health, not just health care.

So, that's ambitious. That's very ambitious, but the places that are starting to do this seem to be showing some real results, but it's not a simple thing to reorient an entire profession and it's not a simple thing to reorient consumers and patients. So, I think having this work is going to involve all of the things that we've talked about, but it's also going to involve just one-on-one relationship building between a care team, between the patients and their families, and that's the hardest work of all.

MR. FISHER: Great. Thank you. So, the challenge of engaging consumers on ACOs, Debra, Jay just cast you a challenge, I think. Maybe we've chosen the wrong name, and *mea culpa* to those of us who were all in the room when it came up, but how should we be engaging consumers? How should CMS be thinking over the next month or two in rolling out the educational program? Change the name? What has your research been showing you?

MS. NESS: Well, what I understand Jay meaning when he says on ACOs as opposed to in ACOs is really the piece of engagement I referred to as involving the consumer advocacy community in the policy development and the shaping and the designing and redesigning of our delivery system, and I have to give this administration very high marks for the work that it's been doing to do that.

Don Berwick is good as his word. His focus on patients extends to a pretty open door policy at CMS and the Innovation Center and an anxiousness to hear what it is that consumer community thinks needs to be built into these models. So, on that front, I believe we have an open administration and I think we have an increasingly active consumer community that's educated and sophisticated and wanted to engage on these issues.

I also want to say in what I think of as the quality measurement enterprise at large of which I think the Engelberg Center and the Quality Alliance Steering Committee that Mark co-chairs, groups



like the National Quality Forum and the National Priorities Partnership, these are groups, multi stakeholder groups that have been grappling with quality and delivery system reform. They have all welcomed consumer participation and made that a central element of the way that they build consensus. So, in my mind, working together in these multi stakeholder venues both with private sector health care providers, as well as with the public sector is the way to get the consumer community engaged on ACOs.

And for the consumer community, I don't think you have to change the name. what we call it to the real world, to ordinary people, that's what we probably need to do.

MR. FISHER: And a couple of focus groups that we ran with another organization had people thinking about accountants when we used the term ACO.

MR. CROSSON: Right.

MR. FISHER: And whether our Tucson ACO really wants to be called a TACO. (Laughter)

MR. CROSSON: It might work.

MR. FISHER: Is an open question. Well, but when we get to engaging consumers in ACOs, I mean, Debra, you had raised the question about how to notify consumers, and I would say that our California pilots are pretty far along in a model that has joint notification of those who -- fully attributed model, no lock in, this is their PPO health plan,

joint notification through a letter that goes to the patients from the ACO and from the payer with a follow-up letter that's going to come from the primary care physician. The development of a Web Site that gives them tools to get access to care. And Will fully described it. You're not locked in to go anywhere, but we're trying to build these resources for you, including a care navigator for the complex patients. So, the way they're approaching this is recognizing this isn't going to be about taking things away from people. The way this is going to be attractive is by making it attractive, if this is providing additional support.

I'm not sure how far we're getting and there probably is much more in terms of consumer engagement on governance committees, on governance boards. Are there patients involved in many of the activities at Kaiser as in the safety work? Are you having a patient tell a story that motivates it? I'm trying to remember the things I've heard.

MR. CROSSON: Yes. We do do that, but, as I said, I think the primary thing is that we're all patients. Every one on the governing board, all the doctors, all the doctors' families are patients. It's a little bit of a circular question as to who's a consumer? The consumers of our own product.

I'd just like to make one other comment. Actually, I agree completely with what Debra said about this question of organized consumer representatives and understanding and participating in the creation of ACOs, but I do think that there's another issue there that Don

touched on in his comments, which is perhaps more fundamental. It goes back to this question of what do people hear when they hear the word “ACO” or in this case isn’t there in the concept of an ACO; certainly I think that’s what Don said, the notion that there’s something in this about managing the future cost of health care, and I mean the best I can tell, everybody who writes about it says this is not just about quality, it is about quality, but it’s also about trying to deal with the problem the country has in terms of escalating health care costs. And if that’s in there as it is, how do we help people understand that and help people understand it in the way that Don explained today, which is this is fundamentally about how to reduce the cost of health care or at least the escalation that continued, increases in the cost of health care in the United States by making care better, by making it more accessible, by making it more efficient in the right way and in focusing in the way that Dr. Gawande suggested in his article, focusing on those individuals where a little bit of investment provides a great deal of return, not just in improvement in their health, but improvement in the overall costs, and I’m afraid unless we find a way of conceptualizing that and engaging people more broadly on that fundamental notion, then this whole idea could be hijacked purposely or inadvertently and made to look like things in the past that people were suspicious of. I hope that’s not the case.

MR. FISHER: John?

MR. CROSSON: Yes, I think most consumers are anxious

to avoid a repeat of the managed care backlash. And, so, presenting this primarily as cost savings is not the way to do it, although that should be a goal. But from an individual patient point of view, keeping you out of the hospital and providing more services at home is very attractive, and of course that's the key to the cost containment anyway.

MR. FISHER: Right.

MR. CROSSON: So, one of the tensions though with this model is that it's going to be hospital-based, it seems often, and, so, how committed are hospitals to lowering their volume?

MR. FISHER: It comes to that great question of authenticity. (Laughter) It comes to the question of authenticity. And performance measures, perhaps.

Debra?

MS. NESS: Yes, I think John is absolutely right. You can't lead with the discussion of the cost-cutting goals of this model. But when we've talked with patients and we've done a lot of message research to figure out how to engage people in this conversation, there are lots of strands you can pick up on and get them to this place.

So, for example, people say to us I want a doctor or a clinician who really knows me, knows me as a person, and knows enough about me that their recommendations will make sense in my particular life. In that statement, there are a lot of things. There's this idea that they know that the same thing doesn't necessarily work for every patient and

that gets directly to the more is always mindset. There's a recognition that when a doctor doesn't really know you and instead you're seeing 14 different specialists and everybody's looking at a different body part, they talk about the fact that that leads to misdiagnoses, duplicate tests and procedures, they talk about it in terms of their own money, co-pays wasted. They talk about it in terms of burden, talk to caregivers about the burden of unnecessary procedures and duplicate tests. They talk about the idea of wanting their doctors to talk to each other. That may be the *sine qua non* most often complaint that we hear, that one doctor doesn't talk to another doctor, and as a result, I have to make so many more visits and they don't reconcile my medications. I think I'm taking more medications than I need to take. So, I think that there are ways to get this framed so that people understand the reduction of waste and duplication and burden and even costs.

MR. FISHER: And if I was going to name this, I'd name it coordinated care organizations. I think accountable is great for policy, but it's not --

MR. CROSSON: Absolutely.

MR. FISHER: No, I'm with you. (Laughter)

MR. CROSSON: I see another article coming.

MR. FISHER: Oh, no. We've written enough. It's time to get going, as Don said.

So, one of the big issues that's been talked about a lot is this

issue of patient attribution, assignment, lock in. Some people are saying we ought to allow patients to choose as opposed to informally attributing them. Some thoughts on that? I mean, we've got some pilot science here doing some interesting things, but I'd love to hear your thoughts about benefit attribution versus signup and how we should be thinking about that.

MR. ROTHER: Well, if we're really going to be patient-focused, that means the patient gets to make some decisions, and, so, therefore, this needs to be a voluntary situation. And one thing that I think that distinguishes it from capitation models is the ability to choose to go outside, if needed.

MR. CROSSON: Absolutely.

MR. ROTHER: But, of course, what we all want is for it to be so attractive to the patient that they buy into it in a committed way, but, again, that's part of the shared decision-making, that really does need to be voluntary or I do think we risk reenacting the kind of backlash that we're all trying to avoid.

MR. FISHER: But interesting, the attribution models, for instance, Advocate in Chicago is using a monthly attribution model to let patients and primary care physicians know who we think your primary care physician is so that we can reach out and take care of you. I mean, the notion that primary care physicians would actually be told who they think their patients are is, I think, a pretty promising step from where we were,

which was 20 years ago or 5 years ago when I was last practicing. I knew the patients I had seen, but I wasn't sure whether they thought of me as their primary care physician or not or whether there was any recognition of who was responsible or the who the other physicians were. So, even the attribution can be useful in that sense.

I'll do one more question and then we'll open it up for some questions. So, sharpen your pencils, think about what you want to ask us. What do you think about the performance measurement? Really, it's a question to you, Debra. If we start with strong, the new version of caps, the ACO caps, is that going to be sufficient to hold these -- if we're doing it in the organization or in every physician? Is that going to be sufficient or how would you think about that?

MS. NESS: Well, I think patient experience is going to be critical to telling us whether or not we're improving care for patients. I think we need a number of vehicles to do that. I think you need validated, standardized survey instruments, and I would like to see us develop an ACO-appropriate caps tool.

MR. FISHER: CCO.

MS. NESS: CCO.

MR. FISHER: Coordinating Care Organization.

MS. NESS: I'm all for that. So, I'd like to see us develop an adapted version for use in this model, and I think we need to be able to trend, compare, and give that information back to patients and give that

information back to the providers of care.

MR. FISHER: Mm-hmm.

MS. NESS: But I also think there is a need for real-time qualitative feedback, as well. Jay talked about a system that provides feedback much more rapidly to your clinicians than --

MR. FISHER: Are you transparent on that? Do you publish that? Each individual's scores? Or is it shared among the physicians?

MR. CROSSON: It's shared among the physicians. They know, but we don't mail it out.

MR. FISHER: We'll work on it.

MS. NESS: Yes, but what I'm saying is --

MR. CROSSON: We'll talk about it.

MS. NESS: Is you need both.

MR. FISHER: Yes.

MS. NESS: You need the standardized information that becomes available to the patients, but you also need the kind of real-time feedback, and that can be more qualitative feedback, it could be more flexibly obtained. There are lots of different models we're doing that, but that's the information that can be used to help practitioners immediately improve their practice, and that's the kind of information that actually doctors and patients could engage around. So, I feel like we need both of those.

MR. FISHER: Right.



MS. NESS: And I also feel like we need to push ourselves towards measures of patient-reported functional status.

MR. FISHER: Yes, we at Dartmouth have been doing this for 10 years.

MR. CROSSON: Right.

MR. FISHER: At Jim Weinstein's Spine Center, where patients complete a tablet or an online survey about their functional status, it's presented at the time of the visit and talked about with the clinician, and then reassessing. The patients love it because they actually see something about themselves.

MS. NESS: Right.

MR. FISHER: The providers initially said I don't want that, and after about three months with it, they said I'm never going back.

MS. NESS: Right.

MR. FISHER: And those kinds of information systems, as the Beacon Program rolls out and the HIT gets more advanced, are going to be possible and accelerate the improvements and the sense of engagement, I think.

MR. ROTHER: Just a little footnote on this, I think we should measure patient experience, health outcomes, functional status, but it's also important to show patients that we're actually to use this.

MR. FISHER: That's the key.

MR. ROTHER: And have demonstrated commitment to be

responsive. Otherwise, you lose credibility and you lose that authenticity.

MR. FISHER: Yes.

MS. NESS: And, anecdotally, I think we hear all the time that the places that are doing this, the patient satisfaction goes way up, but the clinician satisfaction goes way up. People get excited, and then actually they are proselytizing the merits of involving their patients in the care process.

MR. FISHER: Right. Yes, there are some technical issues that need to be overcome to make it accessible everywhere, but I think those are increasing -- those barriers are falling.

MS. NESS: Yes.

MR. FISHER: As meaningful use extends us.

Well, let's open this up for about 10 minutes of questions from the audience. We have mikes wandering around. Let's have the folks with mikes come forward. And let me see, why don't I start from the front here? I'm afraid I don't know everybody's names. Mark probably does, but I'm just from the sticks of Vermont.

MR. GHOSH: Hi, this is --

Introduce yourself, if you could.

MR. GHOSH: Sure.

MR. FISHER: And then ask your question or comment.

MR. GHOSH: This is Tip Ghosh from Strategic Health Resources.

To echo Dr. Berwick's comments this morning, there's provisions in the Affordable Care Act specifically on reduction in health care disparities. So, as the movement for accountable care grows, and you're talking about consumer engagement, especially for chronic conditions, it's really important to understand not only diversity, but the diverse needs of patients.

So, if you can comment, Debra and others, on how does reduction of health care disparities for heart failure, for diabetes, which are key conditions?

MS. NESS: Well, one of the things I said in my opening comments was that all of our measurement work needs to be stratified so that we can monitor the impact on different populations. That's a given. The patient engagement work, the interaction with the care community needs to be culturally sensitive, it needs to be sensitive to health literacy levels, it needs to be sensitive to disabilities, and I think we have a long way to go, and this has to extend at every step in the process from how we notify people. Those materials have to be culturally appropriate, to actually the patient engagement tools that we use, whether it's shared decision-making tools or whether it's self-management support tools. All of those have to be made culturally appropriate.

MR. FISHER: If I could just add, I think one of the keys would be hiring support staff from the communities who can relate directly to the entire diversity of the population served.

MR. CROSSON: And I think there are also structural and investment issues here because the question is: Where in this ACO transformation is the role for these hospitals, federally qualified health centers, and the like where a fair portion of this care is delivered.

MR. FISHER: Right.

MR. CROSSON: And I know there's a lot of activity going on trying to think about that, but I don't know necessarily that anybody has a clear notion of where the money is going to come from, where the expertise is going to come from, and the like, and I think in the absence of that, we could end up having this very valuable idea serve only to further widen the gulf of care that exists that we have.

MR. FISHER: Yes, Debra, do you want --

MS. NESS: There's one other thing I want to say. The article that John referred to by Atul Gawande, "Hot Spotters," talks about the Camden experience and the team that they used, and it's very interesting because in addition to the physician and the nurse practitioner and the social worker, they have a whole slew of health coaches that are modeled after the ProMatura model, and these are folks from the community who actually speak the language of the people in the community, understand them, and actually have more success in helping to change health behavior than any of the other players in that team.

MR. FISHER: Yes, I mean, I think it comes to a couple of things. One is about new payment models that enable those practitioners

to be supported, and then some tools that let them actually do the work like article about Jeff and also much of his stuff I believe is available online in terms of the Medicaid ACO work that's he's developed in New Jersey. It's really quite a promising -- it'll also come back to the risk adjustment issue that we'll talk about in the next panel, which is in addition to a new payment model, you need to be able to make sure you're not disadvantaging systems that are taking care of the highest-need populations.

MS. NESS: That's right.

MR. FISHER: And I'm pretty confident CMMI -- some of that, I hope that that early rollout of innovations in ACO models over the next year, the vanguard will include some vanguards that are dealing with dual eligibles, on dealing with those populations.

Let's have a couple more questions. Cindy, do you want to -  
- yes, great.

MR. KRISTOFFERSON: Gary Kristofferson, former VA, DoD, CMS.

Well, first a big, loud applause for Don and what he's doing up there. I mean, the words he was using, the phrase, the vision, very key to where we want to try and go, where CMS needs to go as an organization.

Don was right in one thing, the focus needs to be on health, and I think that's one thing we're missing by the ACO concept is we're on

the care side, not on the health, health status, functional status side of the equation.

There was another part where words are very important, and a word we still don't get quite right. You've used "consumer," you've used "patient."

MR. FISHER: Yes.

MR. KRISTOFFERSON: You may use member, you may use beneficiary or whatever. What we came to both in DoD and VA much more was the term person, it's about people because what you get into in the patient side is you get to them too late. It's after they show up and they're sick. If you look at consumer, it kind of gives up sort of a stake and notion about what their role is. If you talk to people, they understand what people are and what persons are, (inaudible) association, retired, et cetera, and so forth there.

So, the question I think really comes back to there. If we really believe that it's about people before they are patients, when they are patients, after they are patients, and it's not just about consuming (inaudible), but it's about behavior, prevention, and those things, how do we get the right terms in here and how do we get them to be consistently used?

MR. FISHER: Great, great question. I would say that I think the measure we are missing in terms of both ACOs, medical home is a measure of health risk that could capture the burden of avoidable

morbidity and mortality that a population has so that we could hold medical homes, ACOs accountable for improving the health of those through measurement. And I think there's some promising work on the horizon that should be coming out in a couple of months.

Other questions? Yes, we might as well march -- oops, Cindy, I'm letting you control this mike since I can't see all the way back.

Yes?

DR. POPLIN: Hi, I'm Dr. Caroline Poplin. I'm a primary care physician.

The problem that I see is that in order to have a patient-centered decision-making or a shared decision-making and the trust that's so important, that requires time. And what we are judged by in addition to all these new things are success, outcomes, we're judged by productivity. That's what it's called inside the ACO. Even at Kaiser, it used to be 12 minutes a visit, 5 patients an hour, now you're down to 20 minutes a visit, 3 patients an hour, and in addition, we have to return all the phone calls and the e-mails.

Sub-specialists don't have to do any of this or at least they have more time and less to do and less supervision. It's the primary care physicians at the bottom who are supporting the whole super structure.

What is happening is that medical students looking at the situation are voting with their feet and becoming procedural or sub-specialists, which is where the big cost-driver is. You haven't mentioned

anything about any of this.

MR. FISHER: All right, well, let me say a couple of things.

Or, actually, Jay, do you want to answer that?

MR. CROSSON: I mean, I think it's an excellent point.

There are many things that could derail all these good ideas that we've talked about today.

We talked about consumer attitudes perhaps being one.

Another one is just what you mentioned, which is that at least with respect to adult primary care, the pipeline is running dry. And it's running dry because of payment disparities or inequities or however you want to call that which have developed over 20 or 30 years, but, also, as you point out, because the workload of particularly internists and family medicine physicians has become greater as the average age of the population they're caring for gone up, and many physicians now see patients every day in their 90s and some patients in their 100s with multiple, multiple problems, and then although electronic technology such as I described earlier is wonderful, it can also be cumbersome, actually, and take more time at least.

So, we have a problem in the country which is if we're going to have this model, we've got to have and get to what I talked about, which is 98 linkage between patients and their physicians, we've got to have the physicians to do that or we're going to have to transform primary care away from physicians to other caregivers or the like.



And I think the solution for that is very complicated. It's going to involve, I think some significant changes in how physicians are paid, perhaps starting with Medicare, and I think it's going to have to involve changes in practice style, and perhaps more team-based care and other things that will, in fact, make the life of future primary care physician tolerable and satisfying, and we're not anywhere near there yet.

MR. FISHER: I'd add two things. One is there are glimmers of hope from the experience of primary care physicians, whether it's practicing at Geisinger or Group Health. I mean, they're medical home pilots where they were transformed in ways that led to much higher levels of patient satisfaction. And you talked to Jeff Brenner about how excited he is about his work and his colleagues when they're in that kind of team model of care.

I think the second thing I would just from my Dartmouth atlas perspective would say that there's no correlation between supply and this perception of scarcity of workload. I think places with many, many more primary care physicians, the physicians feel just as overworked and just as disorganized care as where there are fewer primary care physicians. So, it's not probably about how many. I think it's about how we work. It's about how we organize care, how we deliver care, new models of care that probably offer some promise, and maybe the new payment models in these coordinated care organizations will enable us to support primary care more adequately, and I think we're starting to see that.

We should now wrap up this panel. I will say that there is a 15-minute break. I want to thank our panelists for joining me up here and for their spectacular comments. Thank you, all. Thank you, all.

(Applause)

(Recess)

MR. McCLELLAN: I know we still have some people come back into the room, but I do want to be cognizant with the time with the weather. We had a great discussion in the first panel which went a little bit long. As I announced before, Nancy-Ann DeParle is not going to be able to join us today, but we are going to continue this full and frank discussion in our second panel. There's a lot more to cover in an hour or so.

I want to reorient everyone who's here by taking us again back to our overall agenda. We spent the past hour-plus focusing on one of the practical issues for accountable care from the standpoint of patients or consumers or persons, an engagement on that side, and now we're going to turn more to the provider side. And this is where the significant payment changes are occurring that are intended to drive this what people have called cultural change and which I think of as more about supporting changes in care delivery.

For all the criticism that the name accountable care has come in for already today, this is where the accountable in ACO comes from. The point is that these organizations for delivering are on a track to become accountable not just for the volume and intensity of services that

they provide, but for improving quality of care and health while reducing costs for their patients and the overall health care system. At the core of this concept is not accountability for its own sake, but providing an effective means for supporting providers in their best efforts to improve quality of care and reduce costs. You can think of it as a reward. I think of it as support as we heard about earlier today with a lot of steps around care coordination, around getting it right for a particular patient, around putting the person at the center of care. A lot of those steps aren't reimbursed in traditional health care systems and we've seen, especially with rising budget pressures, the difficulty of making piecemeal changes in those systems to expand fee for service or something like that that don't seem to be getting us there.

Accountable care takes another approach and it starts with this concept of shared savings. Because providers that are now tracking the overall results for their patients, get a share of the savings when they reduce overall cost trends while improving quality and that's what drives the additional support for these reforms in care delivery, and that notion of shared savings is what Don Berwick this morning called a core model for how CMS is thinking about and moving forward on implementing the ACO program. These steps are intended to make improvements in care more sustainable in a way that current reimbursement systems do not. Providers have many ideas about how to improve care, how to get costs down or remove unnecessary costs, but often they're swimming against

the financial tide and it's harder to make ends meet in their practice when they're taking this extra time or taking this effort to reform care delivery and make investments in changing their practice, so that is what the accountable care payment reform side is intended to address.

The most basic version of this is the co-called one-sided shared savings model which may operate within a fee-for-service environment if that's the baseline on which this new payment stream or new payment track is being added. It means no new risk for losses if spending continues to go up without improvements in trends. It's an opportunity that if reductions in spending tends occur along with the kinds of measured improvements in care that we've already heard about today, it's an opportunity for new resources. Many people view this as a relatively straightforward way of starting to implement ACOs. In fact, in some of our previous papers we've described a stepwise approach to ACOs starting here, starting where many organizations that are trying to improve care and lower costs are likely to be in 2012 where they have limited availability of IT infrastructure and support for these kinds of care or improvement efforts and it can be a first step or an incremental way of moving into a different way of being paid. You can think of it as having two tracks for payment starting to operate at the same time so that we're still barreling down the traditional payment track with fee-for-service payments or whatever, PPO arrangements are already in place, but in addition to that there's a separate track set up where providers are now

starting to be explicitly paid based on tracking and improving overall results for patients, patient experience and overall cost trends and the shared savings approach just adds that onto the existing payment track.

For these ACOs, many implementation issues have already come up. Even this kind of step is viewed by many and understandably so as a real change. Don Berwick outlined a number of these kinds of challenges for implementation, things like how ACO incentives can be aligned with other reforms like medical homes, IT payments that are coming along now, movements toward episode payments and other steps that can help provide more of the up-front resources needed to support these cultural and delivery changes.

There are a range of other issues as well. How do you attribute beneficiaries to an ACO? What are the antitrust implications? And do the antitrust authorities like DOJ and FTC need to provide more guidance going beyond what they already have produced on issues like assessing the benefits of coordination on the one hand and integration versus the risks of market power on the other? These are all very important issues and we've held a number of events and have written a lot on them as well as many others recently.

I want to highlight one further issue though that was at the very top of Don's list and that was specifically the issue of including some element of downside risk. That may be a technical term for putting more of the payment weight for providers on decreasing costs trends and

improving quality by placing them at some financial risk. I would think of it though as how much weight you keep on that traditional payment track, the one that's based on fee for service or the way that reimbursement has traditionally gone for the providers in an ACO versus moving to this second new track that's based on as best we can measuring results, measuring patient experience and measuring impacts on cost trends. There are a couple of versions of this. One is a so-called two-sided or symmetric-risk model in which payments are still predominantly going to be based on that traditional model but they also include the provider groups being at risk for losses if spending exceeds the projected benchmark so that that is a stronger incentive potentially for keeping costs down and maybe more support from the businesses or the other payers who are involved in these reforms confidence that the provider groups are really going to take steps to improve care or to transform care. This is still a relatively limited disruption or relatively limited discontinuity from traditional payment systems.

Going further than that would be a partial-capitation model where more of that weight in the traditional payment system is moved over to this second new track that's now running in parallel so that instead of having fee-for-service payments or full PPO payments, some portion of those funds would go over to this new track that's based on results of care and that gives providers more flexibility in how they change the delivery of care and how they can provide financial support for that in the

implementation of the ACO. These are two different versions of so-called downside risk with putting more weight on more flexibility in how providers can deliver care, but at the same time it means more of a movement away from traditional payment systems and traditional ways of delivering care.

As we and others have written about in the past, one way to think about this movement might be tying moving more of the dollars over to greater flexibility for providers and using it to reform care to implement the kinds of steps you've heard about already today when they have a better capacity in place to demonstrate that they're tracking patients well and they're improving care particularly for vulnerable patients and the like so that these movements may occur in tandem, the financial reforms along with delivery system reforms and support for changes in the way that care actually occurs, more extensive IT capabilities, more extensive coordination capabilities, a demonstrated ability to help patients get to the best providers for their own needs and so forth. So over time as care quality and technical support systems and IT systems get better, ACOs could implement payment models with increasingly more risk, giving them more resources to change the way that care is delivered, more financial support for those changes and moving to payments that are increasingly based on results and not just volume and intensity.

As with many other complicated undertakings involving both process changes and changes in the way that care is delivered, cultural changes and financial changes, this may be a gradual process. People

may start with relatively changes and move forward from there as capacities improve on both the care delivery side, the performance measurement side and the financing to support and this raises some important questions. How quickly can it be done? How can CME and Medicare beneficiaries be confident that these risk-related reforms or these shifts of more of the weight of financing into supporting better care directly are achieving the intended results and not just simply providing as was talked about earlier a new label for supporting organizations that have easier patient populations or would have had lower costs anyway?

Once again with all of these issues we're not starting from scratch in answering the questions. There are a number of efforts to implement ACO-related reforms right now that are already moving down some of the tracks that I was just describing in the last few minutes that are incorporating some significant shifts away from traditional reimbursement models and toward paying more for better care. Under the ACA, the Medicare Shared Savings Program, included is a potential opportunity to build in this more significant shift in payment models, and a number as I said of private plans are already taking steps in this direction.

These are some of the topics that we want to cover today. In fact, a couple of the panelists on the stage with me from Blue Shield of California and Atrius Health as well as some of our own pilot sites in the Brookings-Dartmouth ACO Collaborative, provide some perspectives on the experiences with implementing these kinds of payment reforms and



practices in what needs to go along with them to make them a success such as how do you do changes in delivery and real reform in health care delivery along with real reforms in payments as effectively as possible? How do you set the spending benchmarks to determine expected costs? How do you address the risk issues that are beyond the control of providers, those related to the underlying risks of the patient populations or just to bad luck in a particular year? Can risk corridors or risk-adjustment systems help with that, and how can they best be designed? How can other steps be implemented for improving care at the same time as ACOs are being implemented so that providers have confidence that these payment reforms and these delivery reforms are going to be sufficient to move forward together?

Questions like these are not going to be settled today, they're going to continue in the months ahead, but it is important to take steps forward now. Private plans and states are doing this now. We heard about Medicaid in New Jersey at length this morning. A number of private plans around the country are doing this. Medicare has implemented some of these ideas in pilots, and as we've already heard, they are required to do more in the coming years. And given the pressures of rising health care costs, the gaps in quality, the frustration among both providers and patients, we need to find ways forward to help support their efforts to delivery greater value in health care. With this tight timeline in mind we're going to try to get practical in the next hour. How

should be included in the CMS regulations for ACOs around these issues particularly for organizations that are ready or feel like they're ready to redirect resources in a more significant way and not just set up this second track focusing on results? What are some other related reforms that can help support the goals of ACOs? This is a tough journey but it's one that we need to move forward on how and we need to do it right moving from concepts to specific steps.

That's what we're going to cover in the panel today and we have a very distinguished set of panelists to help us get through these issues. You're going to hear next from John Bertko who is a guest scholar here at the Engelberg Center for Health Care Reform and he's going and he's going to provide an overview of some of these more technical issues. John is working hard to translate a lot of these actuarial technical details into the important practical implications for care delivery.

After we hear from John, Ed Cymerys who is the chief actuary at Blue Shield of California which is currently implementing an ACO-type pilot in Sacramento will give us some perspectives from his experience. John Goodman also with us today is the president and the CEO of the National Center for Policy Analysis and he has written prolifically on a variety of ways in which health care providers are trying to change the way that care is being delivered and the kinds of payment changes that might feasibly support those reforms in delivery and we're going to hear his perspective, too.

And Gene Lindsey, the president and CEO of Atrius Health which is participating in the Blue Cross/Blue Shield of Massachusetts Alternative Quality Contract also has some direct experiences on these issues.

That's how we're going to do with the same format as last time. After we hear the opening comments from John, we're going to hear some perspectives from the other panelists and have a little bit of discussion and then open it up to all of you again.

With that, thank you, and I'd like to turn this over to John Bertko.

MR. BERTKO: Thanks, Mark. As Mark said, I'm an actuary so that I will try to keep you awake during this period as opposed to the usual technique of most actuaries.

One thing is that we get paid for measuring things and that's what I'll try to do and describe, one, how we can be fair to both provider groups, doctors in particular on one side, and to CMS and the Medicare Trust Fund on the other side. I'm not going to talk so much about the budget-setting mechanism today because there are several options for doing that, but think of the budget as being set generally on the basis of the history of claims that get associated with the people who would be in an ACO but, rather, the more technical aspect of what if the population changes and how do you measure how sick they are, and that is a term that's usually called risk adjustment? What I want to bring today is 20

years of experience working with this including 10 while I was both at a private insurer and then more recently working with Mark and Elliott here in terms of the way risk adjustment has evolved and developed over the last few years.

There are a couple of things to note here. Among the populations that you can do risk adjustment with, seniors are the best and that's because they're the sickest. They have lots of chronic conditions. I think Elliott's work and his crew have shown that seniors visit some provider on the basis of about 93 percent of them every year so that there are lots of visits there to measure what's going on with them.

The next part is as I said, CMS has had a fair amount of experience with risk-adjustment methodology. It first started on a very primitive basis in 2000, but since 2004 we have had an encounter-based risk-adjustment system. That also means though that Medicare Advantage plans and many, many providers have had the experience of collecting the diagnostic data, and more important, submitting that data stream. This all depends on how good the data streams are and how well claims and diagnostic information has been organized and collected.

You could ask is risk adjustment good enough? I would say, yes, it works pretty well and it works really well for groups of people. In the laws where a minimum of 5,000 people are to be in an accountable care organization for seniors, I've found that when I was in my practice and I did a lot of work with Medicare Advantage groups there, that was a

very stable group of people and the predictive power of that is fairly high that's up in the 70 to 80 percent range for a group. On an individual basis as to look to one person or another, it's much lower, but there have been improvements over the years. Most importantly, prescription drug data is a very good add-on. The current risk adjuster used by CMS doesn't use it, but the data is now out there for the last four years so that we could grab and insert that data.

One thing that Debra alluded to that I'll say that you worry about, does risk adjustment work well enough for the sickest people? There's another technical term called the predictive ratio which is how much does the risk-adjustment mechanism pay for a given person who's pretty sick, say a senior with congestive heart failure? The good news is that for most of those kinds of procedures, predictive ratios are close to 1.0 which means they pay very close to the amount that on average is needed for an individual. I'll probably have to give you one of my bad actuarial jokes. Did you hear about the actuary who drowned because when he walked across San Francisco Bay, on average the bay was only 3 feet deep? (Laughter) Thank you. On average works pretty well for the whole group of people, and of course it doesn't work perfectly for individuals.

One of the things that's very important I think that was alluded to or mentioned by Don Berwick and then alluded to by Debra was whether you do prospective or retrospective attribution and that's closely

connected to the need for risk adjustment. On the retrospective side, that is, you look at what happened over the last year, you assign providers to patients based on the actual treatment patterns and then you do the measurement. The Physician Group Practice Demo uses that kind of a measurement method to see how well things worked. It does a very good job of assigning people to the providers, the physicians in particular that they actually saw, but it violates one of I think Debra's principles, that is, notifying. Nobody knows. The doctors don't know who their patients are going to be. They know who their panel is of course, but they don't know whether a certain patient was part of the ACO measurement group or not.

The second part of the way to do this is prospectively. I'm biased in the way of prospective methods in most cases. In this case you would know who your patients are based on perhaps 12 or 24 months of claim history. Again Elliott and his team's work have shown a high degree of loyalty of patients to the care system. I think was in the area of 75 percent or so range so that people do stay in general with the care systems they're in. A, you know who the people are, B, you can notify the physicians, C, you can notify the patients that they are in this care system and it can be made voluntary if you like. Then I think most importantly in my consulting with physicians and hospital systems but physicians in particular, they're achievement oriented so that you can tell them if your patients are like that you can then monitor and manage what the actual to predicted experience should be and things then get moved around.

I see Jay is back in the room here and I hope you're going to nod Jay when I say you guys do budget for your individual physician groups and pods and measure them and if something goes wrong or they're out of sight, you nod I hope when they say they fix it along the way. He's nodding.

I think that's an overview of all of this, the tool is out there and I think we are ready to use it. I would look to Ed here if he wants to make some comments about how that's been used. In my experience I worked for a very large private insurer and we used versions of risk adjustment for capitated medical groups. The groups wanted to be paid an appropriate amount and we need to be fair to them because we didn't want them to run away and not be part of our system and they want it to be fair so that they could be paid the right amounts for their group of patients they were treating. Thank you.

MR. McCLELLAN: You've looked ahead so maybe you can help and tell us a little about your experience in implementing reform in California around accountable care.

MR. CYMERYS: Thanks for inviting me. It's always good to get a taste of some different weather. I live in San Francisco, so we don't have that stuff falling from the sky too often.

California has a long history of managed care and Don Berwick mentioned that we can't have amnesia here, that we have to learn from the past and Mark talked about this accountability over time and

having a starting point that's grounded in where we're at. Providers in California have been taking risk as I said for a long time under both the Medicare program and commercial HMOs. I think right now there's about 8 million covered lives in commercial HMOs that on the physician side are fully at risk. They have full capitation, multispecialty capitation so that the physicians are fully at risk for the care that they provide. There is I think probably an order of magnitude of half a million members in the MAPD program where they're taking risk. So there has been quite a long track record of that. As a result, infrastructure to effectively coordinate care, I think we've been talking about integrating care, has been developed over the years that have come from both medical groups and the Independent Practice Associations that are under these arrangements.

However, there have also been some tough lessons along the road. I think in the late 1990s there was a whole rash of physician organization bankruptcies that highlighted the need for some oversight over these groups that in effect were acting as mini insurance companies. One of our current congresswomen, the second most-famous one, Jackie Speier, sponsored legislation when she was in the California Legislature that created a Financial Solvency Standards Board, this was back in the year 2000, to advise regulators about solvency for these risk-bearing organizations and how that should be managed. I was one of the original appointees. I was appointed by Gray Davis just to give you a timeframe for how long ago that was.



I think what we found in that process was that some basic steps for an organization that's taking on risk like having an audited financial statement was important, that they have IBNR calculations which took into account liabilities they have outstanding for care that was provided by maybe their specialty network that they've referred to, that they have to have positive surplus, to essentially be solvent and that they have some reporting process going on regularly. I think those steps have helped lessen the number of provider insolvencies that been experienced and right now that board which I'm still a member of is looking at what kind of rules California should have around solvency for ACO organizations so that this is a timely topic on a lot of fronts.

I thought I'd make another comment, too. The results of capitation have been a little bit mixed on another front too. For Blue Shield of California, our business is roughly 50 percent PPO and 50 percent HMO but changes a little bit over time. When we compared on a risk-adjusted basis how the HMO delivery system was comparing to the PPO, we found that in roughly a third of the areas that we looked there were clear cost advantages through the HMO delivery system. Another third was within the statistical variation and you couldn't draw a firm conclusion. Then another third where the HMO delivery system was less cost-effective than the PPO and also those latter areas were pretty typically in areas where the capitation rate had gone up dramatically over recent years through negotiating leverage because of conditions in those

areas.

Our most recent pilot that's going on currently is with our largest customer CalPERS that is in conjunction with the Hill Physician Group and the Catholic Health Care West hospitals in the Sacramento area so that there are roughly 40,000 CalPERS members that are part of that. It's a sort of attribution model within an HMO model if that works with people because we have a broader population there in an order of magnitude of 200,000 members in northern California and the ones who are using these providers are part of this model. In conjunction with CalPERS we set a target of keeping health care costs flat year over year in 2010 compared to 2009 and all three organizations -- Blue Shield, Hill Physicians, and NCHW -- stepped up to commit to that and all of us have taken on significant risk. In an order of magnitude on the hospital side, they signed up for \$10 million of risk to make sure that this happened and that they could deliver these results.

The way that the buckets of risk are apportioned, which is the devil in the details, is around the areas that the different parties to this contract have the most impact on those cost areas so that there is a whole matrix of risk share by different medical areas and it has been surprisingly successful. My team is overseeing the analytics of this and in our last look it really looks like they're going to hit their target and compared to the rest of the northern California results the medical trend is roughly 8 percent lower which in our business we get a good control group, but this is as

close to a good control group as we get.

They've gotten a little help from a mild flu season, but I think they've really done a great job and the results have been there and I look forward to talking a little bit more about this as we get into some of the questions.

MR. McCLELLAN: Ed, thanks for telling us about some of your experiences.

John, maybe I could turn to you next. You've written a lot about a range of things going way outside the bounds of just integrating coordinated care that could lead to significant reductions in costs. Ed talks about some big cost savings that they're seeing from their approach with significant reductions in cost and improvements in quality and I'd like you to maybe talk to us a little bit about how you see those payment reforms going forward and how it may or may not fit with some of these ACO reforms.

MR. GOODMAN: Thanks, Mark. I put a post up on my blog yesterday and I said that I'm going into the lion's den at the Brookings Institution tomorrow and I'm not going to be one of the lions. A lot of people believe in evidence-based medicine and I believe in evidence-based public policy and evidence-based public policy is the opposite of wishful thinking. With that in mind let me confront you with four pieces of bad news this morning and then I'll give you some good news.

The first piece of bad news is the latest issue of *The Journal*

*of Economic Literature* surveys all the studies of hospital report cards and other quality reporting measures, and concludes that the evidence just isn't there that the benefits exceed the costs. And they go out of their way to point out how hospital report and other kinds of reporting could cause quality to go down, that just as teachers will teach to the test if that's the way their paid, doctors will practice medicine to the test if that's the way they're paid and if you're the patient that may not be good for you.

The latest comprehensive survey of all the studies of electronic medical records concludes they're just not delivering on their promises.

Number three, the latest study on pay-for-performance medicine from Britain says that it just isn't working in that country.

And the fourth piece of bad news, maybe the most important of all that I want to bring to you is that in some ways low-cost, high-quality health care is like pornography, and I didn't get that from the study. It comes from experience. They're alike in the sense that we think we know it when we see it, but we can't define it. And not only can we not define it, but we can't even list the characteristics that you would need to have in order to produce it.

There is a study done here at Brookings that looked at high-performing hospital regions across the country and they listed their characteristics and, lo and behold, I couldn't find, Mark, when I looked through your study any objective characteristics that they had in common.

In other words, some had electronic medical records and some didn't. Some had doctors on staff and some paid fee for service. So if I ask the question how can I be a high-quality, high-performing hospital region, the answer is we don't know.

Now let me quickly turn to the good news to balance off the bad. If we look at all the markets surrounding the third-party payer system, all the markets where predominantly we have patients with their own money, things actually look pretty good. In the markets for cosmetic and LASIK surgery we have price competition, quality competition, transparency, over the last decade real costs going down and quality going up. I know with an audience like this you all are too young and too well preserved to know much about these two markets, but they bear looking at because they're working well. The same thing can be said for the market for medical tourism both internationally and in the United States, and we do have a growing market for tourism in the United States, it's just that you don't get to take advantage of it. The Canadians can come here and get package prices but we can't unless we're willing to travel.

With the online market for drugs and medical tests we have price competition and transparency. At least in the drug area the quality seems better where the error rate is lower than it is at the local pharmacies. With the walk-in clinics and telephone and e-mail consultation services, the *New York Times* tell us this morning that the

concierge doctors are all using electronic medical records that describe electronically not because they're required to do so or are subsidized or nudged to do so, it's because these are essential parts of their business plans. What I'm describing to you right now are markets that work really pretty well. In fact, if the whole health care system worked as well as these markets, we wouldn't be here talking about the things that we're talking about today.

Within the third-party system we have what I would describe as sea of mediocrity punctuated by little islands of excellence scattered almost randomly. Elliott and others here have studied these little islands of excellence and some of them look really, really good. All of this is good news in the sense that from my perspective there is a lot of low-hanging fruit here. There are a lot of ways that Medicare can substantially reduce its costs simply by taking advantage of what's already out there and not by going and creating something new.

For example, we could start tomorrow and pay the market price at all the minute clinics for every Medicare enrollee in the country, and since the studies show that these minute clinics have higher quality, they're more consistent in the service they provide, they have lower money prices, lower time prices than the competitors, we could not only start paying for all of that, but we could charge Medicare enrollees more if they went to the emergency room or to other more costly places for the same kinds of services.

If somebody said to me that would be politically hard to do, if you can't take the low-hanging fruit and pay more for what you like and less for what you don't like, if you can't do that then it's most improbable that you're going to be able to get to the top of the tree and do the really hard things. The same thing for the telephone consulting services. That would seem to be almost a no-brainer. The money price is lower and the time price is lower than the alternatives.

Within the third-party payer system if Geisinger wants to offer a warranty on its heart surgery so that you don't pay again if you have a readmission, then we ought to pay Geisinger more for the initial surgery. That's a deal we really can't afford to turn down. If Virginia Mason wants to offer us a deal so that all the back pain patients go to the therapist first and then to the MRI machine, we ought to be able to pay more for that kind of therapy because that would appear to save us money.

Here again, if we're going to pay more for what we like, we can afford at the same time to pay less for what we don't like. If the pharmacists want to do what the pharmacists have done in Asheville, North Carolina, and give consultations to diabetic patients, we ought to be able to pay more for those kinds of services or start paying for it, period. If that appears to work again we can pay less for the kinds of physician services that we think do not work as well.

What I'm talking about here is going after the obvious ways,

obvious to me at least, where we can save money, a lot of money I would think, and in the process of doing so we should send out a notice to every doctor, every hospital, every provider in the whole country and say we're open for business. And the parameters are if you to be paid a different way, you have to lower the cost to the taxpayer, you have to raise the quality for the patient and you have to suggest a way that we would know a year out or two years out how we're going to measure this or how we're going to make some determination that you're doing what you said you would do. And as long as we stay within those parameters it seems to me that we ought to be open to business and we ought to be open to everything that the providers know.

I've always believed that no one in Washington knows how to lost quality in Tyler, Texas, but lots of people in Tyler know a lot of things about Tyler and they probably have all kinds of ideas about how to lower costs and raise quality. So instead of us telling them what to do, let's let them tell us what they're prepared to do and if it saves us money and raises the quality of care to the patient, then we're all better off even if they're the only place in the country that's doing what they do. Those are my quick thoughts.

MR. McCLELLAN: Thank you, John.

Gene, I'd like to turn to you next. You have some direct experience recently with trying to reform the way that care is delivered with an emphasis on some of the things at least that John emphasized,



telephone consults and e-mail, more of a concierge-type of physician availability through our practice that is supported by some of the payment reforms in Blue Cross of Massachusetts' alternative quality contract. So that with your perspective on all of these issues we've been talking about today, how do we get to what I think everybody on this panel has emphasized, which is there are a lot of ways out there that clearly can lead to better results for patients and better patient experience and save money at the same time, we just don't seem to be doing as much as we'd like and how do we get from here to there and your perspective on that experience.

MR. LINDSEY: Thank you. I'd like to begin as positioning myself as a foot soldier reporting from the front of battle in Massachusetts where, in fact, we have challenged ourselves to be a pilot literally for the rest of the country in terms of discovering that there is an outer limit to what we can afford to pay for health care and I think underlining the absolute genius is the importance of the Triple Aim, and Don can change the name of it if he wants to. I should tell you a little bit our organization because the AQC as a trip home for us and not a new adventure.

We are the legacy practice of the old Harvard Community Health Plan. And when Dr. Ebert started the Harvard Community Health Plan in 1969 while he was dean of the Harvard Medical School, he made a speech where he made a statement something to the effect that we couldn't solve the health care dilemmas -- and he was talking about those

of 1969 -- by spending more money, hiring more people, building more resources, that we literally had to come up with a better operating system, a better approach to health care. We've spent the last 40 years proving that he was right. As Churchill said, you can count on Americans to do the right thing after they've tried all the wrong things. So we are back to trying what Dr. Ebert tried to introduce to us more than 40 years ago.

We I think have had some significant success but we shouldn't be too proud of ourselves. We're somewhat like Kaiser Lite. We've had an automated medical record since 1969, always at the upper limit of what the technology could offer, so that we have had for many years patients on electronic patient portals through our Epic System. What we have learned over the last 40 years I think would totally underline what the first panel focused on which is that if you're going to successfully manage care and if you're going to make any difference at all in terms of achieving the Triple Aim that your first focus has to be on the therapeutic relationship with the patient who come to you for service. We are reiterating the importance of that to ourselves through the AQC, the Alternative Quality Contract, which has many domains in it that measure things from the effectiveness that we manage patients with diabetes and hypertension, but also focus very specifically on the experience of care as well. Sort of facetiously I've gotten to the place where the only thing that's important to me about attribution is the data. I really, really don't believe that it's important for the patient to have contractual change that keep us

to the practice. If we can't win their allegiance by the quality of the service that we offer them and I don't think we have any success in assuming risk, by having a tight relationship with our patients in the last two years we've been able to do some remarkable things.

As we've been seeking to be successful with the AQC, we've moved huge amounts of clinical activity from one large teaching institution to another where we felt that the care was better integrated. That required a relationship with our patients that couldn't have been achieved by just them being assigned to us. They had to have a relationship with us to be able to trust their doctor in moving from one facility to another. In fact, we've transferred lots of care from tertiary hospitals to community hospitals again recognizing that what the patients want is a relationship with their physician that actually is meaningful and that they want care that's convenient, closer to home. And if they feel that quality is high and our scores in Massachusetts in terms of quality in commercial contracts is the highest there is, then in fact they're willing to do what we need them to do to be able to accept risk.

I will also say that unless the physicians and the institutions understand that there is a downside to a lack of performance, I think it's highly unlikely that there ever be any change in performance and I say that from I think a pretty significant wellspring of experience. I've calculated up that I think I've had more than 150,000 patient encounters either in hospital or office so I know of what I speak in terms of how you

interact with people to lead them to a position of it being easier for them to have health care which in essence is what we're trying to accomplish. I think the AQC to get back to your initial question has been very helpful for us because in fact we have since Helen Hunt put a dagger in the heart of managed care back in that movie *As Good As it Gets*. We've sort of been aliens in the land of fee for service. In fact, we used to call it "free for service" because we were so bad at it because the only thing that we knew was managed care and we literally had to go the reverse trip, that instead of learning how to accept risk we had to learn how to build budgets based on encounters and revenue.

The sad thing is that we're now in a position where we have a whole new generation of physicians who never have had to manage in a managed-care environment or have had to learn it relearn it from the gray heads in the organization who remember the mid-1970s and the mid-1980s and the late-1980s and have the deep reflection of the mistakes of the early-1990s. As we have approached the AQC, we've discovered the joy of trying to reestablish a meaningful relationship with our practice focusing on achievable things in terms of the domains of quality that have been established for us and recognizing that if we don't do it there is a financial downside. I think that that more than anything enables us to engage in the real work that's necessary to move from -- it's an easy thing to say volume to value.

Trust me, having gone into fee-for-service for the last 15

years in a very significant way, it's almost like substance abuse; you literally have to reprogram your mind to begin to think about delivering care to populations within a budget. You build your budgets on encounters and on the number of clicks from your radok (?) and things of that sort rather than approaching the budget from the point of view of what do these people need and how can we deploy ourselves in a fashion that's efficient and will achieve what they want which is personalized health care that's of the highest quality. The AQC has given us the structure to think about that and our desire hopefully is to in very short order return to what the image of the Payment Reform Commission in Massachusetts was, which is 100 percent global payment delivered through nothing but ACOs and that is our goal and I hope within my lifetime it will be achievable.

We have about 800 health care and 250 other health care professionals delivering care to about 700,000 people in Eastern Massachusetts within this paradigm that I've just described. Hopefully later this year our affiliation will extend all the way out through Central Massachusetts and we'll have about a million patients getting care that's organized around this thought process that I've just been describing.

I will say that the technical attributes that we have including data warehouses, the automated medical records and managers who understand or can dimly remember how we once did it are important assets that we're trying to share with our community. Everyone has referenced Atul Gawande's article. I have to put in this plug. Don spent

the first 12 years of his career in our organization. Glen Steele spent an equal amount of time with us about the same time. And our most recent famous graduate is Atul, who practiced ambulatory, endocrine, and general surgery in our facility before he moved his activities completely into the external world. Nevertheless, his article last week pointed to Verisk as a tool so that we've invested also in this software that will I think in a complementary fashion help us get even closer to those hotspots within our practice.

You might remember from the story the woman with \$50,000 migraine headaches which wasn't because she was an abuser of the system, it was because was getting fragmented care. And we know that even at this moment there are cases like that within our practice that we have to find and change if we're going to eventually deliver I think on the prospects of what the AQC has to offer so that I'll leave off there.

MR. McCLELLAN: Thanks for those comments, and maybe Gene and Ed I could stick with you for a minute and I want to do a follow-up with the Johns here. You talked at some length about both the payment reforms that you've implemented and the care-delivery changes that have taken place. John earlier went through a pretty compelling litany of lack of evidence in general in efforts to try to improve quality whether it's by supporting EHRs across the board or just reporting on quality. Why has your experience been different? Why are you confident that you're achieving significant improvements in quality of care and reductions in

cost? You both mentioned downside risk as being an important element of this, but it sounds like there are some other key elements, too. What's been more important in that and having an impact?

MR. LINDSEY: I think the most recent understanding that we've had is that it's not just technical change we're talking about, but adaptive change and that we have to have real conversations with our physicians about what's expected of them and why are we doing this. There has been help in the lay press in Massachusetts when you realize that the last billion dollars of money given to public education in Massachusetts ended up paying for health care premiums rather than for teachers and you begin to recognize that we've really hit the upper limit of what we can spend on health care in our community and expect to have a community that we're proud to live in.

I think that getting our physicians to understand that this is a professional and a civic responsibility and the public really isn't interested in how bad their lives are or how threatened they feel by economic change, but in fact it's the other way around, that it's the community that's threatened by us unless we can change I think is a first step. That is a very difficult position for physicians to come face to face with. But there is a tipping point in these sorts of conversations where people begin to get it and then get excited about resolving the problem and I think we've gotten there.

We've focused on the positive deviants in our practice, those

folks who innately knew how to do it and we've gone and asked them what they were doing and then tried to transfer what we've learned from them to other people. We've been using tools like lean process management and things of that sort also to help us reawaken the creativity that's associated with the practice of medicine for a lot of our clinicians and staff. Those have all been things that have helped.

MR. McCLELLAN: Ed?

MR. CYMERYYS: I think that what has helped drive the success that we've had is maybe a more simple explanation. It started with transparency, and because this was an arrangement that involved our biggest customer CalPERS, we have a very transparent relationship with CalPERS in that we opened up those same books to the provider partners so that we quickly got over the concern that the providers are going to do all this work and it was just going to enrich the bottom line of the evil insurance companies and it was a really open book. Then for the hospital and the physician group in conjunction with our organization to be able to look at the total results of the population that was now under this arrangement to see what was happening and have the complete picture and be able to collaboratively work around making changes, that really is what drove the results.

With this whole idea of lock in or not lock in, I think if you live in California and you're part of an HMO that I've been with for at least 20 years and probably longer than that, you don't necessarily feel locked in



because every year you get to change and there are probably a bunch of other ways you can move. The other part of this was to make sure that Kaiser is another alternative in that area and they do a great job and they're tough competition that keeps people motivated and they had to be able to have an arrangement and a coordination of care that people found attractive that they would join that arrangement and word of mouth had spread and make it more popular. I think it's been a combination of some indicators that have been very positive, shorter lengths of stay, fewer readmissions to hospitals and more people joining through word of mouth that it seems to be working that have helped make it successful.

MR. McCLELLAN: I want to go back to some basic points that both Johns alluded to. If we're talking about a real goal is here which is getting providers to come forward more where they have ideas on how to improve quality and lower costs and recognize that those aren't going to be lost because of regulations, third-party payments or other barriers to implementing real reforms in care. I think throughout the morning everybody has emphasized that if the overall goal is to improve quality and lower costs, a lot of those ideas if not most of those ideas are going to come from providers out in the community in the trenches changing the way they deliver care. The second component of this that John emphasized that is behind a lot of the ACO focus that we've been discussing today is having a way to measure that with providers coming forward with a way to measure that presumably having some agreement

between the providers and the payers so as Ed said there is transparency and all these things can happen at once, I'd like maybe some final or some further reflections from both of you about what's it going to take to make that happen based on the experiences that we've seen around the country.

SPEAKER: Let me start with TACO, the Tucson ACO, that is still a prototype. I think part of it went live on January 1 with the docs there working with the Tucson Medical Center. In many ways it's different from Kaiser, different from your legacy system because it's developed with community providers and under the umbrella organization of the sponsoring hospital. The docs say we know how to save money. We know how to keep people out of the emergency rooms. In particular, we know how to reduce the readmissions.

I have to tell you that sitting in the room, the senior hospital people are all highly in favor of this and the hospital's CFO gulps and says, yes, I know hospital revenue is going to go down. But because it's a nonprofit with a strong community mission, he has been convinced. I think their process of going forward on that basis to do the right things as in reducing cost with probably what I think Gene would say, very simple things for getting the first low-hanging fruit is on its way to being successful.

MR. McCLELLAN: It did come, John, with these changes in system.

SPEAKER: Yes.

MR. McCLELLAN: While the simple things may seem simple from the provider's standpoint, it's often not so simple to get the reimbursement to keep up with that, to have enough confidence that the actuaries and the payers are really going to put their money where their mouths are behind not just saying they want to back these changes from individual providers but they're really supporting them.

SPEAKER: Yes. This is absolutely the case. We are cooperating with one of the biggest payers, United Healthcare in this case, who has gone forward and said, yes, we are willing to do gain sharing. I think probably much the same way that Ed and Blue Shield are cooperating in the Sacramento area with CalPERS so that it is very important to have a cooperative payer.

MR. LINDSEY: I don't think we would have made the progress we have made without the cooperation with the payers in our market. The ACQ from Blue Cross is the one that's gotten the most press, but we've had other significant positive relationships with the other payers in the market. I think they're each approaching the concern slightly differently, but with the same fundamental principles. And we're all, I think, learning that in fact if we ask our physicians and patients what it is they need help doing that they're beginning to understand that things have to change and I think there's a moment of hope that's beginning to well up from all of the cacophony about missing that. It's really pretty

simple in the end. It's don't do the things that don't work, do the things that do work and if you don't know which it is try to understand and to treat everyone with the dignity and respect that you would treat a family member. It can be reduced to some pretty simple sorts of approaches.

MR. McCLELLAN: John, I take your point about these parts of the health care system where there is no third-party payment but where you need as others have talked about this alignment between what the payers are willing to pay for and what the providers really think matters for changing care. Do you have any further thoughts on how to make that happen?

SPEAKER: I think there are two things that are really, really hard for most people to understand. One of them is if we can spot things that we think are really good like the Mayo Clinic, the Cleveland Clinic or TACO or whatever and it looks great, you think why can't we copy that? Why can't we do a cookie cutter of what we see and that we like? The answer is because we don't know how to do that. If it helps in thinking through that, remember we've been trying to do this in education for 25 years. For 25 years we've been trying to copy stuff that works and we have not been able to do it. That's point number one.

Point number two is whatever works today is probably not going to work 10 years from now so that if you lock people in and you give them a -- and you say you have to practice medicine this way then you have an organization that does not have the flexibility to change over time.

I think what's going to happen.

I haven't said this yet, but one more aside. I think we're going to have a huge, huge rationing problem in four years. The demand for health care is just going to soar. We've done nothing on the supply side. People are going to not want to wait in line as long as they're going to be forced to wait. I think we're going to see a huge exodus from the system. The Mayo Clinics are going to leave it altogether and so are a lot of doctors. Outside the system we're going to have a lot of stuff happening that you will like. You'll have electronic medical records and you'll have kinds of neat stuff and it will change over time. My prediction is that the most admiral things that happen over the next 10 years will probably happen outside the system and not within the system.

MR. McCLELLAN: I know we're close to the end of our time. I'd like to open this up for some comments and questions from those of you here. Once again we've got the microphones present in the audience. Is there anyone with a common or question before we break?

MR. HAUGHTON: John Haughton from Covis. The question or comment is about whether we know what to do is one piece of it, and then the second is can the ACOs end up in a place where they separate the gain sharing on the quality of care and the actuarial risk and the reserves that torqued a bunch of physician groups a long time ago and was alluded to in terms of the fiscal diligence that is happening in California? In terms of the elements of knowing what to do, it seems like

the articles like Kawamoto's and others said that there are about three things you do. You know the population, you get lists of patients who are falling through the cracks and you get what's needed at the point of care for the communication and those details are not getting incented on the -- side. Will that make care end up working better?

The second question is do you guys think a group of physicians without reserves or without audited accounting can end up playing in this game if there is a gain share versus holding the actuarial risk and having full capitation?

MR. McCLELLAN: I think maybe we'll start with John for that and if anyone else has comments too. If you could specifically talk about this issue of smaller groups and groups that don't have a lot of integration, groups that I think to John's point may have some better ideas about how to do things but it may be hard for them to show it and take on some of the accountability that we've just discussed.

SPEAKER: I'm going to start by perhaps recalling what Mark said, that there are three levels of risk here, bonus only or symmetric upside/downside. Who is the organization or the entity that holds that risk? For Medicare it's still CMS so that you don't have the fairly stringent things that happen that Ed and I are familiar with from the 1990s in California.

Secondly, as part of having an ACO, I think Mark, Elliott, and I have all been proponents of having that infrastructure that's needed to

record what's going on both in electronic medical records for clinical stuff, but also in collecting the data and budgets and where they are, actual to budget is what actuaries call it, and being able to monitor that as we go along. There are organizations there. That article on advocates that was in the most recent *Health Affairs* is a good example of it, but there are a number of other organizations many of them capitated today that do that, but the infrastructure and the components are out there. They can be rented by ACOs rather than having to develop them from scratch.

SPEAKER: Part of the question was can you separate out the capitation and the holding of financial risk from the gain-sharing quality improvement and say the power of the pen is to make that change in care coordination but a lot of those smaller groups or IPAs just simply don't have capital structures for them to take risk and are we in a place where now you can separate those? CMS can say we'll take the actuarial risk and we'll gain share with you maybe even symmetrically up and down but you're not risking the overall expense of the population, you're risking the delta that you're willing to take responsibility on.

MR. LINDSEY: I'm very positive that you can and I think we have several natural experiments occurring in our market where this is the case. I don't think that every physician should be accepting full risk. We have assets that have been developed over years and even in that context feel always marginally the breath of the possibility of financial failure on our necks. We have reinsurance and all those other sorts of mechanisms,

but what's happening is that part of the interest that we have in affiliating with like-minded folks in Central Massachusetts is that they have been reaching out to one and twosies in that more rural environment and extending to them without bringing them into their organizations access to their automated medical records. We've created a coalition of folks who meet in Central Massachusetts who bring smaller groups in from all the way out to the New York border where we are beginning to have conversations of sort of self-help groups about the nuts and bolts of some of the technical changes.

Also, if any of you remember Balint groups from the 1960s -- maybe I'm dating myself -- where physicians got together to talk about the angst to practice, that can happen at the group level, so sharing best practices and transferring best practices, which is essentially what Atul has been doing in all of his articles. He's been showing that somebody someplace can do it. And if they can do it in Camden, why can't you do it in Worcester types of conversations I think are very important, and we shouldn't pull the rug out from under that by saying that this is hopeless and we can't do it because I do believe there is a momentum that is developing and you can feel it beginning to happen in Massachusetts.

An interesting thing happened the other night on WGBH where Emily Rooney, the daughter of Art Rooney, has a television program. She brings on the president of the Mass Medical Society and a physician representing a group that does accept the AQC. The idea is to



create some conflict here. By the end of the conversation they were saying the same thing. They had come together and coalesced around the realities that they both understood about the practice, and the issues that she had hoped I guess to create some tension for an interesting audience experience resolved into sort of a love fest around the idea that we had to do this. I think that when that sort of experience occurs, it gives heart to people who are trying to deal with these issues on a day-to-day basis.

MR. McCLELLAN: We have time for one more quick question up here.

MR. LITWIN: My name is Gordon Litwin from Meridian Health System. In the financial markets everybody talks about the need for predictability and stability. In health care I haven't heard today any discussion of the long-term resolution of these problems. We're talking about innovation. But, for example, if you talk about the electronic medical record and you talk about the subsidies program for the physician component of that, right now while we're writing the regulations for meaningful use, the money for the physician component is to some extent at risk based on certain political situations that appear to be rearing that view coming forward.

Secondly, with gain sharing as a component of accountable care, you find the medical community concerned as they get into it and the low-hanging fruit is obtained what happens in the long term. How do you

resolve the long-term stability issues in dealing with the innovative solutions that you're seeking?

MR. GOODMAN: I make a prediction?

MR. McCLELLAN: Please do.

MR. GOODMAN: Here is my quick prediction, that most of the insurers in the exchanges and in the employer markets are going to go to what's called reference pricing and they're going to say you go to our doctor and our hospital and we'll pay for everything, if you go anywhere else you will pay the marginal cost. What's going to happen is everybody with money is going to go some place else and we're going to have a huge explosion of concierge doctors, concierge facilities, people essentially outside the insurance system with insurance paying maybe the bulk of the fee, but the market really responding to patients paying marginal costs.

MR. McCLELLAN: Are there other thoughts on this?

MR. CYMERYYS: One thing that was very encouraging for me as a result of this pilot that we undertook was leadership of the CHW hospitals. It's almost like the light bulb went on and they said we are going to have to find a way to live within what we get paid by Medicare for our Medicare patients, that the days of cost shifting will come to an end. I've heard people now where they've now started to think differently about how they budget, how they go into their labor negotiations with the real goal in the organization to lower their piece of the cost that goes into this

whole equation. I think that's got to happen across the board and then I think what will be left is growth in chronic conditions that we're suffering with from obesity and all the other conditions that are going to have to be dealt with because that keeps pressure on the system. Even if you are very efficient in the way you deliver care, sicker people increase the demand.

MR. McCLELLAN: I think that this panel has done a terrific job in bringing out some of the core issues and challenges in health care reform especially from the provider side which was our focus. On the one hand we are facing these enormous cost pressures with a lot of evidence of inefficiency, lost opportunities to improve health and delivery higher-value care. On the other hand, there are some real concerns and this came up on the first panel, too, of being too aggressive or ham-fisted or taking too much of a sledgehammer approach to try and reduce costs is going to lead to some real problems with innovative quality care, which if you talk to the American public seems to be their biggest concern about them and their loved ones getting access to high-quality innovative care. So there have been some good discussions about the way forward so address these challenges but by no means are these resolved.

I do think, though, that we've taken this discussion toward another level of concreteness. These are problems that are not going away, the challenge of innovative care on the one hand and the challenge of reducing costs at the same time. And there seems to be a lot of

support behind finding better ways, whether it's through ACOs or other payment reforms or all of them hopefully in combination synergistically will help providers identify and get support for steps that they can take to improve care, lower costs and have that accountability, as John said, measuring it confidently goes along with it so that we can get the confidence of the public and we can spend our money as effectively as possible.

I want to thank all of you for an excellent discussion and I'm going to invite Elliott back up to make some brief concluding remarks before we break. While he's coming up I also want to thank the whole Dartmouth team for co-hosting this event and also the Engelberg Center staff that did as I talked about real health care reform earlier and their real work to make these kinds of events happen: Larry Kocot, Beth Rafferty, Cindy Chen, Todd Wintner, Erin Weireter, Tucker Page, Josh Pfeifer and Sean McBride, who was up late e-mailing with me last night. I want to thank all of them for making it possible as well as all of our panelists and all of you for getting here to make this an excellent discussion. Thank you all very much.

Here are some final words from Elliott.

MR. FISHER: I want to thank you all for coming. This is such an important moment. It was wonderful to hear Don with us this morning to talk about his vision for the future. I think we heard some wonderful specific things from our panel about consumer engagement and

about all the things Debra told us that are possible. This was a spectacular panel. We have a great responsibility and opportunity to our children to make this work.

I will remind you that the toolkit is available on the web and I hope you'll all download it and share it with your friends. We are trying to make this, the learning network that we've created, use it as an opportunity to go learn from our participating hospitals, the pilot sites, and then share that with as many people as possible. We have a lot to learn. We're absolutely right. I remember Yogi Berra. What was Yogi Berra's statement? Prediction is really difficult, especially about the future, so that it really is in our hands what we want to make of all of this and I think we have a tremendous moment.

Thank you all for coming.

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