THE BROOKINGS INSTITUTION

THE STATE OF ACCOUNTABLE CARE: EVIDENCE TO DATE AND NEXT STEPS

Washington, D.C.

Monday, October 20, 2014

PARTICIPANTS:

Welcome and Overview:

MARK B. McCLELLAN
Director, Health Care Innovation and Value Initiative
The Brookings Institution

Keynote: The Medicare Shared Savings Program (MSSP) Proposed Rule:

SEAN CAVANAUGH
Deputy Administrator and Director
Centers for Medicare and Medicaid Services (CMS)

What We Know About ACOs So Far:

J. MICHAEL McWILLIAMS
Associate Professor, Department of Health Care Policy
Harvard Medical School

DAVID MUHLESTEIN
Director of Research
Leavitt Partners

MICHAEL RANDALL
Vice President, Clinical Innovation
Advocate Physician Partners

MARCUS ZACHARY
Senior Medical Director
Brown and Toland Medical Group

Big Issues for ACOs Going Forward:

MOREY MENACKER
President and Chief Executive Officer
Hackensack Alliance

JENNIFER SWEENEY
Vice President
National Partnership for Women & Families

KELLY TAYLOR
Director, Care Management and Quality
Mercy Clinics

ACO Policy Issues and Solutions on the Horizon:

JOE DAMORE
Vice President, Population Health Management
Premier Healthcare Alliance

PAUL GINSBURG
Norman Topping Chair in Medicine and Public Policy
USC Schaeffer Center for Health Policy and Economics

MARK MILLER
Executive Director
MedPAC

MARK WAGAR
President
Heritage Medical Systems

Closing Remarks:

MARK B. McCLELLAN
Director, Health Care Innovation and Value Initiative
The Brookings Institution

* * * * *

P R O C E E D I N G S

MR. McCLELLAN: Let me welcome you to the Engelberg Center for Health Care Reform here at the Brookings Institution for today's event on The State of Accountable Care: Evidence to Date and Next Steps.

I'm Mark McClellan. I'm a Senior Fellow here and the director of the Health Care Innovation and Value Initiatives at Brookings, and we're very glad that all of you could join us today both in the room and participating by webcast. We'd also like to thank C-SPAN for broadcasting this event today, and we'd like to acknowledge support from our ACO Learning Network here at Brookings and from the Merkin Initiative on Payment Reform and Clinical Leadership. These are two of our major initiatives on payment and improving care in the United States and around the world.

This is a good time for today's forum. The idea behind accountable care is to pay for better quality care, better results, and lower cost at the person level. This is different from the traditional approach, a fee-for-service payment for specific services and procedures, and it's intended to give clinicians, hospitals, and other health care providers more ability to customize the treatments needed by their patients, especially the treatments that are not paid much or at all under the traditional fee-for-service payment systems. This includes things like spending time with a patient to discuss their condition, hiring a nurse or a pharmacist as part of a care team to help patients stay on their medications or change their behavior, or coordinating care across all of the different physicians and other health care providers that are increasingly involved in patient care. Clinicians get more flexibility in care, but they also have more accountability for demonstrating that they are getting better results and avoiding unnecessary costs.

The physicians and other health care providers who take on accountability for the overall results and costs of a population of patients are called an

accountable care organization, or ACO. And as we'll discuss, ACOs have been growing in Medicare, in private health insurance plans, and in state Medicaid programs across the country.

Now, while this all might sound good in principle, there are some concerns. On the one hand, accountable care has been criticized as requiring too much change without strong enough support for it. Health care providers have to make real investments of time, effort, and money to change the way that they deliver care with bigger changes requiring bigger investments; and the savings from better results to pay for this don't come till later if at all. In this view, the idea of shared savings is not enough of a change away from fee-for-service payment to be able to support innovative payment models. Instead a bigger shift away from fee for service toward more capitated payments, more fully person-level payments, as in the Medicare Advantage program for private health insurance plans might be needed in this view.

On the other hand, others are concerned that movement away from fee-for-service payments and ACOs would make them look too much like a replay of the managed care plans of the 1990s that were viewed by the public as skimping on care. In any event, there's a wide range of ACOs in existence today and a wide range of early experience and growing evidence behind the programs.

Finally, many hospital-based accountable care organizations have been viewed as part of a trend toward consolidation in health care, which many view as leading to higher prices.

So, what we're going to do today is look at some of the latest evidence on accountable care, discuss strategies to overcome the unique challenges that ACOs face in succeeding in their mission of better health and lower cost and also to provide an overview of the ongoing accountable care reforms across the country.

Now, here at the Engelberg Center for Health Care Reform we've been working on issues related to ACOs and other forms of accountable care for quite a while through our ACO Learning Network and our initiatives on value and innovation in health care. And we're very pleased to bring together a wide range of experience and expertise from the public and private sectors to address these issues.

The issues are very timely. Initial results of early ACO experiences are starting to emerge, and while better data are needed, it's time to start looking closely at what the data show and what it means from next steps for accountable care.

We're also approaching the next major phase in the Medicare ACO program with the next version of ACO regulations expected soon and probably including some significant revisions. And both private insurers and states are taking the accountable care concept in new directions. All of this should be informed by the discussions we're having today.

I'd like to just mention a few brief housekeeping items. As I noted at the beginning, this event is being broadcast on C-SPAN and via webcast as well as being video recorded. A full recording will be available on our event page at Brookings Health in the coming days. We're also expecting to have some time for questions in each of our sessions, and we'll be using microphones in the audience for that.

I encourage all of you in the room and those joining us by broadcast to follow us further on Twitter using the hashtag *ACOFuture*. Please also follow the Engelberg Center Twitter account at *BrookingsMed* and the ACO Learning Network Twitter account at *aco_ln*.

So, I'm going to start with a brief overview of some of the current ACO trends. This is an outline for the day. I'm going to start with a brief overview of the current ACO trends and results to date.

Then we're going to have some opening remarks from Sean Cavanaugh, the deputy administrator and director of the Center for Medicare at CMS. Sean's going to describe some of the latest ACO results in Medicare and some of the issues that CMS is considering in terms of the future of the ACO programs there.

Next we're going to have a panel discussion on what we know about the evidence on ACOs so far. We're then going to have a short break with refreshments out in the hallway. After the break we'll reconvene here in this room for a panel on some of the big issues for ACOs going forward, and that will focus on issues like engagement of beneficiaries.

Immediately after, we'll have a final session on ACO policy issues and solutions on the horizon.

So just, again, with a little bit of an overview of where we are with ACOs in the United States, over the past few years a number of organizations forming ACOs have grown rapidly. Our own internal tracking shows over 640 ACOs in every region of the country working with commercial health plans, the Medicare program, and state Medicaid programs. As you can see from this chart, Medicare ACOs continue to outnumber private sector ACOs, but private plan ACOs have been growing steadily as well and are now part of almost every major health insurance plan in the country. In addition, 19 states are now in the process of implementing Medicaid ACOs.

This slide summarizes some of the current take-up and results of ACOs. There is quite a bit of variation and beneficiary enrollment around the country and in the public and private sector, but it's becoming a significant part of both public and private insurance programs. Medicare ACOs now serve over 5½ million patients, and commercial ACOs are providing care to 10-15 million beneficiaries through around 280 plans.

In the results from these programs that we've seen to date, Medicare has released some results over the past month. I think you'll be hearing more about that from Sean. These results generally show better quality performance levels on these performance measures that are a key part of ACO reimbursement. And in the Medicare Shared Savings Program, the largest ACO program in Medicare -- which represents a step toward paying, in part, based on beating a cost benchmark while improving quality -- doesn't take away the fee-for-service payments that the ACO providers receive as well, but it does set up a second track of payment.

In that Medicare Shared Savings Program, overall savings were around one percent or so in the first year with significant improvements in quality. That's on top of the slow rate of growth that Medicare has experienced in recent years. And a subset of these ACOs -- about a quarter -- has achieved significant savings, a large enough savings, large enough reductions off of expected trends to get some of those funds back -- the Shared Savings fund back.

I will talk more about Medicare Pioneer ACOs in just a minute.

I did want to spend a moment on private plan experiences so far. As you'll hear from our panel, these results were a little bit harder to compile comprehensively. Different plans report on their results in different ways and perhaps not as comprehensively as we'd like either. But if there is a basic finding that is worth noting, I think it's that many of these private plan ACOs do more than just provide shared savings up front. They provide more investment support through, maybe, partially capitated payments to primary care providers as in a medical home; they provide some infrastructure support, data, care managers. But in conjunction with that, they also expect more in terms of impact on financial performance, and that means more risk sharing -- so, instead of just shared savings, a two-sided risk with the providers being

accountable, in part, for holding trends close to overall growth in the economy or achieving larger savings and facing some downside risk if they don't.

Many of these plans have shown some more significant impacts on savings, as well as -- as in the Medicare case -- some significant improvements in quality with reported savings on the order of 2-12 percent in many of these major private plan implementation efforts.

In Medicaid, the programs are in early stages, but some promising results are there as well. Many of the Medicaid plans are also going beyond shared savings in traditional health care to integrate other types of activity, such as coordination with Social Services or behavioral support in other community-based programs that may have a bigger impact for some vulnerable individuals than just the medical interventions alone.

This is a slide that highlights some of the early Medicare ACO performance. It shows the distribution of Medicare plans in terms of quality performance compared to the overall Medicare provider community. Most of the ACOs perform at or above the 70th percentile, so that's a shift on the slide to the right toward a higher level of performance on the quality measures that were established by Medicare for this program, particular good performance in areas of patient experience and coordination of care, as you might expect.

It's also important to note that there are a lot of different kinds of ACOs out there, some that are led by academic medical centers, some that are led by federally qualified health plans, some that are led by hospitals or integrated delivery systems, and a growing number that are led by physician groups, often primary care physician groups that are willing to take on overall accountability but with a much smaller number of providers directly involved. And we're starting to see some differences in performance

both across and within these categories of ACOs.

The next slide highlights for the Pioneer Program, as you'll hear more about from Sean, a program for a smaller number of accountable care organizations that have been willing to commit to Medicare to move further beyond shared savings into some more significant financial reforms and accountability for both cost and quality.

The ACOs that are continuing the program are showing some further improvements in the second year relative to the first year. Again, this is percentile of performance, so you can see the shift to the right on the slide. That's higher levels of measured performance.

This is a chart for the Pioneer Program that shows for their first two years results on both quality versus savings. As you can see here -- and this is something I think we'll discuss as well -- many of the Pioneer ACOs, just like many of the ACOs overall, are doing quite well on the performance measures, so they're over to the right side of this chart. But some have not done as well in terms of achieving savings, and some of the Pioneer ACOs have dropped out of the program. As you can see from this chart, those are the ones that are the red dots. All of those are ones that did not do well against the financial performance benchmarks that were set up by the program, and one of the things that we'll discuss today is why is that, what's going on with the benchmarks, and is this really reflecting the ACO performance accurately or are there ways to learn from this early experience to try to encourage better performance and lower cost at the same time?

So, that's a little bit of an overview. I would highlight that a good bit of this evidence came from our work with a range of health care providers, payers, associations, experts, and others through our ACO Learning Network to compile some of this evidence and share experiences. I'll have more to say about that a little bit later.

But what I'd like to do right now is introduce Sean Cavanaugh, the deputy administrator and director of the Center for Medicare at CMS. There Sean is responsible for overseeing the regulation and payment of Medicare's traditional program providers, the privately administered Medicare health plans, and the Medicare Prescription Drug Benefit program.

Medicare collectively provides health insurance coverage for 50 million elderly and disabled Americans with a budget of over $550 billion, so Sean definitely has his hands full in his day job.

Prior to assuming his current role, Sean was the deputy director of Programs and Policy in the Center for Medicare and Medicaid Innovations, so he came to the oversight of the overall CMS Medicare programs from some experience with the pilot programs like the Pioneer ACO Initiative that I just described and there he oversaw the development and testing of a range of new payment and service delivery models as well.

Previously, Sean was the director of Health Care Finance at the United Hospital Fund in New York City. He's also served in senior positions at Lutheran HealthCare in Brooklyn and in the New York City Mayor's Office of Health Insurance Access and the Maryland Health Services Cost Review Commission.

He started out his career on Capitol Hill on the Ways and Means Health Subcommittee.

Sean, we're very glad to have you here with us today. Please come on up.

MR. CAVANAUGH: Thank you, and good morning.

I'm going to speak for about 15 minutes and then leave about half the time for questions and answers, partly because that's what Mark asked me to do but partly in recognition -- I looked at the other panelists and the people here in the audience,

and I think we have a very distinguished group. In groups like this, people like me from the government should do less speaking and some more listening.

So, my remarks -- quickly I just to give you some very big-picture context of how we think of the Shared Savings Program, so starting at 40,000 feet and then coming down fairly quickly to ground level and talking, as Mark indicated, about we are in development of a proposed rule for the future of the next generation of the Shared Savings Program. So, I'll talk to you a little bit about where that might be headed.

So, first, we're about four years out from the Affordable Care Act and, probably more importantly, we are one year out from the 50th anniversary of the Medicare Statute passed in Congress 50 years ago.

So, where are we on the most important measures, which are controlling costs and improving the quality of care that our beneficiaries receive? Well, on controlling costs, the news is historically good. We are in the middle of about a four-year period where the cost per capita of providing care to a Medicare beneficiary is essentially going to be flat for four years. Some of that is data that's already in; some of it's the actuary forecast for next year. So, unprecedented performance on reducing the growth and the cost for care.

That bodes well for the program in many ways. One, the trust fund, the life of the hospital insurance trust fund. If you go back to 2009, the forecast was that it was eight years from being exhausted, that it would be exhausted in 2017. This year, the trustees are saying we're 16 years from being exhausted, that the life has been extended to 2030. So, that's good news. Also I think when you control health care costs, it allows not just relief for the federal deficit, but also allows for better health care policy. Probably the best example is serious discussions now about getting rid of the sustained growth rate provision in the Medicare statute, which many feel has outlived its usefulness, but

the discussion to get rid of it is only made possible by the low cost in Medicare spending. So that's the cost side.

On the quality improvement side, again, historically good news. Hospital-acquired conditions -- many forms of hospital-acquired conditions are dropping: ventilators, associated pneumonias, early elected deliveries -- I could go on and on. But lots and lots of signs of improvement in the care that our beneficiaries are receiving; hospital readmissions dropping. So, historically one in five Medicare beneficiaries -- about 19½ percent -- readmitted to the hospital within 30 days of being admitted. That's now in a precipitous decline, now at about 17½ percent.

So, what's causing all this good news? Well, there are a lot of factors. Some of it is public policy, both predating the ACA but also things coming out of the Affordable Care Act. Some of it has nothing to do with public policy. It's changes to the professions and the hospitals and the delivery system they've made on their own, because I think what you see is the beginning of a genuine quality improvement performance, improvement revolution in health care, which we've had in other industries but sort of late coming to health care. We see actions by other payers, commercial payers, state Medicaid programs that are incentivizing these changes. So, we're in a very good position. We've got challenges ahead.

How do we continue this level of performance and improvement? Well, first of all, the challenges ahead are significant. One, the actuaries, although they're predicting that Medicare costs will continue to be flat next year, when they looked further out into the future predicted a return of inflation of about 5 percent of price growth every year, which is a challenge for us.

But more of a challenge is the baby boomers. In the next 20 years -- we have 50 million, give or take, Medicare beneficiaries today -- in the next 20 years we'll

add another 30 million, so 60 percent growth in the next 20 years. Very substantial challenge, even if we continue to control growth per capita.

So, that's sort of the landscape that we view the program in. We're in a great position in controlling costs. We have made some significant strides in improving quality, but we face very, very significant challenges. So, I think the way we look at the landscape is we need to continue to support delivery system reform.

And how do we do that? Well, Secretary Burwell, within her first hundred days, articulated a vision of delivery system reform, which was providing information to providers so that they know how to improve and then where they need to improve; improving the incentives, so making sure all of our payments incentives support improvement; and building capacity within the delivery system for improvement. And I think the ACA has already initiated a lot of that work.

As you see on the quality side on information, we're providing quality measurement in almost every one of our provider groups that are in Medicare. We're providing transparency with publishing these on our websites, whether it's nursing home compare, hospital compare. And, more importantly -- and this is where I wanted to get to -- is we're injecting the notion of value of paying for quality and efficiency into all of our payment systems.

And what are those payment systems? Very briefly, we have the Medicare Advantage Program; we've got the Fee-for-Service Program; and we've got new models of care that Mark referenced. In the Medicare Advantage Program, a lot of progress. The Affordable Care Act I think set us on a course to pay more reasonably, so we're getting significant savings there. But at the same time, we're getting higher quality care in Medicare Advantage. Sixty percent of Medicare Advantage beneficiaries next year will be in four- and five-star plans. Premiums have been essentially flat since the

passage of the Affordable Care Act. So, good news there.

And fee for service, hospital-based purchasing, physician-value modifier. Even in dialysis payments we're building in the concept of paying for quality, paying for efficiency into all these fee-for-service models.

But, as Mark said, for many providers, they believe that to truly achieve change and to fundamentally change the way they deliver care, they need to move out of fee for service and move into a different model. And that's where ACOs and other models come in. I'm not going to go into depth unless we get questions, but the Innovation Centers testing any number of models around ACOs, primary care medical homes, lots of variations all focused on ACOs. But, as I say, it's an important part of our strategy on new payment models.

So, where do we stand on the ACO program? Early results -- and I would use very similar slides to what Mark did -- the early results are very promising, particularly on the quality side. On the quality side, it's pretty clear that mostly ACOs have figured out how to improve care beyond what's provided in the fee for services.

And we see that in beneficiaries. One of the measures we do is patient satisfaction. And patients in ACOs tend to be, almost across the board, more satisfied with their care than patients who are not in ACOs in the Fee-for-Service program. But there are more quantifiable measures. The Pioneers from one year to the next improved collectively on almost all objective measures of quality. I think 28 out of the 33 measures they improved on. In the Shared Savings Program, the shared-saving ACOs outperformed fee for service in 17 out of the 22 measures where large group practices had reported quality measures. So, in the quality story, very good promising results.

On the cost side, a little less -- more of a mixed result so far, but I would caution that it's very early in the program. If you recall, you know, if you went back to

January 2012, there essentially was no such thing as an ACO, and now we have, as Mark said -- I usually use the number 360 in the Medicare program but many more in the private sector as well, with 5.6 beneficiaries participating in that.

Several Pioneers have clearly figured out how to generate cost savings and do that consistently from year to year. A number of shared savings ACOs as well. But the story is still mixed, and the question isn't can the leading edge figure out how to generate cost savings but can we get the fast majority of the ACOs in the long run generating cost savings to go along with the quality improvement.

So, if the situation is promising but needs to do better, how do we move forward? Again, I go back to the Secretary's vision. We need to improve the incentives that the ACOs receive, improve the information and help build the capacity of the ACOs.

Since, as I mentioned, we're developing a new regulation for the ACO program, I can't tell you specifically -- what I'll talk about now briefly are some of the areas where the private sector, the ACOs, have come to us, including through the Brookings Learning Network, and have told us areas where they think we could improve. And they map perfectly to the incentives -- the information on capacity building.

On capacity building, we've heard, you know, a lot of small practices that want to get into ACOs or are in ACOs need help in understanding how to transform themselves, and we've heard this outside the ACO community: How do we help small practices in clinical transformation? And that's something the federal government is talking a lot about. We even have spoken publicly about and solicited ideas on how could the federal government support small practices in transforming better?

But specifically in the ACO context, one of the things we've heard is: Well, since this is fee-for-service medicine, when we assign a beneficiary to an ACO in one year, many of them are not assigned in the second year, and some have referred to

that as the churn of beneficiaries. So, it's harder for the ACO to focus their interventions and resource investments on a beneficiary if they're not certain that they're going to have that beneficiary in the long run. And I think Mark made reference to some of the savings opportunities are in the long run.

So, we've been talking to many of the ACOs, and we've thinking long and hard: How do you get a more stable population for the ACOs? The challenge there, of course, is this is fee-for-service Medicare, meaning the beneficiary is not locked into a network in the current vision of what an ACO is.

And then, broadly, I think how you get a nonchurning is part of a broader category of how to get more beneficiary engagement. And I would say this is true, not just in the ACO context but in any context where a provider is trying to provide care better and in a different way: How do you get the beneficiary engaged in your care? So, they're doing self-care following medication adherence, those sorts of things.

On information, we've heard consistently that ACOs need better and more timely information from the Medicare program. We've been working hard to do that. We have a ways to go. I would say, though, on CMS's behalf, that two years ago we essentially were sharing claims data with nobody. Now we're sending monthly claims fees to over 300 ACOs every month with data of over five million beneficiaries. This hasn't been an enormous change for what the house CMS saw as its role, but I think it's been a successful one. But it has a ways to go, and I think working together we can figure out better ways to share information.

And then most importantly we've heard quite a bit of talk from the ACO community about changing the payment rules for the ACOs. One of the things we do is we don't pay on the first dollar of shared savings, because there's a lot of variation year to year in Medicare spending, so we created what are called minimum savings ratios and

minimum loss ratios, which is the first couple of percentages considered just statistical background variation. Many ACOs have balked at that, feeling like they did generate change, it wasn't a statistical anomaly, and they'd like to be paid for that.

One of the things that's implicit in all the numbers marked share on who generated cost savings is what is the formula for what is a cost savings. The Shared Savings Program followed the statute in the Affordable Care Act of using a national benchmark, meaning you start with the cost of your own beneficiaries historically, but you trend that forward based on what happened nationally in the Medicare Fee-for-Service Program.

A couple of things to observe about that. One is it's an interesting time to have started the ACO program, because the Fee-for-Service Program has essentially been not growing at all. So, that's a very difficult benchmark to meet regardless. Two, a number of ACOs have said, well, I'm in a community where costs have been growing much faster than the national average, and it's not fair to only give me a benchmark that grows by the national average. The only thing I would say is we've been listening very closely to these, but this was the point of contention in the drafting of the Affordable Care Act. It was very delicate regional balances that come out in those discussions, so. But we are hearing quite a bit about whether the benchmark and methodology is the one we should stay with.

We are proposing that ACOs that generate savings over a number of years and then continue in the program, that they would do something called rebasing, which is we're using a historical-base period; we've rolled that base period forward. Some ACOs feel like if we keep rebasing them over time, the opportunities to generate savings will be diminished. So, we're hearing a lot of ACOs asking us either to not rebase or to approach it differently.

Mark made reference to -- a lot of ACOs want to provide care differently in ways that aren't paid for by the Medicare Fee-for-Service Program. And they can do that, but they're not paid on a fee-for-service basis when they do that, so essentially they're investing their own funds. So, we've been asked by the ACO community for a number of waivers, meaning they don't want to have to follow the three-day prior hospitalization rule in Medicare. They want more generous access to the home health benefit.

And then finally, and probably most conceptually tricky, is, as Mark said, many of them want to not be paid during the year on a fee-for-service basis but would prefer to be paid on a capitated basis. And that would free up the dollars for them to do a lot of innovative things.

As I say, it raises some conceptual challenges, which is would the ACOs then be like an MA plan, making payments to other providers? Would it imply that there's a network?

But these are all interesting ideas, and they're ones we're taking very seriously and considering as we propose a new rule. We're hoping the new rule will be out shortly so that the public can comment on it. We will go through the normal public comment period. This will be a proposed rule. We would solicit comment and adjust the rule as appropriate to public comment and hopefully have a final rule early next year.

But again, in conclusion, this is a major part of our strategy to continue the improvement on controlling costs in Medicare and improving quality. It's part of an array of strategies that range from Medicare Advantage all the way to our fee-for-service payment systems, but it is one of the keystones and one we're looking forward to working on with all of you.

So, with that, I will pause and take any questions, and I'm almost right on

time.

MR. McCLELLAN: So, while Sean's getting situated, there's a little microphone he can clip right on there. I'll just start with framing the first question.

Sean, you did a very broad overview of fitting the ACO program into a wide range of payment reforms taking place in the Medicare program generally and CMMI in particular. One of the things that you highlighted was basically how important it is to think of ACOs as not just about a payment model, that there are other changes that are needed, too.

You talked about a lot of the regulations and Medicare payment systems on things like no requiring a three-day stay at a hospital before going to home health or a post-care facility, uses of home health services. Typically, they're limited because of the restriction, because of the fee-for-service nature of Medicare payment.

And you also talked about the need for further steps, especially for smaller accountable care organizations or smaller provider groups to be able to get off the ground in these kinds of big payment reforms. I know that more of this is going to come up in that regulation, which is coming out soon?

MR. CAVANAUGH: Soon. Soon. My official position. (Laughter)

MR. McCLELLAN: Great. (Laughter) But you have made some other announcements recently from CMS, and the administration has, that pick up on some of these other issues -- for example, just recently an advanced payment program for rural ACOs. I wonder if you'd talk more about that, maybe about recent announcements from the Office of the Inspector General, I believe, on extending programs to give ACOs and some other providers that are participating these new kind of payment arrangements, a bit of a pass from some of the restrictions on sharing money across providers, and the like, and sharing resources across providers that, again, are intended to block some

challenges and fee-for-service that may be less of an issue in these coordinated care approaches.

I wonder if you could talk a little bit about how you see ACOs in the context of some of these other policy changes and where those might be headed as well.

MR. CAVANAUGH: Sure, and thanks for that question.

And, again, just part of what I was trying to say in my remarks is ACOs are important, and they're big and they're a growing part of the program, but they're part of a broader strategy to improve care and reduce costs. On the specific topics you raised, we had, as some of you might know, created at the start of the Shared Savings Program something called the advanced payment model. This was to recognize that there were a lot of providers who looked at Shared Savings Programs and said: I get it, I think that's the right direction for us to go in; we can do well by our patients; we can improve the quality of the care but we see that it requires an up-front investment but we're just a group of small physicians, our rural hospitals, we don't have the capital to do that initial investment, and so for want of that initial investment we won't be generating savings for years to come and improve quality.

And so to help some providers get over that hump, we provided what's called "advanced payment." The name was chosen very carefully, because what it meant was this is an advance on future shared savings you're going to generate. So, we gave it to 40-some ACOs and said: Here's some money to help you through the beginning to hire care coordinating nurses, to maybe beef up IT system, so you can improve care; but when you generate shared savings, you will pay this money back to the federal government. It's been very popular. Some of them did very well in the early rounds of the shared savings program, but we also heard that we left some groups on the outside when we designed the original one.

We also heard that some shared savings ACOs were able to get into the program but weren't sure they could remain in the program without some help. So, we tried to design the new round of advanced payment to capture some who were in who wanted to stay in but needed some help, but also rural hospitals. I think we really didn't define it right to get rural hospitals, particularly critical access hospitals.

On the waivers you were referring to when we created the program initially -- I mean, if you can think about the Shared Savings Program, these are often not already integrated health systems coming together. These are independent practices and FQHCs and providers who are coming together for a common purpose. But oftentimes when they do that, they run up against some existing fraud and abuse laws about how much they're allowed to cooperate.

So, the original program included some waivers from fraud and abuse laws. Those waivers were due to expire this year and the office of the inspector general has extended them for a year, and I think once we come out with the new rule and show where the program might be headed, I imagine everybody will go back to the drawing board and decide do these existing waivers still fit the new program?

MR. McCLELLAN: But that sounds like a longer-term commitment to making sure that the fraud and abuse protections are appropriate for the payment systems being used.

MR. CAVANAUGH: Yes, I think you'll see continually, as the program evolves, continued re-evaluation of have we tailored these waivers correctly to the way the program is operating and to what providers need and what the current government is comfortable with.

MR. McCLELLAN: And also quickly in the same spirit of reinforcement of the basic ideas in an accountable care payment arrangement, we're seeing in the

private sector a lot of insurers putting in a number of different reforms at the same time, so not just ACOs with shared savings or two-sided risk but also medical home payments, bundled payments for special services and more advanced care, a number of payment reforms that all can be reinforcing. It has to be a little challenging when Medicare is trying out some of these new payment models and trying to figure out what the effect of each one is. I think what many of the private payers are finding is they can get more mileage by putting them all in together. Is that something that you all struggle with in terms of --

MR. CAVANAUGH: We do, but as you know the Innovation Center is testing many different models. We've tried to allow participants to participate in multiple models, including the Shared Savings Program.

There is one statutory prohibition, which is the provider cannot participate in more than one model that involves shared savings. So, we try to be cognizant and enforce that. But certainly medical home models that don't involve shared savings and other models we think could be complementary; it does pose a challenge, as you say, for the proper evaluation of, if you see a positive result disentangling, what contributed to that result. The one promising thing there is the creation of the Innovation Center. We have much more robust evaluation budgets than we've ever had in the past. So, we'll do better. It will still be very much a challenge though to disentangle its effects.

MR. McCLELLAN: I'd like to open this up to comments from some of you here in the room. We have microphones. If you would put hand up and then wait for a microphone. I'll try to get to as many people as possible.

Over here, had their hand up first. I'll wait for -- just a second.

MR. ANDERSON: Thank you. Jerry Anderson, Johns Hopkins University.

Sean, you mentioned the evaluation budget. So, you've got a whole series of evaluations ongoing at CMMI. Some of the programs are working; some of them are not. What are the commonalities of the programs that are actually saving money?

MR. CAVANAUGH: So, first of all I'd say -- I think I'm being rewired. I think it's too early to say. I apologize, but, you know, Innovation Center first models went up January 1, 2012, so to see measurable results, best case scenario would have been, like, this time last year. That's if they had immediate substantial impact. And even then it would be limited to the Pioneer ACOs and the Partnership for Patients, which was a big quality improvement. But the bundle payment for the care improvement initiative is really just getting off the ground now. Some of the medical home models -- actually we have some early results.

Speaking qualitatively from what I've seen and not applying the level of rigor that you tried to teach me at Johns Hopkins (laughter), I think what you see is it's providers who were in this mode long before the Affordable Care Act passed, meaning providers who saw the problems with fee-for-service medicine but were pursuing the right form of care, communicating well with other providers, staying close to the beneficiaries, focusing particularly on the high-risk beneficiaries long before all of our payment systems might have caught up to that seem to be the ones who got going right out of the gate and did well.

Those of whom are responding to the new incentives, I do think there's a learning curve. I think (inaudible), and that's why when we talk about the shared savings ACOs, I think you have a mix of those. I think you have some that are coming in saying: This is great, this is what I always wanted to do and some saying: This is great, this is what I've always been doing and now I'll get rewarded for it. And so I think early on

you're going to see that diffusion of performance, but the hope and expectation is the big middle will catch up.

MR. McCLELLAN: For those early -- those organizations that were committed early to this kind of approach to care, it's still important, though, to be able to have a sustainable business model to do that.

MR. CAVANAUGH: Absolutely.

MR. McCLELLAN: And do you think the Shared Savings Program is enough to get there? Is your sense from many of those that they'd like to do more in the way of payment reform?

MR. CAVANAUGH: Again, I think there's a huge diversity out there. There's certainly a leading edge of ACOs that want to move as fast as possible to more financial risk, meaning almost capitation -- though, they tend to want to get away from shared savings, meaning they want a budget, a perspective budget; they want capitated payments based on that budget; and they want to, you know, let the government take a couple percent off the top as a discount, and then they're on their way. I would say that's a small minority but very large, sophisticated organizations.

I think there's a larger group that are still feeling out what is the business model and what do they need exactly. But many of them clearly want better upside potential with less downside.

MR. McCLELLAN: Time for another question. Here on this side.

MIYUM: My name is Miyum, and we talked about evaluation of this (inaudible), whether it is budget or whether it is care, I have a very strong concern about it based on my research, my hospital (inaudible), and based on personal observation.

I just wonder if you can address the issues on accountability and the record and the (inaudible) patient care. (Inaudible) they say if we want to compare the

(inaudible) workable, and in writing the response is totally absurd. And then you had a lot of views and unnecessary visualization whether there is a, you know, (inaudible) or anything like that or even mental care. They had a proved patient rights advocacy. They were paid by the hospital, but they are really absurd. They can even run the patients. So, if you don't address these types of issues, the whole thing is meaningless. So, could you --

MR. CAVANAUGH: Yes. I think you're making what is a point that I should have said at the beginning, which is our focus on cost containment needs to be matched by our focus on quality improvement. And I think we've tried to do that, but you're right, any time you create a new payment system -- every payment system has incentives, whether it's positive or negative, whether they're moving in the right direction. But when you create payment incentives to increase efficiency, you need to have some confidence that your quality measures are making sure that efficiency doesn't come at the expense of the patient.

With that, I would say, you know, the results, at least so far in the Shared Savings Program, are very promising. Patients are happier; seem to be getting better care. But whether it's the Shared Savings Program or elsewhere, I think our measures of quality have a long way to go, and I think -- they've come a long way, but I think there's a long way to go to make sure we're really measuring things we care about and (inaudible).

The other tension I would say is there's a tension in the Shared Savings Program between those who would want to measure everything, meaning we don't want any possibility something adverse is happening to this patient versus the ACOs who are saying don't drown us in reporting and measurement, allow us to focus on things that really matter, that are just a handful of really salient measures. And I think that tension hasn't been fully resolved.

MR. McCLELLAN: Right, and one that is -- I think part of the reason why you're doing so much work to try to expand out the scope of measurement while still reducing a burden on providers.

I would just point out that there are a lot of aspects of patient safety where it's very much aligned with the reforms and accountable care. So, preventing re-hospitalizations, avoiding costly medical errors that lead to complications -- all those are steps that accountable care organizations, just like the hospitals that you mentioned now that the payments for remissions are being reduced -- those organizations have stronger incentives to address.

Are there any particular areas, though, where you're worried about the other direction, that the higher-quality care may actually be more expensive maybe for some special conditions where there are expensive treatments needed? Any particular area standout there? I know you're generally trying to pay attention to these issues.

MR. CAVANAUGH: Yes, what I'd say about that is we've had some technology firms, some medical device firms come and say, you know, all this new payment is wonderful but you're going to squelch innovation. And what we've said is, you know, we don't want to squelch innovation. One, there's a type of innovation that I just said reduces cost, but even the ones that may increase cost but that are lifesaving or life enhancing. So, we're trying to find ways to measure that.

We've been working closely with those industries to try to see if our payment system should adapt and allow -- you know, they've asked for a pass-through, meaning if we come up with something new, don't include it in the reconciliation whatsoever. We're not willing to do that. But we're continuing to focus on that to make sure, as you said, that that particular type of innovation isn't being (inaudible).

MR. McCLELLAN: I'd like you all to join me in thanking Sean

Cavanaugh for joining us here this morning.

Sean, thank you very much.

MR. McWILLIAMS: I'd like next to go straight into our next panel and ask our panelists to come on up to the stage. We're going to talk now about, in terms of the state of accountable care, what we know about ACOs so far. So this panel is going to explore in a lot more depth the kind of evidence that you heard about briefly in my introduction and in some of Sean's comments, the evidence on ACO implementation, practice, and results.

While our panelists are getting seated, I'd like to introduce them. They include Michael Randall, the vice president of clinical innovation for Advocate Physician Partners in Chicago. Randall previously served as manager of business advisory services and hospital operations for the Camden Group, a consulting group that provides support on strategic and business planning, financial advisory and compliance, and hospital and physician services.

Next I'd like to introduce Marcus Zachary, the senior medical director for quality and population health at Brown and Toland Medical Group in California. He's primarily responsible for the strategic and operational oversight of medical services related to the ambulatory care network at Brown and Toland and the ACO portfolio, which includes their Medicare Pioneer Program. Within Brown and Toland, Dr. Zachary helps design and drive initiatives linking quality, utilization, and information technology in pursuit of the triple-A goals of improving quality outcomes and reducing costs. Before being at Brown and Toland, Dr. Zachary was lead physician working on implementing electronic records and informatics for Dignity Hospital in San Francisco.

Next, J. Michael McWilliams, glad you could join us today, too, down from Boston. He is an associate professor of health care policy and a practicing general

internist at Brigham and Women's Hospital. His research -- he's an M.D. and Ph.D. -- focuses on health care spending, quality access, and disparities in aging populations with chronic conditions. The overarching goal of Michael's work is to inform the development of health care markets, delivery systems, insurance coverage, and regulatory and payment policies that support value and equity in health care and particularly in Medicare. Much of his work relates to evaluating accountable care programs, including the Massachusetts Blue Cross Alternative Quality Contract.

And, finally, David Muhlestein is the director of research at Leavitt Partners. It's a health care intelligence business where he oversees the firm's quantitative and qualitative evaluation of the changing health care landscape. He studied the growth of accountable care organizations extensively with the Center for Accountable Care Intelligence at Leavitt, and he leads the firm's study of geographic variation in health care markets. His research interests focus on applying a legal and legislative framework to evaluate the evidence of health policies for the benefit of government and private policymakers.

Now, I've asked each of our panelists to start out with some opening comments for this session on how they see the evidence on ACOs emerging, any particularly challenging areas -- notable findings, what they'd like to see happen next -- comments along those lines. Then we're going to have some discussion across the group and then with all of you here today. So if I could start with Michael Randall, please go ahead.

MR. RANDALL: So first to start, Advocate -- we're excited to be here to share our journey with you. I lead many aspects of Advocate's strategy and operations. In total we serve about 600,000 lives. This includes commercial, Medicare, and Medicaid lives.

In terms of how we make the model more sustainable, I think you've heard some things that Medicare's looking at; I think commercial PERs are also looking at. How do we design a model for shared savings that is able to support provider organizations to have funds available to invest in information technology and care model design?

Before I get into those aspects in particular, I just wanted to share some of our results both in the area of quality and also cost savings. So first in terms of quality, on the Medicare shared savings side, we had our estimated total quality score. We saw that increase in 2012 from 79 to 86 percent in 2013. Of the scored measures, 21 of the 27 improved during this period of time. On the commercial side, we're also seeing improvements in quality. We tracked eight key indicators for our HMO populations; six of those eight improved in 2012. We're still finalizing results for 2013, but overall a net positive improvement. 2013 was a baseline saving year for our PPO population.

On the cost side, our results mirror that of the national experience for the commercial plans, both HMO and PPO. We're seeing a year-over-year improvement of about 1 to 3 percent. For Medicare shared savings, a little bit less. But our first performance year was a .2 percent improvement ahead of the national benchmark, all of which came in the last six months. So that equates to about .6 percent improvement or about $3 million in net savings to the Medicare trust fund.

To make the model more sustainable, we believe there are two areas of focus. One is information technology and the second is care model design. So in terms of information technology, it's very helpful to have the claims information. It gives us a glimpse into the total care that patients are receiving, but it's not enough. And so for us we're focused on marrying up the clinical and claims information. One example of that has been our partnership or collaboration rather with Cerner where we developed a new

hospital readmission risk tool that has a predictive value that's 20 percent better than anything else on the market today.

A second example of how we're trying to merge clinical information and claims data is our support of the development of a regional health information exchange. Advocate has supported this through leadership as well as investments of funds and in the model design of the regional information exchange. We're anticipating about 50 percent of the area hospitals will be participating in this by the end of the year, starting first with the exchange of admission, discharge, and transfer data with clinical information to flow about the middle of next year.

The second area to address is care model design. Like other organizations, we started by focusing first on our high-risk population. We designed an outpatient care management program today that employs over 100 care managers working in the field with our physicians to coordinate care for these patients. A second key program was investments in post-acute care services, development of a network. Advocate only owns one skilled nursing facility, yet we refer business to over 100 independent skilled nursing facilities throughout Chicago. And so for us to be successful, we had to identify those organizations that shared a common vision to improve quality and lead to greater efficiency.

Looking forward we recognize that we need to go deeper into the population triangle to engage not only the high-risk, but the moderate-risk patients as well. We've done some of this through our patient center medical home implementation. We have implemented this past year three new pilot programs, one of which is a community health worker program. And as we look at 2015, we will be making additional investments in pilot programs. I think for you in the audience that have the ability to influence public policy or commercial development efforts, supporting the efforts to

promote interoperability of data and the exchange of data as well as research to understand what truly is having an impact and what's working, would be the areas of focus.

Thank you so much for your time.

MR. MCCLELLAN: Great. Thank you very much, Michael. I'd like to turn next to Dr. Zachary.

DR. ZACHARY: Thanks for having me. So I'm Marcus Zachary. I'm from Brown and Toland. I'm having a disconcerting moment that I'm the gray-haired guy up here on this panel. I guess I've reached that age.

So for those of you who don't know because there's not a lot of folks from California here, Brown and Toland is a fully physician-owned and operated independent physician association, the largest in Northern California with over 1,700 docs. So we are truly hospital agnostic. We have no private equity partners. We have no hospital financial partners. We have a long history of managing mostly professional risk in a capitated environment. We, like Sean was saying, are interested in taking more risk. And so with payment reform that was happening with the ACA, we jumped right in. So we have shifted about 100,000 lives over the last three years into some form of risk-sharing program and that runs the gambit of alphabet soup. So we've got HMO, ACO, PPO, ACO. We've got a limited key for taking first dollar of Medicare Advantage patients. And then, of course, we're Pioneer participants and happy to say we were one of your red dots up there where we've achieved savings, significant savings actually, in the first two years of payout with good quality outcomes and we're very proud of that.

I think on a high level what we'd like to see, I think one the things is that I have worried about from the beginning is that if the payers' attitude is what have you done for me lately, I think we're going to be in trouble. We're coming from double-digit

inflation in the health care space and now we're talking about actual savings. And there are a lot of inefficiencies and there is a lot of opportunity to raise the sea level, but at some point it's only going to go up so much. We will have to, I think, accept the fact that there will be some growth for inflation, also taking into account -- again, Sean was actually quoting the exact figures. We know the Baby Boomers are really going to put a stress on the health care system financially and resource wise. So I think there has to be some dose of realism that the remarkable performance that we've seen early on, at some point that's going to regress to the mean to some extent. It doesn't mean we have to go back to double-digit inflation, but something realistic.

And then I think the other thing -- and this is just from Brown and Toland's perspective because we have been managing risk and our docs are used to it -- is we definitely would like to see the continued evolution for the opportunity to take on more risk and to get at that first dollar, which I think Sean was sort of alluding to. And it's not going to be for everybody, and I would caution anybody who was thinking about it to really understand your organization and your ability to handle that risk because it's not easy. When we get into questions, I'd be happy to talk about tactics and strategies that we're using -- sort of more into the weeds -- that seem to have been important to our success. But I think I'll leave it there for now.

MR. MCCLELLAN: Great, thanks very much, Marcus. So we've heard about results to date from the standpoint of a couple of the major organizations that are participating in ACO efforts in both the public and private sectors. And now we're going to hear from a couple of the experts on looking at the bigger picture across all of the ACO experience in the U.S. so far. So next up for that I'd like to turn to Michael McWilliams. Michael?

DR. MCWILLIAMS: So I'll speak more from a research and policy

perspective, as Mark said, and I'll comment on three things: Two challenges and one as far as results go.

I think one of the key challenges ahead from a policy perspective is getting the benchmarking methodology right, the spending targets for ACOs. Under the current model, the incentives for ACOs to generate savings are quite weak, particularly because of the rebasing that's implied by the current rules. So if an ACO achieves spending in one contract period, carrying the current rules forward would mean that their spending target or benchmark for the following contract period would be lower by that amount.

So to give you a sense of why that really diminishes the incentives, if you think about an ACO increasing spending during a contract period -- a Medicare shared savings Program ACO, for example, that isn't facing any downside risk -- they are penalized for doing that. It increases their benchmark for the following contract period and then they can receive a shared savings bonus for doing nothing. Under the Pioneer program, they are penalized for doing more, but, again, there's that offsetting effect by the benchmark going up in the subsequent contract period. So for Pioneer ACOs the incentives are more akin to fee-for-service with a lag.

Then thinking about the fixed costs of investing in systems to actually control spending, the rebasing is that much more of a problem because it may be hard for ACOs to recoup their investments of investing in the right systems. So that is one challenge. I know Sean and his team is working hard on a revamped proposed rule for the shared savings program.

Another challenge that's related is that unless ACOs have more control over where patients get care in the ACO programs, it diminishes the incentives further. To give you a sense of that, we analyzed outpatient care patterns at baseline among

ACOs and found, for example, that only 80 percent of patients that were assigned to one ACO in one year were assigned to the same ACO in the next. That's just over a two-year period. Among the high-cost patients, that number was even lower, about 75 percent. So that instability, that churn in the assigned population, suggests diminished returns on investing in specific patients. A lot of specialty care leakage, so even among the most specialty-oriented ACOs, we found that over half the specialty office visits were occurring outside of the ACOs.

And then something we termed contract penetration, the proportion of outpatient care revenue that's devoted to the patients under the risk contract, was only 40 percent in our study. So that suggests very weak incentives to roll out or implement changes that might spill over onto other Medicare patients. And we think that those spillovers are probably, likely -- for example, we found spillovers in Massachusetts from the Alternative Quality Contract, which is a commercial ACO contract sponsored by Blue Cross Blue Shield onto the Medicare population. So those are two challenges that require some rule changes, if not some developments, in the market like Medigap Select Plans oriented around ACOs to help sharpen the incentives.

And then thirdly, despite those weak incentives and the constraints that ACOs face, the results have been quite positive. I think there've been some fairly convincing reports of early savings. We have some results coming out soon demonstrating a positive impact of the Medicare ACO programs on patient experiences, including improved or more timely access to care, better overall care ratings among the complex patients that are more likely to be targeted by the care management programs, as well as patients perceiving their care to be better coordinated.

So from my perspective, I think overall it seems like a good start, but some need for some changes and new developments to make the program a true win-

win both for Medicare providers as well as patients.

MR. MCCLELLAN: Just one -- before going to David just one quick follow up. As stated as a research hypothesis, I think you're basically saying that if the new financial incentives created by an ACO program are pretty weak because of things like churn or shared savings and no downside risk and the potential for losing out on that contract in the subsequent year, you're not going to see very big effects. You have done some work as you mentioned with the AQC, the Blue Cross Alternative Quality Contract, which is I would think bigger in terms of those kinds of financial incentive measures. Have there been bigger effects there? Are you willing to say anything about whether doing more in terms of these kinds of strengths of incentives will lead to bigger effects? Is there evidence for that?

DR. MCWILLIAMS: So the AQC doesn't have that rebasing involved, so if an ACO is looking over a longer time horizon the incentives are certainly stronger. And I think that's true among most of the commercial ACO contracting. So there's a negotiated budget and it will stay there or there's at least no rule saying that it will get ratcheted down every time savings are achieved.

The AQC is rather interesting in that it was implemented in a very broad HMO network, so there are no restrictions or financial incentives for patients in the AQC to go to the participating AQC provider groups. There are, however, mechanisms because it is an HMO plan for providers to deny care outside because the patients need to have primary care doctors and PCPs can approve or deny referrals. Anecdotally, it sounds like the AQC groups, the provider groups, have successfully without those financial incentives been able to sort of corral care in and contain it within their provider groups. Many of those groups are quite large relative to --

MR. MCCLELLAN: And more effects on savings as well as quality?

DR. MCWILLIAMS: Right and so the other thing you see is real savings effects and real improvements in quality. So whether that's related to the stronger incentives or not I think just remains to be seen. It's Massachusetts, so that's also a potential difference.

MR. MCCLELLAN: Well, still need more research and I know, David, you've been doing a lot of work around the country on this. I'd really appreciate your perspective on what the research has shown to date.

DR. MUHLESTEIN: Sure, so I want to focus on three different areas. The first is the variability among ACOs. So when we talk about accountable care, it's often referred as somewhat of a homogenous group of providers. But, in fact, there's a lot of variability among them. There are ACOs that have 30 physicians and there are ACOs that have 30 hospitals. And as you can imagine, they have very different needs, concerns, and approaches to managing a population. And so what we're starting to see is that when you talk about accountable care, it needs to be subdivided into the different aspects of the providers that are participating. And the reason for that is because they really have a different glide path. They have a different opportunity to progress toward achieving the same common objectives. So if we want to provide better care, we want better patient satisfaction and lower costs, it can be achieved but with different provider types that are going to focus on different things. And they really should prioritize different things from day one. So one of the challenges is that many of the ACOs are focusing on Topic A when really given their individual structure, they should be focusing on Topic B.

The second area talks about the real challenge of becoming an ACO and managing populations. There are two, kind of core, broad groups of ACOs. Some of those have been in effect ACOs for a long time. They've been managing populations. They have relatively integrated services. They have somewhat developed HIT. And then

there are those organizations that have been strictly fee-for-service shops in the past and they're trying to make that transition.

What we found is that it's a long and hard transition to become a population-focused provider group. And so it's not that we expect organizations to make that transition over the course of the first year. It's not even something that's necessarily going to happen within three years. It's going to be an ongoing challenge. Some of the big challenges that they mention are obviously the HIT, what they should invest in and when. But probably the biggest challenge is just getting the provider buy-in. So you can imagine if you have a group of physicians that have been working on a fee-for-service basis for the past 20 years and you say now we need to focus on a population, getting them to change their practice patterns, getting them to work more as a team, getting them simply to change their referral practices, is a challenge and it takes a lot of time and effort. And so while we'd like to see results in the first year and have a good indication of whether ACOs are going to work or not, one year really isn't enough time if we're trying to evaluate the organizations that are trying to make that transition.

The third thing to talk about is the strengths of the different types of accountable care programs -- so Medicare, Medicaid, and the commercial. Medicare I really view as an enabling program. It has a relatively low threshold to entry, so a lot of providers are able to go in and start to manage or start to focus on population health in the short term. Also if you only have -- if there's no downside risk, there's not a huge financial barrier or disincentive to enroll. And so while there are startup costs, it's really a way to enable a lot of providers to start to bear risk and experiment with this.

On the commercial side we think of this as a program that allows additional resources to the ACOs. A lot of the large commercial PERs out there have a series of different contracts that they work with providers on. So initially they're not in a

full-risk bearing contract. They're not a full-blown ACO, but will do pay-for-performance bonuses. But it's a stepwise progression where over a period of years they help train the providers in the skillset necessary to manage a population. And so it's really a longer term track as opposed to just jumping in and being an ACO right away.

On the Medicaid side, this is really where I see there's a lot of opportunity for states to push the accountable care movement. And the reason for that is that they have a disproportionate ability to force providers into bearing risk. And so where we've seen these states that have a strong focus on accountable care, we're seeing a lot of activity both within the Medicaid space and also outside of the Medicaid space. As providers are being forced to consider becoming an ACO for the Medicaid program, they'll want to look for other opportunities to experiment. And so those where they're afraid that the Medicaid program will move that way, the providers, for example, are more willing to just enter into the Medicare program.

The last point that I would make is that ACO growth within a market does not happen by itself. There's very much a lot of strong market dynamics at play and you don't see an isolated ACO. When there's one ACO, all of the competitors in the market either form an ACO right away or create an ACO plan over the next few years. And so within individual markets, there's a lot of overlap in terms of the different providers that are participating and it really is happening at a market level, not just at the organizational level.

MR. MCCLELLAN: David, thanks for summarizing a lot of evidence and experience quickly. I'd just follow up on the point about states and Medicaid programs. So you mentioned a lot of activity, including some fairly significant reforms away from fee-for-service payment. Anything you can say about the actual results from some of those programs so far? They are pretty early.

DR. MUHLESTEIN: Sure, the one good example is Oregon. They have what we would consider to be the most aggressive tactic of moving their entire Medicaid population to CCOs or Care Coordination Organizations. They have seen generally positive results. They are mixed, but they are somewhat positive. There are a number of other states that are just starting this year to move their population or next year or even over the next few years and so really preliminary results, even earlier than the shared savings program.

MR. MCCLELLAN: I'd like to thank both of you for those research presentations and maybe go back to Marcus and our other Michael to get a follow-up sense from you about whether that overall summary of the national experience with ACOs to date fits with your own. You all are obviously not at that early basic stage of just starting to get provider buy-in and making some of the initial investments. You all are both organizations that have been at this kind of approach to patient-focused care delivery for a while, but you're different kinds of systems. Advocate has a hospital base involved and, Marcus, you highlighted that Brown and Toland is a physician group. Any comments on what you heard or points that you'd like to especially emphasize or clarify?

DR. ZACHARY: I think particularly that point about the fee-for-service transition and it being a painful one. Spending a lot of time in California I think sometimes you get a little bit isolated. We're surrounded by groups that have been in capitation, managed care, heavily so for a long time. And then when I have the opportunity to come out of the state and meet folks who really haven't managed risk, you really begin to get a sense for what that really means. You don't have any of the infrastructure that any typical organization, provider group, that I would encounter in California in other states where there's just fee-for-service or heavily fee-for-service. They've never had to adapt. They're never had to develop these services. And so

beyond what happens at the provider mentality level, for the organization that's supporting them there's a lot of work to be done and that takes a lot of time and a lot of investment.

But one point I do want to make, which I think is important, is as a physician one opportunity that I hope is not squandered in this is that the fee-for-service churn is so misaligned for the patient and the provider. There really is an opportunity here where folks can get the right care with the right person at the right time. Physicians, if they're willing to give up a little bit of their autonomy and work in a team-based approach, will be able to spend more of their time working to the top of their license and most importantly, spend a lot of time talking to the patients who really need them the most. I mean that's what really drives me, what really motivates me, to see this work through. And I'm fortunate that we've got a great group of physicians in our provider group. I think that more than anything has to do with our success, but that's what I really work towards.

MR. RANDALL: I'd just like to build on that, you know, David's comments on what does it take to change culture of an organization. So you've heard some examples shared in terms of physician culture. We, too, while we've had ten years of experience working with our physicians to improve quality to our clinical integration model, it's been a shift for our organization to now take a perspective outside of the four walls of our hospital. And to do that we created what we call an advocate care index, population-based measures that all of our senior executives down to the director level as well as on the physician side create alignment for the organization to move towards improving overall quality and cost of care, regardless of where that care is delivered.

And the physician office, the points about patient center medical home, supporting staff to practice at their top for a license, a cultural shift for our organization

has been actually physically placing care managers that we hire into independent physician offices. So that's a big shift in dynamics in that office space environment.

MR. MCCLELLAN: And back to Michael's comments about the shift in your financial support to make those kinds of business models sustainable, I expect there's some challenges around especially being a hospital-based system where a lot of the revenues have come from the kind of procedures that Michael was highlighting is maybe that revenue getting in the way of making some of these changes. How have you dealt with that?

DR. MCWILLIAMS: Clearly the model needs to move towards taking costs out of the system and that is through -- I think there was a comment earlier about evidence-based practice, reducing unnecessary use, so that's a component of it.

There's also a component of how do we achieve greater economies. Part of that is scale in terms of an organization, but also looking at greater efficiencies in terms of systematic change, marketing services, human resources, those types of aspects, supply chain. So we're on a three-year journey to take out about 2 percent of operating costs each year to make sure that the model is sustainable.

MR. MCCLELLAN: I'd like to open this up to discussion from the audience as well. So there's a question in the back.

QUESTIONER: Hi. Josh Seidman from Avalere Health and the Avalere Center for Payment and Delivery Innovation. Dr. McWilliams, I was interested in the comments you were making about beneficiaries of experience of care. I'm curious if you, also the providers from the groups, have any insight into whether some of the incentives in the sometimes critiqued CMS approach to beneficiary attribution and assignment are having an impact on how you're engaging beneficiaries.

DR. MCWILLIAMS: So it's hard to know from the empirical analyses

we've done what's specifically mediating the changes in patient experiences that we observed. As far as the mechanisms for patient engagement go, I doubt they're playing a big role. My understanding is that most Medicare beneficiaries are unaware that they're even in an ACO. They get this letter about data sharing that some are confused by and some throw away and some opt out of. But the patient experiences that are in the quality part of the ACO contract are very much more along the lines of CAPS measures, overall ratings of care and physicians and how access to care is -- whether physicians are interpersonally connecting with them, whether they think their care is coordinated. Those are things that I think the ACOs are probably impacting more through the systems that they're putting into place, whether it's new scheduling, referral access systems, care management programs that are really focusing on the needs of the complex patients, rather than anything going on between Medicare and the patients.

Now, this does beg the question, though, how will patients view the Medicare ACO programs. I think certainly one concern is that if patients do not like the brand of care that ACOs are providing, then that would not bode well for the programs because they are voluntary and that could lead to market share losses and maybe discourage groups from staying in the programs.

MR. MCCLELLAN: Michael, Marcus, how much do your patients know that they are a part of accountable care arrangements or are they just experiencing care differently for other reasons?

DR. ZACHARY: I think it definitely varies and there's truth in that there are beneficiaries who probably don't realize that they're in the program. Patient engagement is definitely a key element that needs to be executed on to be successful, and we also participate in some other CMMI innovation projects like IOCP. So I've had a lot of discussions with other provider groups and it's interesting. The Medicare

population is not one-size-fits-all, that there is regionalism even down to the level of certain cities. So for our group, reaching out sort of cold-call style to beneficiaries was not well received, whereas in other communities that was acceptable and they were able to get patient engagement. So we've generally had to kind of circle back around to our providers and work through those offices to get to those patients.

I think to your comments as far as patient experience goes, I think that we have put a point of emphasis in the provider groups for patient satisfaction. They get scorecards every quarter. It's part of their bonus incentive program. So there has been some attention and some improvement there, but a large part is, as you were saying, you're creating a large organization behind the providers and the patient experiences all of that and that is generally good. So that's a good thing that's coming out even if it's not directly coming from Medicare or directly coming from the provider's office per se, the patient is still benefitting.

MR. MCCLELLAN: And, David, you highlighted the different types of ACOs and how that might mean different steps that they should take to achieve some of their goals, presumably better patient experience is a key goal for all of them. Any comments about differences that you're seeing in how they're approaching the challenge of more effective patient engagement and experience?

DR. MUHLESTEIN: One observation is that I agree with Michael that there is not really that focus on telling them that they're part of an ACO, but it's really that benefit that they view by what is the provider serving. So they say we're going to provide additional care coordination. We're going to provide enhanced access with primary care. But it's not saying you are part of an ACO now, so that's not the marketing strategy.

Across the groups it really does vary, and it also varies across organizations. Some really don't put the patient engagement as a high priority. Others

are trying to build their entire strategy around that, so a lot of variability across organizations.

MR. MCCLELLAN: Thanks, next question up here and then in the back.

QUESTIONER: I'm Dr. Caroline Poplin. I'm a primary care physician and an attorney and this is actually a follow-up question. I'm perplexed by the fact that the ACOs, many of them, are getting high satisfaction ratings and you're also having trouble with churn, that people are drifting outside the ACO. And usually sick patients who are happy with their care -- what they're concerned about is being forced to change their provider rather than -- they want to stick with providers who know them and that they know. So I would think that would reduce churn relative to a sort of wide open fee-for-service, and I'm curious about who is drifting away and if you've looked into why.

DR. ZACHARY: I can address that. So what we're talking about is the attribution methodology and the joke I have is that attribution is the longest four-letter word in health care right now. It's an evolution in terms of how much data is being used into the methodology and the logic, and I think that fundamentally is the issue at hand. And so what we experienced at Pioneer over the first two years is about a 30 percent turnover rate between people going out and people coming in.

And I get, Doctor, the question that you're asking, and it's not as simple as that and it's not just about the relationship between the patient and the provider. It depends on, for instance, what doctors you put into the attribution model. So, for instance, we have 1,700 physicians in our network, but only 300 of them are part of the Pioneer ACO and that was a strategic tactical decision that we made. So that's one aspect of it.

There were some rules in the beginning about visits, how frequently they were occurring and if they weren't occurring, you would lose the attribution. So that plays

a role as well. And actually we found that for folks who aren't technically attributed to us, they're still going to see our physicians. They're still connected in our network. And that's not going to be true for say, Orange County, where there's a tremendous amount of competition, more provider groups competing. The Bay area, San Francisco, is a little more concentrated. So there are a number of factors that go into it and I wouldn't take what you're hearing as an indication of dissatisfaction from patients. It's more about the attribution methodology.

MR. MCCLELLAN: Other comments on this? I know the attribution methodology and this issue of relationship to churn and the relationship of churn to beneficiary dissatisfaction is an important area and I know all of you have thought about this.

DR. MCWILLIAMS: I might just add that if there is increased satisfaction, then it may very well decrease the churn. I don't think we know that. We don't have a good handle on that, but there may be a sizeable effect from that.

And I'd make one other point, which is that I think sometimes the knee-jerk response is to fix the attribution methodology, but that probably won't accomplish a whole lot without addressing the fact that beneficiaries assigned to an ACO have unrestricted choice of providers without any incentives to direct them back to the ACO providers. And we just know that there's tremendous care dispersion among beneficiaries in part for that reason and that's sort of what the ACOs are up against.

MR. MCCLELLAN: Other comments on this? Okay, great. We have a question up here. I haven't called on the front of the room much yet.

QUESTIONER: Hi, Morey Menacker from Hackensack. I heard Sean discuss very, very briefly information and his comment was that monthly they were supplying claims data to the ACOs. But we all know that the claims data from CMS can

be up to be 12 months delayed. So even if you're getting it monthly, you can't accurately predict what's happening with your population and make changes.

Now, we've had some brief discussions about health information exchanges and data sharing, but it seems clear to me that the successful organizations, either ACOs or not, are able to share clinical data and be able to make appropriate decisions based upon that information. But yet the government, with all its regulations, has absolutely no regulatory oversight over electronic medical records and transfer of information and it sort of left that to the private sector. And the question is is there a mechanism that we can utilize to improve data sharing to be able to really change our ability to quantify best practices and minimize wasteful spending?

MR. MCCLELLAN: I do think we're going to come back to policies, new policies, around information technology and data sharing later. I would like to ask -- both Michael and Marcus emphasized the importance of information technology in everything that they're doing, but what is the state of the research evidence on the extent to which better access to data, whether it's through health information exchanges or other areas, translates into greater success of the ACO efforts, or is that just another area where the research is limited? I'm asking David and Michael to start on this one.

DR. MUHLESTEIN: So this is more observational data. The first is that information technology is still very much a work in progress with most organizations. Most of them have an EMR that works. They're able to look at patient-level data. Being able to aggregate that to a population and track that overtime is more challenging. There's a lot of investment right now going into predictive analytics and care management platforms, but, again, whether or not they're choosing the right platform or they're doing it at the right time is still to be determined. So there's a lot of kind of push and pull among ACOs about how they're going about this.

One other observation about information exchanges is that the primary focus of the organizations is sharing information within the organization as opposed to sharing between organizations. The focus is trying to keep people in network and communicating between people that are "on the same team." And so the focus right now is how do you make sure that your outpatient is talking to your inpatient, particularly when you might be on different EMRs? We know of ACOs that have over 20 different EMR platforms that they're just trying to integrate and speak amongst themselves, let alone trying to bring in all the other outside platforms.

DR. MCWILLIAMS: I would just add quickly that it's a major research challenge. I think the data that David's group, for example, is collecting will be a major contribution to allow really rigorous analysis on that front.

MR. MCCLELLAN: And Michael and Marcus, any final thoughts on working effectively with CMS data?

DR. ZACHARY: We've spent a lot of time working with their actuaries trying to sort of solve the black box.

I think one last closing comment I would want to make is value-based purchasing is here. There was a lot of handwringing back with the election and the Supreme Court case. But by that point, particularly with deals like what DaVita did, it's very clear the marketplace has spoken. Folks that are doing fee-for-service now have got to start changing their ways because this is coming. It's in Medicare fee-for-service, it's in commercial now, and so it is imperative for their survival really that they start making the changes we're talking about here today.

MR. MCCLELLAN: Any other final thoughts from the panel? It is a fast-moving area and fast-moving attention around value-based payment. It is a very challenging area for the research to keep up. We very much appreciate the discussion

that all of you had about the state of that research and its implications for further steps with ACOs.

So I'd like to ask all of you to join me in thanking our panel for an excellent discussion. We are now going to take a short break until about 10:45 when we're reconvene with our next panel on big issues for ACOs going forward. As you can tell, there are a number of them. Thank you.

MR. MCCLELLAN: All right. I'd like to welcome all of you back to our event here at Brookings on The State of Accountable Care. We've had a chance to hear this morning already from Sean Cavanaugh, a CMS perspective on where accountable care is headed, and a panel of expert researchers on the evidence so far about accountable care. We're now moving into our next panel which is more an on the ground look, an on the ground set of perspectives on big issues for ACOs going forward. So we've talked a lot about the national context, what we want to do now is turn to some of the major challenges on the ground for existing and new ACOs as they implement changes in practice, as they move forward on engaging and activating patients, as they take steps towards the culture change around improving care and a focus on value as you heard in the earlier remarks this morning. In those panels there's a big emphasis on patient experience and patient engagement, about some of the challenges to that based on both the way that Americans have historically gotten their healthcare and the challenges related to the fee for service payment system. On the other hand patients are and have been a bit skeptical about being engaged in payment reforms that are in the name of improving quality, but too often end up seeming more focused on reducing costs through reducing access. So the set of issues around challenges for ACOs success are definitely focused on some of the challenges around effectively working with patients in

new ways, in these new kinds of care models.

Just briefly I've highlighted engaging beneficiaries as a key challenge facing accountable care today. Related to this are issues with payment formulas, paying based on quality and cost is different than paying based on volume and intensity. As you heard earlier the methods are evolving and may not be aligned as well as they could be with some of the key goals of better care for patients at a lower cost. We talked about bearing financial risk. On the one hand the advantages of moving from shared savings to more of that first dollar ability to redirect resources to improve care and lower cost, but also some of the concerns about skimping or access to care that come along with those kinds of larger shifts. Managing start up costs has definitely been a key issue. We heard about some of the new steps underway to help address those challenges for organizations that especially are smaller and don't have a lot of resources in house. Better data and performance measures, ways of combining accountable care reforms with other reinforcing payment reforms like medical home changes and other kinds of value based payment reforms. And then finally identifying best practices for clinical transformation. This is hard work as you've heard and the best step forward for a particular organization depends very much on its market circumstances, its own characteristics, and the best opportunities for improvements with their patient population.

All this makes being an ACO a challenging task to undertake. And we've got a panel to discuss some of these key issues related to accountable care organization success going forward. This includes -- I'll introduce them now then we're going to hear from them -- Jennifer Sweeney, the Vice President of the National Partnership for Women & Families where she works with foundations, Federal government leaders, healthcare providers, community based organizations, consumers, and others to develop and implement strategies for improving the quality, safety, efficiency, and patient and

family centeredness of the healthcare system. Jennifer has extensive experience with multi stakeholder engagement in processes intended to achieve these goals and a deep knowledge of delivery system models and quality improvement strategies aimed at more patient centered high quality healthcare. Next is Kelly Taylor, the Clinical Director of Quality Improvement for Mercy Clinics in Des Moines. She received her BSN and MSN from the University of Iowa. She's nationally certified in case management with over 15 years of case management and disease management experience. And there in De Moines she's getting some firsthand experience with some of these challenges and opportunities around not only case management and disease management, but engaging patients more effectively in their care. And finally Morey Menacker, the President and Chief Executive Officer of Hackensack Alliance accountable care organization. Morey's been a member of Forest Healthcare Associates since its inception in 1997 and he worked there on implementing a comprehensive multidisciplinary approach to help patients become partners in their own care and wellness and is very much engaged on the ground in trying to implement some of these ACO reforms.

So I'm going to start out as we did with our last panel asking our panelists to make some opening or framing comments and then we'll have a back and forth discussion. Jennifer, I'd like to start with you please.

MS. SWEENEY: Sure. Thanks for having me. I enjoyed this morning's presentations. So I work for the National Partnership for Women and Families who are here in Washington. We are a consumer organization and we've been around for more than 40 years working on healthcare issues including system deliver reform. And as a consumer organization we have historically been supportive of new delivery models that have the potential to lower costs, to improve outcomes, and to improve patient experience. So I think from the beginning we've looked at ACOs as a potential benefit to

consumers and to patients.

I think though like the provider community, from the beginning we've also had some concerns about ACOs and you touched on some of them, Mark, in you remarks. I think the two biggest concerns we've had is that this would sort of devolve into just a financial mechanism instead of ACOs taking the opportunity to really transform care clinically. I think the second concern we've had is on the issue of patient engagement. Sometimes when people talk about patient engagement it sounds like what we're really looking for is patients to be better patients versus looking at an opportunity for healthcare providers and ACO leaders to really partner with patients at multiple levels. And I'll go into that in a minute. So as we look across I think today's landscape of ACOs, some of the other speakers on the previous panel talked about the variability. We see variability as well in terms of those two areas. We think some ACOs are really looking at this as an opportunity to transform care clinically; some are really looking at this as an opportunity to partner with patient versus getting them to be better patients. But my sense is that a lot of ACOs have also sort of shelved those two issues. And I understand that I think to some degree. You know, there's a lot of challenges in starting up a new business model, the financing, the measurement, the attribution, but as I look forward into the future in my mind representing consumers and patients this model won't realize its potential without the focus on the clinical transformation and the patient engagement.

So I'll just take another couple of minutes to talk about the patient engagement piece. I think, you know, there's four levels that we see patient engagement. First is at the direct care level in things like shared decision making. Second is at the governance level. And it's interesting to me when I talk about this with ACOs about, you know, including beneficiaries on the governing bodies of ACOs as a way to help the ACO understand what it is patients need and want from an ACO I think

I'm seeing a lot of confusion about that and frankly lack of interest which is concerning to me. The second piece is partnering with beneficiaries and patients at the design level. So we know that some ACOs are doing a really good job of not just surveying patients about their experiences in the ACO, but then they're forming patient and family advisory councils and working with those council members to co-design care that really meets their needs. And then the other level I would say is also the community level. I think in my experience ACOs, but healthcare providers in general don't partner with community based organizations like Meals on Wheels, like the Area Agency on Aging. Those are critical to doing transitions well, among many other things.

The last thing I want to speak to is this concept of, you know, whether or not patients will stay in an ACO and how we help them understand that they're in an ACO. And one of the things I'm hearing recently is this concept of marketing to patients about an ACO. And I really think that's a misguided approach. I really think we need to take a building awareness and an education approach instead. This isn't a sales pitch. Patients don't need to be sold on ACOs if they're getting that patient centered care that they need and want and if they're being partnered with at all four of those levels.

So I'll stop there.

MR. MCCLELLAN: Thanks very much, Jennifer. Kelly?

MS. TAYLOR: Good morning. My name is Kelly Taylor and I'm now the Director of Quality and Care Management for the Mercy ACO. So Mercy Clinics has traditionally for the last 12 years really worked on care transformation, focused at the primary care level. In February of 2012 we became an ACO and on 1/1/15 we'll have over 200,000 patients and about 1,800 providers. So we've had rapid growth and that's one of the big challenges I think to really sustaining this. We have been successful as an ACO, surprisingly so. I think one of the things the data puts you on is this rollercoaster

because in our interim report we did not save enough monies for Medicare. In our final we did by a lot. And so with that it kind of was the accumulation of a really good year for us both in the commercial setting, the governmental setting, and then also with our own employers, our own employees. So we have a big initiative in working directly with employers now going on as part of this work.

I think part of the reason, kind of taking off on your comments, doctor, about that this is here and it's here to stay, I think one of the reasons we were successful is we've kind of been saying that my leader, Dr. Dave Swieskowski, who many of you probably know, has said that for 10 years. We've been planning and working towards this for 10 years. And I would just add to it that for those of you that are in 100 percent fee for service world like we are in Iowa you don't have to wait. You can do it now and you can make it work in a fee for service world as well. Ten years ago we did some fairly inexpensive things in terms of implementing disease registries which are a heck of a lot less expensive than EMRs and you can get an immediate return on investment with them. And we embedded health coaches in our primary are clinics. And in a fee for service world that more than paid for itself. I didn't have to have a growth strategy for health coaches because once the providers realized that this was good care, they could be successful and pay for performance and they made a little money on that, you know, in a fee for service world. And no the same group of wonderful nurses are leading us into the value world. So the same things that they've been doing all the time, working with patients, focusing on quality, working with them on the issues of medication adherence, of self management support, finding out from them what's important to them, what do they want out of their healthcare, and helping the reset of the care team then implement those importances and desires has really been I think what has made us successful and I think is going to take us a long way into the future as well.

MR. MCCLELLAN: Thanks, Kelly. Morey?

MR. MENACKER: Thanks for inviting me today. A little bit of background. I've been a practicing internist for about 30 years and also the Director of Population and Health for Hackensack University Health Network. In that role I initiated and was assisted by the hospital in developing our ACO. We were in the first group in 2012 for the MSSP program.

We looked at it a little bit differently. Our philosophy was we're going to use this as a clinical laboratory; we were jumping into the value based reimbursement scheme. And so we decided to limit to primary care physicians, to mandate patient centered medical homes for all of our primary care offices, that we bore the cost of all of the training for the patient centered medical homes. We mandated electronic medical records and we purchased a relatively strong population health electronic health system which EMRs fed data into. This was all up front monies that the hospital surprisingly enough was willing to invest in this organization. We started with a little over 12,000 MSSP patients, with a little over 50 physicians, and I'm happy to say we saved in excess of $10 million on those 12,000 patients.

Now I also agree that this model is not the model for everyone and that there are many models out there. The end result is what counts and we all want to get to the same point, and clearly our paths will all be different. We chose somewhat I guess we consider to be innovative projects, demonstration projects which helped fuel our success. Number one is we invested heavily into nurse navigators. We embedded them in each of the practices. Therefore they were there to see the patients during their visits, to develop a relationship with the patients that the physicians may not have had time to develop, to call the patients on a regular basis, especially the high risk patients, and to intervene when necessary as the first line of defense when one of the patients wasn't

sure which medication to take or should they go to the emergency room, et cetera, et cetera. We were able to cut down our readmission rate dramatically; we were able to cut down our emergency room rate dramatically. The only thing that went up in our database was primary care visits. And once again not necessarily perfection, but I think as a clinical study it was shown to be effective. And once again the reimbursement and the savings bears out that case.

We also initiated some relatively interesting demonstration projects. We identified our congestive heart failure patients who were having problems with frequent readmissions. We did something very simple, we put scales in their house that automatically sent their weights directly to the doctor's electronic medical records. Not a very expensive proposition. As soon as it was greater than a one pound change in each of these patients they got a phone call to find out what had changed and whether or not they were being non compliant with either medication or diet or what changes had occurred. And in patients who routinely would have four, five hospital admissions in a year, we were able to keep them out of the hospital by intervening at that level rather than waiting for the patient to identify that they were in extremis and then the doctor would say go to the hospital. And we also started a demonstration project with electronic tablets for these elderly patients preprogrammed with their medications as a medication calendar. So the tablet would give a ring when the patient was required to take their medication. The patient was required to press the button on the tablet that they took the medication. Once again directly connected to the physician's electronic medical record so we could monitor compliance on patients that were taking multiple medications on a basically a daily level, not waiting for claims data to come back from CMS.

And we also initiated a program where anytime any of our patients, the ACO attested patients, would arrive at any hospital facility, inpatient, outpatient,

emergency room, urgent care, an automatic notification went to the nurse navigator. So they became aware that the patient was entering the system. So if a patient shows up at midnight on Sunday on the emergency room and the emergency room doesn't have access to the patient's medical history which is on the EMR that doesn't connect to the hospital, the nurse navigator can contact the emergency room, hopefully know the patient or has access at home to the electronic medical record, and sort of navigate that patient through the system or contact the physician to intervene. These were small demonstration projects we did with a few hundred patients that once they became successful the hospital network said let's roll this out entirely.

One other thing that we did which was hugely successful was that every ACO patient upon discharge from the hospital received all of their medications prior to discharge. We have an outpatient pharmacy as well as an inpatient pharmacy at our hospital. Patient is given all the bottles of medication, instructions, told to go home, throw out every pill that they have in their cabinet, start with the new medication, see their doctor in 48 hours. We believe that this had a major effect on limiting readmissions based upon confusions, patients not filling their new prescriptions, patients not knowing to take the new medicine, the old medicine. And we've rolled that out to our entire hospital which is 750 beds after we'd shown the benefit through the ACO. So it's sort of the partnership that the ACO has with the organization and trying small demonstration projects on a local level and then rolling them out to our patient network in Northern New Jersey.

MR. MCCLELLAN: That sounds like that's continuing to move forward. Both of you actually it sounds like you've had fairly positive experiences with accountable care efforts so far.

I'd like to connect that back to some of the comments earlier today in

Jennifer's opening remarks. As we discussed earlier the evidence does show some mixed results, especially when it comes to what people might characterize as true care transformation. And, Jennifer, I know you expressed concern about ACOs just being a financial model and not really being the facilitator getting to truly better patient center and care. There are some organizations though that seem to be moving down that road and I think we've got a couple of examples here with us this morning. Just to push on your comments a bit more how can we best support real changes in care delivery, real systematic changes in how patients are part of these potentially beneficial care systems and separate that out from the organizations that may just be putting a toe in or not really getting it yet?

MS. SWEENEY: Well, I think it goes back to the four levels I talked about earlier with really partnering with patients and beneficiaries at those four levels. So a couple of more examples. We've seen where some ACOs have actually gone and done home visits with their higher cost patients to understand the barriers that they're experiencing at home, whether that's to fill medications or to get to appointments. You know, I think that's really key, that's really getting at that patient centered cared that patients need and want. I think going back to what we talked about earlier with sort of helping patients understand the benefits of an ACO -- and I know this is a little bit more complicated in the Medicare space but, you know, I think there's a lot of documentation you can send to patients, you know, a welcome packet, a frequently asked questions document. But the ACOs who we think are doing the best job are the ones who assign care coordinators and case mangers to have actual conversations with patients about what the ACO is, you know, what the benefits are for them, what care will look like for them in this ACO. And that's taking it that step further than just sending home a piece of paper. I mean we all -- you know, we all have too much paper in our lives. I think we

need to have more conversations in healthcare. I think also it's -- you know, it's all the things that we know patients care about. It's materials written from the health literacy perspective, it's starting discharge planning at admission, it's really connecting patients with the services in their community that they're going to need to rely once they've left the ACO. And those are just some of the examples that we're seeing that ACOs, you know, who are really looking at doing a patient centered job of this are spearheading.

MR. MCCLELLAN: Now the evidence base is starting to get better on what kinds of interventions can be undertaken feasibly by ACOs to get that kind of progress with patient engagement, but, you know, from your comments and Kelly and Morey, your comments as well, I mean this sounds like hard work. There are a lot of things that could be changed for the better. You've got limited time and resources and, Morey, even though your organization -- I guess, you know, Hackensack essentially fronted the funds necessary to try out these specific reforms and expand the ones that work. That makes a lot of sense as a model, but it does suggest this is going to take some time, there are going to be some failures and bumps in the road along the way. Are there steps either through better evidence sharing or other policy steps that could accelerate that? That could make the work that you're doing or trying to do go more quickly, maybe happen at a faster pace?

MR. MENACKER: I think that you hit the nail on the head. And that is we once again started with a small group, basically a clinical laboratory. The question is where's the benefit to jump into the pool rather than just sticking your toe into the pool? Hospital organizations, very large physician organizations, are dependent upon the fee for service dollar right now to pay their bills right now. And there needs to be enough of a carrot at the end of the road to make organizations willing to sort of hit that tipping point and say we're going to jump in whole hog on value based. Now for example, you know,

there are certain sticks that CMS is using such as, you know, the decreasing reimbursement or the penalty for not hitting certain quality metrics for hospitals, but the carrot at the end isn't there. And I think we've already had discussions about that, how from a standpoint of the shared savings program there's not enough benefit on the back end to really make a concerted effort to drive everyone into a value based system. And I'm not sure how we're going to get to that tipping point, but I'm not sure it's even going to be an ACO. It's going to be something, whether it's the bundled payment program that we're doing, the ACO program that we're doing, Medicare Advantage. You know, we talked about that. Medicare Advantage has a fixed benchmark that you're working against. If you're going to sit there and say I can either put my patient in Medicare Advantage or put them in the MSSP, where am I going to get more bang for my buck, I don't know what the answer is but it most likely is going to be Medicare Advantage today. We're waiting to see what Medicare comes out with with the new regulations. And so I think that that idea has to pervade a lot of the decision making here I Washington because the idea is great, we've got to move in this direction, but the devil is in the details.

MR. MCCLELLAN: Kelly, anything you'd like to add about how to make more progress faster?

MS. TAYLOR: I don't know that I have the answers, but I can certainly tell you that's the world we're living in right now. Having two feet in both worlds is very stressful as an ACO. Having had success in it I think has helped us leverage at least getting in the room and getting to the meetings and talking to people more about it, but it is very difficult. And the fact that it took us until now when we started in July of 2012 in MSSP to get to this point. In the meantime we've had to cut some staff, you know, we've had to level set. We keep talking and we keep pushing forward and I think that's just kind

of the culture and the philosophy that we have had at least in the quality department, you know, for a physician setting to always think that, you know, if I'm doing whatever is beset for my patient then I'm doing what's best for me and for our system. And so that's just kind of been the consistent message for a decade. And I think that that really makes a big difference and it certainly gives us reason to keep moving forward, but again I would say, you know, that this isn't something that you have to wait for to do. If you're in a fee for service world you can start to learn how to do these things and have a positive business case for doing that.

So I guess I'm more focused on that than I am -- I'll let other people come up with the answers.

MR. MCCLELLAN: Yeah, you definitely seem like a glass half full kind of person. Yeah, go ahead, Jennifer.

MS. SWEENEY: So one of the things that I'm not seeing with ACOs is a collaboration typically between consumer organizations and ACOs. And I think it's because you all are -- you know, ACOs are doing a lot of work right now and that makes sense, but, you know, consumer groups have expertise when it comes to communicating with patients and families. And, you know, my organization in particular has expertise around performance measurement and re-design from a patient center perspective. So I think one of the messages I would share is that we're open to working with ACOs to figure out some of these problems and to lend a hand where we might be useful.

MR. MCCLELLAN: And you're starting to get some experience in actually working with ACOs on some of these issues. You want to comment on that at all?

MS. SWEENEY: Yeah. Well, you know, we've worked -- I mean, well, one we've done a lot in the policy arena around patient centered criteria and then also we

have a coalition where we comment on anything that comes out of CMS. But we've also worked with some of the pioneers and others to help them to two things. One, find beneficiaries to engage in their governing bodies and then ensure that those beneficiaries engage effectively, but also we've helped some of the ACOs build patient and family advisory councils that they can then collaboratively design care to really truly meet the needs of patients and families.

MR. MCCLELLAN: Very interesting. I'd like to ask for those of you in the audience any comments or questions for the panelists? I'll start up here in the front.

MR. RABINOWITZ: Thank you. Very interesting. Davie Rabinowitz. And the whole issue of healthcare, and especially the Affordable Care Act, has been heavily politicizes. And I'm wondering if you're feeling any of the influence of these politics on your patients, especially their acceptability of ACO or whether they're even interested?

MS. TAYLOR: From a Central Iowa perspective I have to really admit that we have not done marketing of the ACO to our patients. We just try to provide them, you know, good care and high quality care. So we haven't really gotten into that perspective, but I think that for us we haven't really seen push back from our patients at all. There's always a few patients that don't want their information shared and that type of thing, but really the patients that I talked to, they are just focused on getting good care and very much appreciate the efforts. In our advisory groups this is what we hear. And I would love if we could do satisfaction surveys only on those patients that are worked with by our health coaches because it's always just, you know, a great relationship and they really feel -- they feel I would say like it's about time that they were taken into the picture. You know, most patients want to be part of what's going on in their life and I think it's a big reason why we've had issues with low medication adherence or low quality outcomes.

The patient is really the missing piece in this.

MR. MCCLELLAN: Kelly, you are living in one of the definitive political battleground states --

MS. TAYLOR: Yes, yes.

MR. MCCLELLAN: -- this year and it sounds like that hasn't really had a direct impact on -- for all the controversy around the Affordable Care Act it hasn't really had a direct impact on the steps that you're taking and the reforms that you're implementing.

MS. TAYLOR: Yeah. I would say that initially the push back was more from the physicians and other folks in the healthcare in our organization that, you know, didn't really think this was going to stick, was just, you know, another project that, you know, Kelly was working on type thing. And others, not just me of course. But, you know, it is now to the point where I think most of the leadership in our healthcare system really does believe that, you know, this is where things are going. And the nice thing is that being part of a catholic institution, you know, this fits right with our mission and our values. So now finally we can talk the talk in terms of mission and values as well.

MR. MCCLELLAN: Morey, you've got a pretty well known governor and a pretty blue republican governor (laughter) and a pretty blue state, but New Jersey has actually been taking some I think fairly bipartisan steps towards accountable care and its Medicaid program and the like. What's your experience been with the politics of this?

MR. MENACKER: Well, interestingly enough I think it's working the other way around in that as the data came out from CMS showing the successes of certain ACOs the politicians tended to gravitate towards those organizations to sort of show their interest in the healthcare debate. And it's given us an opportunity to educate our elected officials to the problems and to what we thought would be some potential

solutions. So I think that the publicity is a good thing because it's putting it on the front page as opposed to deals being made in the back door and those of us who are actually the providers of care having to deal with decisions that were made without anybody's input.

MR. MCCLELLAN: Other questions? I think in the back here.

MS. HEINRICH: Thank you so much. This has really been very interesting. I'm Jan Heinrich; I'm with CMMI/CMS. You all mention some very interesting approaches that are focused more on team delivery of care and my question is how are you paying for it? So we heard about the nurse navigators, you have health coaches, we're bringing the patient in as part of the team, in the prior panel we talked about community health workers. And is there an effort to really document how we're using our workforce differently? But really important, how are you paying for it?

MR. MENACKER: I'll start with that. And basically our hospital network is fronting the cost as they would for any other new program. Now the question becomes, you know, how do you determine whether or not there's appropriate profit on the other side of the ledger? I mean clearly there's benefit. The question becomes, you know, can you show that it's worthwhile in the long term. The problem is that there are very few hospital organizations that run a cost based healthcare accounting system. A physician's office, a physician organization can tell you where every dollar is spent because every dollar is valuable. If you walk into pretty much any hospital in the United States and ask them what it costs to perform a gallbladder surgery because you want to pay cash plus 20 percent nobody will be able to tell you. They'll tell you what they charge but they won't be able to tell you the cost. So my argument to the administrators were this program is going to be successful and you have to, you know, let us run with it. Now what we did as an offset because of course the bean counters didn't just take my word

for it, was that we involved our employee health plan and we created a management structure for our employee health plan so there was cost savings on that side as well as the bundle payment program. The bundle payment program which was initiated by the hospital required an infrastructure for management. We actually are participating in more bundles than any other hospital in the country. And so therefore I said to them I'll also do the clinical management of that as well. So, you know, the short answer is this is being privately funded by our institution. The long answer is I think in the long run there's an awful lot of benefit to the hospital and even just the PR that they've received from us, you know, saving money in the MSSP program is money well spent.

MR. MCCLELLAN: Kelly, any thoughts on this topic?

MS. TAYLOR: Yeah. You know, kind of the same thing. Our hospital has made the initial investment in our ACO and we are projected to have losses for a couple of years. We were really honest about that. And, you know, didn't quite turn out that way. We're having some good success. One of the things we've done it the past is partnered with other people. We've aggressively gone after grants. We just got a grant from CMMI to spread health coaches and disease registries throughout all of rural Iowa in our critical access hospitals and rural primary care networks. So, you know, we try a lot to try and find different things like that that then can help us build the case. That coupled with I think in our market knowing our competitor was jumping right in was a big reason of course to do it as was talked about earlier today. And then again just kind of going back to mission. You know this is really what our Board of Directors -- this is how they directed us. They absolutely jumped in with two feet and have supported it ever since. And I think in the long run it will be -- I mean again it goes back to if you're doing the right thing for patients you're doing the right thing for yourself. Whether that's at an individual physician level or at a, you know, statewide ACO level.

MR. MCCLELLAN: Let me ask you if you all feel like I guess the quantitative business case is getting clearer and better for these kinds of reforms? I mean I get -- and we hear this a lot around the country, especially at organizations that are committed to this goal of better patient experience and more person focused care and hopefully getting savings at the same time, are just going ahead with what they think are the best opportunities to do that and they're either funding it themselves or if they can get a CMMI grant or a foundation grant, they're taking those steps. But that by itself is not really a sustainable long-term business model. I mean you heard Dr. McWilliams talking earlier about a kind of conceptual approach to think about for specific areas of care. You know, what the implications for net revenues would be of different kinds of payment reform models. That's hard to calculate across the board and not only that as you pointed out other healthcare organizations just aren't set up to calculate cost versus new revenues this way because they haven't been paid this way. But is it getting better? Are you finding it easier to make the business case? Do you have better data that you're actually able to bring now compared to several years ago or is it more still in the realm of well, you know, we've been doing this for a few years now and so far it's turned out okay so let's just keep doing what we're doing? Is it getting more systematic?

MR. MENACKER: Well, I'll tell you from our perspective it's a multilevel answer. Number one is we can't keep doing business the same way we're doing it. That's clear. Number two is if we're successful -- and I'm not talking about us, I'm talking about the healthcare system, is successful, there are going to be less hospitalizations and more than likely less hospitals. And so hospitals are going to have to think about their business and their business model in a different way. So a hospital like mine which was willing to make that investment, was basically looking and saying how are we going to be able to change our business model? Is this a direction that's going to make us

successful in the future? And I can't speak for administration, but so far they've been very supportive of every effort that we've made, not necessarily just with the ACO, but in population health as a whole, changing the way that we provide care. Quick example, I requested a computer program for appropriateness documentation for radiology procedures in the hospital. As we all know anybody on the outside that's not a Medicare patient needs to get an authorization for a significantly expensive diagnostic test. The result is doctors admit patients to the hospital and do every diagnostic test they can possibly think of while they're in the hospital regardless of diagnosis. We just purchased a program which sits on our EMR that basically blocks orders of anything that's not indicated based on the American College of Radiology. Now this is not something that is going to be an upfront win for the hospital, but they see it clearly as a long-term gain to them and I see it as a benefit because it's going to change physician practice patterns and therefore is going to bring doctors more in line with population health thinking.

MR. MCCLELLAN: Thanks. I think we have time for one more question back here. We want everybody on line to get the benefit as well so hang on just a second.

MS. O'KEEFE: Hi, I'm Teresa O'Keefe. I'm CEO of My Body Count and we've created a consumer health score. So I'm very interested, and, Kelly, I thought you said that you work with employer populations? Because a lot of what I'm hearing -- and my orientation is employer population health -- is things that seem to be working are already happening the employer sponsored healthcare. And so I'm interested in the differences -- and I've already kind of played some out in my head -- but are you also considering incentives for your populations or have you got to thinking that far?

MS. TAYLOR: Yeah. Actually our hospital system was really our first test case to try to prove this point and so we've worked really closely with them. And

there are patient incentives that have been built in to work with health coaches on lifestyle changes, to work on self management support, and, you know, those types of things. And we've learned from it. You know, it hasn't been perfect. The first year all you had to do was have three sessions with the coach and you got the benefit. And, you know, that was a HR designed thing and then we were able to come in and say, you know what, it's really an ongoing relationship and so they've kind of spread it out so that, you know, you get the incentive but you maintain that relationship with your medical home. And so, you know, I think there's lots of opportunities that way and I think there were -- you're right, there's already a lot of things that are working and I think adding care management, you know, kind of as an overlay to that is probably what has led to the success that we've had. You know, we've decreased hospitalizations, we've decreased ancillary usage, you know, all those things, with healthcare workers who traditionally are high utilizers. So, you know, I think it's a combination and again, just another idea of partnering with people, what are other people doing, you know, leveraging that and working together and having that same consistent similar message. It's really led to lots of employer groups within Central Iowa coming to us and saying what can you do with us, what can we do with you.

MR. MCCLELLAN: Jennifer, with employers concerned about the cost of healthcare and the quality of the coverage that their employers are getting as well as with the health of their employees, I expect you all have seen some examples where employers can work to support these same models of more effective patient, person, family engagement and care?

MS. SWEENEY: Yeah. So we also co-chair the Consumer Purchaser Alliance at the National Partnership. And, you know, what I thought was interesting with what you said, Kelly, is that there was, you know, an initial uptake, but then without sort

of creating that relationship it wasn't going to work. And I think that's our concern as a consumer organization is we don't want to just want to give people gift cards and just say okay, great, you know, everything's take care of. That's really not -- that's a quick fix, will not be sustained over time. We want to change the way clinicians and patients partner together to get the results we all want in healthcare. So it's really about that relationship and understanding what it is patients need and want, and then working collaboratively with them to design it.

MR. MCCLELLAN: Great. Thanks. And I think this point about no quick fix is as illustrated by the goal of some fundamental changes in how patients work with their healthcare providers in achieving care transformation is a good point to end this panel on, illustrating that this is hard work, but clearly some opportunities to make progress in improving care, lowering costs, and especially by thinking outside of the traditional approaches to healthcare.

As you all continue to work through this I'd like to give you a round of applause for the great presentations on this panel. Thank you very much. (Applause)

MR. MCCLELLAN: All right. And we're going to move right into our next panel, and while they are coming up to the stage, I'd like to talk about some of the big issues for ACO policy going forward. I'd like to introduce the topic of big issues for ACO policy going forward.

Some of the main topics that we're going to discuss here build on the discussion that you've already heard. We've heard about the state of the evidence on Accountable Care, and about some of the key issues and challenges facing Accountable Care organizations on the ground. Now, we're going to turn to the potential policy and regulatory reforms to help address these challenges.

Obviously, some of these topics have already come up today, but just to help get the discussion going, I wanted to highlight a few. One of them is the issue of the benchmark and payment systems. We've heard about some challenges around how the benchmarks are calculated, whether those savings are retained over time or go into a new base; how attribution works.

We've talked about transitioning to more person based payments; payments that are more at the person or capitated level -- that means more significant financial risk, but it's something that many ACOs seem ready to take on. We've talked extensively on this last panel about steps and policies that could support increased beneficiary engagement. Issues related to performance measures have come up, both performance measures that are less burdensome to report, but also, measures that could be more meaningful for capturing issues like underuse of care and more meaningful patient reported outcomes and the like.

We've heard about challenges related to data availability, since timely, comprehensive data is really critical to many of the steps to improving care being targeted and having an effective impact. We've talked about some of the other payment reforms going along with Accountable Care organization payments that can potentially reinforce their effects.

We've talked about steps to overcome startup costs through things like bonus payments and other incentives, and we've highlighted the challenges of actually implementing effective reforms in clinical care, and how opportunities to share experiences and research on what really works to improve care and lower cost in particular kinds of healthcare settings and markets today can be very important.

So, plenty of opportunities for further discussion, debate, and hopefully, constructive next steps on the policies affecting the ACO programs in the country, and

particularly the Medicare ACO programs -- a very timely issue right now with the upcoming regulations and payment -- and further payment and regulatory reforms that are coming.

And we've got a great panel to discuss these issues, so I'd like to introduce them briefly now. Starting on the far end is Mark Wagar, the president of Heritage Medical Systems, which is an affiliate of the Heritage Provider Network that serves over a million patient members and integrated population based programs through medical groups and independent practice associations in California and New York and Arizona.

Heritage Provider Network also manages one of the largest pioneer ACOs in the United States and one that seems to be doing quite well so far, in the pioneer program. Next, I'd like to introduce Joe Damore, who is vice president for Population Health Management at Premier. Joe has extensive experience in leadership roles for successful hospital and health systems including 19 years as a hospital and health system CEO.

He has successfully developed several integrated health system and his expertise includes strategic planning for hospitals and integrated care systems, financial and operational management, governance and leadership development, business planning, quality enhancement, health insurance plan and ACO development and physical hospital integration. No shortage of skills needed for success in these kinds of healthcare reforms.

Next, I'd like to introduce my longtime colleague, Mark Miller, the executive director of the Medicare Payment Advisory Commission. MedPAC is a nonpartisan federal agency which advises the U.S. Congress on Medicare payment, quality and access issues. Mark came to MedPAC in 2002 -- has it really been that long -

- where he previously was at the Congressional budget office as assistant director of the Health and Human Resources Division. And before that, Mark Miller was the deputy director of health plans at the Medicare program.

And last but not least, I'm very pleased to introduce Paul Ginsburg. Paul is a Norman Topping chair in medicine and public policy at the University of Southern California, and also, a fellow here at Brookings. From 1995 through the end of 2013, he was president of the Center for Citing Health System Change, and prior to founding Health System Change, Paul served as the founding executive director of the Physician Payment Review Commission, now part of the Medicare Payment Advisory Commission.

As with our last panel, we're going to start out with some opening comments from our distinguished panelists, and then, turn to a further discussion of some of the policy issues and potential solutions on the horizon. So, Mark, let me start with you.

MR. WAGAR: Sure. Thank you, Mark. Heritage is probably at the other end of the spectrum for many people in the audience and participating in the ACO program. So, of our million patients, 800,000 are fully delegated, completely capitated. We pay the claims. We do the care management. We have almost 3,000 physicians in medical groups that are employed. We probably have 30,000 contracted physicians, primary care and specialty in independent practices that surround those.

So, we try to focus on concentrating in markets and presenting a delivery system that can actually produce differentiated results. Our success in the pioneer, I think, is primarily driven by that experience that was referenced earlier, so Dr. Merkin has been at this since the ’70s -- been through all of the ups and downs of different versions of managed care.

And we were able to extend in the pioneer ACO program all of the

internal things that we do for those prepaid populations. So you know, the independent practice that was a first timer to the ACO, you know, gets the social worker who is going to work with the family; gets the community care worker, gets the Meals on Wheels.

I was pleased, by the way, to hear the conversation about consumers, because we have about 30 percent churn. Does that sound familiar to a lot of people out there? And number one is how do you financially survive that? But number two, what we're finding, given that we've had some success and we've taken the education road with consumers, so we found they didn't know a thing about it, didn't understand they were in it. So we had group meetings not to market -- they're already in the program. But we're a part of your physician office.

If it's the patient or the family member who often accompanies them, here's what we've added to your physician's office capability. Then, when they get moved by whatever attribution mechanism, they're calling back and saying, well, why am I moved? You know? I liked the social worker who was working with us (Laughter) and take care of mama, what have you. So, that's a challenge.

I think you know, the secret draw of success, like the Hackensack system, we spend money that we make elsewhere to try to demonstrate that this program will work. It ultimately, like all of the organizations that are participating, if we don't evolve the payment mechanism to something more population based, it will run off the cliff.

So, the big organizations like us, we may -- and our hospitals systems or what have you, other big medical groups, we may have the staying power to stay with it a while longer, but if you don't end up doing something other than like the rural thing, effectively what was done when you give money in advance for providers who don't have it and then you have to give it back out of your savings, that's reverse capitation. Okay? That's what we have in advance.

And we don't have any argument about whether or not you need an air conditioner or whether or not you need a ramp. We don't have to look up the benefit design. You know, the answer to access is could you come in this afternoon? If you can't come in and you don't have anybody to bring you, we'll go get you. If you can't come at all, we'll send somebody to see you. You know?

We think we -- with all of those providers and hospital relationships we have, we're great at taking care of people when they present and need care. But more importantly is, can you find them before they present and they're sick enough or injured enough to fall in the door, so maybe they don't need care? Or they need a different kind or it's not as intense. So, we think the program is a great learning ground. I think we've proven that with the independent practices. But you know, we want to see what happens next and be an advocate for the change that's coming.

MR. MCCLELLAN: Great. Thanks. And please, go ahead, Joe.

MR. DAMORE: Great. I work with a team of people in population health management who work all over the country. We've worked in about 150 markets in the last three and a half years helping organizations transform into population health. On the Medicare side, we've worked with Pioneers and MSSPs, probably over 50 of them. On the commercial side, we work with a lot of the major commercial payers of Blue Cross plans across the country to build new models.

We work with Medicaid programs, for example, putting in district programs across the country. So, we work across the entire continuum. And what I'm going to try to do is just summarize, how do our people feel about -- including with Morry's organization in Hackensack. And I would just add that one other thing. Our organizations that we work with have done much better than the national average in regard to hitting savings rate, you know, like Hackensack. They've done a great job, and

we've got a lot of others that have done well.

I think almost 80 percent of the organizations we work with hit their minimum savings rate in year one. So, not all of them got shared savings, but a really high percent hit their minimum savings rate. And we'd like to think it's because the exhaust from the success we share with each other. We have a collaborative that allows us to share with organizations what's working.

And then, the second thing we really try to do is stage what you build, because what we find is many organizations try to do too many things too early. And what we've learned is, stage them over time. And there is a staging process that we think works. So, our experience has been that number one, on the MSSP and pioneer side, people need accurate, timely data, and we're still not there yet. And it's kind of like flying a 747 without an accurate instrument panel.

If your attribution changes 30 percent in a quarter, it's really difficult to get an accurate denominator on all of your quality metrics, your financial metrics. So, we've got to fix that. We have to fix that attribution issue in this next round. And then, on the top line, if we don't have accurate claims and timely claims, you really can't manage on a day in and day out basis. So, we need to fix that. So, data is really critical to be successful going forward.

Second is, there's a number of areas in the economics that need to change. For example, the minimum savings rate issue. As I said, we have so many organizations that hit their minimum savings rate. But what happens next year, it's dialed back to zero again. And that doesn't make sense. So, somehow, you should be able to take a credit for the success this year and carry it over towards your target for next year.

It seems terrible to say, well, you did pretty good this year, but you didn't hit the minimum savings rate. But you're going to start all over again. That doesn't make

sense. So, we think those kind of things need to change, and I can give you more and more like that; the risk adjustment process is not really sound, in our opinion. The benchmarking and the metrics need to be realistic in setting in their targets, rather than saying you've got to hit a hundred percent (Laughter) of some of these metrics, in order to get full shared savings.

The third area would be, where do we think we need to go? So, number one, we think we need to allow organizations to continue the one sided risk model for several reasons. One is that if they don't have totally accurate data, I don't think it's appropriate to go to two sided (Laughter). That doesn't make sense.

But also, there are organizations -- and I think that there was a great summary earlier about the types of organizations in MSSP. There's a lot of organizations that are in risk for the first time, and I think it's too early for them to go to two-sided risk, is our experience.

Second, there are organizations that are ready to phase into two-sided risk, and they should be given the opportunity in that model to maybe go to track two and phase it in over time. The third is, we do have a small number, as Mark pointed out earlier, of organizations that want to go to full capitation or a full global payment, and they should be given that opportunity.

And the fourth, we've got a couple that would like to go into full capitation plus part D. So, we see those four options as a prudent way maybe to offer the current MSSPs the ability to stay involved, make decisions that fit their market and their organization. So, we're hoping -- we're hoping that CMS will come through with something like that. So, I hope that makes sense to you.

MR. MCCLELLAN: Joe, thanks for the comments. Mark, in you know, MedPAC has extensively analyzed these issues, and he has a number of

recommendations already, and I'm looking forward to hearing from you.

MR. MILLER: Yeah, and I think there is some overlap with what you --

MR. WAGAR: We have talked in the past (Laughter) and we were --

MR. MILLER: Yeah, so we've met. So, there's a couple of things. We spent the last year or year and a half talking to ACO's -- site visits, case studies, surveys, and lots of people who rolled through the office to talk to us, and we put together a set of short run comments which I'll go through. And then, we started talking about what the direction is for the future.

There's two products -- you know, I have to mash it into five, seven minutes here, which I will do. But there's two products you should keep in mind. There's a June letter that we wrote to the administrators -- and obviously, we're always writing to the Hill staff when we do this, and that's up on our web site. And then also, our June, 2014 report talk about some of the future stuff.

From the comment letter, we were trying to make comments based on things that we had heard from the field that we could also reconcile with the, you know, taxpayer and beneficiary interests on the Medicare side. And we made a series of recommendations for the next round of the ACOs. And on the issues of attribution and the prospective benchmark, which is already -- or the benchmark, which has already been mentioned, we made the argument that both of those need to be on very clear and consistent prospective bases.

So, whether it is set up to be retrospective -- you know, your attribution changes during the course of the year or the benchmark changes during the course of the year, or whether there are methodological issues that effectively change the benchmark as you're going forward, that shouldn't be the case. The benchmark and the attribution should be on a prospective basis.

There is a certain stability and just a predictability that we think will allow the ACOs to manage better under those kinds of circumstances. Now, there's much more detail in how to do that in the letter, but the basic issue is attribution and benchmark on a prospective basis. A legislative thought just on the side, but just to get it out, is, is that for attribution purposes, advance practice nurses, nurse practitioners, PAs should be part of the attribution process. And again, then that requires a change in the law. And again, I won't get into this, because it's much more complicated than five minutes.

But there is a specialty attribution process that we have talked about changing, and we would say the ACO should be able to designate certain specialists who are engaged in relatively primary care types of activities -- you know, like when you're going to your cardiologist because you have a heart condition and that type of thing. Again, there's more detail, but just to blow by it in less than five minutes.

The next thing is -- that I would say was a big deal in our comments is the quality indicators. Throughout this process, we made the point that there were too many, and that they weren't particularly the best ones, at least in our judgment, that should go. And we were concerned about the administrative burden and actually, just some of the measurement issues.

We heard very clearly from the ACOs that this ended up being a lot more resource intensive than they had anticipated. And we have argued pretty consistently through this process, not just in ACOs, but in MA and fee for service for a smaller set of population based quality measures. And so, we made that point. Again, there's more detail and more complexity, but you know, you can look at the letter.

We do want to encourage movement to two sided risk. We know that there is some reluctance and concern about that, but we do want to move to two sided risk, and there's a couple of connected thoughts here. One is, we heard a lot of

concerns, and some of it was echoed in the previous session and right here about the notion of being able to engage the beneficiary better in order to kind of get the leakage under control, and also, just to engage the beneficiary in their care.

We made a recommendation that if the ACO is willing to accept two side risk, they should be able to forgive cost sharing for the primary care visit for the beneficiary. And this way, some of the way you explain the ACO is rather than explain here is an ACO, here is how it works, which lots of people -- it's hard to understand, is to say, look, if you go to your primary care physician, there's no cost sharing. You kind of get them in, and it's from that point. And there's people who should know how to manage from that point.

And then, the other thing we said is, is that if you accept two-sided risk, there should be some regulatory relief. That lots of rules and fee for service are about kind of curving the fee for service volume oriented behaviors. But once the risk shifts to two-sided risk and some actor has said, I'll accept the risk, then a lot of that should fall away. And we gave examples of where we, ourselves and the rest of the community should start focusing on regulatory relief to roll back.

We heard lots of comments from the ACOs who wanted to talk about an enrollment model, a capitated model, which I think involves more discussion, and also, on other ways to engage the beneficiary. And in wrapping up, the June, 2014 report talks about the future and how the ACO kind of fits in the large picture. Now, this gets a lot more complicated and a lot less clear, but the point that we're kind of driving to is the notion of a single unified benchmark that says for fee for service, ACO and MA, the government may have a support rate.

And then, within a given market, whichever model can dominate or be a strong player, that model can come forward. And some of our concern here, and this is

the last comment, is MA plans have a lot of overhead. They have enrollment. They process claims. They do that type of thing, and you may not have enough utilization in a market to finance all of that and still make a profit.

And an ACO might be a model where you have thinner utilization, and you can capture one or two points and make that model work relative to MA and fee for service. And I know that's a lot to throw at you, but that may be a question -- we can talk that through, so --

MR. MCCLELLAN: Mark, thanks for covering a lot of ground in a few minutes, and also, giving people the references. Paul?

MR. GINSBURG: I'm going to try to avoid repeating some of the things said, which I agree with. But let me just start out saying I think the ACO is a very promising concept, and I see the concept as providers taking a moderate degree of performance risk to lower the trend in spending -- should be the beneficiary in its improved measured quality. But good concepts cannot overcome flawed details.

And the Medicare ACO models have been important catalysts for ACO's becoming a significant part of provider payments. And I think the shortcomings and the details are becoming better understood over time, and this is the time to fix as many of them as possible. My sense is that the ACOs have been tolerant of these details in the model, as long as risk is one sided.

But the prospect of two sided risk, which is important to get to, has really raised the pressure to resolve the problem. So, it's not just the organization's capability of taking two sided risk, it's their confidence in the model and whether they're actually risk willing to risk a loss on a model they don't really believe in because of the details. So, I think the nation needs an effective ACO model for its most important payer, which is Medicare.

So, I won't repeat -- I'm in agreement about the comments about patient attribution, beneficiary attribution that the ACO's need to know who they're responsible for, and they need the ability to reach out and engage them. I had a couple of thoughts that Mark started off about enrollment. I think in the long run, we need to develop an enrollment model ACO, and in fact, CMS could offer temporary reduction in the part B premium for enrollment as an incentive to go there.

An enrollment model would allow a network approach of lower co-insurance for network providers and higher cost sharing for others. And it's also a way of actually engaging more specialists in the ACO who may not be part of the risk sharing body, but in a sense, could have a network relationship with the HMO. I think if you're going to go to an enrollment process, you need to find one which is going to have very low administrative costs; as Mark said, a lot lower than Medicare advantage.

Perhaps, just involving attributed beneficiaries with a communication from CMS and one from the ACO they are attributed to of, would you like to enroll? Here are the benefits for you. It might be a way of getting into that model. I think I'd want to run the enrollments alongside the attribution model because of concern about the number of years it might take to get a critical mass of enrollees, and I wouldn't want to jeopardize the entire approach in that interim.

I think many of the reforms and the direction of patient engagement that involves incentive are going to need reform of Medigap or Medicare supplemental insurance. You know, we know that Medicare raises over all Medicare spending, and that overall reform in that has been overdue for decades. But basically, you cannot work with large proportions of beneficiaries having no point of service financial responsibilities.

A group I work with at the Bipartisan Policy Center in the 2013 report recommended that Medigap be limited to providing catastrophic protection and needs to

leave at least half of the Medicare deductibles and co-insurance uncovered. And this is -- it's particular important to design any reform so that Medigap does not cancel network incentives for enrolled ACO beneficiaries.

I also have some comments on benchmarks; that the benchmarks we have now are based on provider specific historical spending. I think it's the right approach to get started with. It's not ideal, but it -- we needed it when we have an essentially voluntary ACO program. Otherwise, Medicare, which has had enormous risk selection planned ACO by ACO against it.

The uniformed national dollar up (sic) amounts for updating helpful in blunting the worst shortcomings of this approach. But we're coming up to a critical decision about benchmarks for second ACO contracts. And I think rebasing to the ACO's most recent experience would substantially undermine the business model for ACOs, which was not very strong to start with.

I think the long-term path to better benchmarks involves higher payments before -- higher payments to incent physicians and hospitals and perhaps other providers to work in ACOs. And the tri committee built to fix SGR really takes this approach, when it created APMs or alternative payment mechanisms with strong incentives for physicians to get into alternative mechanisms. And so if you have some broad incentive to go there, then, you can start bringing community or countywide experience into your benchmarks with ACOs. And I think ultimately, we're just going to have to go in that direction.

Let me just talk briefly about some of the opportunities for ACO policy changes. Of course, the immediate focus is on the upcoming rules from CMS. But we should not write off the opportunity of legislative action for bigger changes. You know, we certainly don't have the greatest expectations for Congress addressing critical policy challenges, even where partisan divides are not that pronounced.

We should take note of the far reaching changes in Medicare physical payment in legislation to fix the SGR that had unanimous support in all three committees of jurisdiction. I think a commitment to payment reform as seen in the incentives for physicians to participate in alternative payment mechanisms could perhaps, be brought over. Obviously, given the SGR fix, and you're waving at physicians the opportunities to get into alternative payment mechanisms, you want to make sure those opportunities exist, which really means it should be natural for Congress, if it goes past the lame duck in dealing with the SGR fix, to start thinking about some critical changes in ACOs and bundled payments to really assure that there will be real opportunities for physicians to engage in alternative payment mechanisms. Thank you.

MR. MCCLELLAN: Paul, thank you very much. And I want to thank the whole panel for -- I went through a range of each individually challenging policy issues in introducing this panel. I think you all hit on every single one of them and more. Beneficiary engagement, performance, measurement, data, reinforcing payment reforms, bonuses for transformation and better support and evidence on clinical transformation and other steps, as well.

You know, we heard from the earlier panels about people who are actually engaged in doing ACO work now, and Joe and Mark here, you're certainly among them about how, in many ways, this is sort of like building the plane out while you're flying it. So, there are lots of changes taking place on the fly, dearing (sic) care delivery with existing policies in place.

But also, what came through for many of these organizations is that they're anticipating things changes; that there is, because of market changes, because of changes in the private sector, payment systems and employers, changes in states, things are going to be changing similarly for Medicare, as you all focused on in many of your

remarks. And so, it seems like on the policy side, there's very much of the same business. I mean, we're sort of building the plane out as we're flying it; that hopefully, that refueling will take place in the air when you need it, even if those systems haven't been built yet.

We could talk a lot more about the details, but I'd really like to ask you about sort of the bigger picture of where the planes are flying to. Where are we trying to get? And Mark, you touched on this with your mention of the -- sorry, too many Marks on this panel -- but, Miller touched on this with his description of the long-term vision that MedPAC has laid out and at the Bipartisan Policy Centers, I had some similar kinds of long-term reform recommendations, Paul, and we've done some of the same work here at Brookings.

But let me just ask you all, big picture, 5, 10 years from now, where would you like to see our policies collectively get us in terms of supporting the next rounds of ACO reform and implementation and the next rounds of care transformation. So, back to the bigger picture. Yes, there are a lot of important policy details that need to be worked out, but big picture, can you help with clarity about where we're trying to go?

MR. MILLER: I think population based is the key. Moving payment that direction. Again, we would have a bias toward the capitation side. I mean, just as some folks are terribly uncomfortable moving away from fee for service, when you inject fee for service into our system, it screws it up. It's, well, do we have to go hunting for it? Is this going to be paid for, or whatever? And we just tell our doctors ignore it. Most of the organization is paid the other way, and we'll figure this out. So, I think population based payment is key.

I think the enrollment idea that's described here is perfect. You know, these members are just old. They're not stupid. And if you don't deserve their business

because they would choose to stay with you even after an experimental period, you probably don't deserve the patient. And I think that's one of the things -- we'd want to create a set of incentives that makes sure that in every market possible, there are competitors. We don't want to be complacent as scientists or physicians or hospitals or health plans or anything else. You want people vying for -- I can do that better for you. I would like for you to trust me and help me work with you over your now lifetime of health status, as opposed to just when you're too sick and fall in the door.

So you know, those types of things. And then, I think the baseline -- market baseline -- we want progress. So, every market in the country has different characteristics. I've spent plenty of time, as some of you know, on each of the coasts. We won't say which one is left and right. But you know, in New York, in the New York area, you know, when I went there in 2004, it was like rolling back the clock 20 years -- you know, whether it was benefit design, whether it was behavioral practices of providers.

And the things that are routine in the Los Angeles basin or in the Bay Area are like you know, Communistic takeover of the parts of the greater New York market. Now, everybody now is moving that direction, because I think as it was pointed out earlier, the writing is on the wall. This movement is going to change things, so you have to move.

But you know, I think having your benchmarks set based on your market -- other than national clinical standards, I think you know, there's certain scientific things. But the benchmarks for cost ought to be market based, and you need to pay for progress. If you ask the actuaries at CMS or you know, Aetna WellPoint United, you know, how do they roll up to a trend of five versus seven, it's the entire thing moving. You can have 110 percent loss ratio segments of a plan, and if you improve those to 105, that contributes to those who are operating at you know, 87. And you're making progress on the whole

book.

So I think, you know, let's focus on making progress in some of the gradual stuff that Joe was talking about, but not too slow. If you're too slow, you'll get sweeping government reform that will be blunt.

SPEAKER: Great. I like Mark's motto. And you know, we call it the end game, and a lot of our organizations that we work with, their vision of the end game would be to have a population based contracts with all of the major payers in their market; Medicare, Medicaid, all the major commercials. So, if I was the CEO of an integrated system that was doing that, I might have 700,000 people that I'm responsible for providing care. And I would have probably a per -- a global target of expenditures for each group.

And then, my bonus might be based on quality, you know, patient satisfaction, engagement, health status improvements. You know? So, that's kind of what we see as the end game, but there's some evolution that's going to have to occur, and that's what Mark was talking about, to get there.

And we're beginning to see that evolution. It's exciting. We are seeing the formation right now, in a number of markets of what I would call multi owner population health organizations. So, this is kind of the latest thing that we're working with, where individual organizations realize that they don't have enough scale, population-wise or capital-wise to be a really strong population health organization. So, they're coming together and forming a multi-owner population whole. And I see that as part of the evolution towards this model. So, I hope that makes sense.

MR. DAMORE: I think for the commission, I think we've been -- we've tried to be really clear about specifics in the short-run. We're starting to frame up what we think the longer run looks like. So again, I think these are comments that are subject

to changes as the commission works through them.

And again, I think I probably garbled this, but I'll go through it a little bit here. You could view the world as this. You have fee for service, and you're probably going to have that for a long time. And by the way, there are parts of the country where fee for service is a relatively -- in a utilization sense, efficient type of operation. So, just keep that in mind.

At the other end of the continuum right now, you have MA. And MA pays its own claims. You know, it markets and enrolls people, and there's a relatively high set of overhead that goes with this. And then on top of that, they get their utilization reductions and they get a profit margin.

At the moment, I think the way the commission views ACO is standing between that. It's an attribution model, but I'll come back to that in just half a second. And its advantage is, is that it doesn't have that overhead. The claims are paid by CMS. Enrollment is done through attribution, so they're not incurring those costs.

So in a sense, maybe they perform well in markets where you don't have very high utilization, but you have some high utilization that an ACO can extract a point or two, and because they don't have the higher overhead, can be a competitive model there. And I think the commission's view is, you don't pick a model. You set a payment system that allows whichever model can perform to emerge in a given market, as opposed to saying we should be here or we should be there. And at some markets, those models will be MA. At some markets they'll be ACOs, and at some markets, it may be fee for service. Now, there's a whole quality conversation that needs to happen, but for the moment, I'm just going to lay that to the side.

Now, attribution, in addition to having the low overhead has this element to it, which is if you want your patient to stay with you, you have to make them satisfied.

And in an HMO, they enroll, but they're in there for a year and then they can switch out. But in attribution, they can wander around. And so, you have to keep the patient satisfied, and that's an important element of what the attribution model requires.

Now, having said all of that, I don't think the commission is inherently against an enrollment based model, but to the extent it takes on all that overhead and you're enrolling people off the street, you have an MA program -- and one question is, is why would you replicate that somewhere else? And I think Paul made some important comments of, but wait a minute; if you've been attributed this beneficiary, you've got him for a few years, and they're willing to actively make a decision, that might be a road that could be discussed.

And the last thing I'll say is, and he made this point, so I think it's pretty important to keep in mind that you need enough end to make these critical -- you know, make them workable models. And if you had strictly an enrollment model -- I'm not sure a lot of ACOs would be able to get enough people in them, at least currently.

MR. MCCLELLAN: Thanks a lot. I think as far as your comment about flying the plane, Mark, it really is -- I mean, I've sensed, first of all, pretty broad consensus in the delivery system financing and policy makers that you know, fee for service should strike, and that you know, whether it's in Medicare, whether it's Medicare Advantage or ACOs or bundled payments, you know, hopefully, we'll be -- because more important over time.

I think the real challenge to getting there is both; you have to put out a policy. And then, I think the policy process has been appropriately attempted to the experience of those that are engaged in these programs. And so, there's a lot of productive discussion about how to change (audio skip) think that will keep going on back and forth. I think probably the biggest challenge is the readiness of different

organizations to go different steps of the way towards population health.

I just wanted to mention specifically that the comment that Joe Damore just made about the multi owner Accountable Care organizations. That's a direction that I hope we see a lot more of, because my concern is that so much in the way of scarce management resources as well as money is going into mega mergers, where I think coming up with multi owner models can actually accomplish as much, if not more, in improving delivery without getting to those resources, and we're not raising these provider concentration issues and (audio skip) --

MR. MCCLELLAN: Thank you all very much for the comments to that very broad question. I'd like to open this up to questions from the audience. Back in the back there?

MS. CRUZ: Hi. Claire Cruz from the Deloitte Center for Health Solutions. A couple of the panelists spoke about specialty positions, and I was just wondering if you could expand on that, talk about the role currently and where you see that evolving.

SPEAKER: I'd be glad to speak to that. You know, some specialty physicians like cardiologists, you know, tend to be fairly involved in ACOs, but there are a lot of specialists whose care is not that integral with care management, primary care, that really, the ACOs have no reason to engage that.

And so, this means that you have a lot of the dollars out there really not being part of the ACO. And I think the problem is the need for a network model in ACOs to get the specialists more engaged. And I mentioned that you know, I think some political needs of providing opportunities for specialists to be involved in ACOs could happen with the SGR fix that we've seen.

MR. MCCLELLAN: Other comments on this? Yeah?

SPEAKER: Yeah. I think you know, one of the things that presents this evolution is big challenges for the organizations that have absorbed a lot of them. So, if you're a big multi-specialty group or a hospital system that, because of the way the system works, your incentives were to collect these providers and make sure that you enabled them to do as much as they could for everybody that they thought they needed it. I'll be polite about that.

You know, this is very different. You know? Hospital systems in particular that are going to move into accepting risk, all of the sudden, you know, how long can they afford the subsidization of the losses they take on the big physician purchases they've made? They're very open about that. The model has changed. So you know, your estimates -- you know, maybe you sold bonds three years ago. Your estimates of you know, how many admissions, how many stents are you going to put in, how many whatever that's fueling your system currently, it changes if you implement every best practice that we know of. Now, we know that takes times, but it's a big economic issue in terms of how do you change a system, take that cost out and make room for the very best providers to still be able to participate?

Two things I'm seeing. One is, in one large organization, they've decided to develop models for three different groups of physicians. One is the primary care, and then the specialists who are sub-specialists that are really hospital focused or inpatient focused, and then, there's the hybrid group in the middle -- endocrinologists, cardiologists, who really do both. And so, they're looking at models for that hybrid group of cardiologists, endocrinologists, nephrologists to involve them more in managing their primary care loan.

The second model that we've been working with another organization is what I would call an episode of care model within an MSSP. So, this is an MSSP that's

been successful, and they want to further engage specialists in the MSSP, so they've designed an episode of care program within the MSSP for cardiologists, orthopedists and to look at setting a target with that episode of care, and then sharing savings among the MSSP and with those specialists. So, that's model to further engage specialists that maybe have not been as engaged in the past. So, those are a couple of models that we're seeing evolve in markets across the country.

MR. MCCLELLAN: Joe, for those second types of models, the ones involving specialists that are handling kind of more discreet, specialized aspects of care as opposed to the cardiologists and the endocrinologists who are very much involved in things like coronary artery disease management, heart failure management, diabetes management -- things that are part and parcel of the population based ACO performance models, are there some other quality measures that need to be developed in this area, too?

Is there thinking about conditions like cancer, rheumatoid arthritis, hepatitis C that is not well covered? And then, I want to go back to Mark's point, and the point that a lot of ACOs have emphasized is that look, the measurement and reporting burdens are too high now, so how do you reconcile that.

MR. DAMORE: And so, a lot of places are -- and I would imagine people most people in the United States are familiar with choosing wisely. And so, we're seeing the adoption of choosing wisely for appropriateness in sub special -- you know, in specialty and subspecialty areas, in large integrate -- clinically integrated in ACOs. So, that's a way to -- I think appropriateness is coming into play in those subspecialty areas, as one area. And I'll turn to Mark to comment.

SPEAKER: Well, one of the things that I was thinking about in particular, and I've got to get this out before I forget it, is as we experiment with sort of global case

payments and packaging everything up, with respect to specialists, we may want to be careful how much we lock that in.

So, if it ends up in law or a regulation that's so strongly defined you can't get out of it, I mean, some of the science is moving rapidly. So, the same cardiologist that you trusted to manage this big case, all of the sudden, they're going to be using an entirely different type of approach that doesn't involve the hospital, doesn't involve interventional procedures, involves other kinds of you know, genomic based kinds of treatments, and it's going to eradicate it. So, I'm sorry, but your follow up question I -- because I was thinking about --

SPEAKER: That makes sense. But this was -- I guess maybe I can talk with this to Mark --

SPEAKER: Yeah, I think it was to this one. Yeah.

SPEAKER: -- about the measurement issues --

SPEAKER: Yeah, yeah. Subspecialties

SPEAKER: -- related to these areas of specialty care, orthopedics, cancer, rheumatoid arthritis and so forth, that are not well covered in the full population ACO performance measures.

SPEAKER: And this is really nerve wracking with all of these Marks up here. (Laughter)

(Discussion off the record)

SPEAKER: So, a couple things that the commission has said in reacting to these comments. I think the commission's comments in its letter about the notion of letting the ACO designate certain specialist as attribution nodes is directly consistent with what Joe was saying for his first model. There are certain special specialists that are really more about the continuum of care and the coordination of care.

And this wouldn't be all specialists, but there is probably a set that immediately rise to most people's minds where you would say that that's logical. Now, that was driven by some technical problem that was being created by a second stage specialty assignment, but that's not worth mentioning here. So, I would say our views are very consistent --

MR. DAMORE: That's right. Yes.

SPEAKER: -- with your first model.

To your point, Mark on quality (Laughter), I think there is real concern, and this concern is not just in the ACO space, but fee for service and elsewhere, that if we say, okay, well anytime we bring a specialist or bring in some other provider, we've got to develop a specific set of measures. And I know that there are disagreements on this point, where a lot of people say you have to be able to measure my thing and my thing well.

At least at this point, the commission's view is from a payment perspective, the view is more of a population based, small set of quality measures that money can be awarded or not, as the case may be, whether you're an MA plan or an ACO plan or whatever the case may be. And then the responsible organization can decide which metrics internally it wants to use to chase its particular model around, as opposed to a, you know, single set of measures you know, for all that type of thing.

And very great concern on the part of the commission that we're kind of over building on the individual measures. So, we have something of a different view there. The other thing I would say to this Mark, okay, is I almost thought you were making this point, and if you weren't, then you can disassociate yourself. I think you have to be very careful about building episodes around specialty care because of what he said.

And I think sometimes, there is -- some specialty groups are kind of

waking up to this process and starting to enter and say, okay, you need to build an episode around my care. And I think in some ways, they see that as a way to preserve what they're getting currently. And I think we should all pay attention to that comment, which -- Mark's comment, because I think those processes could be changing. We should think very carefully about how episodes are constructed. Okay?

SPEAKER: Yes. That was the point. Yeah.

(Simultaneous discussion)

MR. MCCLELLAN: Great. Paul?

SPEAKER: Well said.

MR. GINSBURG: I just want to say something about the quality for specialty care. And I think what Mark Miller sketched out was probably fairly practical, but I don't want to give up on the fact that often, specialty specific measures are much stronger as far as outcome measures of quality than the general measures for a population. I was influenced by studying the calipers experience with joint replacement reference.

MR. GINSBURG: And you know, if you look at the very specific quality measures they have for joint replacements, you know, they seem to me to be much, much stronger than many of the general quality measures that you would tag, say for an entire hospital. So, I think it's worth thinking about some very strong quality measures that may only apply to a very important, frequent procedure and working that into the system at some point.

MR. MCCLELLAN: We have time for maybe one more. Back here?

MS. MCDERMOTT: Hi. I'm Laura McDermott from CapG. You guys have all spoken about different changes to the ACO program, and I'm wondering of you could speak a little bit about to what extent you think legislation is needed to make those

changes versus what CMS or the innovative center could do to advance the next generation of ACOs.

MR. MCCLELLAN: (Laughter) I know why everybody is pointing at Mark. That Mark, but --

SPEAKER: Well, I think number one, since along with a lot of people, I was going around talking to both sides of everything. I think getting the SGR fix done, it is right minded. It's headed in the right direction. We have to get comfortable that some providers should get more money than others, because they are demonstrating participation in an organized system that's supposed to do better things for consumers. So, we need to get comfortable with that.

I think that you know, the -- I believe it takes legislation to solve the payment changes that are going to go off the cliff if we don't, you know, reset how things are paid and the baseline information. So, I think you do have to have that, otherwise, people who will identify we should change, but they won't have the legal authority to, from a regulatory standpoint, make a change.

MR. MCCLELLAN: Other thoughts on the legislative outlook?

SPEAKER: Well, I don't know about the legislative outlook, but I think a lot of the recommendations that we made in the June letter can be achieved regulatorily (sic), although there are things that clearly require legislation, and we tried to point that out as we go.

And then, I would also say that, particularly thinking about the future and going forward, there probably is a legislative change that needs to go along with this, and it's always clear if the Congress says, these are the changes I want, that you know, the secretary will then be much more likely to take those -- undertake those changes.

MR. MCCLELLAN: Any final comments from the panel?

I'd like to thank all of you for an excellent and wide ranging discussion about the ACO policy issues and solutions. Thanks for covering the short-term and the long-term.

(Applause)

SPEAKER: Thank you.

SPEAKER: I always enjoy listening to you.

MR. MCCLELLAN: All right. We are about done. I want to thank all of our speakers today and all of you for participating in today's event. We looking forward to working with you on these issues in the future. Obviously, accountable care and the ACO experience is a work in progress with some notable results on quality, some important successes on costs in Medicare, in Medicaid, in private and employer kinds of plans. But obviously, a lot more work to do.

We've talked about some of the research on what can succeed in terms of care transformation and public policies to support it. We've talked about some of the policy steps that can help people who are trying to engage in care reform on the ground, both provider organizations and patients and consumers and their families, to do that more effectively. But there's obviously more to come.

I just want to also give a quick thanks to our ACO learning network which made much of this event possible, both in terms of the technical expertise, the contacts with many of the experts around the country and people who are actually engaged in ACO activities and helped putting this all together. We have more information available on our ACO learning network, for those of you who are interested. And that's the contact information for it.

The Brookings ACO learning network is aco@brookings.edu. For right now, though, I want to thank you all very much for attending, and thank you for your

concerns about improving the quality and addressing the cost of healthcare in the United States. Have a good rest of the day. (Applause)

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

) Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2016