CMS LISTENING SESSION ON

HEALTH CARE DELIVERY SYSTEM REFORM

DECEMBER 17, 2010

P R O C E E D I N G S

DR. FARRIS: Well, good morning. Thank you for being here. A couple of very important announcements that we need to make preliminarily.

The emergency exits are to my left -- this door and that door -- and the restrooms are right outside both these doors on the wall -- on the opposite walls. So we always want to make certain that we get the logistics out of the way before we start the meeting. A couple of people have already been looking.

So good morning and welcome to the CMS Listening Session.

(Interruption.)

DR. FARRIS: Okay. While they're standing by, we will go ahead and say a few more words.

This is the CMS Listening Session on Health Care Delivery System Reform, and we definitely want to thank you for being here. I am Randy Farris. I'm the Consortium Administrator for Quality Improvement and Survey & Certifications Operations at

the Centers for Medicare and Medicaid Services, and in my role, I am quality improvement.

I am tremendously happy to have the opportunity to be here with you today to participate in this important forum. As you know, we have new leadership at the Centers For Medicare and Medicaid Services, and Dr. Don Berwich is the United States Quality guru and probably the health care quality improvement expert in the world, and we're really, really excited to have him as our new leader.

And we have a couple of people with us today from our Washington and Baltimore offices who are a part of the leadership team. You'll get to meet them in a few moments. But as a part of the excitement that we have about our new leadership, we're having meetings, such as this, around the United States, and in my role, I get to travel all over the United States to meet with groups on quality improvements, and certainly part of the thrust of what we will be talking about involves quality improvement, as well as savings of money and making certain that we provide the best services for the people that we are

all here to serve.

Over the years, the CMS Dallas office has partnered with many of you individuals and with the entities which you represent in a number of other efforts to improve the health care and well-being of Medicare and Medicaid beneficiaries, and we thank you for those partnerships. I see many people in this room that I know who have worked with us in the past, and I especially thank you for taking time out from your busy schedules to participate in this listening forum.

And I want to emphasize that this is a listening forum in the sense that we really want to hear from you. We have people here who have come from Washington who are working on some new programs that we have, and your input will be invaluable to helping to craft the systems and the programs that we are about to start.

I think that all of us in the room can agree -- whether we are consumers or physicians, employers, hospitals, health care systems, health care quality experts. I think we can all agree that we

want the highest quality health care services and programs that we can possibly have, and what would those high quality programs look like: They are systems that coordinate and integrate care; systems that eliminate waste; and systems that encourage the prevention of illness.

I think we can probably also all agree that our current health care system is broken. We pay a lot of money for a system that is fragmented, disorganized, and in some instances, fails to provide the sort of care that many patients need. And the problems with our health care and delivery system have been created by a payment and delivery systems that reward fragmented care, care that is delivered on a piece-by-piece basis and in a seamless, uncoordinated manner. We need to change that system.

Patients want care that is high quality; that is delivered timely; and that meets their needs, and they don't want to pay an exorbitant amount of money to receive that sort of care. Patients also want to be treated as individuals. They want their wishes to be known and respected, and they also want

their values to be known and respected.

Now, health care professionals are in the business of helping people. That is why we chose these careers that we have. And every day we work to provide the best possible care for the patients that we serve. We want to help the people that we work for, and we want to help our patients.

But our current health care system often does not allow us to provide the care that we would ideally like to deliver, and very often that care does not support health care professionals in being able to provide that care. We need to change that.

And the purpose of this listening session today is to highlight some ways in which we might be able to make those changes. We are implementing a number of new programs around health care service delivery reform. You will hear about them today. They are a product of the Affordable Care Act. The Affordable Care Act -- I'm sure everyone in this room has heard about. But this Affordable Care Act provides CMS with a number of new opportunities to improve the health care delivery and payment system.

And so today in our discussions we will highlight three areas of interest: The Accountable Care Organization's shared savings program, the CMS Innovation Center, and the Federal Coordinated Health Care Office. As I said, we have some very important people from our leadership here to talk with you today, and, again, we really, really are desirous of hearing from you. There will be ample opportunity for you to share your ideas with us during this meeting.

So thank you for your partnership in this important effort; thank you for the partnerships that you formed with us over the years and for all the work that you have done in helping us improve health care service delivery for the people that we serve.

And now I'd like to introduce my colleague, Dr. Renard Murray. Dr. Murray is the Regional Administrator for the Atlanta and the Dallas regional offices. His primary responsibility involves the external affairs division, and in that capacity, he gets to work with the 13 states that are in the Dallas and the Atlanta regions in reaching out to health care providers, to consumers, to beneficiaries

to make known the new programs and initiatives that we have but also to receive feedback from you.

Dr. Murray has been with the Centers for Medicare and Medicaid Services for a number of years and has had a very long and a very illustrious career at both with CMS and with the Social Security Administration that is ideally situated to provide services to folks in both the regions, and he will announce and introduce the luminaries from our central office who are here with us today.

So thank you again for your presence here today, and thank you for the ideas that I know that you will share with us during this important session.

Renard.

DR. MURRAY: Thank you so much, Dr. Farris.

Good morning.

AUDIENCE: Good morning.

DR. MURRAY: That's wonderful. Since this is a listening session, I want to make sure we all have voices here, so I appreciate that feedback here.

It's exciting to be here in Dallas, and thank you-all so much for taking time out of your very busy schedules to be here. I know that it's a difficult time of the year with a lot of things that are going on -- holidays, health care, and all those other wonderful things -- but you've taken time out of your schedule to come and provide us with some feedback and some comments that we think is going to be helpful for us as we build this program going forward.

And it's our (inaudible), it's -- you know, you're invaluable in this process. We can't do it without you-all, and I cannot display that enough in terms of what we hope to gain from you all today, so we expect that your voices are going to be ringing out at the end of the presentation with Dr. -- Mr. Blum and Dr. Gilfillam. But nonetheless, we hope that you will give us a lot of feedback.

One of the things that you see that's going on with Jessica Jenkins, who is on our staff -- but we've got some callers that are on the phone, as well. We're trying to connect them to the phone line,

so just bear with us as we go through that process. So you'll probably see her up and down and back and forth as we try to perfect that process and get it going. We have about 150 callers out on the phone waiting to hear from us, as well.

So with that, I'm going to first introduce our speakers to you-all. As Dr. Farris mentioned, our illustrious presenters from our central and -- central office in Baltimore, as well as Washington, first of all, to my extreme right is Mr. Jon Blum, who is a deputy administrator and director for the Center for Medicare, who's with the CMS office in Baltimore, and he works very closely -- and he works very closely in Baltimore, as well as in D.C. He has two offices. That just goes to show you, you know, how -- how diverse he is there.

But Jon oversees the regulation of payment for Medicare Feature Service Providers, and he also is in charge of Medicare Health Plans, as well as overseeing the Medicare Prescription Program. So if you know somebody that's more busy as Jon, let me know because he's got a tremendous task in terms of what he

does but does a great job with that.

And in terms of the Medicare budget, I mean, he's responsible for such a large chunk of that, and we appreciate the work that he's doing in that regard. He's an expert in terms of CMS programs. He's been around for quite a while. I think Jon was one of our first political appointees in the agency, and so we often refer to Jon as -- as the one that's been around the longest in terms of political appointees.

He worked with the Center's Finance Committee as an advisor to Senator Max Marcus, and has also in that regard worked with Prescription Drug Plan Programs, as well as Medicare Advantage Policies in that role.

Jon has also worked as a program analyst with the White House office of Management and Budget, and before joining CMS, he worked as Vice President for Avalar Health Care Systems, and we're elated to know that Jon was also involved as the Health Policy Advisor to the Obama/Biden Transition Team, so Jon has a wealth of experience in this regard, and I know that

we are waiting to hear his comments.

Thank you, Ms. Jenkins.

The next presenter is Dr. Richard Gilfillam. Dr. Gilfillam is the acting director of the Center for Medicare and Medicaid Innovations, and you've seen that on the -- in the invitation that you received. But in that role, he's developing and implementing innovative programs that that will help to improve the Nation's health care delivery systems.

Dr. Gilfillam started CMS in July of 2010, so he's been involved with us for about -- almost six months now, and we're excited to have him on board on our team, and he's worked as -- when he joined the team, worked as director of the performance based payment policy staff, which is responsible for overseeing the accountable care organizations and value based payments initiatives.

Dr. Gilfillam also worked as president and CEO of Geisinger Health Plans, and prior to that, he has a tremendous amount of experience in health care management, so we're honored to have him as part of our team. Some to note, Senior Vice President of

the National Network on Management Coventry Health Care, which has a network of about 5,000 hospital and more than 500,000 physicians, also worked as general manager of IBC as American Health New Jersey Health Managed Care Subsidiary.

So Jon has been around the health care arena -- I'm sorry, Richard has been around the health care arena for quite a long time, and I think that the comments that he's going to share with you-all today is going to be very well received, but most of all, I think we want to -- you know, after we receive comments from Jon and Rick, hear back from you-all, so I'll be back up to talk a little bit more in terms of that process of how that's going to occur once Jon and Rick have spoken.

So Jon and Rick.

MR. BLUM: So good morning, everybody. It's a real pleasure to be here. Rick and I are going to tag team a little bit. I don't see the slides on the screen, but we -- we'll figure it out.

I think our goal here really is to hear from folks here in the audience, hear from folks on

the phone, and we are embarking on a change to CMS, and I think the way that we see CMS is that we need to be hearing from folks in the health care field, the beneficiary fields, the entire health policy community that we interact with.

But we have historic new opportunities coming into CMS to change the way that we finance and oversee health care to the Medicare and Medicaid programs and also throughout the entire delivery system. The Affordable Care Act not only expands coverage to the uninsured but really has a goal as to change the way that we pay for care, change the way that health care is delivered through our -- through our payment systems, Medicare and Medicaid, but really gives us some new tools and new opportunities, and we're here in the spirit of, one, kind of understanding priorities, understanding goals, understanding opportunities.

The Congress that -- that authorized Affordable Care Act really is impatient for change. They want to see a more efficient health care system, as do we. We want to see a more accountable health

care system, you know, and lower cost health care system, and CMS can't start from scratch. We have to leverage, build upon good ideas, new idea that are happening throughout the ground, that are -- that are happening at the state levels, local levels.

But we're here, one, to understand what is happening, but, two, is how can we help. And we have funds, we have ways to -- to -- to waive certain rules, certain requirements, but really to expand innovations back into our payment systems. And I think the way that Rick and I think about our different roles of -- at CMS is that the work that I help to lead is current payment systems -- how we currently pay for Medicare, both in the fee for service context but also in the private paying context.

And Rick's role is really to build a next generation of payment systems, to build a next generation of ways of thinking about how care is financed through -- through both the Medicare and the Medicaid program, but hopefully that the innovation -- the developments will get folded back in to our

permanent payment systems, and so Rick and I work very well together and our staff work very closely together to figure out what we do well within the Medicare program, what we all know needs to be improved but that we can develop innovative models that he can get folded in very quickly.

We have three topics we really want to get -- get -- get feedback on. The first topic is the new Center for Innovation that -- that -- that Rick directs, and this is a -- a pool of funds, basically 10 billion dollars for the next 10 years that Congress has authorized to CMS to test, build, innovate the next generation of payment systems delivery models.

We also want to talk about the Accountable Care Organization Program. We know there's tremendous interest throughout both the hospital/physician communities regarding this new program, and the way that it's authorized within the Affordable Care Act is there's two pieces to it. One is a permanent program that is built within our permanent payment systems but also flexible to how we can think about testing new models beyond just what is

authorized -- the law for Accountable Care organizations.

Third is that we want to -- the -- the law authorizes a brand-new office within CMS, an office for dual eligibles. We know that both in the Medicare context, the -- the -- the Medicaid context, that the highest spenders, that most in need are dual eligible. Those who are entitled for both Medicare and Medicaid. We know that the programs don't work well with each other, that they don't coordinate well, that beneficiaries who are eligible both for Medicare and Medicaid oftentimes have competing programs, competing requirements. There's -- there's tremendous --

Can we put the phone on the table.

There's tremendous cost shifting that happens between Medicare and Medicaid. This office really is intended to -- to improve care for the most vulnerable of our populations and to make sure that we can talk better to each other, Medicare and Medicaid.

But, again, both Rick and I have ideas of what needs to improve, but we don't have all the

ideas. We really want to hear from folks here and to get feedback and to get thoughts. And just thinking about, you know, how we kind of see this work happening -- and it's not about payment systems but it's about how care is really delivered to -- to our beneficiaries, and we -- Dr. Berwick has challenged all us -- I think quite well -- to say, don't tell me about the payment system; don't tell me about payment rate. Tell me how it impacts the beneficiary; how is the care improved when a beneficiary interacts with the health care system, and that just caused a challenge to us is, don't bring the idea to -- how to pay hospitals differently; bring me ideas about how we can truly bring better care to -- to individuals that do have quite scary interactions with the health care system.

I talked about our topics. And just, you know, kind of thinking about how we all see our mission here at CMS, we don't see our -- our mission anymore as simply paying for the bills. That -- what Dr. Berwick has brought to CMS as -- and again, Secretary Sebelius, is that CMS needs to be much more

of the driving force to how we want to think about care going forward, think about more accountable care.

We know that we have a tremendous tool, tremendous leverage but -- but -- but no longer do we see that simply as paying the bills, and, you know, kind of, you know, creating hassle within the folks -- folks' daily lives but really about changing the delivery of care, making it more accountable, making it better for patients, both Medicare and Medicaid, and also those that -- that -- that are under provider pay arrangements.

But really we -- we see ours more of a force of change, and we're here, again, to understand how -- how we can use our leverage, our payment systems, our -- our -- our programs to -- to build a health care system that I think we all think beneficiaries deserve and are entitled to.

We really -- you know, now I think today we see the programs -- Medicare and Medicaid -- largely fee-for-service, largely about paying for fragmented care. Beneficiaries largely have -- have discrete episodes of -- of care that get -- that get

reinforced to our payment systems, and so our vision, our work, our hope is that in Dr. Berwick's mind, patients have journeys; they have -- they have care's hand out. They're, as well, integrated hand-offs, no matter if you're Medicare fee-for-service, Medicare private plan, Medicaid fee-for-service, Medicaid private plan, dual eligible. Our goal is to build better payment systems, better programs, better models to create better journeys of care for -- for our beneficiaries.

Again, Dr. Berwick has given us three challenges and has said that our job is to -- to ensure that care is improved when beneficiaries go to a hospital, physician, or office. That care has to be the best possible care. We're also focused on ensuring that population health is maximized. I'm really kind of thinking CMS has more of a public health --

(Interruption.)

MR. BLUM: More of a kind of public -- a public health organization, and, third, is that our charge to think about lower cost. And so we are

about, you know, trying to achieve all three of these goals at the same time, not just better health, not just lower cost, not just better population health but doing all three at -- at once.

And our job at -- at CMS is to improve but also to challenge the entire health care system to improve as -- as well.

I talked a little bit about some of the new -- new authority, but maybe I'll break here and then turn it over to Rick to talk about the Innovation Center and to kind of give some thoughts about what our statutory and new authorities are, but then to build the conversation that we're hoping to have.

So Rick.

DR. GILFILLAM: Thanks, Jon, and thank you, Randy and Renard. It's -- it's great to be -- it's great to be in Texas actually. This is the first time I've been on the ground for any length of time in Texas personally. I admire your highway systems. It's supported by big pillars with stars and stripes on them. I -- I don't think I've ever seen that before.

So it's great to be here and to be with you-all. We look forward to a lot of interaction.

The Center was established -- (inaudible) was established in the Affordable Care Section 3021, and it based that the charge from Congress was pretty clear and direct. It said, the purpose of the Center is to test innovative payment and service delivery models to reduce (inaudible) expenditures while preserving or enhancing the quality of care furnished. That's pretty specific; right? And what that -- we interpret that as saying, we -- there's three ways to think about projects that come to us and models of care and models of payment.

One, we're interested in models that maintain the same quality for lower cost of care; right? That makes sense. Two, we know that there are times when there's going to be programs and models of care that do a great job at improving the quality of care but may not change cost; okay? So quality gets a lot better; cost stays the same.

Are we interested? Yes. Is that everything we're going to do? No, because the charge

is pretty clear. We need to be looking hard at the total cost of care. So we'll do some of those projects. But the projects we're most interested in are the ones that improve quality and lower cost.

And we believe and we think there's ample evidence that there is plenty of opportunity to do both -- to improve quality and reduce the total cost of care, not by limiting care but by improving the delivery of care over time and working with care providers to find new and better ways -- more efficient ways of delivering care.

We just had a conference yesterday in Washing D.C. We had about 900 people there sponsored by health affairs. We had a number -- about 10, I think -- different organizations coming in, talking about initiatives that they had pursued, most of which actually demonstrated improved quality and lower cost, more efficient care. That's what we're interested in, and that's the charge, as we see it, from the Congress.

Jon mentioned the funding -- pretty substantial, 10 billion dollars over 10 years, not a

billion a year necessarily, but that amount of money over 10 years. It also gives kind of a clear path to do this work, so it gave us some -- some ability to not get -- not be constrained by what has been in the past limits around demonstrating budget neutrality or paperwork reduction acts, which sounds like not much but actually ends up getting in the way quite a bit in terms of being able to move rapidly, and our goal is, indeed, to be able to move rapidly in evaluating these new models of care.

One interesting aspect of the bill and an essential aspect of the bill, if we can find new models of care and new model of payment that meet our objectives of improving quality and reducing cost and we can convince the CMS actuary -- how many people here know what an actuary is?

(Audience responds.)

DR. GILFILLAM: That's a lot. Good.

You know, there's -- they're tough-minded, very intelligent, by nature perhaps a little skeptical. We have to convince them that, indeed, the program -- or the models of care will

reduce cost. And if we can convince them, then the secretary, through rule making, through regulations can change the payment mechanisms at CMS.

So as Jon said, we are totally connected at the hip. We need -- we -- we -- we're operating those new models -- I'm sorry, operating those current payment mechanisms but we also know that we have now a dynamic ability to change those mechanisms gradually as we can demonstrate that they make a difference.

So if you think about the -- the vision of moving from a somewhat fragmented care system where care tends to be broken up -- and people often notice when they go from house to hospital to home to nursing home. There are a lot of disjoints frequently in that care.

If we think about creating a system of care where people feel that is much more engineered and much smoother, it feels seamless when they make those transitions. To do that, we need to change the way we support you providers in making that change and delivering that new experience.

So if today our systems pay you as for

units and we get fragmented care, not surprising, what we need to figure out what to do is how to pay you and support you as you provide that kind of new seamless care experience. And this ability in the Center, to evaluate models, to evaluate payment mechanisms, to change the way we pay over time is kind of a central piece in managing that transition.

So what's our mission? Our mission is to be a trustworthy partner with you to identify, validate, and defuse those new models of care and payment to make you more successful in delivering that new experience for folks.

How are we going to do it? We think about care models at three levels, so we think about the patient care model. How do we deliver the best OB care, the best hip surgery? How do we do that in a way that's evidence-based and that gives us the best results every time. So that's one level of new models that we'd be interested hearing about.

A second level is, how do we build that sense of integrated care across different sites? So seamless care models, we're interested in those --

ACO, medical homes, those kinds of new approaches to care.

And third, we're interested in level and care models at the population or community level. How do we work with other activities going on in the community to deliver services in a way that optimizes the fundamental determinants of health for a population. So when we think about kind of parsing up our work, we think about models of care, models of payment that operates across these three different levels.

What's the organization look going to look like? What are our activities? Well, just to give you some idea of this, on this slide, we've laid out the different functional areas of the organization as we're currently thinking about them. We've got the three levels. If you see, we're going to have people in charge of working these three areas -- models in these three areas, and we're currently recruiting folks to do that who are experienced in each of these areas.

So expect to have teams of people working

with you, looking to you for suggestions of new care models, new ways of building -- excuse me, new ways of delivering care at each of these three levels. So that's one set of our organization.

We are going to have a segment of our organization that's very actively engaged in diffusion -- in spreading these new models across different communities and across the country. And we believe that if we think about what -- where these new models are going to come from, we think probably 60 to 70 percent of those are out there today already, that people are already doing things that if we spread them, they would have a significant impact on the cost of care and the quality of care and the outcomes of care.

So a big part of what we are going to do is look for those models that are out there that many of you have probably in place already and look for opportunities to test and validate them and then help them spread across the system. That means we're going to make a big investment in learning systems and provide technical assistance at times to you-all and

as -- as you need it to support in development of new -- and spread of new models.

We also know that we need to -- we need to have a way of getting ideas and simulating ideas, and our goal is to create an innovation -- a national innovation infrastructure that will drive and support and manage, to some extent, the flow of ideas into the innovation center for evaluation.

So we'll have folks working on our Web site where we will accept ideas. And think of it as a giant funnel where we are going to look to gather from you-all as many ideas as we can about new models of care payment that will have the impact that we've talked about. We'll manage them through a process of selection and then implementation and then evaluation.

And we know that -- because if you think about that -- that cycle of identifying a model, getting it in place, helping get it started, providing some technical assistance, evaluation of the model -- did it demonstrate cost and quality changes -- and then sign off and -- new regulations to change payment mechanisms.

So if you think about that cycle, evaluation is critical to that. We need to build it at every step along the way. So a critical part of our organization will be to have an evaluation process that's very sophisticated and -- and very able to do rapid cycle evaluation. That's going to be a key part of our organization.

We're looking for folks, by the way, who can do these things or interested in doing these things. So if you know of great folks who you think would like to be part of an organization with this mission and with these activities, let us know.

Where are we? Well, we've opened our doors now. We're open -- I guess it's about -- it's actually four weeks, now that I think about it, the 16th. We're building the team, as I mentioned. We are in the process of creating an operating plan and a strategic plan for the organization, trying to figure out work, how we're going to work, who we're going to interact with folks out here in the delivery system.

And as part of that, we also decided that we didn't want just to do a plan to plan. We wanted

to start a -- to get active, to start doing the work. So we actually have begun our work and announced four activities that I'll go through in a sec.

One other point, we are looking to get input from you-all now. We have a Web site. It's Innovations.CMS.Gov, and right now it has a lot of information about the center. It will soon have the ability to gather information from you through a standardized form. That -- if you keep an eye on that over the next several weeks, we should have that capacity built in.

So started -- we announced four activities from CMS that begin the process of building towards the seamless care approach. The first was a multipayer primary care medical home initiative that will support 1,000 medical homes in eight different states that are already up and going. And this exhibit is a key characteristic. We want to be engaged with other payers.

We want to work shoulder to shoulder with other payers because we want to operate and -- and present for providers a rational, consistent,

predictable environment with payers within which to work and to be successful. So we want to double-down whenever possible on activities that are already going on in the marketplace with other payers.

We also announced the Medicare Health Home State Plan option, which reimburses states 90 percent for health home initiatives that they create in their states for Medicaid beneficiaries over the next two years. That was part of the Affordable Care Act, and that is coming out of our -- from our colleagues on the Medicaid side of CMS.

We announced a plan to help support the development of 500 medical homes and federally qualified health centers coming out of the innovation center, and finally we announced a plan for supporting the new federal coordinated health care office that is intended to find new ways of delivering that seamless care experience for people eligible for both Medicare and Medicaid.

And there's an opportunity for states to write proposals for new ways of integrating care for that dual eligible population -- a very important

population that accounts for approximately 40 percent of Medicare and Medicare spent in nine percent of the population, so there's a great opportunity to do a better job for folks.

They're subject to strange, conflicting, one would say, crazy incentives operating into state and federal level. The result of which is, there's no real well-coordinated approach to care for these patients.

So a partnership is central. We're here because we want to learn how we can work together to help support you-all in doing this. We understand that we don't deliver the Nation's health care in Washington or Baltimore. You do it out here in your local communities. It will be local. We want to understand how we can support you and work together with other payers, employers in your community to help you be successful in providing these -- this new care system.

Jon, do you want to take a --

MR. BLUM: Yeah.

I also want to spend some time talking

about the ACO Program. The law -- the Affordable Care Act requires that by January 1st, 2012, that CMS allow organizations coming into the Medicare fee-for-service program to -- to have the opportunity to -- to earn share savings, meaning that if they can come into the fee-for-service program and better manage cost, better -- better manage care, that there is -- there is an opportunity to share in the savings.

The saving just don't accrue to the trust funds, but they can also -- they can also accrue to organizations creating that the -- the clear incentive for -- for better care management, more clinical improvement, and it can also lower cost for the entire program.

We are in a process now of developing proposed rules that we anticipate to have out publicly by -- by -- by next month, January, with the goal to have the program up and running by January 1, 2012. We're not here yet to be able to talk about our proposals, though they're still in development, but we can talk about some of the principles that we are -- that we are putting in -- or that we're considering

when -- when crafting these rules, and we know that there is tremendous interest in the ACO Program.

We have -- we have organizations coming into CMS Baltimore or D.C. almost on a daily basis saying, we want to be an ACO; we are an ACO; please -- please let us start. And we -- we hear the urgency, and we are working as fast as we can to ensure that we have the program up and running.

But some of the principles that we are putting into place as we are going through the proposed rule making, one is that we want the program to be a very flexible model. We don't want it to be a model where only hospitals can come in to kind of dominate the marketplace. We want to create that opportunity for hospital organizations to come in but at the same time also encourage more -- more physician-based organizations, more small-based physician-based practices to come into the program, who are really coming into -- coming into the principle that it's not a one-sided only model.

Again, going back to the earlier comment. We want to be patient centered. We want it to be

organizations that are organized and that are building care models that are -- that are organized regarding the -- the patient experience. Thinking about Dr. Berwick's notion, that -- that patients should have journeys, not just simple episodes of care.

Again, this is a program that's part of the Medicare fee-for-service program. We want it to be organizations that share our goal to demonstrate something different than just open fee-for-service, something better, more clinically appropriate care, more efficient care, more coordinated care, also lower cost.

We have to point out that independent to our innovation center or this new ACO program, that lots of other changes will be happening throughout fee-for-service to lower market basket updates, to put more pressure on hospitals to -- to adjust their -- their readmission.

So, again, the ACO program needs to be something that's going to be better than just -- just what's happening to the fee-for-service Medicare independent to the ACO program -- lower payment rates,

more -- more pushes on higher performance quality, and that -- that -- that we see the ACO program to capture even more savings, even better clinical improvement than the other changes that will be happening -- happening independent to the fee-for-service payments systems.

We want the organizations to be about continuous learning, continuous improvement. That is just not coming into the program on year one to set a target to set some clinical goals, but these targets, these goals will be readjusted continuously to ensure that organizations and CMS are -- are out to constantly improve.

We are thinking through, too, how we can be more transparent, more -- provide on a more real time basis our fee-for-service claims data to organizations that want to come into the ACO program. We understand that for organizations that truly want to better manage care and cost, they have to have more information coming from our claims systems. This will be attention that we have to balance.

So, one, we all share a goal to provide

that information, but at the same time, we know that the information can be used for good and it can also be used for not so good things, you know, such as direct marketing to -- to patients and to use information that -- that -- that violates the trust that beneficiaries have that their ben -- that their data, their claims history will be kept in confidence.

So we're trying to think through how to balance those two tensions, but I expect that will be a very robust part of our discussion through the -- through the proposed rule-making process.

You know -- but also, you know, while we're trying to think what an ACO is, we're also trying to think about how -- what an ACO is not, and while we are very excited about the opportunity, there are some risks. One is that the statute contemplates organizations as earning one-sided to share savings. Meaning that if you come into the program, you do well, you share in the savings; but if you don't do well, you cost the program more, for example, there's no penalty.

And so some have argued that a one-sided

share savings program, you know, creates -- creates strong incentives for organizations to come into the program, kind of roll the dice, see if they earn share savings -- some years they may; some years they may not, but no harm, no foul. That is really contrary to how we see the ACO program.

Again, going back to the notion of it has to be something different, something special, something better than a traditional fee-for-service program. We're going to be working hard to think about ways that -- that we encourage organizations to come into the program that truly share our goals, that there should be more value, higher quality, more integration, more coordination, lower costs than, again, what's going to be happening, you know, throughout the fee-for service program.

The folks that are thinking about the ACO program, we're going to be pushing as hard as we can both through clinical measurement, cost, you know, the kind of organizational structures, really to -- to encourage those organizations that share our goals to -- to come into the program.

Second, we're hearing lots of concerns, not so much from the -- from the CMS payment side but from the kind of overall competitive side -- from the colleagues, at the FTC and DOJ -- who are worried that the ACO program could be a means for organizations to build competitive power to now put -- put pricing leverage on us, pay fee-for-service, we set the fee schedules put on private payers who have to negotiate these rates each year.

There are concerns, there are arguments that the ACO program could be a means for organizations to consolidate, to gain more market power. Some of the organizations that come to us that have a strange interest to the ACO program really have a mind-set to kind of become the dominant player within a given marketplace, which causes us concerns, not from a Medicare payment perspective but just from a public policy perspective.

And to con -- to control that concern, we are working very closely with our colleagues at the FTC and DOJ, and so -- so I expect that organizations that want to come to CMS to say, we're an ACO; we're

ready to play -- we'll have to be thinking about issues on the FTC/DOJ side to ensure that those -- those changes, those -- those initiatives don't just simply consolidate market power. That -- that kind of undermines the goals to the ACO program of causing cost to increase on the private side and to work very mindful that we're not just about Medicare, we're also -- we also have tremendous impact on private payers, as well.

And, again, we see the ACO program not as a static organization but a nimble -- you know, kind of always improve an organization. So we're going to be thinking about rule-making that, you know constantly pushes that improvement that I think we all -- we all share.

So, again, we don't have the answers. Our proposed rule making cycle for the ACO program will be in the spirit of taking comments, taking ideas. We -- we put out a -- a request for -- for preinformation last month, and we're going through those comments right now. We've got about 600 coming in -- coming in from the health care communities that

our staff now are poring over to help inform our proposed rule-making.

But I encourage everyone here in this room to comment, to read those proposed rules for those that -- that -- that have an interest in the ACO program. We're all -- we're all building this together, and CMS will be as responsive to the comments as we can but still pushing our at goals to see the ACO program as something different, something better, something -- something better than just fee-for-service Medicare.

And with that, maybe we should just it open, just, you know, kind of start taking comments. So we'll kind of -- can our facilitator come up?

DR. MURRAY: Thanks Jon, and thanks, Rick. What we're going to do is open up for comments, and as I heard your speaking voice this morning when I said, good morning, you came back and said, okay, we can speak. So we're now looking forward to hearing from you. What we're going to do is ask you to possibly limit your comments to not more than three minutes because we want to hear from as many people as

possible in the room.

And if you have multiple comments, feel free to -- you know, to come back and -- and -- and -- you know, with another comment. We're going to ask that you do use a microphone, however, because we've got some people on the phone. We've got that worked out, and we want them to hear your comments, as well.

And so as you're getting ready, we're going to try to ask you if you can maybe approach the microphone, and we're going to try that out, first. If it doesn't work, we'll get some mike runners who can run the mike around for us.

So what we want to ask you to do is focus your comments basically on the Innovation Center, on the Federal Qualified Coordination Center, as well as on the Affordable Care Organizations. And so when you give you comments, if you'll provide your name as well as your affiliation, that will help us to kind of parse some things out.

So our first comment, please. Thank you.

MS. TAFF: My name is Lou Taff, and I'm with the Senior Source, the Social Service

Organization.

And, Jonathan, you were talking about the ACOs and the data rich criteria principle that you were talking about, and I want you to comment a little bit more. You were talking about balancing confidentiality versus making data available for marketing purposes, and that's the way I interpreted what you said. If you would comment a little more on that.

MR. BLUM: Let me clarify -- let me clarify the -- the comment. We do not want to see Medicare data being used for marketing purposes or for -- or for, you know, violating patient confidentiality. So when the Medicare beneficiaries come into the program, they have a trust, which is true today, that their information will be held in confidence and will only be used for the purposes to provide and deliver care.

That being said, that we know that if organization -- you know, physicians have more data regarding drugs that -- that a beneficiary is using so that pharmacy management can be best -- best managed,

best coordinated, there is argument that more data is needed by the physician and the caregiver to best manage and coordinate the care.

And so we're trying to balance that tension, and so we're never going to do anything that would say, we want more information to get out that would help drug manufacturers or, you know, others to -- you know, to market directly to beneficiaries, but at the same time, we're hearing a lot from the clinical profession that if we had more data, not just on the physician side but, say, on a hospital use, the pharmacy use, the long-term care use, care could be better managed.

And we're thinking hard how to balance these tensions. I'm not saying we have any answers yet, but that's going to be an area that we need a lot of help and a lot of comment to ensure that we are protecting beneficiaries' information but at the same time helping physicians, caregivers best -- best -- best managed care.

So did that clarify your question? Good.

DR. HAYWOOD: Hi. I'm Dr. Trent Haywood, Chief Medical Officer for VHA, a National Organization with about 1,400 health care organizations across the nation, primarily a not-for-profit in urban rural cities, and I was also -- I was previously the former Deputy Chief Medical Officer at CMS.

Several comments that I want to quickly highlight, that we are looking actually to work closely with both CMS and particularly the Center for Medicare and Medicaid intervention. And the first area, about the accountable care organization, we'll probably release that paper in February, somewhere along those times, where we went back and looked at the physician group practice demonstration (inaudible), and when I was there, we helped deliver that one.

The concern there is that most people probably haven't taken the time to look at -- there's a lot of risk financial for the individual physicians. I know you talked a little bit, Jon, about this not being a plan for playing the odds. Because of that, our concern is that if we don't actually model -- or

fix some of the model, there's a way that we can talk to you about fixing that model.

And all these people that are pretty excited about doing ACO are going to be disheartened when they find out there's no dollars there. Most of them -- 80 percent in the people in the first, 60 percent of the people in the second year had no share or say whatsoever, but there are ways to do that, but we have to actually switch the model versus the way the OMB is thinking about, so we want to talk to you about that financial model.

The second area relates to a little bit -- an area that often is -- is not necessarily addressed, which it is on the Medicare coverage side but not necessarily maybe on the patient interaction with the physician, which has to with supplies and -- and the costs related to the devices, and so as that organization that I represent, we probably saved about 1.4 billion dollars to the health care economy just in 2009 by looking at these particular areas.

And so we think there's a way that's based on the pharmacy benefit model that you guys need

to apply to the supply benefit model where you actually have patients working to understand some of those elective devices and so working closely with patient decision to make that go forward.

The third one -- area relates to the fact that because there's not going to be a lot of opportunity early on the ACO side, we think -- in -- in terms of the current model where a lot of our members are really interested is in bundle payment and not necessarily wanting to wait two years from now because a lot of them are deciding whether they're going to do ACOs or if there's an opportunity to start getting around bundle payment now.

They really want to start moving forward with CMS now so that when they get to January 2013, we're up and running versus learning in January 2013, so that's another opportunity where we want to work closely with you is just on bundle payment.

Now we have a lot of people that are ready to get going with that, instead of waiting two years to find out how we're going to move forward in that particular language.

MR. BLUM: So when you say, more, what do you mean by bundle payment because that means different things to different people. So to your members' definition, what do they mean when they say, we want to see bundle payments?

DR. HAYWOOD: Yeah. Thanks for the question and the clarification.

And this is one of the reasons why people are saying that they want to know now versus 2013, but we're separating it from gang sharing; okay? So we separating it from gang sharing. We're really talking about a situation where we probably have dollars from part A to part B be combined and those are being shared from the provider and the -- and the individual clinician that are participating in that care of service.

And so it is designed in such a way whereas the integrated model is taking care of patients where you combine those part A and part B dollars but is separated from a gang sharing model.

MR. BLUM: Okay. Thank you.

MS. HOCHHALTER: Hi. I'm Angie

Hochhalter. I'm from Scott & White Healthcare. Scott & White is a large integrated health care system, and we -- we really appreciate the opportunity to hear directly from you-all and to make some suggestions, ask some questions.

The first is that we've been wondering the degree from which the CMI projects will be available to organizations that are officially deemed an ACO, and I know that is a question that's going around a good deal, but it has to do with the ACO rule about not taking part in other shared savings programs, so I guess that's the degree to which some of the CMI projects will be based on shared savings, I -- I think is what that question comes down to.

We would like to suggest the -- maybe the possibility of there being CMI projects that would allow us to enroll persons who are either Medicare or Medicaid beneficiaries. That way in an integrated system, it allows us to serve more of our patients by using some of same models of care for both Medicaid and Medicare beneficiaries. We've started trying some pilot projects with transitional care and lower income

persons who are younger and are finding good results for that.

And the third is that -- I'm really excited to see the focus on public health being and being able to work more with our communities on their health. We, as an organization, find a lot of value in working with some national groups. We're part of AHRQ's new Action II network. We've been part of the HMO research network, and we also part of the healthy aging network that the CDC runs, and those seem like groups that may be able to -- to help in different areas, if you-all would be willing to partner with them, but it would get you both organizations and some groups of networks that are already established.

Thank you.

DR. GILFILLAM: Thanks, Angie.

A couple points -- a couple of responses and clarification, so the issue of being involved in multiple initiatives, I think that the rule is you can't -- the intent is you can't share the same dollar, you know, of savings multiple times; right? So it's clear that you need to be -- we need to be

watching kind of those streams of -- of incentive payments and making sure that that is not happening.

So we're mindful of that. But we also know that many of these initiatives will be nested, in all likelihood, within -- you know, it could be a bundle payment within an ACO; it could be a medical home within an ACO; it could be a community initiative that has all of those things in them.

So I think -- I think the issue is to watch the stream of incentive payments, and we are working on that already. But we do not see -- within the center, we have not -- we don't see that any rules, like, you know, you have to be an ACO to participate in center initiatives.

We're -- we're much broader in our thinking, and as I said, we want -- we -- we're going to open up a giant funnel to your ideas that many of which will cut across all three of those levels. Some may go beyond it. I don't know. We -- you should -- what I'd like you to hear is that we're wide open to ideas for care models/payment models that deliver the outcomes that we're after. So that would be in

response to number one.

We -- it's easier for us within CMS to see how we get engaged in initiatives that are affecting the Medicare population, but we know that -- that we have both responsibilities, and we want to work with states that are involved in -- in projects that are addressing Medicaid population.

In fact, the MAPCP project that I mentioned is specifically that. We are aligning with states that are already using a medical home model to -- to -- to improve care for Medicaid Beneficiaries, so it's totally our intent. How it works out in every different case, we'll -- you know, we'll figure out and we'll look at proposals.

The dual eligible is obviously the big win, so that if we can get -- if we can get projects that address both, we will do that. And I just want to mention, Melanie Bella is the director of the federal coordinated health care office for dual eligibles.

And Melanie is former Medicaid State Director in Indiana and just a fabulous person who --

one of our colleague that we work very closely with, and she is filled with ideas and anxious to get more ideas from you-all about how to best address that population and, by the way, has made great progress in assembling data sets that for the first time really do a great job of bringing together the state Medicaid and Medicare information.

So she's rapidly running down that road, and we will be looking for very innovative proposals from -- from states, and at some point we'll be reaching out to providers for ideas about how to address that population, as well.

And we are also hearing from interested and looking forward to creative suggestions as to how to work with some of the national groups and how to work with some of the organizations that our own, you know, colleagues within HHS and elsewhere in the government have put together, so we'll be -- we -- we'll be open to proposal suggestions.

All that is my way of saying, we're looking for you to come to us with ideas, proposal, but we need more specific times about going forth with

our fees, et cetera, but we also intend to solicit from you great ideas that are very specific, start with patients, as Jon said. What do the patients need, what are the interventions, how is that intervention going to change matrix on those three dimensions of better health, better care, lower cost and tell us that story very concretely, and we're going to be interested from hearing from you regardless of where it fits in the -- in the framework I've laid out.

MS. TURLINGTON: I guess I'm next.

DR. GILFILLAM: Yeah.

MS. TURLINGTON: Susan Turlington, Hospital Corporation of America.

Jon, on your last slide that you had up, third bullet, the capitation model, it spoke of the organizations being built within the fee-for-service program. Also, it mentioned that the beneficiary must have provider choice. So when I think about an ACO, I think of a much smaller -- much like Angie at Scott & White where it's very local, as opposed to the Blues, CIGNAs, Aetnas today that have -- you know, there's

very little differentiation between the networks really. Most providers are in on networks.

And so maybe I'm wrong of thinking of an ACO as a smaller, local provider of health care. So how are we going to give provider choice? Within the ACO, I can see that, but it won't -- to me, it won't en -- enclose everybody in a community.

Can you speak on that?

MR. BLUM: Yeah, and that's great question.

We need to, I think -- when we're talking about an ACO program, all that's recognized that the ACO program doesn't take away Medicare beneficiaries' right within the fee-for-service programs to see any physician or to see or to go to any hospital that -- that accepts Medicare patients, so, you know, that's premise number one.

The ACO program doesn't do anything to take away beneficiaries' fundamental right of provider choice. Now that being said, we want ACOs to be accountable for the -- for the patients that -- that they are seeing that -- that -- that see -- that

patients see the ACO as their kind of primary medical, you know, kind of center or home.

So we have to think about rules to -- how we assign patients to an ACO. It's not like the MA Program, the Medicare Advantage Program where a beneficiary signs up with a health plan. I mean, beneficiaries are (inaudible) the fee-for-service program.

So we're -- so that's how we see the -- the -- the program working (inaudible) in the cost (inaudible) to law but also operational. So we're going to be curious to our proposed rules to how we think about the assignment of beneficiaries to -- to -- to an ACO, but also those -- those -- those organizations that are very interested in this program also need to understand that they're going to be operating without a captured population.

If I'm Jon Blum and I'm at -- you know seeing my primary care physician and he or she is in an ACO, I still have the right to go to Mayo Clinic and get my care there whenever I want to. So that's going to be the challenge for the ACO, to create that

value proposition where the -- where the beneficiary, Jon Blum, wants to get all of my care through that ACO organization.

So -- but -- but -- but we're hearing recommendations of the -- the beneficiary have to be captured. They can't go out of my network in order to get care or else it -- or else it won't work. But that's not what the law says. The law does not take away the beneficiaries' fundamental right to see any physician, any hospital, and that's going to be a challenge to ACO organizations, but to our minds, if they are doing what the program is wanting the organization to do, create that value proposition and to create that coordinated care, hopefully beneficiaries will want to stay within that organization because they get better care.

Did that answer your question, or --

MS. TURLINGTON: Yeah, I think it did. It cleared -- it cleared up a point that I was --

MR. BLUM: Okay.

MS. VANWAGNER: Yes, my name is Karen VanWagner, and I'm the CEO of a company called North

Texas Specialty Physicians. I appreciate the opportunity to -- to be here and hope we can work together on making some fun things happen.

Just as a point of context, we take care of about 30,000 Medicare Advantage patients and have been for 10 years. Our physicians also take care of another 40 to 50,000 fee-for-service Medicare patients. And our experience has been that although there -- there's a lot of spillover, the cost profiles, what we can do in terms of case management and support we can give to our Medicare Advantage patients is greater than fee-for-service medicine.

If we -- for example, 50 percent of our care management patients come from applying predictive modeling techniques, and we can do that because we know the patients are assigned to us in advance and need that kind of care based on claims and clinical data.

Can you share with us a couple of things; number one, what is your thought process now on prescriptive assignment? Is it going to happen beforehand, or are we still looking at some thoughts

on retroactive assignment; and, number two, for your -- your slide on capitation is -- is -- is not an ACO is a little troublesome to us. Is there another way? Because our ACO -- and we feel the fee -- the fee schedule is the problem, not the answer.

On promoting better value for people who want to do an ACO with the risk-based approach, what is the process we should follow?

MR. BLUM: Well, I think there's a couple of things within your question that I will respond to.

I think going back to your question about the MA Program, Medicare Advantage. We are operating on the premise that the ACO program is not going to replace or undermine the MA Practice. Now, the MA Program independent of ACOs, payment rates are coming down over time, but we still believe the MA Program will be a very strong option for beneficiaries and is our greatest source for -- for accountable, you know, care.

And so we're going to do everything we can to push -- to push the MA Program to be more focused on beneficiaries. We're putting in place the

Five Star Quality Bonus Payment System that we have great hopes that we'll see even greater things from the MA Program.

Now we know that today about 20 percent of Beneficiaries are in an MA plan organization. That number is probably going to stay the same, you know, give or take -- probably going to grow actually but not -- but not tremendously over the next several years. So we still have to create that accountable care home for those beneficiaries who are in the fee-for-service program.

You know, I think one of the top three hardest issues we're going to be facing with our proposed rule is the issue of assignment, prospective versus retrospective, and there are good arguments on both sides of the issue. We're still weighing pros and cons, making -- decision-making about that, and we'll throw out our ideas, and I can't, you know, give you a sense yet, but you'll see it in January though our proposed rules, but expect lots of comments lots of feedback.

But that's going to be an area that --

that I think will be one that we need to push hard.

I forgot the second part of your question.

MS. VANWAGNER: The second part of the question -- excuse me, was for -- for folks like us who think the fee schedule is the problem, and we want to pursue a more risk-based ACO product. What do you recommend the process -- or what do you see that process being?

MR. BLUM: Well, I do think there are lots of organizations within -- not just Rick's innovation work but just in the base program that want to see different payment models, other than one-sided shared savings, and so that's another area that we're thinking -- thinking hard about.

But, you know, I think going back to the -- to the statement of what's the goal of ACO program, it is better management, better -- lower cost than traditional fee-for-service Medicare. And so we can think about different payment models that change the incentive, that change the delivery of care. That's -- that's -- that's what we're going to be

thinking hard about.

But -- I mean, I think part of your question is, the MA Program pays better than a fee-for-service Medicare, so we have more opportunities. I mean, I think we're going to be pushing both programs down because we have to because of the Affordable Care Act, and we're hopeful that with better management, better coordination that organizations will still be financially healthy within those -- those -- those payment changes.

MS. VANWAGNER: Okay. Thank you.

And one other follow-up question. We take care of several thousand dual. We have written some ideas, shared some ideas in written form with Ms. Bella's office. Can you share what the process might be to follow up with those ideas?

DR. GILFILLAM: Yeah. Hi, Carol. It's good to see you again.

You've got some great organizations here, represented here, and doing this great work in Texas, so I just want to acknowledge that, and I'm sure there are lots of others -- Scott & White in North Texas.

I'm sure lots of others are doing this important work. Lots to learn from them. We look forward to learning from you-all nationally.

I think the process that the -- you can come through Innovation Center when we get the portal up and -- or the import capable up on the portal over the next few weeks. We'll be interested in hearing your idea specifically about -- about duals and also about perhaps alternative arrangements.

I think it's important to note, Jon's slide said what it's not -- the assurance savings program is not a capitation program in the sense that it is not MA again for all the reasons he just explained. And we'll -- we'll be looking at alternative financing approaches and payment approaches across the two programs in kind of a corporative way so that it makes sense so you can give us your ideas. We're interested in hearing them, but we'll be exploring a variety of different approaches that -- you know, has -- has been written about nationally by lots of people.

Thanks.

MR. McMAHON: Good morning. My name is Jim McMahon. I'm vice president of Product Management Innovation at Well Point. We operate as the Blue Plan in 14 states across the country. I'd like to thank you for the opportunity to meet with you-all today.

During the last couple -- probably five to 10 years, many of the commercial carriers, including Well Point, have in our commercial business developed high-performance network which -- whose goals, I think, are -- are very similar to some of the things that we are trying to accomplish here in the Medicare program.

And our experience has shown that there are sort of two issues. If we focus on developing networks that are exclusively high-performance, we found them to generally have quite limited appeal among members, that they're -- they're not particularly interested in having a very narrow network, the value of the chain, the -- the choice that -- that's offered by broader networks.

However, within a very broad network, it's also, then, different, then, to drive the quality

that we're looking for. So we have, in our commercial business, found that really one of the best ways to -- to drive members to quality -- high-quality providers is through benefit design, so we would be hopeful that there would be some possibilities for benefit design that would support driving members to high-quality providers.

Thank you.

DR. GILFILLAM: You know, we -- we'd be -- that's -- that's a great deal suggestion. We'd be interested in specific ideas about how you structure that. If you think about, you know, kind of the nature of the Medicare beneficiary, the benefit package, and the -- the options that need to be there for folks to go wherever they want to go. It kind of becomes, you know, an improved bene -- benefit if you go someplace kind of thing.

So we'd be very interested in proposals that people would have -- might at some time -- you know, something that might align well, something you-all have in a particular market and be wide open to hearing suggestions about that.

MR. McMAHON: Thank you.

MR. GILFILLAM: Another question, too, is, you know -- you know, how can we define what a high-performance network is, and I think when these ideas are -- are brought to us on the MA side, the beneficiary communities, I think, are very concerned that, you know, these are means to discriminate, are means to avoid certain -- certain beneficiaries.

Today we can -- we can get some help and ideas to how we, you know, define rules that -- that drive toward the goal that you want, beneficiaries to go to the highest perform -- performing hospital, physicians, what have you, but at the same time, you know, there -- there is push back, and, you know, beneficiaries often say, well, this is just a means to -- to -- to -- you know, to avoid my care.

I think that's the tension we face, that I'm sure you face, as well and what CMS needs help with.

MS. HOCHHALTER: Hi. Angie Hochhalter again.

I'm wondering if you could talk just a

little bit about whether there are plans to communicate from CMS to beneficiaries about what CMI is, what an ACO is. We're finding the focus groups lately trying to work on group cost analysis for care transitions, and when we talk about the fact that CMS might be interested in proving some of those things, they don't necessarily connect that. That's not the message they've necessarily gotten about the Health Reform Bill and that type of thing.

So I know that for each individual project we'll communicate directly with -- with people in our area, but I was wondering if there was any plan for sort of a national campaign about getting words out to beneficiaries.

MR. BLUM: The answer is, yes, and I think it's going to be one of our hardest challenges, you know, going forward is when we think about how much effort the agency spends on helping beneficiaries just to understand, you know, their -- their plan choices.

You know, they have fee-for-service; they have the Medicare Advantage, Medicare Part D. This

is -- this is the Medicare side. It doesn't even, you know, consider the Medicaid side. But now we're thinking about sort of the kind of payment reform, delivery reforms, and, you know, beneficiaries have the right to understand what is happening.

And we're thinking hard about how we communicate, you know, that possibly their physician is being -- you know, working with ACO, and they have a different payment incentive, and the goal is to better manage care. But there could be incentives, otherwise, so that's going to be our challenge.

And, also, beneficiaries don't -- don't understand these terms. They don't even understand what the MA Program is oftentimes, and they think of it as Medicare, and so that's -- that's going to be our challenge. We're going to need a lot of help, help from provider organizations to beneficiary communities, both to understand what -- what our responsibilities are but how can we use language in a way that's -- that's meaningful for beneficiaries, and it doesn't create further confusion.

MR. McLAMORE: Hello. I'm Mike McLamore

with Texas Association for Home Care and Hospice, and home care providers are wanting to be a big part of the overall process for the delivery of care. We think that we can be a bigger part of the integrated care between hospitals, nursing homes, and care-in-the-home setting.

So one of the issues dealing with the ACOs is, what is the -- any type of potential restrictions out there that could be involved with home care providers, home health providers. We're not wanting any restrictions in terms of access to beneficiaries out there in the open market.

Another point is the home-bound status. We think there could be a great cost of efficiencies in the home-bound status were it to be removed to have patient care in the home setting. At no point is telemonitoring -- there was an Avalar study recently that showed 30 billion dollars in savings over 10 years through use of telemonitoring in homes through home care and home health.

The other issue is nurse practitioners and physician assistants being able to sign plans of

care dealing with home health services. We think that if flexibility were to be allowed -- and it was allowed in hospice situations through the Affordable Care Act but didn't extend into home health -- that would be another efficiency for delivering more efficient, timely care to patients.

Then on bundling, we are concerned about the cost of bundling. I think you guys really need to look at -- you know, in terms of trying to come to cost efficiencies, is bundling really going to be cost efficient.

In terms of timely payment, we've got quite a big -- big workforce out there. If payments are going through larger, more costly organizations, what does that do to the home health agencies out there in terms of being able to pay our workforce and have timely payments for the services that we provide?

So there's just a few aspects there.

DR. GILFILLAM: Just a quick comment. Those are great comments, and, again, we'd be interested in hearing some specific proposals.

Just by way of kind of, like, reflecting

on that notion of doing rapid cycle evaluation and understanding, it's real -- I think it's really important that we all commit ourselves as an industry to being disciplined in how -- how we think about and talk about savings opportunities. I don't -- I don't mean this, Mike, as a criticism of what you said, but I want to just pick up on it as an example of we -- we -- there's been so much loose talk in the industry about, you know, what does and doesn't save money and, you know, what reports are out there.

The New England Journal -- I think, was it last week -- had actually the first significant study of the use of in -- tele -- well, telemonitoring -- using phone lines for folks at home with chronic illnesses, and it was -- basically it didn't show any impact.

So I can't ask everybody to take the, you know, statically significant pledge, but I -- I would, you know, suggest to our friends at Avalar and elsewhere that the time in our -- at least in our center, the time for loose talk about savings is over, okay, and we are going to be very rigorous about

people demonstrating that what they allege can be demonstrated.

Because, remember, we have to prove to a skeptical actuary that it actually makes a difference, and so I just want to reinforce that, and it's -- it -- it -- there's -- you know, there are industries that go on for 15 years in health care making claims about the value ad, and, yet, the industry is replete with -- you know, at the end of the day finding out that things don't make a difference, so we're going to really kind of come at this with a renewed sense of discipline and rigor around demonstrating impact.

And that -- and by the way, that's from someone who's been a strong believer in home-based monitoring and still believes that there's an opportunity to do things in a very different way.

MR. McLAMORE: Well, and we appreciate that, and we do understand that there is -- just monitoring the home and whether or not it's effective, and then what -- what kind of support has to be there and what kind of response has to be followed through in order to keep that patient in the home and have

their conditions, you know, within their parameters.

And so I think that's a big part of the picture. There -- there's been some work here in Texas, as well, on telemonitoring, and when you have the proper response in the home to when those parameters get out of -- our of order, you are able to avoid rehospitalization.

And here's -- here's some statistics, and I'll give this to you after the presentation. I've got some documents. Home Health Partners here in the State covers thousands of -- of patients. They are doing some telemonitoring models. Their hospital -- rehospitalization rate for those not on monitors -- up around 19, 20 percent going back into the hospital within 30 days; with the telemonitoring, the proper response down to 6.7 percent rehospitalization.

So it -- it does take the proper response, and I think with that -- those kind of features, you're going to get good results.

MS. RAWLINGS: Good morning, and thank you again for being here for -- with this presentation.

I wanted to follow up on the question and comment from HCA regarding the concern for the -- for the patients themselves and the choice of providers, and I understand that you feel that you had that question responded to, but it brought up a follow-up question from me in thinking about the rural areas.

I would like a little clarification with respect to the accountable care organization, the level of patient -- the patient population base necessary in order to establish an accountable care organization because I see a concern in the rural areas. If you establish an accountable care organization and it'll be probably in a more populated area because of the patient base needed.

So for your rural patient -- Medicare especially, instead of traveling maybe 15 or 20 miles to see a provider, now they're going to need to travel 50, 75 or 100 miles to a provider, depending on what -- what the parameters are to establish the accountable care organization and for that rural provider to still be able to provide the service and not have sort of some type of competition now because

inability to -- to continue their practice because of the accountable care organization.

MR. BLUM: That's a great question. Going back to the notion of the very skeptical actuary, I mean, you know, I think from one of the actuaries -- take a look at the ACO language. They want -- they want assurity that what's happening is not just due to statical fluke but due to actual care improvements, and so they've made the determination -- they being the actuary God -- have made the determination that that 5,000 population base is about the right number.

And so the law says that an ACO -- the law basically has very few statutory requirements, but one of them is that the organization has to have a population primary care base of about 5 -- of 5,000 beneficiaries, which may create challenges to how we create ACOs in rural areas given by definition of that 5,000 population basis is hard.

So we'll have to think creatively. We'll have to, you know -- you know, ask organizations to think creatively because there's still the same demand

for more accountable care in -- in rural areas and the same need that in large urban areas, so it could be leading to test models on the Innovation Center side. It could be that we need to think about ACOs as sort of much larger organizations within -- within -- within rural communities, meaning more, you know, kind of networks of hospitals, physicians.

But we're in a 5,000 limita -- 5,000 population limitation, but we'll have to think flexibly and take that comments -- take those comments from the rural communities.

MS. RAWLINGS: Okay. Now, I apologize. I didn't introduce myself. Sylvia Rawlings. I'm the past president of the Texas Rural Health Association, so I was wondering what the rules do here in Dallas, and I'm based out of Arlington actually.

But that -- that is concern, and I also would -- would really encourage and invite CMS to really visit carefully with some of the rural hospitals. They -- because of the nature of the business, that they're out there with a low population base already and -- and current challenges already

with reimbursements and such, that they have had to establish their own individual models of quality of care and reduced -- reduced cost as much as possible.

So there's some models out there already that I would venture to say we could learn from.

DR. GILFILLAM: Sylvia, this is Texas, and it's a big state, so the distances are bigger, longer than some of the other states we've been in and we heard from folks in rural -- from rural areas.

But, you know, could you just help us understand that point you made about, you know, a patient who travels 20 miles a today might in the future have to travel 50 to 75 miles. Just tell -- take us through the logic of why you think that might happen so we can understand that because it's not obvious to me why that would happen.

MS. RAWLINGS: Some of the -- the providers who already feel that they are pretty stretched on margins or there -- you know, there is no margin or -- or profit margin or such. They feel that they're not going to be able to participate or become involved with -- become an accountable care

organization or become involved with one, so their concern is that they -- some of the rural providers are saying it's getting now to the point that it's better if I just hang my hat and -- and close down my -- my practice.

So that -- that is a very big concern out in rural areas, so that if you're looking at doing that, then you're definitely going to now put the population base at a more disadvantage with respect to -- to distance and travel to get -- to get care.

DR. GILFILLAM: Yeah. I -- just to be clear, going back to the point Jon made, there's nothing about the way we are thinking about ACOs that would say an ACO 75 miles away could require a patient to go to them, as opposed to their local provider; right?

MS. RAWLINGS: Uh-huh. Yes.

DR. GILFILLAM: It's more of -- you're -- you're saying this may threaten the business model of rural hospitals?

MS. RAWLINGS: Right. Or that rural provider or that primary care physician.

DR. GILFILLAM: Or even the primary -- yeah, even the primary care physician, though -- presumably if that patient wants to see that primary care provider, then there's nothing about the ACO model that we've talked about that would change that, unless you're thinking about it differently. And I just want to make sure I understand what the dynamic is that you're concerned about.

MS. RAWLINGS: Well, there -- all of the other -- all of the other changes that are -- and I guess it's not just isolated to this specific -- specific. It's all the other changes that are coming with respect to health care reform and everything else involved. It's going to affect our business model.

DR. GILFILLAM: I see.

MS. RAWLINGS: Uh-huh.

DR. GILFILLAM: So your advice is for us to think very concretely about their business model here in Texas because we're not talking about five or ten miles. We're talking about 75 or 100.

MS. RAWLINGS: Absolutely. And actually I do a lot of that traveling in -- in Texas, and you

go out in the Big Bend area, you can drive 75 an hour for an hour and a half and you're still in the same county, so there are definitely some -- definitely challenges out there. Thank you.

MR. FRAGANO: Hi. My name is Ben Fragano, and I work for Texas Health Resources here, and I'm an application analyst. I do some parallels between what we're trying to do with your -- your patient care model and going out and -- and learning and -- and diffusing the ideas for best practices for patients care model to our electronic health record deployment here.

We're a pretty large organization, and we have large and small hospitals, and we're able to -- a lot of the ideas -- a lot of good ideas have come out of some of our smaller hospitals. And so I guess my question is: When you're going out -- and I think maybe this meeting or this -- this forum today and your Web site are good examples of the plan to -- to kind of get those ideas.

But I think -- is there a large plan to maybe ensure that some of the smaller entities out

there are included, engage -- like an engagement model to go out and try to, you know, pool those ideas, but more proactive than -- than -- than reactive to get those ideas?

DR. GILFILLAM: Yeah. We -- you know, essentially we have -- we have some -- a guy by the name of Todd Parks. Todd is the -- kind of -- I'm trying to think what his title is. I guess he's the chief informa -- technology officer for CMS -- for HHS? Yeah. Technology, yeah.

And Todd's very entrepreneurial. He started a couple of companies and spun them off and is someone who thinks often, if not incessantly, about how to make sure we -- we get out to people who are not the usual suspects. And so he drives us in our regular Innovation Center planning sessions to -- to -- to think about ways to do that very proactively.

So it's -- I'm going to tell him you made this comment actually because he'll get a big kick out of it. So, yeah, we are trying to do that. We'd be interested in ideas as to how we best do that, but -- but we are -- it -- it's something that comes up

regularly, and we want to make sure that we get out and -- and behave in a way and interact in a way that makes it clear that we are interested in getting proposals, ideas, et cetera, from -- from just the sorts of small organizations that you're referring to.

So if you have any other suggestions as to how we might engage, we'd be happy to hear them.

Thank you.

MR. RUSH: Hi. Good morning. My name is Carl Rush. I have a small consulting firm in San Antonio. I specialize in working with community health workers.

There have been a lot of us involved in this field, which is kind of a specialized field. We've been very excited about developments in -- in recent years, and particularly the provisions in the Affordable Care Act that either explicitly mentioned you need health workers or where they -- they present apparent opportunities; for example, looking at reducing rates of hospital readmissions.

The Patient Center of Medical Homes, some people with whom I've worked have -- find it hard to

imagine a medical home that doesn't have community health workers because of their ability to improve the quality and continuity of communication between patient and provider.

My -- my concern at this -- at this juncture is that -- that a lot of folks and people -- very smart people and very well-intended people who don't really understand community health workers.

DR. GILFILLAM: I was going to ask you, could you, like, be really specific and define that part?

MR. RUSH: Sure, sure. Well, it is now --

DR. GILFILLAM: As I'm claiming to be one of the intelligent people, and certainly not one of the luminaries. But I -- I am a person who doesn't the answer to this question. What -- what are you referring to exactly?

MR. RUSH: Okay. The community health worker is now actually recognized by the Labor Department as an occupation. These are folks who are generally hired from the community being served.

They're generally dealing with underserved populations, but they're generally hired from that population to provide nonclinical services, including sort of cultural brokering, helping the provider understand the cultural community context of the patient and their family, providing various forms of informal health education, informal social support.

They've proven to be very effective in things like motivational interviewing around chronic disease, self-management, and thing likes that, and they provide a range of things -- everything from outreach and education to -- to advocacy in the community acting as advocates for and with the community and so on. They play active roles in a number of settings in care coordination.

But, again, their -- their role is understanding the community and the community cultural context of the patients' situation so that they can function very effectively in -- as part of the team in -- in helping the other members of the team understand those things. And they -- they've done -- for example, a study -- it's about to be published now

from Arkansas -- a Medicaid study demonstration working with a population on elderly and disabled population at risk of requiring placement in long-term care facility.

Their bottom line came out from that saving in terms of total cost of care for those patients relative to a comparison group, that they saved in total cost of care almost $3 for every dollar that was spent on employing the community health workers because basically they were able to connect them in many cases with nonmedical service which enabled them or their caregiver to -- to continue to keep the person in the home setting.

That's a long definition. There is an official definition in the -- in the Labor Department classification, but -- but this is -- it's -- it's emerging as a -- as a -- a valuable part of the workforce.

So I guess because of this -- and another example, folks I've worked with in the Medicare program had involved what they thought were community health workers in the Avery Diabetic Accounts

demonstration in Florida.

The -- the -- the results were disappointing until we pointed out to them what that what they were calling community health workers is basically any willing volunteer who was willing to learn to get up in front of a class and deliver a diabetes self-management class. That really doesn't meet the definition of community health worker. They didn't get the benefits of employing them.

I guess I -- I don't want to take too much time on this but ask whether you would be -- whether you have or would be willing to designate folks within your organization with whom we could invest some time in bringing them up to speed and truly understanding this field so that if there are opportunities, to take advantage of what they can do, that -- that we can do that.

MR. BLUM: Well, I think it's probably fair to say that -- that CMS needs to learn more about the role and their responsibility. I think that -- that I was glad Rick asked the question because I wasn't sure of the answer either.

I believe we talk beforehand that you have been talking to our staff, which is great, but maybe we need, you know, one, to understand better what -- what the role of responsibility is but then to understand, too, how it fits within this new concepts of medical homes, ACOs, and whether we can encourage those kinds of programs to develop, you know, throughout all the communities.

MR. RUSH: Uh-huh. Okay, great.

DR. GILFILLAM: Carl, see me after this. I'll give you an e-mail address.

MR. RUSH: Thank you.

MR. BLUM: Thanks very much.

DR. GILFILLAM: Thanks very much for that education.

DR. MURRAY: Jon and Rick, I think you've seen that there is a funnel of ideas going from Dallas, and so we appreciate all the -- the comments and recommendations that were given here this morning. And I wish that we could get it going because there's been some great information shared here.

But I do want to kind of pause for just a

second. I know there's got to be one common comment coming up, and so as you're staging that comment, just provide you with a little bit more information because I know that if you're like me, after the meeting, you've thought, doggone it, I wished I asked that comment. I didn't have a chance to do it, so I want to give you some e-mail addresses that you can share with your friends or colleagues and others, as well as for yourself that once you've left this meeting, if there's something that comes up, we do want to get that.

So the first is, ACO@CMS.HHS.GOV. It's A, as in apple; C, as in Charles; O, as in Oscar, @CMS.HHS.GOV, and that's for comments related to the -- the Accountable Care Organizations. And then also for the Federally Coordinated Health Care Office, F, as in Frank; C, as in Charlie; H, as in Harold; C, as in Charlie; O, as in Oscar, @CMS.HHS.GOV. Again, FCHCO@CMS.HHS.GOV. And then, also, the Innovation Center, as well. Innovate@CMS.HHS.GOV.

And Rick is still at the Innovation Center where you can go in and log in. I believe Rick

will get the information from the center, which is Innovations@CMS.GOV that he mentioned earlier.

Do I need to repeat any of those? You got them? Good. I'll be looking forward to your written comments, as well. And like Raymond (Inaudible) said, if there's something that you want to share in terms of a model or something, you can always send those in to those centers, as well.

So we've heard a lot of great information, and thank you-all for being here. We would not want to close this session without hearing from our wonderful regional director, Marge Petty. Marge comes from the Department of Health and Human Services, and Marge has the responsibility of overseeing the activities of the regional office operating divisions under HHS.

She was appointed by the Secretary, but she represents Secretary (inaudible) in her efforts. She's also worked previous as a Director of Public Affairs and Consumer Protection for Kansas Corporation Commissions for about six years. Also, has done some more work with that commission and also comes to us as

a former State Senator of Kansas, and so she has done a fantastic job of representing us in Washington, as well in D.C. area and Baltimore, as well as across the region. So we appreciate Marge being here, so I've asked her to come and provide us with some closing remarks.

So, Marge.

MS. PETTY: Thank you, Dr. Murray. It's a pleasure to be with you here today. There was a lot there about Kansas, but I'm not in Kansas anymore. I actually grew up in West Texas, the area of Texas where they were talking about not a lot of providers out there. If you drew a line down the center of Texas, the East part is populated; the West part is not.

One of my first health care providers was a veterinarian because there was not a health care provider nearby. So that gives you perspective, in addition to the fact that one quadrant of the East part of Texas would contain probably 20 states on the East Coast. So it give you a little bit of perspective on the breadth that we're dealing with.

And I want to thank so much the providers who are in this room because the context you've provided in terms of rural health delivery, in addition to the incredible expertise we have in Dallas and the depth and the understanding not only of the continuum of care that is possible through the new ACA and the emphasis on quality that brings about the -- the look at the community, the relationship of the community and community health workers.

What's unique about Kansas -- what's unique about Texas in terms of providers, such as Promotoras, just an aside, for ten years, community health workers have been certified in Texas and supported by the Medical Association. Those are the types of community health workers that were mentioned earlier -- unique to this population.

But the emphasis and expertise in this room that moves the journey that Dr. Berwick was talking about, that health care is not an event but it's a journey and it's a continuum from community to hospital to individual providers, and let's not forget the patient because the emphasis now on the ACA, on

prevention aspect, and engagement of the patient with all the health care providers in the systems that you-all represent is the crux of the health care reform message.

I want to also thank Dr. Gilfillam for being here, for taking the time, and Dr. Blum -- Mr. Blum. We appreciate your expertise and willingness to be here and listen to what's unique about our region and take the great expertise that is in this room.

Again Dr. Murray identified the key Web sites that you can go to to provide your comments, and we truly appreciate the comments that you've provided today. Angie, Carol, the -- Susan, the requests for definition on the ACOs and the perspective that you-all have brought has been very important to this discussion.

Again, this is a journey, and it's been mentioned that in the end, getting it right will be the important thing. The end is not 2014, and as a journey, it's going to require counting relationship and dialogue between the federal -- your federal partners, between the providers, between the health

plans, and the health care system.

So, again, continue to push for that dialogue because that's an important way to make this evolve in a way that is right.

Thanks so much.

DR. MURRAY: So that concludes our session. Thank you-all, as I've mentioned, for taking the time out of your busy schedules for being here, and we really appreciate your presence. Happy holidays to all and be safe in your travels. Thank you.

(Proceedings adjourned at 11:18 A.M.)

STATE OF TEXAS)

COUNTY OF DALLAS)

I, Kathy E. Weldon, Certified Shorthand Reporter, in and for the State of Texas, certify that the foregoing proceedings were reported stenographically by me at the time and place indicated.

Given under my hand on this the 29th day of December, 2010.

_____
Kathy E. Weldon, Certified
Shorthand Reporter No. 6166
My commission expires 12-31-10

E

F