

Capital Reporting Company
CMS Listening Session 12-17-2010

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CMS LISTENING SESSION ON
HEALTH CARE DELIVERY SYSTEM REFORM
DECEMBER 17, 2010

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

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

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

12 So good morning and welcome to the CMS
13 Listening Session.

14 (Interruption.)

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

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

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

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

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

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1 all here to serve.

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

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

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

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

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

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

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1 their values to be known and respected.

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

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

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

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

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

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

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

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

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

14 Renard.

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

17 Good morning.

18 AUDIENCE: Good morning.

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

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

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

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

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

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

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

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1 does but does a great job with that.

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

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

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

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1 we are waiting to hear his comments.

2 Thank you, Ms. Jenkins.

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

10 Dr. Gilfillam started CMS in July of
11 2010, so he's been involved with us for about --
12 almost six months now, and we're excited to have him
13 on board on our team, and he's worked as -- when he
14 joined the team, worked as director of the performance
15 based payment policy staff, which is responsible for
16 overseeing the accountable care organizations and
17 value based payments initiatives.

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

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

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

16 So Jon and Rick.

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

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

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

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

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

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

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

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

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

7 We have three topics we really want to
8 get -- get -- get feedback on. The first topic is the
9 new Center for Innovation that -- that -- that Rick
10 directs, and this is a -- a pool of funds, basically
11 10 billion dollars for the next 10 years that Congress
12 has authorized to CMS to test, build, innovate the
13 next generation of payment systems delivery models.

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

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1 authorized -- the law for Accountable Care
2 organizations.

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

15 Can we put the phone on the table.

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

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

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

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

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

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

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

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

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

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

19 (Interruption.)

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

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

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

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

14 So Rick.

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

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

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

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

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

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

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

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

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

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

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

17 (Audience responds.)

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

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

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

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

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

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

22 So if today our systems pay you as for

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

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

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

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

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

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

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

22 So expect to have teams of people working

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

5 We are going to have a segment of our
6 organization that's very actively engaged in
7 diffusion -- in spreading these new models across
8 different communities and across the country. And we
9 believe that if we think about what -- where these new
10 models are going to come from, we think probably 60 to
11 70 percent of those are out there today already, that
12 people are already doing things that if we spread
13 them, they would have a significant impact on the cost
14 of care and the quality of care and the outcomes of
15 care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 Jon, do you want to take a --

21 MR. BLUM: Yeah.

22 I also want to spend some time talking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So, one, we all share a goal to provide

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

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

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

22 And so some have argued that a one-sided

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 possible in the room.

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

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

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

20 So our first comment, please. Thank you.

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

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1 Organization.

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

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

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

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

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

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

21 So did that clarify your question?

22 Good.

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

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

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

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

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

12 The second area relates to a little
13 bit -- an area that often is -- is not necessarily
14 addressed, which it is on the Medicare coverage side
15 but not necessarily maybe on the patient interaction
16 with the physician, which has to with supplies and --
17 and the costs related to the devices, and so as that
18 organization that I represent, we probably saved about
19 1.4 billion dollars to the health care economy just in
20 2009 by looking at these particular areas.

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

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

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

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

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

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

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

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

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

21 MR. BLUM: Okay. Thank you.

22 MS. HOCHHALTER: Hi. I'm Angie

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

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

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

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

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

15 Thank you.

16 DR. GILFILLAM: Thanks, Angie.

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

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

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

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

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

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1 response to number one.

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

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

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

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

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

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

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

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

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

11 MS. TURLINGTON: I guess I'm next.

12 DR. GILFILLAM: Yeah.

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

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

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

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

8 Can you speak on that?

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

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

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

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

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

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

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

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

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

17 Did that answer your question, or --

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

20 MR. BLUM: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 I forgot the second part of your
3 question.

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

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

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

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1 thinking hard about.

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

11 MS. VANWAGNER: Okay. Thank you.

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

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

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

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

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

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

22 Thanks.

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

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

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

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

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

8 Thank you.

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

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

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1 MR. McMAHON: Thank you.

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

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

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

20 MS. HOCHHALTER: Hi. Angie Hochhalter
21 again.

22 I'm wondering if you could talk just a

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

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

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

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

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

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

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

22 MR. McLAMORE: Hello. I'm Mike McLamore

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

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

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

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

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

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

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

18 So there's just a few aspects there.

19 DR. GILFILLAM: Just a quick comment.

20 Those are great comments, and, again, we'd be
21 interested in hearing some specific proposals.

22 Just by way of kind of, like, reflecting

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

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

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

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1 people demonstrating that what they allege can be
2 demonstrated.

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

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

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

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1 their conditions, you know, within their parameters.

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

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

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

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

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

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

15 So for your rural patient -- Medicare
16 especially, instead of traveling maybe 15 or 20 miles
17 to see a provider, now they're going to need to travel
18 50, 75 or 100 miles to a provider, depending on
19 what -- what the parameters are to establish the
20 accountable care organization and for that rural
21 provider to still be able to provide the service and
22 not have sort of some type of competition now because

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

3 MR. BLUM: That's a great question.

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

13 And so the law says that an ACO -- the
14 law basically has very few statutory requirements, but
15 one of them is that the organization has to have a
16 population primary care base of about 5 -- of 5,000
17 beneficiaries, which may create challenges to how we
18 create ACOs in rural areas given by definition of that
19 5,000 population basis is hard.

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

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

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

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

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

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

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

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

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

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

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

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

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

17 MS. RAWLINGS: Uh-huh. Yes.

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

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

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

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

15 DR. GILFILLAM: I see.

16 MS. RAWLINGS: Uh-huh.

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

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

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

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

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

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

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

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

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

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

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

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

8 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 demonstration in Florida.

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

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

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

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

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

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

12 MR. RUSH: Thank you.

13 MR. BLUM: Thanks very much.

14 DR. GILFILLAM: Thanks very much for that
15 education.

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

22 But I do want to kind of pause for just a

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

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

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

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

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

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

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

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

7 So, Marge.

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

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

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

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

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

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

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

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

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

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1 plans, and the health care system.

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

5 Thanks so much.

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

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

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3 COUNTY OF DALLAS)

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5 I, Kathy E. Weldon, Certified Shorthand
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7 the foregoing proceedings were reported
8 stenographically by me at the time and place
9 indicated.

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

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