

MEDICARE and MEDICAID
HEALTHCARE SYSTEM DELIVERY REFORM
CONFERENCE

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KAUFFMAN CONFERENCE CENTER
4801 ROCKHILL ROAD
KANSAS CITY, MISSOURI

1 MS. BAKER: If you wait just one moment.
2 I'm Judy Baker, the Regional Director from HHC,
3 Health and Human Services. It's our pleasure to
4 welcome you all here today. I'll just tell you a
5 little bit about our region. Region 7 consists of
6 Iowa, Nebraska, Missouri and Kansas. And I've been
7 here about a year, and I work with the most fabulous
8 CMS team in the nation, as far as I'm concerned. And
9 I'm very pleased to be with them here today.

10 We are very, very lucky to have visitation
11 all day from our senior leadership in the Center to
12 Medicare and Medicaid Services. They've been
13 listening to us, and specifically came out here to
14 listen to the regions, and what our special concerns
15 are, what our needs are, what our opportunities are.
16 And Dr. Berwick has been here listening to us all
17 day. He's been visiting some of our model programs
18 in this region, and we're just really pleased we
19 have him here today.

20 We've been working on some special
21 projects that we hope will bring some new
22 opportunity to our region as well. So as we all
23 work together as partners, we welcome you today.
24 These are all of our best health care leaders, Dr.
25 Berwick, in the entire region, and we're glad to

1 have them here.

2 You know, we have, in this region,
3 presidents of the American Hospital Association. We
4 have senior leadership that's been involved in the
5 NAIC from this region. We have the president of
6 Blue Cross. We have former leadership from the
7 American Public Health Association, and numerous
8 other healthcare leaders actually residing in this
9 region. So we're small, one of the smaller regions,
10 so we outsized in what we bring to the health care
11 table.

12 So it's been my pleasure to be a regional
13 director for quite some time. It is our goal to
14 build a health care system that keeps patients
15 healthier and realizes its full potential.

16 There's no one who has more experience in
17 this very respected field as our next speaker, Dr.
18 Donald Berwick. In June President Obama named Dr.
19 Berwick administrator for the Centers for Medicare
20 and Medicaid Services. As administrator Dr. Berwick
21 oversees the Medicare, Medicaid, and children's
22 health programs. Together these CMS programs
23 provide health care coverage to 100 million people,
24 nearly one in three Americans.

25 Before assuming leadership of CMS, Dr.

1 special word of thanks to Ann Foster Reilly, who is
2 our special administrator here in Kansas City and to
3 Neil Foe, who's been -- who's the regional post for
4 me here. I've been having a terrific visit. I'm
5 sure I'll be back soon and often.

6 I will try to honor the intent of this
7 session. It's a listening session, not a talking
8 one. So I'm going to be try to be very brief when I
9 set the stage for what I hope my colleagues, Rick
10 and Melanie and Nanette and everyone can learn from
11 you by listening. The context, of course, is just
12 this marvelous area of history of healthcare in our
13 country, introduced by the Affordable Care Act and
14 the challenges it now brings us.

15 The topic is delivery system reform. Let
16 me motivate the topic a little bit by telling you
17 how I'm thinking about it. How I think it will be
18 constructed for not just CMS but all of us in this
19 country who think about the future we want to create
20 for ourselves and our children.

21 The social need of health care is evident,
22 and it's not all that hard to describe. It's what do
23 we want for our country, for our citizens. What do
24 you want from your region or your state or your
25 community. My proposition to my colleagues at the

1 Center for Medicare/Medicaid Services is drawing a
2 straight line back to the rest of my career, what
3 brought me here.

4 We need three things, three things at
5 once, three particles. Goal number one is we want
6 better care. When we are sick, injured, worried, we
7 want to enter a health care system that meets our
8 needs. That's why it's there. Those needs are well
9 defined, and we understand a great deal about the
10 performance of that system due to work that's gone
11 on for 34 years now, studying how American health
12 care performs.

13 The turning point, hallmark of that work
14 came out of our National Sciences Institute of
15 Medicine in 1999 a report on medical safety, whereas
16 human. And the report of 2001, crossing the quality
17 chasm report stated basically the health care we
18 have and the health care we could have had lies not
19 just in the gap but a chasm. It was a finding. A
20 finding that there are dimensions of performance in
21 American health care that fall short of the
22 potential we have if we use all the knowledge we
23 have. And it falls short of these expectations that
24 we ourselves bring to care for patients.

25 These who in medicine labeled six

1 dimensions for improving safety. It's not injured
2 people in care, but in the converse, not to be
3 injured by care. The effectiveness, which means we
4 promise you the care that will help you, according
5 to all the knowledge we have, and we promise not to
6 subject you to care that won't help up. Patient
7 centeredness. You're the boss. You, your family,
8 your loved ones, you're the boss. We're guests in
9 your lives. And when you come to us for help, we
10 need to understand you, the individual, your
11 texture, your background, your needs, the
12 individualization of the care that is good care for
13 you. Safety effectiveness, patient centeredness,
14 timeliness.

15 Delays. Delays are unwanted. It's
16 instrumental in all this health care also.

17 Efficiency, which is the elimination of
18 waste. Follow a nurse through her day in the
19 hospital and you will watch her struggle to spend
20 time doing what she's trained and wants to do, which
21 is heal the suffering, to work with the people that
22 come to her. She doesn't want to fill out needless
23 forms or go hunting for innocent supplies. That's
24 wasteful to the citizens, as an example.

25 Inequity, closing the gap in socioeconomic

1 status. That's a cluster of goals: Safe, effective,
2 patient centered, timely, efficient equitable care.
3 That's goal one. That's a social need. We have
4 every reason to expect and want that for health
5 care.

6 The second goal has to do with the
7 Austrian generators of illness. Why did you have
8 your heart attack? Why did you break your arm? Why
9 are you depressed? Why are you suffering from lung
10 disease? Well, these are all consequences and
11 causes, those causes owned by health care or absent
12 the care. Only 10 percent of variation of health is
13 due to health care. And we want to get a healthy
14 society, if you want your children to live long and
15 drive. And we have to attend to things that might
16 make them ill. Choices they make about behavior,
17 substances in our society. Obesity and habits,
18 nutrition, exercise that don't serve us well.
19 Disparities among us that lead some people to be
20 more vulnerable than they need to be, the risks,
21 environmental risks. Better health you can pursue
22 somewhat through health care, but mostly through
23 working on these generators of good health. And
24 it's the second goal that we want to help the
25 community alter society to live long.

1 The third need is to do all of that safely
2 at a level of cost that we can afford. It's to
3 reduce cost through improvement. Not reducing cost
4 through harming anyone or withholding any piece of
5 needed care, but to reduce cost by ensuring that the
6 care we give is the care that will help. It's the
7 reduction of cost through improvement.

8 That three-part goal, better care, better
9 health, lower cost through improvement is, to me,
10 the need that we all face in this country. We want
11 to have a health care world that we can sustain and
12 that will meet our needs. That through part A is
13 what I've been articulating, and it's no resistance
14 at all to my colleagues at CMS. That's why I think
15 CMS is there, better care, better health, lower
16 costs. In our case for 100 million beneficiaries
17 for Medicare/Medicaid. Of course, that is an
18 isolated task. CMS as it exists in the context of
19 the care system as a whole, and, indeed, there's no
20 way to improve care for 100 million people. We're
21 all in this together. And so the nature is better
22 care, better health, lower costs through
23 improvement. It's not a CMS goal only, or
24 Medicare/Medicaid goal. It's national. It's a
25 national goal.

1 Right now, we have a reality that's
2 troublesome with respect to those goals. With
3 respect to better care, we know there are gaps.
4 We've measured them for years and they persist. Take
5 patient safety, for example, there was a very
6 important article in the Journal of Medicine last
7 week that has followed for six years the trajectory
8 of patient safety in one state, ten hospitals in
9 North Carolina. You read it in the newspapers. No
10 problems. The race of arms to patients are the same
11 now as when that started. Not nonprofits for sure.
12 Patient centered care. Are we truly organized now,
13 so that every single person is treated now with
14 individual honor and respect to their backgrounds
15 and their choices. We're not. There are very
16 successful patient as to what the test itself when
17 you went to the hospital were you treated where your
18 particular needs were reflected in what they were
19 able to do for you.

20 For health, better health, we're under
21 invested. The way we police in our country is a
22 little mathematical and almost working, and it
23 effects all of us. Risks for today's society that
24 we could mitigate if we were more serious than we
25 are right now about production of health. And costs

1 is the head of our topic right now. We're over the
2 top. It's beyond what we could sustain.

3 I just met with the Medicaid directors of
4 four states trying to figure out how to help. Every
5 one of them was recounting very, very dire pressures
6 statewide that derive from the cost of care. And
7 there are very real trade-offs being made between
8 education and health care, the infrastructure and
9 health care, between other forms of society and
10 health care. So you could take pessimistic view on
11 that. Better care, better care, lower cost needed,
12 but not in hand. I'm not at all -- I'm an extreme
13 optimist, the reason is that for 30 years I've been
14 able to go around this country and find gems
15 everywhere on all of those dimensions and more.
16 Every single thing we need and want to be, we
17 already have in our hands, in pieces all spread
18 around.

19 This morning, I visited the University of
20 Kansas Hospital, which several years ago set in
21 place an intention to reduce death in the hospital.
22 They've done it dramatically. You can see the
23 graphs and charts, watch mortality fall through
24 systematic work in that hospital, process by
25 process, patient by patient, case by case.

1 I've seen patient-centered care beyond
2 belief this morning. I visited Children's Hospital
3 here in Kansas City. And when I was taken up to the
4 ward, the person that showed me around the ward --
5 it was an oncology unit -- was the mother of a child
6 who had spent 300 days in the hospital, now cured of
7 her cancer. But an experienced parent hired to help
8 at the hospital, day after day, to be on the ward to
9 coach the staff about how to improve care patient by
10 patient. Patient centeredness is beyond belief. A
11 prototype we should all be thinking hard about.

12 I've seen population health improve in
13 communities that get committed. And I've seen costs
14 fall. Denver Health, Denver, Colorado, \$50 million
15 reduction in costs last year, simply by reduction in
16 the number of smokers. In fact, making things
17 better for patients and families. So we know how to
18 do it. The problem is being trapped in the current
19 designs. There's a rubric in the model world of
20 quality that goes like this. Every system is
21 perfectly designed to achieve exactly the results it
22 gets. You know that. You know that through the
23 rest of your life. You know that your tennis game
24 will be about the same unless you change your
25 stroke. You can't keep doing the same thing and

1 expect a different result. Your car has a top speed
2 and if you don't like it, you need a different car.
3 You can't go in your car, put it in a different
4 place, and get an instant improvement, it won't
5 work. In Africa it's the same. Weighing a pig
6 doesn't make the pig fatter. The only way to
7 improvement is through change. And you know that
8 the rest of your life. It's true in health care,
9 too.

10 When we talk about living system reform,
11 we're giving a label to change. We're saying we
12 want better care, better health, lower cost. And
13 the way to get it is to have health care that looks
14 different than what it does today. Better for
15 everyone. Better for patients, for families,
16 communities. Better for the economy. Better for
17 people who give the care. That's achievable through
18 change, through the investment, finding the spread
19 in better way. So many answers are upon us. I wish
20 I could take that prototype of Children's Hospital
21 here and prototype on mortality work at the
22 University of Kansas Hospital and just spread it all
23 over the country tomorrow, if I could. Mortality
24 would fall, and patient centeredness would rise.

25 So we have answers upon us. Others we

1 don't have. We have to figure them out because
2 they're important. We got that promise to patients,
3 to do that. And that idea altogether is the key. I
4 think it's the keynote to this meeting. This is not
5 any one agent at work on the others. This isn't CMS
6 police doing something to the country or doctors
7 doing something to hospital or hospitals doing
8 something to doctors or patients doing something to
9 anyone else.

10 The only route to the kind of new kind
11 that I think we need to find is altogether. I don't
12 know another way to do it. I've already been
13 impressed by a sense up here in this part of the
14 country, especially here in my visit today, a
15 knowledge of that. I can't tell you everybody
16 showed me around their place and then showed me
17 something about the city they're proud of. So
18 there's something about being here in Kansas City,
19 Missouri, Kansas, Nebraska, Iowa. There's something
20 about being here that we already know is better
21 together than separately. It's the same thing now.
22 It's the only way to get the health care that I
23 think we want and need.

24 The Affordable Care Act, the new law is an
25 amazing piece of legislation. It has many, many

1 answers in it. It's a piece of legislation that now
2 will offer coverage to people that otherwise who may
3 not be able to find it, being bankrupted by health
4 care. They won't be bankrupted by it now. They
5 can't be. It has coverage. It's the answer for
6 people with chronic illness, who have been excluded
7 from insurance because they need it. Now that we
8 have the law, it isn't possible anymore. The young
9 people, like my own daughter, who can be covered
10 under their parents' policy now instead of drifting
11 as they find their way in this economy.

12 There are answers throughout this law.

13 Even prescription drug benefits now will
14 be available to people who might have had to go
15 without badly needed medications. But the question
16 the law raises is the one I've been talking about:
17 Will we be able to rise to the occasion to find
18 better care, discover it and move it into our own
19 local setting or invent it.

20 The law has resources for that. Two of
21 the biggest ones are today. We have the opportunity
22 to support an unprecedented level of improvement in
23 this country through the new Center for
24 Medicare/Medicaid innovation. The Innovation Center
25 that Rico Phillip is getting right now.

1 That center has resources. It has
2 mission, and it exists, in my opinion, to release,
3 mobilize around the country an imagination, so that
4 people who understand the goal of better care,
5 better health, lower cost, that's the goal, that's
6 not negotiable. Commend best their time and
7 energies in offering up ideas and are participating
8 in projects and demonstrations and explanations,
9 expeditions, I'll call them, that will lead us to
10 protocols that we may have in our hands and spread,
11 and the innovation center will spread as part of its
12 charter, in my view, is to be a place that could
13 help you discover something that's someone else
14 knows that you might want to know, too. Put it to
15 work for you.

16 The Center for New Eligibles is the same
17 thing, by the way. Focused on a very, very
18 important segment of the population, the 9.2 million
19 people who are eligible for Medicare/Medicoids
20 because they have very, very special important
21 needs. They need support more than most others do.
22 They're placed in the hands of people to take care
23 of them, and we're not doing well with. Their care
24 is fragmented, and because it's fragmented, it's
25 worse care at higher cost.

1 With this focus now, congressionally
2 mandated, to now bridge across Medicare/Medicaid, to
3 build a net around these people that need us the
4 most. It is an act of wisdom and law. It gives us,
5 under the leadership Melanie Bella, great promise
6 that we can work with you, community by community,
7 state by state with coming up with better answers
8 for the drug problems. What we do need states
9 regarding are talk about better care, better health,
10 lower cost.

11 Dual eligible population of those 9.2
12 million people, is only I think about 17 percent of
13 the population, explain 40 percent of the cost in
14 the state Medicaid programs. So if your governor is
15 fretting at night about the costs of running the
16 state, a good deal of that fretting is coming
17 exactly from that population, and we can work the
18 magic for doing better for them while serving social
19 sources.

20 These are works in progress. We're
21 learning our way to what the innovation center
22 should be, the dual center, how the duals program
23 should work. And importantly across both of them,
24 how these new forms are integrated here to work.
25 There's one unifying idea underpinning the search

1 for better care, better health, and lower cost.

2 Integrating care, coordinating it, helping it be

3 seamless.

4 I was recently in Atlanta visiting a group

5 like in a senior center, and one of the seniors

6 there was a very worried woman. I said, what are

7 you worried about. She said, I have five doctors.

8 I'm on six medicines and I go to four places to get

9 care, and I don't think they talk to each other.

10 I'm worried. I'm worried doctor number 1 is going

11 to prescribe a medicine that I couldn't take with

12 medicine prescribed by doctor number 2, and neither

13 doctor will know it. That was what she was worried

14 about and that's an eloquent explanation of what

15 happens with care for seniors. She might not

16 understand the term accountable care organization or

17 health home, home attainment. Those are meaningless

18 to her. But the idea that doctor 1 talks to doctor

19 2, that they share common information, could be

20 rewarded and supportive to cooperate around her,

21 that she's the center and everyone weaves a net for

22 her. That's what she wants and that's what all of

23 those innovations that are now a cost for us,

24 accountable care organizations, medical health line,

25 that's what all those mean, based on the data on the

1 center of duals and the innovation center and other
2 activities CMS is going to have very much that
3 activity on our minds, because it's the best, best
4 route to better care, better health, and lower cost.

5 I'm going to be looking forward to your --
6 to your teaching us today, and we're going to be
7 reaching out to communities all over the country as
8 we have for some time now. But we could give more
9 focused energy as we move in these next stages of
10 planning. We're going to focus on these topics of
11 beneficiary and person centered care, delivery on
12 the specially important population of duals and
13 others with severe chronic illness.

14 We want to work with you to nurture your
15 ideas and harvest them, get both your concerns and
16 your thoughts available to us, not just today but
17 when I'm going away.

18 Today you will have the two leaders of
19 these important functions at CMS, Dr. Richard
20 Gilfillan from the CMS Innovation Center and Melanie
21 Bella from the Federal Coordinated Health Care
22 Office, which is a formal term for calling it the
23 duals program. Rick and Melanie are here to learn
24 from you, to share your thoughts, and most important
25 just to hear you so we can be there, so they can

1 lead your future and ours.

2 MR. GILFILLAN: Good afternoon. It's
3 wonderful to be back in Kansas City. I've actually
4 spent some time here over the years. And I was
5 going to tell you, I actually worked on a medical
6 home program in my prior life when I was working for
7 Geysler Health Systems. And it involved bringing
8 nurse practitioners in doctor's offices, among other
9 things.

10 And the first time we did that was right
11 here in Kansas City, actually working with a couple
12 of practices up off the beltway in the northwest
13 part of town. So much of what I learned from about
14 delivering better forms, new forms of health care
15 actually started here in Kansas City about six years
16 ago. So I'm just happy to be back.

17 Don kind of laid out the mission for us at
18 CMS. He described it somewhat, but specifically
19 here's how we're thinking about it from within CMS.
20 CMS will be a constructive force and a trustworthy
21 partner for the continual improvement of health and
22 health care for all Americans.

23 And he talked about that reform health
24 care delivery system, and we really see ourselves
25 working at CMS together with other payors, as well

1 as partners, providers, other stakeholders in the
2 industry to really get at the issue of the care that
3 we have today and creating the care system that we
4 have tomorrow, and I -- that we want to have
5 tomorrow.

6 And I think it's clear, we all know that
7 health -- people in health care work hard. They're
8 well motivated. They have great values, and they're
9 trying to do everything they can to improve the
10 lives of the people they care for. But it's not
11 something -- we've kind of put them in a context
12 that doesn't allow them to do that as well as they
13 could.

14 We put them in a fragmented care system,
15 and we at CMS and other payors have a great ability
16 to support fragmented care. We do it very well. We
17 pay doctor, we pay hospital, we have A, B, C, all
18 sorts of payment approaches. We have different
19 payment programs that encourage, actually, and
20 reward the delivery of fragmented care, because
21 right now the business models most providers operate
22 are better off from a financial standpoint when they
23 provide fragmented care. And so when we think about
24 where we want to go, we think at the onset, we want
25 to go to a seamless coordinated care world that has

1 those three aims of better health, better care,
2 lower cost through continuous improvement.

3 And that's the movement that needs to
4 occur. We know we need to go from what we can call
5 B, fragmented care, to A, seamless care, and we need
6 to find a way there. We need to design what
7 seamless care looks like, but most significantly,
8 we're all facing the issue of transitioning. How to
9 get from B to A.

10 And our job is to work with you all to
11 both find out what those models are and fund those
12 models of care, but also to find that path from
13 where we are today to where we want to go tomorrow.

14 A little bit more detail on Center for
15 Innovation. Specifically to find in the Affordable
16 Care Act, the purpose of CMI -- or the Center is to
17 test innovative payment and service delivery models
18 to reduce program expenditures while preserving or
19 enhancing the quality of care furnished.

20 So we are -- and to be an innovative
21 organization, but when you think about our charge,
22 it is pretty clearly focused on program expenditures
23 in the context of improving quality. And we think
24 about three possible ways to frame that.

25 We can deliver the same quality of care at

1 a lower cost. We can provide better care at the
2 same cost; although we can't live there. We can't
3 backhand our major effort within the center, because
4 we know there's a need to reduce expenditures. But
5 we know also this gives us the opportunity to
6 improve care and improve health care for the same
7 costs. We're going to pay close attention to that.
8 Or ideally and as we think is very possible and, as
9 Don said, is demonstrably possible, we can improve
10 quality and reduce costs.

11 So we are interested in models of care,
12 and models of payment that drive those changes,
13 those changes in quality and cost. That's what we
14 are about. We were given \$10 million in funding
15 over 10 years to pursue those new models, and given
16 some specific relief from some provisions of normal
17 Medicare operating principles, to facilitate our
18 ability to move forward and work with providers to
19 find those.

20 The most interesting aspect of the
21 legislation is, ordinarily, if you want to change
22 how Medicare pays for a service, it requires an act
23 of Congress. What this bill says, if we can
24 demonstrate to the satisfaction of the chief actuary
25 of Medicare, not an easy task in itself, but someone

1 who's opening -- who is open to certifying the fact
2 that the new model will save money, if we can
3 convince them that that's the case, then the
4 secretary has the authority, through regulation, to
5 change the way we pay providers of healthcare.

6 This is a very significant change in the
7 ability of CMS to be that continuous force, because
8 as you think about it before, we had a static set of
9 tools to drive change. The Affordable Care Act gave
10 us a new set of tools. Now what we have is a
11 dynamic set of tools, and what that means is we're
12 supporting continuous improvement in the delivery
13 system of care. We need to continue to improve our
14 payment approaches, and that's what the act gives
15 us. So our mission now then is to go forth and find
16 those new models.

17 So identify, validate, and see how they
18 work, and diffuse those new models of true payment
19 that deliver seamless, coordinated care, improve
20 health care and lower costs. That's our mission.
21 The Center of Innovation, that's what we're about.
22 And we're pretty clear in thinking about that as our
23 job. We wake up every day thinking about how to do
24 this, as a matter of fact, and it's really exciting
25 work.

1 So when you think about that and how you
2 operationalize that -- and there's some key
3 functional activities I just want to lay out there
4 for you to think about. One, this is about -- this
5 is not about stuff happening in DC. And that's why
6 it's such a pleasure to be out here, where people
7 are taking care of patients and doing this work
8 every day. This is about change in the delivery
9 system. This is about finding ways to -- if today
10 we support you in delivering fragmented care,
11 tomorrow we want to support you in delivering
12 seamless care.

13 And our job is to build an operational
14 model that identifies models and payment approaches
15 that allow you to do that.

16 These are kind of the key functional
17 activities that we're thinking about in that regard.
18 First being a diffusing learning system approach
19 where we need to be out here with you, you need to
20 be teaching us, you need to be identifying new
21 models, and we need to be working with you to
22 diffuse those new models to support the system.

23 When we think about models, as Don said,
24 we think about three levels. Patient care model,
25 how do we do the best OB care, how do we do the best

1 back surgery, how do we do the best bypass surgery.
2 We need to think about systems, again, coordinated
3 across the spectrum. So we need to think about
4 ACOs, medical homes, and other coordinated methods
5 of care. And then we need to work with that
6 community level to find ways to work with you really
7 well.

8 We need to find ways to manage the
9 innovation site, and we're learning about that, and
10 we're very interested in learning from other folks
11 who have managed the innovation process
12 successfully. As we saw earlier today at Cerner,
13 there are private companies doing outstanding work
14 to drive the ability for healthcare to continuously
15 improve, and we're learning from you all. And then
16 we need to do rapid cycle evaluation, and find ways
17 to rapidly evaluate these new models of care, study
18 them, and produce results, demonstrating that they
19 do, indeed, change those three dimensions.

20 So people asking, gee, how can we interact
21 with you, what models are you looking for, and what
22 we say is, think about it this way. Think about
23 patients, and think about patients' needs, and what
24 patients' needs are not being met, and think about
25 interventions you can put in place to change

1 patients' lives, such that those needs were filled
2 or met better. And think about a population of
3 those patients and think about how your program will
4 actually change the outcomes for that population of
5 patients across the three dimensions of better care,
6 better health, lower cost. So start with patients.
7 Start in the field, start thinking about those kinds
8 of models, and tell us a story, build a model that
9 will produce those changes -- that change in those
10 patients.

11 We saw great examples of this today at
12 Truman Medical Center, where the team there is just
13 tackling to talk to us. Populations, I can imagine,
14 in finding ways to take needed services, be it
15 health care, social services, coordinated care to
16 these people where they are, where they can benefit
17 from them. That is a perfect example of what we're
18 talking about. So if you really want to understand
19 what it kind of all involves, if you're interested,
20 talk to John and his team, and there's a lot to be
21 learned there.

22 What are we doing in the center over the
23 next 90 days? We've opened our doors. We were born
24 legally two weeks ago with the federal register
25 notice. We're building a strategic plan. A part of

1 that is coming out and listing and meeting with you
2 all and being out in the delivery system, out in the
3 communities so that we can understand and benefit
4 from the innovations that you already worked on. So
5 we want to capture the ideas. We have a web site,
6 Innovations.CMS.gov. It's up. It was also just
7 born, so it's rapidly evolving.

8 And we'll have forms on that not too far
9 down the road so you can actually use to submit
10 ideas to us. And we're beginning work. So we've
11 started working on peer models, that process of
12 evaluating peer models is underway.

13 We announced with our opening, four
14 initiatives. Two of these are coming right out of
15 the Innovation Center. Two of them are coming out
16 of the parts of CMS.

17 The first is what we call the MAPCP, the
18 multi-payer advanced primary care practice. It's a
19 model we're doing in eight states. We expect to
20 have about a thousand medical homes, serving almost
21 a million Medicare beneficiaries up in this program.
22 We've announced the Medicaid health home safe 10
23 option, which we talked about earlier with the great
24 folks running your Medicaid programs in the four-
25 state region. And we learned a lot and understand

1 the challenges so much better from being out here
2 like for three hours than we do sitting in
3 Washington for two months. I do. I got a real
4 education today on this. So it just validates the
5 importance of being out here with you all.

6 Third, we are undertaking the partnership
7 with some of our federally qualified health centers
8 in building medical homes in 500 federally qualified
9 health centers. And finally we're working directly
10 with Melanie, as Don said, in the Federal
11 Coordinated Health Care Office, evaluating care
12 models that better integrate care, very explicitly
13 integrate care through the dual health or
14 population.

15 We know this is about progress, as Don
16 said. It's local. We need simplified targets,
17 models, clarity of outcomes, with thought and
18 purpose for providers, and we want to work together
19 with local payors to do that and providers to design
20 the system. And we know it's important because all
21 patients will benefit, and we know this is better
22 care for people. So we're here to get your ideas,
23 suggestions, exactly learn together how we can all
24 work together.

25 Let me turn the mike over here to Melanie,

1 and then we'll take questions. Thank you very much.

2 MS. BAKER: Hi. And I just wanted to tell
3 you a little bit more about Dr. Gilfillan before we
4 bring our moderator up here. Thank you so much for
5 your presentation.

6 Just so you know a little bit of his
7 background, he served as president and CEO as
8 Geisinger Health Plan, executive vice president for
9 system insurance operation at Geisinger Health
10 System in Pennsylvania. He was responsible for
11 their managed care companies and helped design their
12 one-low payment health care reimbursement system
13 that rewards surgical and medical care providers to
14 provide quality outcomes. He has also served in
15 leadership positions in health care management, and
16 vice president, senior vice president, and national
17 network management of Coventry Health, where he
18 managed a network of 5,000 hospitals and more than
19 500,000 physicians. He comes well qualified for
20 this position. But just to reiterate, he is now the
21 acting director of what we're calling the Innovation
22 Center.

23 And now I'd like to also introduce a woman
24 that we spent the morning with this as region. Many
25 of our health care leaders and our CMS staff got a

1 chance to spend some good quality time. Melanie has
2 recently been appointed the director of Federal
3 Coordinated Health Care Office at the Centers for
4 Medicare/Medicaid Services, established by the
5 Affordable Care Act.

6 We also have a shortened name for that
7 now. We're calling it the duals office officially
8 now for us. We call you the duals office.

9 She is leading the work for the office
10 charged with the more effectively integrated
11 benefits for individuals eligible for both Medicare
12 and Medicaid and improving coordination between the
13 federal government and states for such dual eligible
14 beneficiaries.

15 Prior to joining CMS, Ms. Bella was the
16 senior vice president for policy and operations at
17 the Center for Health Care Strategies. She led the
18 organization's efforts to integrate care for complex
19 populations, including people with multiple chronic
20 conditions, disabilities, serious mental illness,
21 and dual eligibles.

22 She's also directed a leadership training
23 institute to help Medicaid providers enhance their
24 skills. Prior to being part of what she's doing
25 now, Ms. Bella served as the Medicaid director for

1 state of Indiana from 2001 to 2005, and during her
2 tenure, her most notable accomplishments were
3 spearheading the creation of the Indiana Chronic
4 Disease Management Program.

5 She's earned a master's in business
6 administration from Harvard University and
7 bachelor's degree from DePaul University. Please
8 give a warm welcome to Melanie Bella.

9 MS. BELLA: Good afternoon. Thank you
10 very much for having us. I will be brief because,
11 as you said, the point was to hear from you. I'm
12 curious though first, just how many of you in the
13 room interact with what we're calling the dual
14 eligible center. You provide for them? You pay for
15 their care? You're a family member. Okay. And do
16 you have a positive experience doing that?

17 AUDIENCE: Sure.

18 MS. BELLA: Yes. Good. All right. Well,
19 that's the goal of our office is to wake up every
20 day and go to sleep every night worrying about the
21 9.2 million individuals that are eligible for both
22 Medicaid and Medicare. The official name is a
23 mouthful, the Federal Coordinated Health Care
24 Office, but simply they are going to do it better
25 for the individuals that are the most complex in our

1 system and for whom we are spending about \$320
2 billion a year. Let me just say one more time.
3 That's \$320 billion every year to buy what we would
4 say is very poor care. Certainly not delivered from
5 the perspective of a real person trying to find
6 their way through the system.

7 So although I'm a bit biased, my belief
8 has been, when taking what Don and Rick are saying
9 in terms of really creating seamless journeys of
10 care and using these opportunities to reform the
11 delivery and payment system, and we have no better
12 opportunity to do it for these folks that we're here
13 to talk about today.

14 So this tells us just a little bit more
15 about the complexity of the population. Those of
16 you who live this, know this, suffice it to say,
17 it's a very complex population, and I believe I can
18 say this officially, and we have to figure out ways
19 to take care of the medical needs and the social
20 needs and all the other issues that ensue.

21 So we were created in the Affordable Care
22 Act, fondly referred to as Section 22.2. The goals
23 are simple. One is to make sure that these
24 individuals have access to services.

25 Second is to improve the coordination

1 between the states and federal governments in the
2 delivery and financing of this care, but today we
3 have not created a very -- a good partnership.
4 There's a lot of opportunity for posturing.

5 Third is to look for innovative care
6 models. So what we're going to do is address this
7 issue to get the 95 percent plus of these
8 beneficiaries who are navigating through our service
9 systems into some kind of accountable system of
10 care.

11 And lastly looking at the financials
12 disappointments. We see a lack of insurance on
13 these beneficiaries. Decisions that are made
14 because of the funding streams, not because of the
15 needs of the patient or what's best for the patient.
16 We can fix that.

17 We're going to start by focusing on the
18 beneficiaries. So for us it's all about how -- what
19 are the beneficiaries' needs. And this is not a
20 homogeneous patient population. So understanding
21 how to look at the substance of the population and
22 understanding how to care differently for people
23 who's needs are driven by serious illnesses versus
24 those who are in a nursing home versus those who may
25 have developmental problems or disabilities. Very

1 important. And everything is person centered here.
2 And it is all about starting with the person and
3 building a system around them and having some
4 accountable for that.

5 We have structured these offices into two
6 main areas. One is called Program Alignment. That
7 is the home for every place where Medicaid and
8 Medicare fall up against each other. So I'm a very
9 concrete person. We literally have a list -- it's
10 about 17 pages long right now -- of all of the
11 areas. You talk about the needs of where Medicaid
12 and Medicare just don't work. They weren't designed
13 to work together. They're working exactly how they
14 were designed to work today, but it was never
15 envisioned that we would have 9.2 million people
16 that rely on both systems for their care.

17

18 And so getting all these things on the
19 list, understanding how many beneficiaries are
20 impacted by that, what would be the cost of fixing
21 it, and what kind of action would be required to fix
22 it. It's going to be an easier fix if we can do it
23 administratively versus if we have to go it
24 Congress.

25 But an understanding office needs to know

1 how to prioritize that and presenting it back out to
2 the public in a very transparent, living document
3 kind of way to say what are we missing, what needs
4 to come first, and how are we taking care of the
5 needs of these people that you interact with
6 everyday and you're sure that we've got this list
7 straight.

8 And also there's a way -- poor Rick has
9 said this several times. But I often think that our
10 office should be called the Office of Translation
11 and Interpretation, because within our own walls in
12 CMS, we sometimes -- you know, like when you need
13 somebody that speaks a different language, we're
14 there. Well, we're there for Medicare when Medicaid
15 is driving them crazy, and Medicaid when Medicare is
16 driving them crazy, and they pick up the phone and
17 call us and we can sort of translate that language.
18 So internally I can't underestimate the importance
19 of having one place to go to within CMS and HHS that
20 is looking out for the needs of the patients that
21 are part of both systems.

22 On the other side, we're looking at model,
23 demonstration, and analytics. This is all where the
24 partnership with the Center for Innovation comes
25 into place. Fortunately, the duals are a priority

1 and I understand that, and we're looking at testing
2 new payment and delivery system models. We have an
3 opportunity to use both the authority and the
4 funding that comes with the Innovation Center to
5 pursue this.

6 Our first step out of the gate is to
7 provide demonstration opportunities for states,
8 because we believe that's where we're going to get
9 the most initial leverage, and states are jointly
10 responsible for this population. And as was stated
11 earlier, duals represent upwards of 40 percent of
12 total Medicaid budget. So we have to start working
13 with our state partners. They can then filter down
14 into the provider and the local delivery system by
15 making some changes at the Medicaid level.

16 We announced the upcoming availabilities
17 of design contracts for state Medicaid agencies. We
18 have up to \$1 million available for up to 15 states
19 each to support them in the design of demonstration
20 proposals that we hope to integrate. Acute behavior
21 and long-term services and support for eligibles.

22 The other thing that is really important
23 that this group is doing is we're getting back a lot
24 of data. So we have a lot of information on how to
25 gather particularly well about our dual eligibles.

1 So enlighten us as much as you could as to the types
2 of care models and delivery systems and evaluation
3 mechanisms that we could have. And we don't have a
4 good sense of that internally. We certainly have
5 shared what we have and what we hope to have with
6 our external partners.

7 So we're focused on developing a stronger
8 analytic underpinning, and then making data publicly
9 available starting with states so they can use that
10 for management purposes. It kind of ties their
11 hands and ties the hands of the providers by not
12 getting the complete picture of what these
13 beneficiaries are receiving, and we aim to change
14 that.

15 So quick update. We have the office
16 underway. We, like Rick, like the Innovation
17 Center, have to establish ourselves to the federal
18 register. We're a couple of weeks behind. Where
19 Rick is, so look for that coming soon. We're
20 interacting with MedPAC and MACPAC. So those of you
21 familiar with those, those are the independent
22 commissions that govern Medicare and now the newly
23 created Medicaid. And that's a very important
24 relationship so we can have a common agenda moving
25 forward. We are doing outreach, welcoming ideas,

1 going out and talking to people that will listen,
2 you want to talk to about this issue. We've set up
3 a meeting mail box that those of you that we can't
4 get to in person, have a way to communicate and
5 reach us on a timely basis.

6 We're developing state profiles so that we
7 all have a better estimate of who this population
8 is, what types of services they're receiving, what
9 are the similarities and differences are in various
10 states. So with that, I think Center needs to hear
11 from you. Those of you that are interested in
12 sending us ideas, frustrations, suggestions, any of
13 the above, this is a good place to do it. In
14 addition we welcome the opportunities to talk with
15 different state health care groups. So appreciate
16 being here today. We look forward to your comments.
17 Thank you.

18 MS. RIOS: All right. And with that,
19 we're going to start our input session. We're so
20 glad you're here. A couple little logistics here.
21 We've got a recorder that's over here that is going
22 to be taking down your comments and input. So we
23 ask that when you stand up to offer your information
24 that you either step to one of the mikes that are
25 standing here. And we've also got a traveling mike

1 that will come around to you because we want to make
2 sure that we don't miss anything that you have to
3 offer.

4 And when you do, we ask that you give us
5 your name, the organization or provider that you
6 represent, so we'll have for that.

7 And it's going to be interactive, and so
8 I'm going to allow you all -- I'll just kind of
9 facilitate here, and allow Rick and Melanie to
10 react.

11 We know that some people are interested in
12 talking about the accountable care organizations.
13 We're in the middle of the federal register comment
14 period. So I know you'll understand if our -- if
15 the comments and interaction seem to be focused
16 around that. So don't worry. We're very interested
17 in learning about that as well. So we hope you've
18 got some good information and we'll have a good
19 discussion. And with that, we'll get started.

20 JIM ROGERS: Thank you for letting us be
21 here today. Jim Rogers from Springfield, Missouri.
22 We're one of the -- along with your alma mater,
23 we're one of the ten cites with a physician group
24 practice demonstration project. We've been living
25 the dream for accountable care organizations for the

1 last five years.

2 Just one of the things when you talked
3 about how it would be nice to start out, is you kind
4 of reached out locally and we appreciate that, down
5 to the very level of the care that is given.

6 As a practicing internist, I can tell you
7 actually seeing patients this morning before making
8 the trek up here, there's a couple things that we,
9 in our organization, have been trying to organize
10 and highlight some places where we see waste. And
11 one of the -- that's within the organization itself,
12 and the competing governmental organizations that
13 give care, the VA system.

14 The VA system is a huge black box when it
15 comes to trying to translate information back and
16 forth, and it tries to get information. We've been
17 on conversations to Washington, D.C., on hold for an
18 hour and a half, waiting, could not get through. And
19 about the time we thought we were getting some
20 information back to not duplicate information on our
21 care objectives, we had quality measures we've been
22 measuring, 32 for the last three to five years in
23 our organizations, we find a duplication of the VA
24 system. It's not shared with us. Our information
25 was sent to the VA system -- locally we interact

1 with about three different systems in our part of
2 the state. It's not assimilated into errors. So
3 it's another case of systems not talking to each
4 other, and if you could have an effect on that, to
5 help us work together for patient sickness. So we
6 don't duplicate some of those things. So we don't
7 chase down patients to have things done. So there,
8 again, trying to help -- it wasn't on your radar
9 screen at all, but I think it's starting -- we need
10 to address those things, too, as we address private
11 insurances, as we address healthcare organizations.
12 Even within the system, the VA has a large number of
13 dual eligibles, has a large number of Medicare
14 patients that we serve. And we can't get
15 information back and forth. It's cost us a lot of
16 heartache and heartburn to be able to get that.

17 And accountable care organizations in the
18 future, moving through, trying to get information,
19 is going to find it very difficult, if they haven't
20 experienced that at this point.

21 Second -- the second one -- and I'll tell
22 a quick story -- is that you have to help us as we
23 try to do innovative things with patients. We
24 started the diabetic module. We started looking at
25 diabetic measures within our patient population. So

1 to do that, we started really pushing out, making
2 sure diabetics have foot exams and we have them
3 recorded and we have them to meet our numbers and to
4 deliver better care.

5 Did we? Yes, we did. We delivered better
6 care within our organization. We had a 17 percent
7 reduction over the last several years of
8 amputations, largely due to -- pointing to that. And
9 the reward we got for that was an inspection, OID
10 inspection and a \$3 million fine and shutting down
11 of our foot program.

12 We have to have help. When we do
13 innovation and it's perceived as turning -- I heard
14 someone say churning a while ago. If it's perceived
15 as turning rather than innovation, trying to give
16 advanced help to improvement in care in a setting in
17 which the rules change for documentation three times
18 and we get called in retro for someone who's hired
19 to do saving -- you know, who's hired to find
20 savings there, and not listen to reason from a
21 provider standpoint, it's a problem.

22 So those are just -- I just want to start
23 out with two examples at a very gut check level of
24 which you try to do innovations, you bring forward
25 what we felt like was a great success story, and now

1 we're scrambling. How do we get our foot care as
2 the model we put up and we thought was very
3 innovative and had data that says we're doing real
4 well as well as our efforts to try to share. And we
5 understand that there's problems with sharing
6 information. And about the time we were real close
7 to sharing information with the VA, there was the
8 incident nationally that came out with the laptop
9 that got -- that disappeared out of one of the
10 clinics and everybody was shut down. We have to
11 figure out a way to reasonably share information
12 that's patient centered and patient focused.

13 Thank you.

14 MR. GILFILLAN: Okay. Is that live.

15 Just one point, Melanie is going to have
16 to leave at 2:30, so we should be sure to get as
17 many questions directed to Melanie upfront as we
18 could. I'll be here the rest of the time.

19 I think on the first point, it's certainly
20 ironic that the VA has, you know, the greatest
21 electronic health system, I think, in the country,
22 medical record system. And you can't get into it
23 and you can't get any information. So we'll take
24 that back. And actually we are working close with
25 the VA, the Department of Defense, trying to

1 identify exactly these kinds of opportunities to
2 improve our interface with the reporting system, and
3 finding ways to try of simplify expectations, kind
4 of present a united front, if you will, that's
5 consistent and easy to grasp.

6 On the other one, this is very interesting
7 problem. You know, in a prior life, in my prior
8 life, we were very interested in trying to get and
9 document the change diabetic outcomes, and
10 particularly in looking at amputations. So I'm
11 really intrigued by the story. And we'd love to see
12 the data, frankly, because it's really important.
13 And more significantly, I don't know the full story.
14 I'd be happy to hear it maybe offline, and try to
15 understand it better.

16 Just so everyone knows there's been a lot
17 of attention paid in Washington to the issue of
18 potential legal constraints for doctors, hospitals,
19 doctor to doctor, ACOs.

20 We had a large meeting in DC with about
21 500 people in person from around the country. And I
22 think there was 5,000 people on the line for that,
23 on the web, our web cast, talking about OIG, FDC,
24 STARK, constraints around folks coming together,
25 working these deals. And I think we're working hard

1 to come up with an approach.

2 We have payment systems that support
3 fragmented care. We have care systems that are
4 fragmented. We have fragmented care. We have
5 regular (unintelligible) that addresses fragmented
6 care. And when we say to you, we want you to
7 develop seamless, integrated care, that change in
8 our environment doesn't necessarily matter. And so
9 we're working hard to find that -- and build that
10 bridge in transition. And we're interested in ideas
11 people have in working hard on it. I think you all
12 have an approach that facilitates an appropriate
13 coordination and integration, and, of course, that
14 will be part of the upcoming initial regulations or
15 proposals.

16 RICHARD HELLMAN: Thank you. My name is
17 Richard Hellman. I am a practicing gynecologist. My
18 day job, as I am in private practice, is an
19 independent practitioner in Kansas City. My
20 volunteer work for the last 13 years or so has been
21 naturally in the area of quality and safety. And by
22 the way, Don Berwick was one of my early. Heroes, I
23 learned from him as so many of us have in terms of
24 the great work he's done with patient safety and
25 quality.

1 I've actually represented a lot of people
2 in this area. I'm part of the executive committee
3 of the Physician's Consortium Performance and
4 Improvement, which makes most of the performance
5 measures that Medicare uses. And I'm on the
6 executive committee and we have a large membership.
7 So that hat I represent people on the quality and
8 safety.

9 So I have two questions. One is from the
10 national respect, and the other one is from a
11 practicing physician and physician respect. First
12 the national.

13 One of the things that we've seen is we've
14 tried to get our arms around these same dilemmas
15 that you have, which is the notion that we really
16 want to improve the quality of the care. We want to
17 improve the outcomes to the people.

18 And one of the things that we see is there
19 seems to be data deficiency. For instance, the
20 American Board of Medical Specialties put together a
21 group, a panel to work on episodes of care close for
22 diabetes, and of course, I should be part of that
23 panel.

24 And we look at that as do -- and this is
25 something that I've worked with the actuaries in the

1 state of Kansas on how does the school -- looking
2 also from that -- when we look at that, one of the
3 characteristics is that the more you look at the
4 comorbidity and the severity of the particular
5 illnesses that are associated with people with
6 diabetes, the more you change your model for what
7 the cross are for an episode of care. And so the
8 question is: Can we get at that data. Because if
9 you don't get at that data, then you start making a
10 payment model that is aimed in that direction. It
11 will be an inaccurate one, and basically the first
12 people who do it lose their shirts.

13 And/or you pay more insurance. That's
14 another possibility. Somehow -- but, back to the
15 numbers, that I think there's data deficiency. And
16 looking at it naturally, as we started to struggle
17 with how we put together things that will work to
18 get to where you want to go and where we want to go,
19 which is really close, and also have a fair model,
20 one of the things that's striking is there' data
21 deficiency as to what it will take to do that, as
22 well as the question is whether the resources for
23 the people who will be doing that will be available
24 to them.

25 For instance, in order to provide the

1 data, you need a sophisticated electronic health
2 record that can actually capture that information
3 and put it back. And I'm not sure whether people --
4 many people in many organizations have the resources
5 right now and where that is going to come from. So
6 that's the first question.

7 The second question is somewhat more
8 personal, because I am a practicing physician, and I
9 actually direct a practice that is multi-
10 disciplinary. The focus is on diabetes care. And
11 just for the record, we actually have published our
12 work on reduction of death rates and kidney failure
13 rates over a long period of time.

14 The problem is -- and it's undermanaged.
15 We published this the diabetes care in 1997. A 14-
16 year study. It took seven years to show a reduction
17 in death rates, that if you looked at the program,
18 it took seven years to get it there. It took
19 shorter to see the kidney failure changes. That was
20 about six years. It took about two years to show
21 the retinopathy improvement. Six to two years to
22 show the problems in reduction with respect to
23 neuropathy. But the question is that the window
24 that people are looking at is short. No matter what
25 you're going to be choosing as evidence of quality,

1 of evidence of the outcome you want is not
2 necessarily going to be the same you want to get.

3 And from the point of view of the
4 independent physicians, I would ask the other
5 question is -- are we included in the system?
6 Because, for instance, although we have a multi-
7 disciplinarian team, technically, as a board
8 certified internist, I'm a specialist, because I'm
9 an endocrinologist. It strikes me that the rigidity
10 with which you're choosing to do things at times
11 eliminates people who may not want to be part of the
12 medical care unit because they don't want to be made
13 to go to a hospital in that area or they don't want
14 to be part of a larger group.

15 If we have the flexibility so we can deal
16 with the independent physicians, who still want to
17 work together to get the outcomes, because you can't
18 deal with patient safety without working as a team
19 in either situation.

20 MR. GILFILLAN: I think there were three
21 questions there. Yeah. Let's start at the bottom.
22 On specialists and working as a team.

23 If you look at the legislation around
24 ACOs, you see that, you know, the definition of the
25 kinds of providers like could be -- I assume you're

1 talking about ACOs?

2 RICHARD HELLMAN: Sure.

3 MR. GILFILLAN: And it was pretty broad.

4 And I think there's ample opportunity for providers
5 in all settings to find their way to another
6 pathway. And there'll be a lot of talk about
7 exactly what those pathways are, but I think the
8 intent is we understand that the world is not filled
9 with, you know, integrated medical -- large
10 integrated health systems or medical groups. We
11 know the majority of care is provided by people in a
12 very different setting.

13 And so -- and we know we have this mission
14 of changing all Americans. Ergo, you know, you
15 can't -- you can't -- solutions need to give
16 opportunities to folks in all different settings,
17 and we understand that. And I can't say a lot more
18 specifically about it, other than I think the
19 expectation is, it's great that your organization's
20 already put yourself out there to be accountable
21 through publishing results and talking about those
22 results, and that is -- that's great.

23 I think kind of the -- one of the core
24 assumptions, I guess, in the Affordable Care Act is
25 more accountability is the right thing to do. We

1 just can't go on with a lack of visibility about the
2 outcomes of care across the health system.

3 So what that mechanism -- you know,
4 ultimately the ACO docs will decide they want to
5 participate in will be something that everybody will
6 decide on. I think it will be quite diverse and
7 there'll be lots of opportunities in our assumptions
8 that is going to continue to be a very diverse set
9 of options for doctors who normally don't want to
10 participate.

11 Regarding data, there were some very
12 important parts of the formal care that addressed
13 making more data, more CMS data available, and those
14 -- those provisions being worked on. And there'll
15 be regulations coming out not too far down the road
16 to get at finding ways to provide more data for
17 appropriate population analysis. And so I think the
18 data will be out there. It is incumbent on all of
19 us to find ways that we know we can adequately risk
20 adjust data.

21 We talked about this a bit today down at
22 Truman. It's important to understand as many
23 variables that determine ultimate experience
24 quality, health wise and cost wise. So I think that
25 is an industry challenge that I think we all need to

1 continue to pursue together. But I think you will
2 find that the clerical outcomes from the
3 implementation of the Affordable Health Care Act
4 will we'll provide much more information that can be
5 used in a very rich and robust way and take us a
6 long ways forward.

7 Interesting conversation at Cerner today
8 about, you know, a lot of our measurement is kind of
9 claims based. And what about the next generation of
10 data that comes right out of the electronic health
11 record, and we're thinking that can be a
12 revolutionary change in the way data, right from --
13 you know, from your electronic pen or whatever, you
14 know, popping right into the cloud, as I learned
15 about today, where it may be.

16 And coming back down and suggesting to do
17 something different at the same time while the
18 patient's still in the office. And producing data
19 that's going to look at your weekly outcome metric
20 for your diabetic. So what will that be in terms of
21 changing cycle times and demonstrating that, I don't
22 know, but we also have a new Innovation Center. We
23 have to think about management portfolio of
24 innovations. Some of them -- and we think about a
25 lot of dimensions in that portfolio. And

1 interesting what you all think about them, but we're
2 open to suggestions.

3 Some of those -- some of those innovations
4 might be seven years out, and some might be two
5 years out. So I'd love to see your paper and maybe
6 that will guide us on some of the diabetes
7 innovations. But I guess that's all. So we're --
8 we appreciate your thoughts, and we'd love to have -
9 - and, again, a lot of dimensions we need to think
10 about. We love to hear from people what you think
11 those dimensions might be as we think about
12 portfolio management, time to demonstrable impact is
13 one of them.

14 AUDIENCE: I was going to say my
15 question's more directed toward center relations. So
16 if anybody would like to go ahead and ask a question
17 about dual eligibility.

18 MR. GILFILLAN: That'd be great.

19 BILL APPLGATE: My name is Bill
20 Applegate, and I'm here today representing the Iowa
21 Rural Health Association.

22 Here's the question, and this is a
23 legitimate question. I'm not used to preaching too
24 much. But a lot of costs in health care related to
25 hospitalizations, we believe that some of those may

1 be unnecessary. I believe that is correct. And so
2 I've been going to Melanie's specific population and
3 say that an awful lot of that cost is
4 hospitalizations in there. And I know you know
5 that.

6 My question is: Given all the things that
7 we're doing in health care reform, why is it that
8 just more direct attention to how we reduce
9 hospitalizations? I know that there's a lot of
10 attention to system reform. I know there's a lot of
11 dressing up for the party, but my question is: Can
12 we not just go to strategies and approaches that
13 honor the other things that are important and still
14 hit more directly at reducing hospitalization, which
15 is really a very substantial cost.

16 And I'm -- I'll use your area because
17 that's an area where a lot of that cost of
18 hospitalization's coming from. So that's one
19 question I have.

20 I have another little side question, and
21 this has to do with the Innovation Center, and that
22 is: In the legislation there are a variety of
23 suggested projects in the Innovation Center. What
24 is your posture on those suggested projects, and the
25 process that you use for those?

1 MS. BELLA: I think I agree on this on
2 hospitalizations, there's a tremendous amount of
3 energy focused on re-admissions, and there's several
4 pilots and there's funding to support that, and
5 within the CMS world it tends to be more focused on
6 Medicare. So we're trying to make sure
7 that it's focused on Medicaid, and then trying to
8 promote alignment with cross payors so that we have
9 greater influences on movement in that direction. I
10 guess the part is I have a question back to you: Is
11 there something preventing you from focusing on
12 unnecessary or avoidable hospitalization today that
13 we could use something to free you to be able to
14 focus on that?

15 BILL APPLGATE: Well, I think
16 particularly in the rural areas we have a lot of
17 critical access hospitals. Reducing
18 hospitalizations is, in fact, contraindicated. And
19 so I'm just being real honest that there's a real
20 push back in rural areas in having things that --
21 even good programs that reduce hospitalizations
22 because there's a heavy reliance -- there's a heavy
23 reliance on those hospitalizations for the
24 enterprise. It's just a fact.

25 MS. BELLA: Yeah.

1 MR. GILFILLAN: Boy, that's a great --
2 that sounds really like that's interesting. That
3 might get other people interested in making a
4 comment? No.

5 MS. BELLA: So we have some work to do on
6 making it a win/win/win and not a win/lose for
7 hospitals.

8 BILL APPELEGATE: I think there's two
9 things. There's some who suggest that if we really
10 enter into those kinds of programs to take a look at
11 rehospitalizations and hospitalizations. I'm not
12 suggesting this. I'm saying someone has suggested
13 it, but we have to come up with some compensatory
14 activity for hospitals. But if you make most
15 formulas for funding difficult, try that one for --
16 you know, for thinking about how you come up with a
17 formula for that. It would be quite difficult. But
18 the other option is to --

19 MS. BELLA: You're volunteering to help us
20 do that, right?

21 BILL APPELEGATE: No. I'm way over my
22 head.

23 But I would say the other thing is it is a
24 reality. And this isn't a ding on hospitals, okay.
25 It's just to say that a real concern about how we

1 keep our system healthy, okay. And how we reduce
2 particularly hospitals that are paid a lot for your
3 dual eligibles.

4 MS. BELLA: Oh, yes, I know.

5 BILL APPLEGATE: And no count.

6 MS. BELLA: Yes, I know.

7 BILL APPLEGATE: And so I think there's a
8 real challenge.

9 MR. GILFILLAN: Yeah. What a quandary
10 we're in, when, you know -- what are there? 150
11 people here? Contemplating the question, should we
12 invest in keeping patients with chronic illnesses
13 out of dangerous places. And the answer, I believe,
14 is hospitals are a dangerous places. People die
15 because of their hospital. They could be elsewhere
16 -- not sometimes -- not sometimes. Most of the time
17 we get better hospitals and they do good work. So I
18 don't mean to make light of that. But for the very
19 people we're talking about, a hospitals are a
20 dangerous place and some of them die. And we say
21 there's a community resource going on today in this
22 rural area and we're using that and operating in
23 this -- I think I kind of keep coming back with
24 this, but in a fragmented way that says, okay, we're
25 running a hospital, so, you know, that's all beds,

1 and we fill beds, you know, and that way, you know,
2 our organization continues. And we're sitting
3 outside that community looking down on it and
4 saying, gee, is the health of that community better
5 because of, you know, people operating that way. I
6 think the answer to the problem is probably no.
7 Right? I think.

8 So the other question is what are we going
9 to accomplish. Well, there's so only much money
10 being paid to them these days, right, and suppose
11 half the hospitalizations aren't necessary, which is
12 quite likely, but maybe not. Maybe not in Iowa or
13 Nebraska, but let's assume you're in rural
14 Pennsylvania, and they are, a lot of them are
15 unnecessary.

16 What we saying, well, if you look at the
17 legislation around ACOs and how the funding is
18 calculated and what the goal is and a big part of
19 all that, you know, there may be a model that says,
20 if I can actually do -- transition to the seamless
21 care approach, manage that population, I'll do
22 better overall if I -- you know, if I go into a
23 sheer saving model or some other sort of financial
24 model, right, that actually provides the -- gives me
25 the opportunity to save and use that money to do

1 different things, like maybe we want to put nurses
2 out of doctor's offices so that patient's care is
3 well afforded and they don't go to the hospital. So
4 maybe there's still the economic impact in town of
5 nurses being employed, but maybe not being employed
6 in a whole different way and a whole different place
7 in doing something that's better for patients. Is
8 that not a viable way of thinking -- of addressing,
9 you know, the problem.

10 The problem isn't the institution. The
11 problem is the community and what we're trying to do
12 for the people in it and the economic impact in the
13 community. Maybe there's a way of the spending that
14 money differently that actually gets better health
15 and better care for everybody. I don't know. I
16 mean, it's like this is the big question, right?
17 This is the -- you know, the 900 pound -- or the big
18 elephant in the room. Are we going to transition or
19 are we going to stay over here, because, you know,
20 we live on fragmented care.

21 JOHN WILFORD: I'd like to respond. My
22 name it's John Wilford. I'm at Truman Medical
23 Centers, and I also happen to be the incoming
24 chairman of the American Hospital Association.

25 That being the case, for the record, I

1 will not say that hospitals are dangerous places to
2 be, but I do think that we could be better places to
3 be. And I think the question that you ask for a
4 response to, Dr. Gilfillan, is how do we refine
5 hospitals.

6 And according to my notes, very good notes
7 that I took listening to your comments earlier, this
8 meeting or this direction is about better health,
9 better care, and lower cost. I suspect in that
10 order. And if, in fact, that's the case, the focus
11 is on better health and wellness, then we need both
12 an alternative delivery system. We're trying to work
13 on that. But we also need an alternative payment
14 system that will reward us for keeping people
15 healthy.

16 I'm first to say that over time we need to
17 redefine the definition of hospital, that it extends
18 far beyond four walls of the building that we call
19 our hospitals today, but really speaks to the care
20 and nurturing, both social and health-wise relative
21 to disparities and other things that keep people
22 healthy and productive and have a stronger quality
23 of life.

24 So one of the takeaways, I think, that we
25 can all agree upon is that we need to change both

1 payment mechanisms and fairness as well as the
2 delivery system and improve in making sure that
3 we're more efficient, more patient safety, more
4 time, and so forth and so on.

5 And I think if we're not up to the
6 challenge yet, we're certainly talking about it.
7 That's one comment.

8 I wanted to really preface all of my
9 comments as simply saying -- I think I can speak for
10 the community, I really appreciate you being here,
11 and coming and being so open and accessible. And a
12 thirst for knowledge, what we can do to help.

13 And I think that as a community, the
14 Kansas City metropolitan area -- and that certainly
15 crosses the state line -- we are a good site for
16 demonstration activity because of scale and size and
17 the collective cooperation among the players that
18 are sitting here in this room. Teaching hospitals,
19 community hospitals, private physicians, health
20 insurance group practitioners. You mentioned our IT
21 partners at Cerner. We have our foundations here.

22 I think that we have a collective
23 willingness to participate and work together to make
24 a difference. And I think, as you look at systems
25 delivery, it's got to be systems delivery and the

1 data is in cooperation, and the partnerships
2 probably will be and should be and need to be very
3 different than they have been in the past. So
4 hospitals who have historically competed against
5 each other, need to work with each other, and I
6 think we're trying to do that.

7 There's a significant movement with
8 hospitals with our FUHCs, both in the metropolitan
9 areas and the rural areas, and that's a big deal.
10 Our local Missouri Hospital Association is working
11 with us to help us on that.

12 Our foundations have been very helpful in
13 trying to create creative solutions to all of the
14 problems that exist in our community, but we do need
15 the help of government, big player, and I can't
16 overemphasize the issues of barriers to doing what's
17 the right thing to do, because of all of the rules
18 and laws and antifraud and HIPAA violations, et
19 cetera, that we bump into.

20 So I for one, and I think the community as
21 a whole, look forward to working with you on these
22 things.

23 MR. GILFILLAN: Thank you. Thanks,
24 Melanie. Melanie's going out to meet some more
25 local characters, right?

1 MS. BELLA: Thank you all very much.

2 MR. GILFILLAN: Thank you.

3 (Applause.)

4 MR. GILFILLAN: Let me just -- finally, I
5 find myself not in a good listening mode, more in a
6 talking mode. So I'm going to say just one thing
7 and try to talk less.

8 We agree 100 percent, and what we want to
9 know is what are the ways we can support you to make
10 that alternative support -- when I say support, what
11 we do -- how can we pay you -- how can we find a way
12 to pay you so that it makes sense for everybody to
13 deliver that kind of seamless care? That's
14 fundamentally the question that -- or one of the key
15 questions is where we aren't 100 percent. We know
16 we're in the wrong place. We need to find our way
17 to right this wrong, and we working to try to find
18 the right spot. How do we do that?

19 MARY JO CONLIN: Well, my question kind of
20 goes to this whole idea of payment reform. My name
21 is Mary Jo Conlin. I'm with the statements area,
22 Business Health Collation. We represent about 45
23 mostly large employers on health care issues. They
24 provide health coverage to over a half a million
25 Missourians and folks all across the country and the

1 world.

2 They generally have two big concerns about
3 payment reform. And I really appreciated your first
4 comment. We kind of talked about purchasers all
5 getting together to achieve delivery system reform
6 and health care reform, because that's what we try
7 to encourage them and support their efforts to do
8 that, but here's their two concerns.

9 One is kind of cynicism a little bit, that
10 purchasers, particularly private sector purchasers,
11 will never share in the shared savings. That the
12 cost will just keep going up or that savings will be
13 distributed amongst providers rather than shared
14 purchasers -- and particularly private sector ones.

15 And then I think, two, more recently
16 concern that, you know, with change in congressional
17 power that you won't be given the resources you need
18 to potentially see this through. And I'm wondering
19 if you can talk a little bit about that.

20 MR. GILFILLAN: As the guy who's in the
21 city or DC for four months, yeah, I'm sure I bring -
22 - or I don't want bring a whole lot of insight.

23 You know, it's such a privilege to be
24 doing this and to be working with Don and the rest
25 of the team, and, you know, with what we've got

1 already, who knows. Right? There's \$10 million
2 that was appropriated. There's, I think, you know,
3 universal understanding that we need to do something
4 different together.

5 We'd like that kind of rationale to
6 prevail as people, you know, go through whatever,
7 you know, automations, that they go through for
8 other reasons.

9 And all we know is every place we go,
10 people want the same thing. I mean, we all know
11 what we need to do. So we're just going for it. And
12 I don't know how you handicap the process, you know,
13 in terms of the likelihood of success. Feels -- I
14 think it feels great. I think -- as Don said, he's
15 an optimist. I'm an optimist. We think, you know,
16 that it makes sense. It's the right thing to do.
17 It is about better health and better care. And we
18 know we can do it at lower cost. I mean, we --
19 that's the case. It's been demonstrated all
20 throughout the comments.

21 So we think if we engage with you all and
22 we kind of join forces, shoulder to shoulder,
23 regardless of political affiliations, whatever, and
24 we all say, this is what we're going to do together
25 and we're going forward, here's how we're going

1 forward, we're very concrete about what we're doing,
2 you know, I got to believe that that's the very
3 thing to do, let's go.

4 I think the challenge is finding, making
5 sure we get that message out there and we're clear
6 about the role that we're all kind of marching
7 together in that direction. And we bring the voice
8 of patients and people into the room as we're
9 talking about this, and they understand, the board
10 of population understands, this is good stuff, this
11 is for them, this is for their kids, it's for their
12 parents. So anyway, that's probably naive, but that
13 keeps us marching forward every day.

14 MARY JO CONLIN: I think our perspective
15 is that the work that you're doing is critical to
16 the sustainability of not only reform but of the
17 system as a whole, and we, you know, hope that
18 you're able to press on.

19 MR. GILFILLAN: Yeah. Well, I appreciate
20 it. And we want to work with you. We want you --
21 we want -- we'd love to be at the table with private
22 payors, doctors, providers, you know, all the
23 community, and say, you know, here's the deal.
24 Here's the deal. We are going to -- here's how
25 we're all going to benefit. Here's how -- we go to

1 physicians, providers, but here's all of it.

2 It has to go back to payors, because if it
3 doesn't go back to payors in the setting of lower
4 costs and then lower premiums, then it doesn't go
5 back to patients, doesn't go back to people. So
6 maybe that's the insurance guy talking, I was
7 reminded me this morning, because I have a little
8 bit of that background. But that's, you know, has
9 to go -- has to -- that's the path on the commercial
10 side right now.

11 BRUCE BETTINGHAM: Hi. My name is Bruce
12 Bettingham. I'm the medical director for the
13 quality improvement at the American Diabetic Family
14 Physicians that's based here in Kansas City.

15 My question is to gain some insight about
16 how you're going to approach your work. It seems in
17 the past that Medicare has designed demonstration
18 projects that are roughly a controlled trial of some
19 kind, let it run for four or five years, and by the
20 time they found anything new, they discovered that
21 it's something that everybody already knows, or that
22 the study design was faulty, and, therefore, we
23 didn't really get much out of it.

24 It would seem to me in a real innovative
25 mode that you ought to be looking for positive and

1 negative variance in the system as it exists, and
2 much like Don said, there's a lot of stuff going on
3 out here that's really working. So it would seem
4 that you should try and identify what really works
5 in terms of social, cultural, and financial models,
6 and then begin to pay based on what you want to
7 happen instead of trying to design a model that has
8 the constraints that we all have in our head around
9 a fee-for-service system.

10 So, I guess I'm just trying to understand,
11 number one, how you're going to go about your work.
12 And as a second question, what's the best way for
13 people like us in the room to interact with the
14 Innovation Center in some way, having some kind of
15 ongoing understanding what's going on there and
16 input to what's going on?

17 MR. GILFILLAN: We are -- we love to hear
18 more -- more of your ideas about where we should
19 find the positive and negative environments, because
20 that's exactly what we want to do. We can't go
21 straight -- if you think about the way the process
22 that was led up to this works, we don't have to
23 start from ground zero. They're there. They're out
24 there. How can we accelerate the learning we need
25 to get to the point -- one point is, you know, if we

1 want to get Medicare's fundamental approach changed,
2 we need to demonstrate to the certain few, the
3 actuary's satisfaction, so we definitely -- we love
4 to hear about those positive and negative variances
5 and find shortcuts to important learning. So we
6 definitively want to do that and are open to talk
7 about that here or talk about it by direct contacts.

8 You know, we met with people. We have an
9 open door approach to hearing ideas from people, and
10 we'll have on our web site shortly forms that we can
11 try to reconstruct it that facilitate good input
12 that we can digest. And then we will be
13 subsequently hung up with RPs and alternative
14 approaches to specific soliciting interests, and
15 also looking for people to come to us and say, you
16 know, we think you should and here's what's
17 involved.

18 So we see ourselves as having a giant
19 funnel kind of pointed towards you are saying, give
20 us -- give us the ideas and tell us why we should
21 interact, tell us ideas about how we should
22 interact. We love hearing about those. And by the
23 way, if you have ideas about how we ensure employer
24 benefit from savings, let us know. Yeah.

25 HERB COON: Herb Coon with the Missouri

1 Hospital Association. Thank you for being here.

2 I'm also -- and I appreciate Melanie's
3 comments as well. I'm also a commissioner on
4 Medicare Payment Advisory Commission.

5 Two things I just wanted to share. One,
6 you asked the question, what work can we all do to
7 support us now on these improvements as we move
8 forward.

9 Obviously the innovations that you're
10 thinking about in the future are long overdue and
11 needed, but also we have to have a pretty secure
12 platform right now in order to achieve some of those
13 objectives as we move forward.

14 Let me give you some examples of what
15 we're seeing in our state right now. We asked CMS
16 for some data to help drive some improvement across
17 the state. The response we're seeing, let's file
18 away the request. It's been 11 months and still no
19 response.

20 We're seeing new things that CMS is doing
21 in terms of medication management in hospitals,
22 which basically turns back to clock. Patient
23 identification that turns back to clock.

24 So as I think we try to move forward on
25 patient safety and to try to get better value, we're

1 not seeing things seamed up under the current
2 services that are out there. That gives us the
3 platform we need to move forward into new
4 innovation.

5 So as you think about the future, I hope
6 you're all looking at the current things, whether
7 it's mission participation or other activities out
8 there that can support us as we go forward.

9 The second thing I wanted to ask a little
10 bit is about the Innovation Center on two parts. I
11 want to test your level of innovation here. And I
12 want to think about rural ACO, for example. If you
13 think about some of the rural areas we have in
14 Kansas, Missouri, perhaps Iowa and Nebraska, in
15 order to put together the minimal directional that's
16 in the legislation right now of 5,000, you will
17 probably have maybe a territory that would exceed
18 maybe some of the sizes in the states of the East
19 Coast.

20 And so trying to coordinate care across
21 that 5,000 population area is going to be very
22 difficult. So would you all be willing to test the
23 notion where you would have maybe an entity come
24 together or a number of entities that come together
25 in some kind of collaboration that looks like an

1 ACO, meets all the requirements of an ACO, but
2 doesn't take all the risks of all the population
3 that's out there. But instead focuses on perhaps
4 maybe disease management. One or two diseases.
5 Diabetes, COPD, CHF, something like that.

6 So would you be willing to test an
7 innovation that since we look like an ACO, but we're
8 not going to take all the risk as we move forward.
9 Further there it was a good rule to test something
10 along that line where the threshold was in -- the
11 PT3 number was 2 percent. In order to deal with the
12 random variation, that why not look at a threshold
13 of zero, or something like that as we go forward.

14 Would those be the innovations or do you
15 have the authority to stretch innovations to go that
16 far. And then my final question on that.

17 As you go through and think about the
18 innovations that come forward out of the Innovation
19 Center, is that something that you all get to
20 approve yourself or does ultimately does the Office
21 of Management Budget have to sign off on these
22 programs as we go forward?

23 MR. GILFILLAN: Thank you. I learned a
24 while back it's always the last question, that's the
25 heavy one, right, the insightful one. And, you

1 know, there's a whole lot of people in Washington
2 who have been telling me -- who want me to say
3 hello.

4 HERB COON: Thank you. Give them my
5 regards. I was a deputy administrator for CMS for
6 the 5-1/2 years.

7 MR. GILFILLAN: So everybody speaks so
8 highly of you. Now I know why. Good question.

9 You know, and the answer to that is we
10 were -- we're learning what -- and developing the
11 operational approaches for the center within the
12 context of the universe as well, in terms of how the
13 federal government operates. So I can't -- I don't
14 have an answer to that. All I can tell you is
15 there's a commitment from the highest levels that we
16 understand these issues. And so we need to create
17 operating approaches that allow us to move rapidly,
18 and I think we did a pretty good alignment across
19 the post matter. That being the case but we haven't
20 found an approach yet.

21 You know, I can't speak to the specifics
22 of the first couple points you made. As I say, with
23 regard to data, I think we'll have -- we will have a
24 much more flexible and much richer approach to that,
25 as a result of the Affordable Care Act and the

1 regulations that will follow.

2 So I think that that is need for -- and we
3 want to -- you know, we're already here. You know,
4 we have phones and we have -- I don't know what
5 interactions have gone on already on the request,
6 but all I can tell you is we want to be responsible.
7 We want to be supportive. It's our intent to
8 facilitate your efforts and deliver those
9 opportunities. And in terms of the rural areas, we
10 understand that the -- there are provisions in the
11 law around specific shared savings with the
12 prescribed ACO program that need to be met, and
13 bring with them some consequences. But we also know
14 that it's a big wide varied world out there, and we
15 need to find ways to support innovative activities
16 in all those -- in all the different geographies and
17 communities that are out there. So we haven't ruled
18 out any.

19 And the answer is, yes, we're willing to
20 think about and consider and be open to those kinds
21 of issues, and the threshold issue is an important
22 one and one that we need to think about, you know,
23 but people can't do it. That's -- and you can't --
24 you can't produce 5,000 people and, you know --
25 sorry. I'm blocking on what will be the town sight,

1 but whatever town it will be up the road. We're not
2 going to change that. So we need to support you in
3 delivering innovative care.

4 And as long as it makes sense, there's a
5 story here, and you can see, again, we can see from
6 the patient's perspective, where the change is going
7 to occur. We understand what the -- kind of what
8 the impact is, and we understand there's a lot to
9 the story there that at the end of the day is going
10 to make a difference and meet the criteria that I
11 laid out earlier, then we're open and interested and
12 more than willing to talk and excited about the
13 opportunity. We want to hear from you about what
14 ideas you have.

15 HOWARD ROSS: Yeah. What's your name
16 again?

17 MR. GILFILLAN: Rick.

18 HOWARD ROSS: Rick. I'm Harvey Ross from
19 the Kickapoo Nation House Center. We're a Public
20 Law 93-638 tribal health facility. You know, we do
21 have a portion that pays medical bills or, you know,
22 fills in the gaps in our primary care, but we
23 actually have that written up where we rely heavily
24 on alternative resources, which Medicaid would be
25 one of those. And we've identified two barriers, if

1 you want to call them, to Kansas care, and I have
2 two specific examples. And this is in direct
3 response to when you said what are the ways we can
4 support you. I'm sitting here putting quotation
5 marks on this verbiage that I'm hearing.

6 Actually we had one person, and I'm going
7 to personalize this a little bit, because, you know,
8 people's lives are real. People we know in the
9 communities are real. Just different things, and it
10 was kind of emotional for me.

11 One particular lady had breast cancer, and
12 she was a grade younger than me. She was like Ms.
13 Charismatic throughout high school and everything
14 like that and everybody liked her. Well, she knew
15 she didn't have insurance because she lost her job.
16 She carried the cancer part of the insurance for
17 years and years and years. The minute she didn't
18 have it, you know, she developed the breast cancer.
19 She would never come in. And I didn't know she was
20 having problems. She would not come into the
21 healthcare center, so there was nothing we could do.
22 So finally when she was approved for her Medicaid,
23 or whatever the case was, they insisted that they
24 did not pay for the genetic mapping and her
25 treatment did not begin until the genetic mapping

1 was completed, okay. They put it back on me. I
2 mean, it's just like saying, Harvey, what are you
3 going to do. I said, where are we going to pay it,
4 it has to be out of our direct funding, well, good,
5 and we got her started.

6 The second instance involved a young lady,
7 which was actually my younger brother's girlfriend
8 in high school. She had cervical cancer. I mean,
9 she had a 6-centimeter tumor or whatnot, and they
10 would not begin her treatment till she got her PET
11 scan. Meanwhile with the help of all the KTA and
12 CMS in Kansas City, we were able to get her
13 qualified for her Medicaid rather quickly. You
14 know, we did everything we could.

15 Okay. The barrier that came up there,
16 they wouldn't pay for the PET scan. So they said,
17 Harvey, what are you going to do. I said, we're
18 going to find a way to pay for that, you know. So
19 the Indian patients come and they don't -- from the
20 get-go, if they have cancer, it does not meet
21 priority level one to qualify for contract health
22 services. And, in, fact they don't even ask. No
23 need to ask. And it's alternate resources that
24 really have to take up cancer care.

25 The contract health services, you know,

1 like everything, contingent upon congressional
2 funding, you know, it's not a -- you know, I mean,
3 we just get X number of dollars a year. When
4 they're gone, they're gone. So those are two
5 barriers right there, the cancer care.

6 The first instance they would not pay for
7 the genetic mapping and would not begin treatment
8 for the breast cancer and in the second instance
9 they wouldn't pay for the PET scan, and that would
10 determine her treatment.

11 And I'm not a physician. I'm a hospital
12 administrator. These are some real issues. These
13 are very personal. And I'm starting to feel some
14 stress coming out of my back right now. I just
15 wanted to present that, what are some of the ways
16 you can support us.

17 And I don't know exactly what the
18 Innovation Center or Commission is, but, the mission
19 of the Indian Health Center is to raise the
20 physical, mental, social, and spiritual health of
21 the American Indians and the Alaska natives to the
22 highest possible level.

23 We have somebody standing in there. They
24 have a diagnosis of cancer. They're down right
25 there. You got medical reports you're dealing with.

1 It affects their lifestyle so adversely, you know.
2 And I can't really give you any examples, but then
3 there's social medicine right there that we're
4 responsible for. So really we have a holistic
5 approach. That's the Indian Health Service mission.
6 So we also have to deal with their social and
7 spiritual health as well. Thank you, and it's a
8 tough job. Thank you.

9 MR. GILFILLAN: I'm sorry. I didn't hear
10 your name.

11 AUDIENCE: Harvey Ross. H-a-r-v-e-y.

12 MR. GILFILLAN: Thanks, Harvey. I can
13 tell you on the first issue that coverage issues
14 like that in the Medicare world are escalated and
15 are -- one of the goals, again, is to have -- be
16 innovative, and the way we do things is to try to
17 short cycle things so we go through an approval
18 process in a much more timely way when we make
19 decisions around coverage on the medical side.

20 I honestly can't tell you how that
21 translates into Medicaid. There are probably people
22 here that know better than I, the question how we
23 relate that to the coverage issue in Medicaid.

24 So we are aware of the importance of some
25 of the -- particularly the genetic tests around

1 cancer here, and there are things that are being
2 addressed, and we're trying to do the right thing
3 from a science standpoint and do it faster so we can
4 avoid situations like you're talking about. Thank
5 you.

6 HOWARD ROSS: Well, you know one of the
7 satisfying things is that the breast cancer lady for
8 today, you know, she's in remission. And for the
9 second individual, there's nothing growing, whatever
10 that means. So thank you.

11 MR. GILFILLAN: That's good to hear. Thank
12 you.

13 TONY SUNGH: Hi my name is Tony Sungh. I'm
14 the medical director here for United Health Care for
15 the Heartland States, which is Western Missouri and
16 Eastern Kansas.

17 I very much appreciate your openness in
18 discussion. I know we're going to finish shortly,
19 very reasonably, and I also want to echo some of the
20 other people who have spoke about Kansas City being
21 a great site for the innovation system. And there's
22 already a lot of innovations that are occurring in
23 Kansas City here, and I think it is a great site for
24 areas of cooperation in various scale. So I would
25 ask your consideration for various things, if it

1 comes to those considerations.

2 Having spent some time with CMS, ACO
3 program as well, I know obviously you got an upshot
4 coming -- managing the ACOs and a lot of the
5 thoughts in regards to two things.

6 One being cognizant a little bit, you
7 know, this is coming from a large purchaser of
8 health insurance about the concerns that purchasers
9 have now in regards to various ACOs beginning to
10 form, and it's specifically to how these merger and
11 acquisitions actually have a dramatic impact in the
12 price and negotiation in those regards.

13 And then the second ones is not
14 necessarily a question, but it's more of a
15 recommendation. We do have tremendous technology,
16 even low technology using Internet visits in various
17 fronts. We actually have a now clinic employed with
18 Delta employees using Internet visit. That was a
19 low technology impact on care using the Internet
20 visits, and those employees at Delta. We can use
21 that. We can scale that to fit different spaces.
22 And I know that United Health Groups is working with
23 CMS and some of those various innovation fronts for
24 those discussions.

25 I think there are low technology that

1 could impact health in various ways, such as group
2 visits. You know, everybody has a cell phone now
3 days. You could have messages sent reminding them
4 of their response. You know, those kind of low
5 technology could have a dramatic impact on how we
6 practice.

7 MR. GILFILLAN: That raises the question.
8 We'd be very interested in looking at proposals
9 ultimately that attempt to evaluate -- scales that
10 evaluate models like that. So we expect a
11 significant -- as we think about managing the
12 portfolio, one of the things we mentioned is making
13 sure we get the technology, high or low, but that we
14 get a good piece of our work focused there, so we'd
15 be real open and interested in hearing about ideas
16 in that space.

17 Is there any connection between no care
18 and being rural and, you know, the 5,000 people
19 spaced farther than New Jersey? Is there a space in
20 there for telehealth in ways that we should be
21 thinking of differently? Is that something you all
22 are looking at or thinking as a possible model?

23 Be interesting to see how much gas you can
24 save.

25 MARTIN KENNEDY: My name's Martin Kennedy.

1 I'm with the Kansas Department on Aging, and we
2 operate home and community-based services waiver for
3 the state through the Medicaid program, and have
4 been working over the past couple of years to
5 develop telehealth services through the waiver.

6 One of the issues -- and it speaks to the
7 fragmentation you talked about earlier. One of the
8 issues that we run into is that the savings that
9 might result from the use of telehealth, we believe
10 probably accrue probably more to Medicare than
11 Medicaid. So that's -- it doesn't give the state
12 policymakers and the state budget decision makers
13 the opportunity to realize the savings of
14 implementing any new service like that through the
15 Medicaid program. That's a small example I think of
16 what you're -- of the kinds of things you're talking
17 about, but it does present challenges.

18 MR. GILFILLAN: Yeah. Well, that was a
19 topic of one of the conversations Melanie had, and
20 that's exactly the sort of proposal we're looking
21 for. So if there's some crazy stuff out there like
22 that, you know, then we'd like to understand that
23 and try and find a way to make it rational so the
24 right thing happens. So keep an eye on our site, as
25 I said, and we'd love to hear more about that.

1 KEN GLOSTEINER: Ken Glosteiner, with
2 Methodist Health System in Omaha, Nebraska. Part of
3 the accountable care organization there. In fact,
4 we have two competitors working together to develop
5 this accountable care organization.

6 I have two things. One of them is on that
7 individual eligible thing at the start. We have 50
8 different states and there's 50 different fee
9 schedules for providers, and it's very difficult for
10 a physician to spend a lot of time with the Medicaid
11 patient when the state determines what the
12 physician's fee schedule and many times it's lower
13 than what Medicare pays. They would really starve
14 to death if they spent a lot of time with a Medicaid
15 patient. And I think that is really a lot of the
16 problem with trying to treat them as a medical home
17 or a Medicaid medical home.

18 My other point, and I want to ask if
19 there's any clarification -- also on that -- there's
20 an NPI number. Every physician has an NPI number.
21 If you want to be selective in giving additional
22 reimbursement to physicians that are doing the kinds
23 of work, do it through the NPI number. Every
24 physician has one. You can be very targeted.

25 Also then on the other side -- and I don't

1 know if things have changed or not, but a lot of
2 people are talking about joining an accountable care
3 organization, when, in fact, I think the way it's
4 written right now, the beneficiary doesn't know he's
5 in an accountable care organization, and the
6 provider doesn't know who is in the accountable care
7 organization either.

8 So I think that's kind of
9 counterproductive. And the reasoning was, well, the
10 providers know who's in it; they will withhold care.
11 So I think it's difficult to get the kinds of
12 benefits that we want when the beneficiary doesn't
13 know and he has no incentives to stay within the
14 accountable care and the provider doesn't know which
15 of his patients are in the accountable care.

16 MS. RIOS: I'm going to let you respond to
17 that, and then I think based on our time, we'll take
18 these last two comments.

19 MR. GILFILLAN: Well, an ACO issue that
20 just -- we're still in the middle of a period of
21 time where you can respond to the RFI. And these
22 are important questions, and it would be helpful to,
23 you know, make them, and weigh in on both aspects of
24 those very important. The question of whether or
25 not beneficiaries know they're in an ACO is one

1 that's -- lots of opinion about that, a lot of
2 debate, and, you know --

3 KEN GLOSTEINER: I would just like to have
4 the incentive that if they -- you know, if they are
5 and want to volunteer to be in it, there's
6 incentive, whether it's a different premium or some
7 sort of an incentive for them to -- if they want to
8 be in it.

9 MR. GILFILLAN: I hear you. You know, a
10 little framing. I think political legislation is
11 pretty clear that the -- this is not managed care,
12 you know, kind of 2.0, right. It's about trying to
13 solve, you know, a real -- we're trying to crack a
14 real tough nut, which is can you significantly
15 change the experience of Medicaid for the service
16 members. And down the road maybe there will be
17 opportunities to talk about the benefit center. But
18 I think it's important to realize that as you think
19 about crafting your approach, it's around fee
20 servicing and (unintelligible) not going to change.

21 AUDIENCE: My name is Nancy Barnes, excuse
22 me, and I'm with the Missouri Nurses Association. I
23 want to applaud you for your efforts in terms of
24 relationships with nurses.

25 This is the first time that I've heard

1 publicly some ideas, and yesterday when I
2 participated in a webinar with the nurses for the
3 future group out of Washington, D.C., and Dr.
4 Berwick was there, it was very motivating for me to
5 believe that we can change the healthcare system and
6 do it very well.

7 And so I applaud you for your efforts. And
8 I would tell you that the nurses in the country are
9 very concerned about you getting success with your
10 efforts. They're very concerned, because they deal
11 with the persons on a daily basis, where they're out
12 of the loop or they don't have access or they can't
13 afford their medicines because they're addicted to
14 something. And we're concerned that those big
15 issues are probably basis of healthcare reform, are
16 necessary in terms of economics.

17 We appreciate all of the administrators
18 and we appreciate all the physicians who do all this
19 work in terms of our articulating issues. Nurses
20 know the issues when it comes to patient care. So
21 thank you so much.

22 And one other thing. This is a comment.
23 The student nurses tell me that if they had you all
24 designing the electronic health record, everybody in
25 the country would know about it and could acclimate

1 themselves immediately.

2 MR. GILFILLAN: Great point. Thanks,
3 Nancy. Thanks for your comments, and thanks for all
4 the work, you all. Is this a -- I just wonder if we
5 look back 10 years, we would have scratched our
6 heads and said, oh, my God, I didn't realize there
7 was this much opportunity for better things for
8 people. I think -- if you ever tend to get out and
9 talk to people who are actually engaged in these
10 kinds of issues, I just see -- you just see the
11 opportunities are incredible. So that all begins
12 with focusing on the patients, and we know you guys
13 do a lot of that, so thank you.

14 JIM: Just a quick reality check on his
15 comment about attribution. We lived -- you know, we
16 had a Medicare risk product, which within our
17 organization had about 9 or 10,000 patients that
18 were pre-attributed, if you will. We knew who they
19 were.

20 Several years ago -- and that brought up
21 the care for everybody, not just them. We had a
22 watershed effect that had an improvement in the care
23 effect, living in the attribution method for PG
24 demonstration, where it was a member prescribed
25 after the fact. We didn't know who it was. We had

1 60,000 Medicare population beneficiaries, and which
2 about half of them were attributed to us.

3 Again, we found no palpable difference. We
4 actually very quickly found who our group was by
5 some studying, and we were focused in on that group,
6 even though it wasn't assigned to us, we got very
7 good at knowing who they were after a year or two.

8 So we attributed our patients on the
9 prospective side as much as we could just to be able
10 to aggressively manage those people and offer them
11 extra services. But what we found within our entire
12 population, Medicare, non-Medicare, non-payer, all
13 payer, the cost of physicians by far and away used
14 all the tools at their disposal, and rising tide
15 floated all those.

16 So to that argument about before
17 attribution being fearful that it's not going to
18 help all patients, we have not seen that. And I
19 would challenge the center to look at the Ten
20 Science across the country. Also look at their
21 attribution record and how they feel like that has
22 helped. So I think the retro-attribution -- the
23 concern for not getting patients care is really not
24 what we saw in public health.

25 MR. GILFILLAN: So, Jim, what would you

1 recommend on attribution? And I think the word that
2 I've heard you use is alignment? Because we're not
3 assigning, we're not attributing, we're saying some
4 patients are aligned -- currently aligned with some
5 practices? What would your recommendation be?

6 JIM: If I were going to -- I would do the
7 NPR. I would balance a historical look at minimum
8 number of flux within a primary care provider panel
9 of who they have and how stable they are. We all
10 know about the flux in and out and what's tolerable
11 for that, but then sending that historically who the
12 patients have been with that primary provider, and
13 that would identify who your control board is and
14 how many they bring to the ACO table.

15 MR. GILFILLAN: And would be the
16 population that you do ultimate reconciliation of
17 settlement on or would you look back and make a
18 decision on some other population. I'm sorry. This
19 is kind of technical, but a very important question.

20 JIM: I would say that would be the
21 population that you go forward and then reclamation
22 on the backside if you want to claim it at the
23 backside -- either way would be fine, but you need a
24 population to go forward to say -- you know, you
25 could have some flux in there, and say we're not

1 going to let it vary more than 20 percent.

2 MR. GILFILLAN: Right.

3 JIM: Just the 80 percent sensitivity on
4 that.

5 MR. GILFILLAN: Yeah. So, okay, you know,
6 your experience of a physician group practice
7 demonstration project went on for the last four or
8 five years, and at the end my understanding was
9 there was -- within the group of 10 practices there
10 was a lot back and forth about which -- you know,
11 which -- from a settlement standpoint which approach
12 should you use, and the at end of the day the group
13 was more interested in going to the retrospective
14 look, knowing that they had no prospective
15 information; is that correct?

16 JIM: There was 100 percent agreement we
17 wanted to go prospective. We were also told that' a
18 no-go. So given the answer we can't do it
19 prospectively. There's no flexibility to
20 prospectively, then retrospective, how do you make
21 it work?

22 MR. GILFILLAN: I see.

23 AUDIENCE: You know, to me it's sounds
24 like if you have that assignment up front and then
25 you really look at a global basis of what their cost

1 per beneficiary is, and then afterwards you also
2 have an assignment of who there still is in their
3 practice -- so you're not comparing that person to
4 person. So at the end of a year or two years, you
5 look at what their cost of beneficiary is and see
6 where the savings is there. If you're trying to
7 catch patients back and forth, I think that will be
8 a nightmare. I think it has to be more focused on
9 the cost of beneficiary, in the base year as well as
10 the out year.

11 MR. GILFILLAN: Again, I'm not sure -- are
12 you saying you should identify them prospectively
13 and those are the only patients that should be
14 looked at at the end?

15 AUDIENCE: No. The total because you're
16 going to have new patients added into your practice,
17 so you're really just looking at a global -- this is
18 your cost of beneficiary in 2010, and you have
19 really a relook, a reallocation to those patients
20 that are still in -- you know, that are in that
21 practice now because they have a relationship.

22 MR. GILFILLAN: Yeah.

23 AUDIENCE: Did the cost of the beneficiary
24 go up or down.

25 MR. GILFILLAN: Yeah. No, I understand.

1 Yeah.

2 AUDIENCE: And so that would be -- then
3 you're not trying to match patients and track them
4 for two years.

5 MR. GILFILLAN: I see. Right.

6 MS. RIOS: Did you want to add anything to
7 end the session?

8 MR. GILFILLAN: I'm good with that one.
9 We're done. Okay. Let me just go back. I guess I
10 want to just make sure that -- I mean, anybody have
11 any other burning innovation ideas they want to get
12 out on the table today, because I want to make sure
13 that we give everybody a shot at that.

14 If not, then we can wrap up. Then I just
15 say, it's great to be back in Kansas City. And it's
16 great community, the modern exposure. A lot of
17 times you go someplace today, Nancy will be pointing
18 out another great spot, another great aspect of the
19 community. So it's nice to be here.

20 You guys have great health care, and a lot
21 of history and a lot of resources dedicated to
22 changing things and improving care.

23 I want to just take a moment to note the
24 leadership of the American Academy for Family
25 Practice and all you've done for moving the patients

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