Pioneer ACOs: Lessons Learned from Participants and Dropouts
Alliance for Health Reform
The Commonwealth Fund
July 2, 2013

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Thank you all for coming, my name is Ed Howard, I am with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt and our board of directors, I want to welcome you to today's program on really one of the most important initiatives in improving the delivery system for healthcare in America, at least potentially most important. And I'm talking about the Accountable Care Organization, the ACO and one particular subset of the ACO, the Pioneer.

There are, you will be pleased to hear, people on our panel today who know a lot more about ACOs than I do. But let me just say that they are usually a collaboration among hospitals, physicians, other providers, and at delivering high quality care at lower cost while improving the health of the population. Now, most of the attention that has been paid to ACOs has been through Medicare, but there are about as many ACOs springing up in the private sector as in the public. And there are hundreds of them in most parts of the country. We are going to be examining even more closely the Pioneer ACO, which is, as most of you know, an initiative of the Centers for Medicare and Medicaid Services that enlisted 32 experienced healthcare organizations in an effort to have some of the likeliest candidates involved for delivering efficient, quality, coordinated care and have them grapple with the task of meeting that triple aim that we were talking about. Now this summer, CMS released results from the first year of Pioneer ACO operations and we are going to take a close look at some of those results and with our export panel – I didn't know you folks were in a new business. Our expert panel. We are going to explore the implications of the Pioneer experience and the ACO initiative in general for reshaping our healthcare system in a positive way.

Now, we are very pleased to have, as a partner in today's program, the Commonwealth Fund. A century old philanthropy established to promote the common wheel or the common good and we are very lucky to have as our co-moderator today, Dr. Anne-Marie Audet, vice president at the fund who directs both its delivery system reform and the breakthrough innovations projects. Anne-Marie, welcome back to the moderator's chair, we are looking forward to having you help frame the issues for us today.

ANNE-MARIE AUDET: Thank you Ed and good afternoon. So I am delighted to be here with our colleagues from the Alliance for Health Reform to organize this panel on Accountable Care Organizations. No doubt it's kind of cliché, but I will say it anyway, that we are in the midst of implementing the Affordable Care Act and several of its provisions and one of them of course is the Accountable Care Act and many times actually you see people writing about the Accountable Care Organization and that is kind of interesting. So as Ed said, this summer CMS released some preliminary findings from the first year experience of the Pioneer program and they are after a lot of ink has flowed

with various perspective and view points and opinions and we thought, the alliance and the Commonwealth Fund, that it would be really important to, in a way to keep the information, the knowledge and the learning flowing, to really put together this panel and we brought together some leaders who have really been researching and know a lot in-depth knowledge about the fundamentals of the Accountable Care Organizations, that is Dr. Elliott Fisher, who will have a lot to say and he is with his group at Dartmouth, is doing a lot of work to understand both qualitatively as well as more quantitative, what is the impact of this model on healthcare and costs. And of course, as important is bringing together here today, groups that have on the ground experience in implementing the model. So that is Dr. Steve Safyer and Dr. Greg Sheff.

It's really important, the stakes are really high, as we all know. The fundamental conceptual model behind the Accountable Care Organization is pretty solid. Now how those concepts get translated, implemented in the real life, is what is really important and I think it would naïve to just say it's working, it's not working, it's successful, it's failing. And what you will hear today, it's not a black and white situation, but really we have to be open to learning, to adapting when things do not work and to understanding why they do not work and also to learning what works and spreading that, in the midst of keeping the expectations quite high.

I'm not going to take too much time because we really want to hear from our experts here, but when you think about it, the ACO model is quite new in it's implementation, it's about two years old, if that. But it's growth has continued at a rapid pace in both Medicare, the private sector as well as states. As I said, the core principle of the model involves both delivery and payment system reform hand in hand, with the goal of moving away from the [Fefer] Service System and rewarding healthcare organizations for quality and outcomes and also for care coordination and at the same time, reducing the cost of care. This is just a graph – you will hear more about this, just to show you the rapid pace at which the model has been implemented. We all know that March 23, 2010 was the enactment of the Affordable Care Act. A year later, HHS released the proposed rule for the ACO in the Medicare shared savings program and October 2011, the final rules were issued. In December of 2011 we had the 32 Pioneers were named and then the following year in 2012 there were two rounds of MSSP ACOs announced, as well as in January of this year, in 2013, there was an additional round of Medical Shared Savings Program ACO and we are expecting one in 2014. So as today, there are about 253 or so Medicare ACOs and I think it's still – we may hear from Dr. Fisher, who is doing a national survey of ACOs but right now it seems that it's probably about half-half Medicare and private sector ACOs.

The big thing is, where are they located? So you probably have seen a lot of maps of the location and I'm not going to go through that because Dr. Fisher will talk more about this. This is a graph from the

Commonwealth Fund performance and bench marking tool called Whynotthebest.org where we profile the performance of healthcare organizations at the level of the organization health system, HRR, state and nationwide. And here is where you see – this is where the location of the Pioneer ACOs in clumps, of course. And here are the Medicare shared savings program and their location and I'm just showing this because what is really important is not really where they are located, but what you will hear more about, what can we learn about the characteristics of the communities and the healthcare markets where they are forming and where they are not forming, and that is going to be really important and you will hear more about that.

This is – the next slide is a slide from the Leavitt Group showing the trends in Medicare and non-Medicare, showing that right now they are about half and half. And they are also quite different models. You will hear from our experts, there are physician led ACOs, there are hospital led ACOs, there are also states that are doing some interesting models of coalitions and that is starting to emerge and be quite interesting.

Finally, as I mentioned, this summer there was some preliminary findings from the Pioneer programs. I'm not going to go through the details because you will hear that from our speakers, but the results were mixed. I'm not going to talk about the cost, you will hear that, but in terms of quality, what was interesting to me is that most of the Pioneers actually outperformed other healthcare organizations on most of the quality indicators and really substantive ones - readmissions and significant clinical outcomes in high risk patients with chronic conditions.

So with that, this is just a little background why we put this panel together and you will learn I hope a lot from those who are studying the program quite intensely and also from two leaders who are grappling and implementing this model.

ED HOWARD: Thank you Anne-Marie. I want to just do a little housekeeping here. You have important information, including biographical information about all of our speakers, and I commend it to you. There is also a list of materials that go beyond the ones that have been actually reproduced in your packets. If you want to look at this later or share it with your colleagues, it's all online at allhealth.org, where in a couple of days you will be able to view video of this seminar, along with a transcript a few days after that. Two pieces of paper I want to call particular attention to, one is green, one is blue, some of you have heard this before. The green one is a question card. When we get to the point of Q&A, we would love to have you write a question or use one of the microphones to ask it orally and the blue is

the blue evaluation form at the end, which I hope you will fill out to help us improve these programs as we go ahead. You can see on the screen that those of you who are prone to Tweet, can do so with the hash tag ACOs with an S at the end. And we would encourage you to do that.

So as Anne-Marie said, we have got some real power packed speakers here. And we are going to listen to their brief presentations and then we will get them interacting and responding to your questions. And we are going to start with Dr. Elliott Fisher, whom Anne-Marie noted is sort of Mr. ACO in the research world. He directs the Dartmouth Institute for health policy and clinical practice, he co-directs the Dartmouth Atlas of Healthcare. His research really paved the way for the development of ACOs in the United States and he's now tracking what makes ACOs succeed or not, and looking at how reforms like ACOs are affecting health system performance overall. Elliott, thank you so much for coming to Washington for us.

ELLIOTT FISHER: Oh, it's wonderful to be here, thank you Ed, thank you Anne-Marie. Thank you Anne-Marie especially for all the generous support the Commonwealth Fund has provided us over the last five years to start to get our teeth into these issues. And thank you all for coming. It's fun to see lots of familiar faces. I certainly am not the only person had anything to do with creating ACOs, there are lots of people who have been involved with this. Glenn Hackbarth, Medpac, many people on the hill. Mark McClellan, Steve Lieberman, there are a lot of people who are trying to help us think through how we are going to make progress in fixing healthcare. Many of you will have seen our Dartmouth Atlas maps, the IOM recently basically confirmed the findings, that there are remarkable variations in spending and quality – surprise, surprise. There are large variations in spending, especially that are not explained by differences in health status. Those persist after you adjust for anything.

So that led to questions, what are the additional services being provided? Many of you will be familiar with this, but it's important to review so we understand why we are going after ACOs. When we compare high spending regions and low spending regions of the United States, and we divide care up into three categories of service – effective care, things that physicians who competent in doing a good job, should be delivering to 100% of their patients. We know that back when our research was starting, we were only getting it right about 50% of the time, so even when we knew that the evidence was good, only 50% of patients were getting the high quality services we knew that evidence expected them to receive. High spending regions did not provide any more of that kind of care than low spending regions; in fact, on average they were just a little bit worse. Surprisingly, high spending regions didn't provide any more elective surgery. Major surgical procedures like hip fractures, hip replacement, or open heart surgery or stents. All of the extra spending in high spending regions is due to how we largely – the frequency of what we refer to as supply sensitive services. If you have a lot of hospital beds, you are

going to keep those hospital beds full. If you have a lot of physicians, especially paid under fee for service, those physicians are going to remarkably be able to stay busy. So that when you look at the first year after a heart attack hospitalization or a hip fracture hospitalization, follow them for a year. Patients in the high spending regions were spending 60% more time in the hospital, 75% more time in then ICU or getting 75% more visits, mostly specialist's visits – they were also spending a lot more time in post acute care, as shown in the slide, and they were getting more imaging and diagnostic testing. And it didn't lead to better outcomes.

So that is what led to another five years of work, working with many to try to say, so what are the drivers are poor performance and what should we do to address them? We know we had inadequate information and we need better information. We need to be clear about what we are trying to achieve. We need some kind of organizations that can provide integrative and coordinated care, because the major failing here is not being able to coordinate and integrate and improve performance as an organization. And then we needed new payment models.

So that is a two minute run through as to why we needed ACOs and then working with a bunch of actuaries and others, people in the CBO and here on the hill, we came up with notion that we can't change the Part B benefit to require patients to do – to sign up for new health plans, that was going to be too heavy a lift. Will it attribute patients to organizations based on where they are getting most of their care and then we will come up with a payment model that rewards those systems for improving care, hitting quality targets and gives them a share of savings if they both hit those quality targets and lowered their per capita costs.

So where are ACOs now? I don't know how anyone can read those, I'm sorry, but you have the handouts. Lots of different estimates, but this is a little older than the data that came from Leavitt that you see. Anne-Marie showed you those other slides. This is based on actual interviews with the CEOs and CMOs to say, so do you have a total cost of care contract so we are a little more conservative than some of the other definitions of ACOs? But our estimate is still that we are around 300 or so ACOs that have total cost of care contracts and some performance based initiative around quality.

Where are they forming? Again, they are forming in places that are not poor. Where there is a relative low poverty rate. They are forming largely in urban areas, compared to rural areas. Although there are some forming in rural areas as well. And they are, as you saw from the early slide, in the Northeast and the West, predominantly much lower in the South and a reasonable number in the Midwest. They are

forming in areas not surprisingly if hitting quality targets is going to be important, where quality is already relatively high. They are forming in areas where costs are relatively high. Not surprising, it's going to be easier to achieve shared savings if performance on cost is pathetic – I think that is technical term – in the community where you are starting your ACO. They are forming in areas where the physician groups are larger. It will be easier to integrate physician groups if they are already in some form of group affiliation. It's harder to pull together 500 independent physicians as Optimus has done in New Jersey. One and two physician practices. But it's still possible to pull together small physician practices, it's just harder. I'm sure we will talk about that on the panel. And they are forming in areas where there is higher levels of managed care penetration which we will hear in the panel, is relevant because those systems have experience with capitation, risk bearing contracts, and are more likely to benefit from adding more fee for services lives into their already capitated or risk bearing contracts.

There are some really interesting things that are emerging. We are going to talk about Pioneer ACOs today, but I wouldn't place all my bets on the large integrated delivery systems. There are a number of these organizations that are forming in the safety net. Our guess is somewhere near 10% of the ACOs that are out there are emerging from purely safety net organizations. Walgreen's has sponsored three ACOs. Many of the partners – so I think there is a question of whether these innovative, nimble, low resource places may be the kinds of the settings where you can have what Clayton Christensen refers to as disruptive innovation emerge. These are organizations that can change more rapidly; you may remember the Wall Street Journal Op-Ed that Christensen wrote with Jeff Flier, Dean of Harvard Medical, saying ACOs are going to fail. It's because they are so skeptical about the capacity of large integrated delivery systems to make major organizational changes when their processes are so stuck in place. Well, that will be a good topic of conversation for us to think about. How to foster the emergence of more nimble organizations that can change perhaps more rapidly.

Early evidence is not just from the Pioneer ACOs, which we will talk about, but my colleagues at Dartmouth evaluated the physician group practice demonstration, an early model, and showed substantial evidence that everyone hit quality targets in those 10 organizations that were participating in the physician group practice demonstration, essentially an early version of the ACO model. But interestingly, where they achieved their savings was taking care of dual eligibles. And that shouldn't surprise us going back to that first slide of the opportunities to improve quality and where the savings are, so that what I think we will see in the conversation we are having is that to achieve what the ACO does is say, you have to quality targets in order to get your savings, so you are going to improve your quality on the performance measures that they have. And you can't save any money on healthy people because they are not spending much money. The place you can save money is by taking great care of sick people. Dual eligibles are eligible for Medicare and Medicaid and I think you see that in our data, that the real savings in the physician group practice demonstration came from taking great care of sick

people. We just had another article come out that said, cancer patients also benefit substantially from engagement in a model that is designed to encourage these systems to follow Sutton's law, go where the money is.

The evidence from the Pioneers – let's get it all up there. They achieved some savings, they all hit quality targets. Eighteen of them actually achieved savings, but only 13 of them were the savings were significantly above the statistical benchmark that was set that they would be eligible to receive a share of those savings. Medicare achieved a substantial savings itself. Two Pioneer ACOs including Atrius in Massachusetts had losses. Gene Lindsay who was the leader of Atrius said, we are in this for the long haul, we are going to stay in the program, we know that we are pretty high performing already. So 30 of them are staying in this payment model, two of them are leaving the program and we will talk a little bit about that, I'm sure.

So what are we learning? Safety net providers are a really important part. Probably a 40% of ACOs have a safety net provider. An FQHC or otherwise, doing really interesting things that we can talk about. ACOs are much more diverse than we would have anticipated. Lots of new partnerships are forming between medical service organizations, provider organizations, ACOs are not surprisingly trying a variety of strategies to improve quality and if there is one thing – and reduce costs. If there is one thing that I would say is the early lesson, is that data is what makes this possible. If you can find your sick patients, figure out how sick they are, predict how sick they are going to be in the future, you will be able to perform better and those systems that have been able to implement good data systems are able to reduce their costs, reduce hospitalization rates by up to 50%, reduce EDUs by up to 50% and it's because they can find the patients who they need to pay attention to, and so the barriers to getting good data to ACOs, we should really think about.

We are pleasantly surprised by the predominance of physician leadership in ACOs, whether it's a hospital at ACO or whether it's a physician led ACO, physicians are playing a major role in the leadership which I think early on in the emergence of this model, there was great concern it would be taken over by the hospitals and I don't think we are seeing that. And I will stop there.

ED HOWARD: Thank you very much Elliott. We are going to turn now to – as Anne-Marie foreshadowed, a couple of folks who have to deal with this on the ground. First, Dr. Gregory Sheff, who is the Executive Vice President of Clinical Systems at Seton Healthcare Family in Austin, Texas, since last year he has also been President and Chief Medical Officer of the ACO formed by Seton and the Austin Regional Health

Alliance. And their ACO was one of the 32 Pioneers and recently decided to end that status and participate in the Medicare shared Savings Program instead. So we are interested to hear a little bit about your experience, Greg, and how it relates to the more general principles that we have just heard enunciated by Elliott Fisher.

GREG SHEFF: Thanks Ed. I will start off, on behalf of Ed and Anne-Marie, by apologizing for the shabbiness of the room here. Next year we will try to have it some place a little bit fancier. We appreciate them hosting this and getting us all together and getting us together in a very historic place.

So I am going to start off by talking a little overview of where I work. The Seton Healthcare Family is a mission driven organization with a specific focus on the poor and vulnerable. We are a member of Ascension Health, which is the largest not for profit health system in the country. We give about two thirds of the charity care in our community, it equates to about 400 million dollars in uncompensated care. We have an 11 county service area on the adult side, 46 counties for our pediatric hospital. And like many healthcare systems, we have hospitals, but we also have an employed physician group. We have a health insurance product and other assets to make us more of an integrated delivery system. That said, as we go through this, you will also hear me talking about Austin Regional Clinic. What Seton Healthcare Family, on the employed side did not have, is a large employed primary care base. So Austin Regional Clinic is a 300 physician, multi specialty group that is primarily primary care and hospitals and is aligned with Seton, though independent and has brought into the partnership, the primary care base.

I would just like to mention on this slide that though the transformation from volume to value is the number one strategic priority for the Seton Health Care Family right now, we do have other initiatives and that plays into some of our thinking as well. One initiative is that University of Texas at Austin is building a new medical school – The Dell Medical School. And Seton will be building a new teaching hospital in order to support that. That of course takes capital and it takes operational focus. The other big initiative that we are undergoing right now is also in partnership with CMS, through the 1115 waiver program, we are involved in an innovative pilot called the community care collaborative, where we are essentially with the county health district, going to manage unfunded lives and take joint risk around the quality and cost of those lives.

The other thing that I want to mention is about the market and I'm not going to speak to the actual points in this slide, but I do want to make the point that all healthcare is local and I think we all know that, but the path to organized care in different communities very much is dependent on pre-existing

conditions. And so as we raise up here systemic issues, I think we can certainly learn from each other and apply lessons, but I also think we have to stay focused on the reality that as we operationalize these things, there is going to be different solutions and different communities just because the inherent organizational differences and aggregating patterns for care.

This slide is essentially a Venn diagram that just gives you a sense of our organization. Seton Health Alliance is the ACO that is participating in Pioneer and we are also now participating in commercial contracts. And it is an unusual joint venture between community physicians on the right and the Seton Health Care Family on the left. To sum it up, it is essentially a physician lead, hospital owned, jointly governed entity. So Seton brings the capital and owns it, the physicians bring their practices and their panels and the attributed lives. And they also bring their clinical knowledge to lead the care redesign efforts and together we do the work. What is unusual about it is that often in these type of structures, where a hospital system is partnering with a physician group, but is funding it, there are tremendous numbers of reserve powers to the hospital and we really have minimized them in this organization, so it really is a sink or swim together structure, which took some cultural change within the hospital, but I think has been really helpful in getting the work done moving forward.

I am going to speak to a few issues around successes and challenges and this a slide that I have used in other presentations and it says "pillars" instead of "successes and challenges" and just – there is really – it's how we organize the work and I don't think it's very different than how other ACOs or value based systems organize the work, but I want to make a few points about key areas. One under care management, Elliott spoke to this, that one of our biggest successes had been on using predictive analytics to find the high risk patients and then get our arms around them. So high risk extensive clinics, care teams, nurse navigators, transition programs, I mean, there is lots of ways to operationalize this, but it comes down to figuring out who is at risk and then allocating resources to them intentionally instead of passively in a fee for service system. The inverse of that is one of our greatest challenges. And that is that – well, not the inverse, but the implication. That is that we are spending just under 2% of the total cost of care for this population to fund all of these high risk interventions. And that is not an inconsequential amount of money and that it means to break even, we have to receive back in revenue, 2%. Now this is an investment from our perspective. There is a lot of efficiency of scale that over time we think that percent will come down. We are doing a lot of platform building and so on and I think we will learn and become more efficient. But I think end of the day, one of things that all of the ACOs and I think all of the country as well is, there is a lot of upfront investment to do this work and how you are going to manage that investment with the return so that we can stay sustainable in any transition from volume to value.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

The other point I want to elevate is in health IT. For us, quite honestly, I would just talk about it is a challenge. As Elliott pointed out, one of the big distinctions between the way we are approaching care management in ACOs and the current trends towards value based care, versus the way managed care was done in the past, is on the emphasis on using data, aggregating it on both the patient and the population level to guide where in a population we need to allocate resources, where for specific patients we need to put particular resources to coordinate care with a longitudinal record and that aggregation and connectivity throughout the community has been substantial effort. It is a big lift and I agree with Elliott that it is key to making this all work, but I think we are all learning that having some guidance on that and some shared experiences and standardization around that will probably make the transition more successful.

The last point I want to make on this slide is on the last pillar which is our transformation to value. We see this as really a clear success for the Pioneer ACOs. We have one year of reported data on the Pioneer program and there is – in the appropriate circles there is lots of buzz about whether things were a success or failure, but really this is a long term view for us. Pioneer ACO is a platform to transform our delivery system and for us, success was, did we get institutional momentum? Which we did. Did we get the provider community to build their awareness and interest and engagement in transforming the value? Which we did. And did we move along conversations with commercial payers so that we can reach a tipping point in how we are delivering care in our community? And again, we did. So for us, that is really what we wanted out of the ACO, was to move down the path and I think we have been successful.

So under course corrections, I'm just going to mention a few of these. The first one I will skip, but data infrastructure I think I have spoken to. The second one is increased focus on post acute care. When many of us think where is the healthcare dollar spent, especially if we are thinking from the perspective of avoidable utilization, we all turn to the hospital system and there certainly is quite a bit of spend in the hospital system. But in Medicare, anyway, with an aged population, about a third of the total spend is in the post acute world. And so there is substantial opportunity to increase efficiency in that world and I think we - one, underestimated going into its importance. And two, underestimated some of the difficulties in our community of organizing it. Not on the level that there is not high quality providers, but historically in our community, the post acute world has been very removed, separated and isolated from either primary care practices or the hospital system and integrating them is going to be key to success. The other issue with post acute is that there are some – it's a very regulated environment and interacting with post acute presented even more challenges than interacting with non employed physicians, which is also heavily regulated. How we refer out of the hospital to post acute is heavily regulated. And so I think there are some systemic issues that could make this more sustainable.

Challenges of population specific care processes is referring to the notion that we are working with our providers and providing resources around specific populations, so in a primary care home, we are saying, if you have an ACO patient, we can provide a nurse navigator. But for the patients that aren't in the ACO, we can't provide them. And on the one hand, the providers understand that there is a cost to it and they can't expect it, but especially a mission driven organization, it's an uncomfortable conversation to be talking about, this is a better way to give care, but we can only give it to some people. And so I think reaching that tipping point, once you have started that transformation, reaching that tipping point is critical.

Last point on this slide is the transition to MSSP and I'm going to make a little friendly jab at Ed and Anne-Marie, which is if I had to title it, I wouldn't have used the word "drop-out". From our perspective, we made an administrative decision between two different Medicare ACO programs. We are very committed to the ACO model and to value based care in general. Some of it had to do with some very kind of local, down in the weeds administrative issues that drove our decision. A lot of it also had to do with; we look at our population health work as a portfolio. So we have a portfolio population health initiative and we have to manage risk across that portfolio. I mentioned earlier, the Community Care Collaborative, where we took on the risk for 50,000 uninsured folks, which is typically a fairly high, potentially high spend population. And so managing risk between Pioneer and MSSP was in many ways just a way of saying, we as a system can take so much risk through value based care and we were managing it. But I want to emphasis that for us, it was a very administrative decision and not an issue with the quality of the model or our commitment to it.

ED HOWARD: Excuse me, let the record show, Anne-Marie was not complicit in that [unintelligible] writing. That was a grammatic license in characterizing it.

ANNE-MARIE AUDET: But it sure attracted a lot of people, so that is a success.

GREG SHEFF: I will speak quickly to this last slide because I believe that most of this is what will take up in questions, which is suggestions for refinement and I will just touch on the first three. One is consideration of local trends. So Pioneer to some extend uses local trends, but really Pioneer and MSSP are both comparing your local experience first a national trend. And there is some very sound reasons why that needs to be for it to keep a program as a whole, whole. However, we all live in a bell curve and some communities are higher than the national trend at baseline and some are lower. And depending

on where you lie, it can make it much easier or much harder to succeed. So I think that this is something people are aware of, have been aware of the whole time. But I think as we refine, we need to focus on how we incorporate local trends so that we can still incentivize people that are in challenging markets to participate.

The second thing is beneficiary engagement and the same issue, I don't think that this is anything that – I'm sure Elliott and others had many, many talks about beneficiary engagement prior to the ACO model, but one common theme of the ACO participants is how can we get our beneficiaries to feel like they are in our network, to be committed to it, to have some incentive to stay in it. So I think again, we are finding that model.

And the last one is on operational metrics and operationalizing quality metrics. CMS will hopefully standardize it's quality metrics across it's multiple programs and I think if we can find a way to choose a standard set across commercial payers as well, that is going to be critical because the work of the measurement in aggregation can actually take over the work of managing the care itself. And along that line, we have to look for metrics that are clinically relevant that also are operationally feasible, based on the existing data that is EMR's and so on. I have already gone over, so I will stop. Thank you for your time.

ED HOWARD: Thank you very much, Greg. Finally, we turn to Dr. Steven Safyer who is the President and CEO of Montefiore. Like our colleague from Austin, he comes from an integrated delivery system, which is also an academic health center and connected to Einstein Medical School. Montefiore was also one of the Pioneer 32 and Dr. Safyer knows that experience and Montefiore very well, having been there for a year or two. Welcome back, Steve, we are looking forward to your take on the ACO story.

STEVE SAFYER: Great, thank you Ed and I also am appreciative of the Commonwealth and appreciative of in particular a nice profile of Montefiore that is in here that was done in their high performing system and to give you a little more background. So the title of my talk is "Our Experience in Building, since 1996." What we later heard from very important people, some of them on the panel, is in ACO. So we were building an ACO back in 1996 and planning for it for at least two years before. And in essence, the reason we did that, what drove us to begin to change the payment system and change the delivery system was a strong conviction that our delivery system is fragmented and our payment system is fragmented and that is what contributes most to the inefficiency and the high expenditures.

In a borough like The Bronx, we predicted that the migration to managed care would be accelerated, we were correct, because of out of pocket expense in Medicaid, Medicare and commercial across the board. That would be mitigated by the recipients. And we have seen a very, very large movement into managed care over time. But we also predicted that managed care was not managed care. Managed care was managing price, it was managing access and it was applying mechanisms that were in Anthem to what I believe an ACO should be doing and how a delivery system should be performing. Most importantly though, for our own financial survival, we felt it critical that we move up the revenue stream, because we didn't find value by sharing the premium with an intermediary and we wanted to keep as much money in the system so we can invest in changing the system.

So just as the introduction was billed, I will tell you a few things. We are an academic medical center. We are the University Hospital for the Albert Einstein College of Medicine, where I went 35 years ago. And we are both located in The Bronx and a few things that I think are important. We have 1300 clinical faculty from Einstein that are employed by Montefiore. And that is an advantage. If you are a scientist and you work with those test tubes most of the time, you are employed by Einstein. If you are a clinician and you work most of the time taking care of patients or teaching or being involved in clinical related programs, you are employed by Montefiore – that helps with incentives. Two, the science is huge. I mean, it's one of the more highly funded academic medical centers in the country and we do that collaboratively. And we work very carefully to bring that to the bedside and to the patient. We are a learning institution, we have 1300 interns and residents and fellows, it's one of the largest in the country, I think it's second. We have 800 medical students at any one time, and we do everything that a quaternary center does, except lung transplant, including a children's hospital that is nationally ranked.

So we are a large hospital. We have 1500 beds, we have 100,000 discharges a year and we have a very large compliment of ambulatory subspecialty care, but that – if I stop there, we would really look like our sisters and brothers in Manhattan that are excellent academic medical centers. Where we change, where we have made a big difference is that we have a distributed primary care network. We have 50 sites in the community. We went from seven to 50 since 1996 and we employ another 450 or close to 500 primary care physicians who provide care in the community. They do a million and a half ambulatory visits. Overall, we have 3.8 million encounters a year; of which only 100,000 are the hospitalizations and unfortunately 325,000 are emergency room, which reflects the high poverty, high health challenges of the borough. Very high acuity in that emergency room.

Let me just say one other thing. This integrated delivery system that we built had basically three components. We tried to change the payment system; I'm going to talk to you about that, we are at a very important moment. We built those primary care clinics in the community, but over time we

integrated the management of all of this, which was not easy. We instituted and implemented health IT early. We were 100% physician order entry in 1998. We built a data warehouse to manipulate the data. I agree, data is probably the most important thing that we try to do over time and to use it successful to drive quality and to drive change. And we have a huge, very large – the second biggest home health program in the state of New York, we do 600 visits. Our primary care sites include some unusual sites – shelters, schools, we are in 30 schools with 15 clinics, so that is a very important contribution to the community. And Montefiore has a long standing commitment to its community and we view what we are doing here as reinforcing that and growing it and strengthening it. It has a very, very long history of doing some unusual things. I ran a tuberculosis program; I took care of inmates at Rikers Island for a long time, where we had a contract. That was in the early days of HIV. We were an early HIV sentinel site. We provide lead prevention – all kinds of programs that we have always gravitated towards and grown. This community has a million and a half people, lower Westchester has 500,000 people. We consider those two million people, within our footprint. We don't desire and need to have everybody in our system, but we have created a regional delivery system where we are the quaternary referral. That cuts across city and states, cuts across voluntary hospitals, we are in essence in league with the other FQHCs of which we have 17 and the rest of the community. So it's a very challenged community. If you look at anything like asthma or obesity, diabetes, cancer, smoking, they are outsized compared to Manhattan and the rest of the state.

When Mark McClellan was the administrator at CMS, I went to him with – I don't know if you can see this, our early aggregation of risk transfer, and talked to him about a pilot program in Medicare that in essence – not in detail, but spoke to where CMMI went. He didn't call it an ACO either at that point. But let me tell you what this construct is. We have IPA, which is just a legal entity in New York State that allows some private doctors to join, but the majority are employed and take risk with less or fewer reserves than if we were an insurance company. We are an insurance company, we can be an insurance company, we are resuscitating those licenses, but so far we have chosen not to be an insurance company because our desire is not to be paying patients who are in Florida or elsewhere and so forth. So we built that IPA and it has grown over time, 2000 was a very important point when we had 150,000 lives Medicaid, Medicare and commercial. It's about 90% of the premium, the insurance companies keep 10% and they – for marketing and for profit, and then we take the rest and we have to work within it. Our administrative costs are about 6% and we have 850 people that in a care management organization. Unfortunately, I still have 850 people who fight with insurance companies to get paid. I will they were all social workers and working in the care management organization.

So we built that delivery system more integrated, changed the payment model and a tipping point happened with the Pioneer because it started to put us close to 50%. By the end of this year we will be 60% or 1.8 billion dollars of the 3.2 billion dollars Montefiore has in risk transfer and/or shared savings.

Our goal is a million lives, interesting enough, that is going to be six, seven or eight billion dollars, depending on the mix. So I'm not going to go into details on this, you will get these slides, but basically this is our performance over the last four years on important snapshots of the group, the cohort that preceded the Pioneer. So our Pioneer had about 23,000 lives – it still has 23,000 lives. It took a little time for them to shake out to add and – well, we helped subtract – 1,000 were dead. And the information lagged for three months. So for three months, we were managing something that we didn't really even know exactly what it was. One third are dual eligibles. It is a very challenging population and its challenging de facto because the insurance companies didn't want the complicated patients in Medicare advantage. By the way, Medicare advantage is 50% in The Bronx of all Medicare recipients. So these are FEFA Service Patients. They tended to be more in private doctors offices and had more dual eligibles. We are working with CMS and with the state of New York through an insurance product to take a vast majority of the dual eligibles into this care management program. 70,000 dual eligibles in The Bronx spend four billion dollars a year, Medicaid and Medicare. Of the 14 billion, that is the overall spent.

I just want to say that there were Pioneers and there were Pioneers, so there were four programs that were in academic medical centers, we were one. And there were four programs with the most downside risk and the most upside risk and we were in that group. Also, trying to stick with the time and I would rather interact, but I just want to tell you that if we look at what happened to admissions, readmissions, care for heart failure, care for diabetics and a number of other areas and I agree strongly, we need to standardize the quality metrics and we need to strengthen them. But they would be better served – we would be better served if they were uniform for all the payers because the cacophony of payers use it to make things more complicated and actually not desirous in my opinion.

So I will give you the punchline. We were very, very pleased with our outcomes. We met the quality reporting goals that we had to do this year and when we looked at those quality metrics, we did very well. It was tough because a lot of the private doctors didn't have health records. It required us kind of moving in to these office practices to gather the information and formalize the collection of information. It was very interesting because a lot of the doctors really had no idea how they were doing, other than seeing patients. They didn't have a big view. But the bottom line is that there were about 670,000 patients in the 32 Pioneers nationwide and Montefiore had 3% of the patients and we earned 17% of the savings for the entire country. So of the 87 million dollars, we got 14 million in a check. But that 14 million was spent already on the care management, the hiring of new staff and putting people into those sites to do what I described. So I'm going to stop here. Hopefully we will have a good dialogue.

ED HOWARD: Great, thank you so much, Steve. Now you get a chance to enter the conversation as I mentioned, there is a green card you can write a question on and it will be brought forward if you hold it up. There are microphones on either side of the room and we have got an expert co-moderator who is prepared to grill people too. So let me just ask, if you do go to the microphone, identify yourself and keep your question as short as you can. Let me start things off – Anne-Marie, I don't want to stifle you. Please jump in, but both Steve and Greg mentioned the notion of getting people involved, getting the patients involved in this initiative and wondering how you might do that. One of the issues that I keep hearing about is when folks are assigned to an ACO, they might not even know it, so it's a little hard for them to get involved. And of course there are no constraints on them going outside your organization or Montefiore to get care for which you are still held accountable. How do you deal with those competing values of patient involvement, patient choice, and accountability?

STEVE SAFYER: I will just tell you an interesting story. I got a phone call from a fellow CEO of an academic medical center, not to be identified, in New York, and said, hey, what is going on? My father is in your ACO. He didn't sign up. So – and indeed he hadn't. I mean, he was attributed to us because he had seen a doctor once at [unintelligible] so shaking it out was not easy. I think it's fair to say that this is a workaround. And it's perhaps a necessary workaround and perhaps it emanates from when the President addressed the Congress at the State of the Union and I always forget his name, but he called him a liar. Which I thought was outrageous. And he said, no, I don't lie, there will be choice. So choice was fated to be literally interpreted. You couldn't have a worse construct. That being said, you still need to engage the patients, which is our issue with even the ones that have fewer choices or a more narrow network. And I think in general that comes from carrots, not sticks. The patients filled out their satisfaction survey on this and we exceeded the country, they were happy. Happy patients is a good thing. And we can get into a whole other discussion, but things like co-pays and all these things, those are not sticks, those prevent people from taking necessary medicines and so forth. So this was, you had to glue them to you.

ELLIOTT FISHER: I agree, I think the history is – with the AARP and the consumer groups who are trying to help us think through this; the notion of constraining choice just was not going to be a realistic alternative early in the days of this and it was long before the President spoke. And since then, most places that seem to be struggling with this are versions of, the grass is greener strategy. You have to want to make people want to – you have to use carrots and it's hard to see Stu over here, Stu Guterman of the Commonwealth Fund, who I think was the one who brought the phrase to Vermont or New Hampshire, a crusty place where there are farmers, you know, the best fence is a good pasture. You have to think about that for a second or two. So I think it will be and area that we want to do some work on, figuring out how to get the financial incentives and create better attribution and better engagement, but there is something very powerful about choice as a way that makes people feel engaged and safe.

ED HOWARD: Dr. Sheff, do you want to comment on that?

GREG SHEFF: The only other comment that I would make is, there are sort of two issues, one is sort of the skin in the game issue about the co-pays, the co-insurance and it costs them more to go out of network. But the other is the psychological aspect of making a choice. And so I think there is a middle ground where patients or beneficiaries can choose to be an ACO and we have to figure out what is the green in that pasture to make them want to make that choice. But just by virtue of making that choice, if there is still an open network but [unintelligible] psychologically, I think that there could iteratively be improvement as well.

ED HOWARD: So we will turn that back to you guys next round of legislation. Let's get some ways of doing that.

STEVE SAFYER: I have a hunch that the fear of choice emanates from a very good place and I made reference to it earlier, which was, managed care of the '90s was a failed experiment. And we have to own that because it was not managing care. And patients knew it. And that is what they are reacting to. If they were getting cared for by integrated delivery systems that are easy to navigate and being kept out of the hospital as opposed to being lying down in a bed, for things that you could argue, maybe they need them or maybe they don't. They would feel different about this system. So we created that monster.

ANNE-MARIE AUDET: Just to follow up on this line of conversation, so how are you engaging your patients within the ACO and so that is one question. Then, if you were to survey them, what do you think they would say what is different?

STEVE SAFYER: They did survey on them and we got very high grades and we were pleased by that. The care management organization that has 850 people has evolved it's view of how we use the data and I would venture to say in the Pioneer program, because we were – knew that everybody was watching it, it was important for us – it was extra important for us to succeed. And we also knew it was more challenging enterprise because of everything we have discussed. So we used more sophisticated risk stratification techniques and Greg mentioned this, I would have to say we have evolved a little bit past

trying to find out who the sickest are. We are trying to find out who the people are who are about to get sick. And it's a little more – it's nuance, but I think it's key, because a lot of the people that have congestive heart failure, as an example, and we can argue about use and overuse and misuse of the system and so forth, it's a bad disease. And unless you get a heart transplant and ten people – one person gets them out of ten who are waiting, and if you know what an LVAD is, which is a bridge to a transplant or a destination – it's not a destination where you want to live. It's not a high quality of life. So these patients are sick. And they are coming back.

GREG SHEFF: I think our experience has been that on – patients that have engaged with the ACO, they have had very positive experiences, so the folks that have benefited from the care coordination and so on, I think have very positive experiences. That challenges on – is on the folks who – back to the story, don't know they are in an ACO and how we can engage with them through brand identity and marketing and so on. I think the other issue around that, that Steve is alluding to, is that people that are sick can see the benefit of giving up the choice. Because when you are sick, you understand how broken the system is. And you are glad to have a quarterback. And glad to be in a system that is willing to take that responsibility. Because of the concentration of illness and cost, you know, it's the other 80% that aren't in that category, but will be and we need to engage with them now to keep them from being there, that those are the 80% that see their choice as more important because it's more of a hypothetical issue to them at this point. And so its engaging that part of the population that I think is particularly challenging, because you also have less to offer them now for giving up their choice, because they are not needing anything right now.

ED HOWARD: I don't want to beat this topic into the ground, but is there any difference that you can discern and I guess I would turn first to Elliott for this question, between the Medicare experience where you have a statutory choice, right and the private sector ACOs that have developed. Do they enroll people without telling them?

ELLIOTT FISHER: Most of the private payer contracts I'm aware of, have some choice on the part of the patient choosing – telling you who their primary care physician is. For our transfer agreements, which are 90% of the premium, a Medicare advantage, they have already chosen a managed care product and we have been delegated all responsibilities by the intermediately. For the commercials, in general, we are working on some new things. There are shared savings and they don't – in Medicaid, they do know because 90% of Medicaid recipients in New York are in managed care and we have a lot of them and we owned an intermediatory not for profit with other hospitals. So they know they are in managed care. The duals are going to be a big deal and the duals, as I mentioned are huge amounts of money. And suddenly, commercial insurance companies are interested in purchasing products or companies that

serve the Medicaid populations. So we have had to – we suddenly have a lot of friends. We are trying to buy RPHSP because they want to get to that dual money and I think its incumbent upon us to keep it in the system.

GREG SHEFF: The other comment I would make on that is we are in a very similar situation in terms of the breakdown between Medicare and Medicaid and commercial and whether it's attribution based or patients are selecting PCPs. But on the commercial side for obvious reasons there is different and lesser political barriers and there is a lot of interest in the commercial side that building ACOs, attribution based, to demonstrate value and then in a year, in a very quick time frame, offering their networks around that product that do require limitation of choices.

ELLIOTT FISHER: On the patient engagement side, I would be curious, each of you, in our survey we are seeing quite a high proportion, well over half having beneficiaries involved in advisory panels and helping design, participate and care delivery design, are either of you doing that?

STEVE SAFYER: We have community representatives and patients involved. I think I neglected to say that these 850 people are social workers, psychologists, psychiatrists, drug counselors, physicians, and psychologists. They are professionals. And they are also people that are emerging in new professions so they are health educators or they are young people who are in search of a degree, we are training them, of care management. We call these people on the phone, we would to visit them in their homes, we installed technology in their home for certain patients. You have to be careful because once you install something in the home; no one will ever let you take it out. But they love being visited. People really enjoy that. Oh, pharmacists are key. There are a lot of people who are not so happy anymore. There was a migration to CVS and Walgreen and there is only three Walgreen's in The Bronx, so I'm not sure they are going to have a big ACO.

ELLIOTT FISHER: Probably not, you guys are already there.

STEVE SAFYER: But the pharmacists are key. Because people as you know have bags of medicine and especially the elderly and they have no idea what they are taking and they are mixing them and it's half the game, in my opinion.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

GREG SHEFF: We have a...All the ACOs as you know, have board representation from a patient, but additionally, we have a patient advisory committee that we meet with on a periodic basis and run through these engagement issues, what can we be doing? We are talking about doing this. What would happen if we called you with this message and tried to find out what their needs are?

ED HOWARD: We have a couple of questions now, you have been very patient, go ahead.

SUSAN VAN METER: Hi, my name is Susan Van Meter I'm with the Healthcare Association in New York State, we are the statewide Hospital Association. This is a great panel discussion today, so thank you. Recently the Institute of Medicine released a report about overall healthcare spending in the United States and there were some results that some found surprising, including low spending in The Bronx, also Rochester, New York and there was speculation about what is the major variable that can explain – or a major variable that can explain the differences in health spending and continuing care was something that some of the members of the IOM had mentioned and we would just like to ask if you could tell us a little bit more about your thoughts about continuing care, coordinating that care and how you see care in nursing homes, home health agencies and the like, changing over time. And again, thanks for the panel.

STEVE SAFYER: Hopefully we go down this rabbit hole, but I'm glad to go there. There was a comment by Greg and I want to draw it out. Medicare payments are different throughout the country and different regions. And a question that one could logically ask is did Montefiore did so well because the payments are so high in New York that there was a lot of room to make savings? I think I would be – if I was lecturing on you on this, you know more about it than most people, but Medicare has a number of things in it that are social missions. It has graduate medical education. It doesn't pay for those 1300 residents that I educate. It has disproportionate share, which has to do with under insurance, not just uninsurance. In The Bronx, there are 17% of the population is uninsured and the vast majority of them are immigrants and they will not get insurance even if we have immigration reform, which we need, because it has been said and it's not politically doable at this moment. It has wage inputs. Three quarters of my work force of 20,000 are in organized labor. They have living wage, they have pensions and they have healthcare and their healthcare is not Cadillac healthcare, its $5000 per recipient, per year and it's $6,000 for a family. It's pretty low. Back to the Medicare – the Medicare side of it. We were compared to ourselves with some bleed in of the national trend. But that being said, The Bronx, according to the HSS survey, is the 6th lowest per capita Medicare spend in the country. In the country. Rochester was number one. So there is micro variation within more global regional variation, which is what the New House Commission at the IOM found and I think it is challenging or maybe an opportunity for the Dartmouth analysis and I tell you why I think it's an opportunity. There isn't a person in this

room who doesn't know who Atul Gawande is and there isn't a person in this room, I bet, who didn't read the New Yorker article and if you did, you are not going to raise your hands now. But it is an intelligent, highly intelligent use of the Dartmouth Atlas because it says, let's take a region and do a deep dive and see if there is a micro variation and let's see what causes it and let's see what is underneath it, because one size doesn't fit all in healthcare, I can tell you that. So he did that and he found in [McClellan] versus El Paso that the spend was twice as high and lo and behold, the doctor's own means of production in [McClellan] and they were getting tests on people for machinery that they owned. It is as simple as that. He came to that conclusion, he is a better writer than I am, saying the words.

So what I believe we learned from this Institute of Medicine report is that there are different inputs and the main input to Medicare variation has to do with continuing care and nursing home care, which is a very rich benefit in some northeast states, including New York. And by the way, the Dartmouth Atlas doesn't include commercial spend and doesn't include Medicaid and doesn't include cash which is a big deal, not in The Bronx, but it is in Rochester and Minnesota. So it is not describing a region's overall spend and when it does, in a place like The Bronx, because there is a lot of Medicare, it gets more added, we find that there is regionalization – micro regionalization, it's not the same in The Bronx as it is when you go into Westchester.

ED HOWARD: Yes, go right ahead.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin, I'm a primary care physician. I have two questions. Both easier than what you have been dealing with. The first is for the gentleman from Montefiore is, do you work with community organizations? Do you help strengthen community organizations? Or are you bringing in all this stuff yourself? Like the care management and the home teams. My second question is, how do you compensate the primary care physicians? Is it all about paper performance and productivity?

STEVE SAFYER: Okay, so we work with a variety of community based organizations throughout The Bronx and lower Westchester. Everything from churches to not for profits, to organizations that work with poverty and through poverty programs and they are very, very important. In terms of the employees of Montefiore, about 10-15% of your salary is incentivized. Most people say that is not enough to make a difference, I'm not sure it does, it's more about the mission. But those are based on quality metrics, not volume metrics and not panel size and not from how well you do in terms of

managing the care. It's just not how we have done it. For the private doctors, we had to incentivize them to bring them in, they had no reason to come in otherwise and a lot of that 14 million dollars went back to them, we tried to use it prudently.

ED HOWARD: I have a question addressed to Dr. Sheff; you mentioned that administrative reasons led you to MSSP and away from the Pioneer program. For what administrative reasons specifically did you decide to shift?

GREG SHEFF: Sure, probably the main one, on the administrative side, has to do with the slight difference between the programs and how providers and patients are added and this has to do with the retrospective versus prospective methodology. So in Pioneer you can only add providers and patients can only be attributed once a year and in MSSP, it is a more dynamic process and in large part we are using this work, as I mentioned, as a platform to continue transformation of our community and so the ability to more dynamically grow it was important to us.

ANNE-MARIE AUDET: So there is a number of questions that have to deal with workforce and wanting to tease out a little bit how your workforce has changed and how you are dealing with or integrating other professionals – nurses, community workers, etcetera.

STEVE SAFYER: I will illustrate it with one or two examples. We have nurse practitioners stationed in each one of our emergency rooms, we have four, and they see, as I said earlier, about 320,000 visits a year. And their sole job is to identify patients whether they are capitated, pre-paid or shared savings or not, irregardless and we made a decision early on that if we were going to sort people by their payment, pre-paid, you go here, you go home, fee for service, we will take you into the hospital, that we were going to lose our way. And we never went that path. So this nurse practitioner in each of them and they are 12 hours a day, has an iPad. The iPad lights up as somebody registers, as somebody likely to be able to avoid an admission or a readmission. And their sole job is to do that. It has also been a very – as I mentioned earlier and I think it's important and we are training people who work at Montefiore or other health centers, to – well, retraining them. They may be billers or whatever and they want to get into the healthcare world and we are training them to be care managers. Learn how to talk to people, make phone calls, make sure they have their drugs when they went home and a whole array of issues along those lines. And the third area that I think is illustrative of the change, which I think even we underestimated, is the confluence of mental illness in every population and its impact. I mean, if you have congestive heart failures as I described earlier and you are not depressed, there is probably

something wrong with you. And if you are a patient taking lots of medications with lots of challenges, there is going to be various levels of either obvious or not so obvious mental illness. So we worked very hard to do a collaborative model where we insert mental health guidance for the primary care people and availability of psychiatrists and psychologists. And so forth. Social workers. As you move up the chain. So those are three examples, but those things keep changing as we learn. I think some of the programs that had health plans that were in the Pioneer that I know of, might have confused the health plan with the care management and they are different. So I think – and the difference is this work cadre. Our system will get to where it needs to go when we get rid of the other 850 people who are just fighting to get paid. They should be care managers, because that's a tremendous waste. Because the insurance companies has 850 people fighting with them. And last time I checked, that is a lot of people.

ELLIOTTT FISHER: I would add two other job categories that we see, both from Dartmouth Hitchcock where I also spend a lot of time, which is another one of the Pioneer ACOs. And that is health coaches; they are the people who are worried about the folks who are going to get sick. They are lay people trained in motivational interviewing that are working in the primary care practices. And the other are data managers, people who are in the offices trying to help figure out and prepare patients for visits and prepare the clinicians for visits so they know what quality measures and preventive services that have or have not been delivered and they are preparing the clinical team – the nurse and the doc, based on the data that is in the registry, to be prepared for that visit. So those are two other job categories that are emerging.

ED HOWARD: One of the questions asked on a card specifically asked whether the involvement of nurses had contributed to the shared savings being able to be generated. Does that show up in any national data or in the experience of our two panels?

GREG SHEFF: I can speak to it, experientially. Perhaps Elliott could speak to it – okay, experientially, I think the answer is absolutely yes. A lot of what Steve is describing is in a fee for service model, you have the care team is the primary care physician running as fast as they can on the treadmill. And then the minimal amount of supports to keep moving the widgets through that treadmill. And a lot of what the care team is about in value based care is building up enough resource around that physician so that the kind of catch phrase that I'm sure you have heard is practicing at the top of their license – or the physician can take care of the complex illness. The nurse can do the complicated education. The health coach can do the basic behavior change. So to that extent, a lot of the navigation work and chronic disease management work is being done by nursing. And I think as we all look at these models and the costs of implementing them, Steve mentioned they received 14 million shared savings and that all went back out, is how do we continue to move that down? So right now it's being moved from physician to

nurse. I think it will continue to be moved from nurse to MA, from MA to lay community health worker and so on.

STEVE SAFYER: Our home health agency has been remarkably transformed and repurposed. Those are nurses that go into the home and we are using them for more and more different populations and not looking at where the revenue particularly comes in, but where the impact could be on this program. The inpatient nurses, we have a lean process that is well on it's way, where we are allowing national experiments across the four hospitals of redesigning care and getting at that issue of top of the license, getting people out of charting and you learn that nurses are spending all of their time ordering things and – they are doing things that no one knows why they started doing it and why it keeps going on and once they are liberated that there is no – like, no one said you had to do this – you know, you can redesign it, you know that it's better to go to the bedside and talk to that patient about going home, as opposed to all the charting and all the other stuff. So we are seeing dramatic change on both ends of the spectrum.

ED HOWARD: By the way, we are buried in green cards here. So if you really want to get your question asked, you better go to a microphone. Go ahead.

CAROLINE MOODY: Hi, my name is Dr. Caroline Moody, my question is for you, Mr. Safyer. How do you see – I'm an emergency physician. How do you see emergency medicine helping with ACOs?

STEVE SAFYER: That is a great question. I am a huge fan of our emergency medicine people and it's an academic department. The chair of the departments in the Institute of Medicine, he is a scholar and he's one of the best physicians I have ever met. We need to really rethink about how our emergency rooms work. Colleagues at Mt. Sinai have a wonderful program where they moved the geriatric patients elsewhere, because they just have different needs. We are looking at that. We have our nurses in the emergency room have said to us, why is everybody lying on a gurney? It's just clogging everything up. I mean, a lot of people can sit. And they are capable of sitting. In fact, it might even be better, because they might not get a pulmonary embolus while they are waiting to be seen. So we are rethinking how that emergency room works. I use the example of the nurse practitioner. There was one person who was an orthopedic nurse who begin the program when she went down there and started telling the emergency room people that she was going to prevent admissions. They thought she had four green eyes. It was like somebody standing in front of a restaurant and in their mind, telling people you could get a better meal down the block or you could go to the supermarket and buy your eggs and it's half the

price. Because they were conditioned to admitting people. And so we really need to get away from that mentality. On the other hand – and this was true 20% of our adults that come in our emergency room, do get admitted and they need to be admitted because they are very ill. A lot of them are immigrants and they haven't gotten care or they are before Medicare and they have been in between and they weren't in an exchange. So we need to rethink that area heavily.

ELLIOTT FISHER: Yeah, I would love to add in just a little bit here. If we think of healthcare as a knowledge intensive industry, I just gave emergency medicine grand rounds and to a wonderful group of emergency physicians and think about how good you all are at diagnosis. At figuring out what is wrong with patients. How much of that really needs to be done in the emergency room? How much of that could be done by Telehealth, to a primary care place, so that we have much sharper decision making done with the combination of an iPad and Skype so that you can see someone. I think that the question of how do we take the knowledge that is accumulated in ERs around diagnosis in complicated settings from triage to observation – read it as in 12 hours, follow up by telephone. So you guys are the experts in that and every ACO will want to have you if you think of your job not as seeing just the patient in front of you, but as managing a population of patients with varying levels of acute illness.

ED HOWARD: Yes, go ahead.

BOB CHRISS: Bob Chriss with The Institute of Social Medicine and Community Health. I haven't heard any discussion of prevention issues so far. I have heard that primary care in the community really works, especially if you identify people who are at risk of various health problems. But I am wondering if the ACO model itself has some potential for integrating medical care and public health in the same funding stream. So that savings in medical care can be redirected to public health, where we are under funding that tremendously and yet, have such a surplus of inefficient dollars in the medical care system. Now most of the discussion has been on how to improve coordination of medical care and I'm sure you can squeeze that in many effective ways, but given the poverty rates in The Bronx and in many communities throughout the country, I'm wondering if we need to focus on a funding mechanism that integrates medical care and public health and I'm wondering of ACOs have any lessons to teach us about that.

STEVE SAFYER: I couldn't agree with you more. I trained in internal medicine in Montefiore's social medicine program and it was – the training that I got was public health and care integrated. I have an institution to run and its becoming harder and harder to live with compressed payments and all kinds of things that fly at us. One of the ways around that is the ACO because we get away from the volume and

putting people in a bed and we share in keeping people well. I can't be the Public Health Department of The Bronx; there is a public health department. So we have a strong partnership with them. Mayor Bloomberg did all his press conferences at Montefiore which had to do with 16 ounces, whether you think that is choice or not and we supported it. And we supported strongly his ban on trans fats, his ABC of eating institutions. His ending smoking programs, they were terrific. We used the [unintelligible] pulpit to do that. In the schools that I mentioned earlier, we fought a very hard battle and won to get full fat milk out of the schools and get 1% milk and we were fought – it's the same people. Big tobacco, big sugar, big milk. They fought us. So I agree with you, but we need to do that at – you guys need to do that. We need more money in the public health infrastructure.

ELLIOTT FISHER: I think you could also think about community based payment models and in creating incentives to establish them. The Akron Accountable Care Community is actually set up to share the savings that are achieved within the healthcare – within that region back toward investments and public health. So the model that could emerge, if one put pressure on the right people, here we are – is payment models that create incentives for all health systems within a region to work together to lower costs and then get a share of the savings themselves. We think Health.org, which is a program of the Fannie Ripple Foundation has been trying to start to think about how to do this. Janet Corgen who left the National Quality Forum is working with them to try to figure out how can these community based payment models be built and the Robert Wood Johnson Foundation has just decided to try to help fund them. So you have a great idea there and I think there is real potential to achieve savings and reallocate them to more important upstream purposes.

ED HOWARD: We have a number of questions that relate to payment and incentives. One of them actually – it's framed as Uwe Reinhardt and others and I think the reason that that is the case is that there is a video to this point on the Alliance website. What can I say? But Uwe and others have warned that ACOs might lead to higher costs in some places as they come to dominate a particular local market. Is that a real danger? Have we seen any of that in the Medicare or private sector ACOs? If it is a problem, what is the solution?

STEVE SAFYER: I neglected to mention that my para mix is 84% governmental. I get paid what Medicare tells me and Medicaid tells me and by the way, that is 50-50. And I have 17% commercial insurance, that is the worst para mix of any academic medical center in the country. There is not a big risk that my prices are going to go sky high based on this ACO. I wish they would go up.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ELLIOTT FISHER: But you also have the right values, it's not about extortion. We see evidence of consolidation, which can have two effects. It can lead to integration and better care and it can lead to monopoly pricing. We actually don't have enough data to know how much monopoly pricing is happening, so the challenge again to Congress is to figure out how to create transparency in local markets around prices. We are working hard to try to figure out – it is a major deficiency of the Dartmouth Atlas, we are trying to figure out how to get all of the commercial plans to collaborate with us to create local transparency to embarrass the places that are raising their prices exorbitantly. We are hopeful that it can be done. But I think it is a choice. Medpak has shown that it is largely a choice on the part of the providers. They can choose to raise prices or they can choose, to some extent to try to control their unit costs. And places like Montefiore wont' be trying to extort monopoly rents – maybe because they can't, but probably because of their values and I think that is the thing that we have to call on our local community health systems to say, why are you here?

GREG SHEFF: I agree with that and certainly the culture of the – and the values of the institution matter tremendously. I think the other part of it is that most institutions that are participating in ACOs do see it as part of the spectrum towards fuller risk and at that point, the high price point becomes a liability. And so I think certainly consolidation raises that theoretical concern and there has been lots of scrutiny about it, but I think most people that are on this journey see it ending with them taking risk and at that point, it becomes irrelevant because you are not billing on a unit basis.

ELLIOTT FISHER: No kidding. Dartmouth wonderfully negotiated really high prices on one of its global payment contracts. Irony, right? No savings, because they negotiated really high unit prices and then couldn't possibly achieve overall total cost savings because they had done just that.

GREG SHEFF: I think the other dynamic that plays into this, you know, our market is more commercial than in The Bronx, is from the health care system side, everybody is aware that per capita utilization needs to go down, at least inappropriate utilization, and the question is, what are you going to do with the fixed capacity and there is some aging of the population and population dynamics in various cities, but some of it is market share too. And so a lot of institutions that are moving towards value based payments are the same time moving towards narrow networks, at least on the commercial side. Which again, are going to incentivize them to keep the unit price down, but to be successful on the whole book of business.

ED HOWARD: Anne-Marie?

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ANNE-MARIE AUDET: A question – I know the topic today is really the Pioneer ACO program, and this is probably for Elliott more – what do we know about – are there differences that are starting to uncover between the private sector and the federal program or - ?

ELLIOTT FISHER: I have to be a little careful about colleagues who are writing peer reviewed papers and trying to get those out. But there are differences. Certainly there is much more variation in the private payer arrangements then there is in the federal, because the federal is a one rule, one size fits all. so that the – there is huge variation in the performance measures on the private sector side. Steve already referred to the difficulty that that causes for organizations that are trying to hit multiple performance targets. Federal programs – I don't think this is going to breech anything, seemed much more engaged with the safety net. Perhaps because of the regulations and the encouragement of having FQHCs as part of the MSSP. So there really is the biggest surprise so far in our evaluation is the very high level of activity in the safety net, in ACOs.

STEVE SAFYER: Our experience has been, some commercial plans with non Medicare were willing to enter into risk transfer as early as 1996. So those are risk transfer. Capitation without a percent of the premium as retained by the company. And then we hit a wall and the biggest bump we got was with HIP, which is not Emblem, which is a very large insurer in New York that insures city workers and that was a big influx of risk transfer. And then we hit a real wall that post Pioneer ACO, we have been able to take each insurance company on again tenaciously to get a shared savings model and we – the difficulty here has been to get them to adhere to basically the Medicare approach because of what Greg said earlier, which was, you wind up employing a whole other cadre of people for each insurance company to do it the way they want to do it. Because their struggle is to do – Aetna wants to do it one way, United wants to do it another way, Well Pointe wants to do it another way and if they would all agree on one way to do it, it would be good.

ED HOWARD: Greg, I think you mentioned tipping point in your remarks. What percentage do you have of payments that are value based and when do you get to the point that everybody is going to climb on the bandwagon?

GREG SHEFF: In our organization, it's easier to answer this on the primary care side in terms of thinking about which patients are in attributed models and it's probably about 20% of the patients now are in some sort of value based arrangement. Tipping point – you know, Steve mentioned 50% and I think that

there is something really to that number. Part of the challenge is, you know, a shared savings patient is not the same as a capitated patient in terms of tipping point, because one is, you are still getting most of your money through the fee for service system with some incentive to make a transition. And so I think also depending on what the value based contracts are, there are some wiggle room on that number.

STEVE SAFYER: The tipping point for me was this year when – I have a monthly meeting with the chairman of the academic departments and the two – this is not a HIPPA violation because you could figure out who the two are. It's the two most verbal in that meeting was the chair of neurosurgery and the chair of orthopedics talking about how they could do less, fewer and appropriate surgeries. How they can really move it and refine it better. They are talking about unnecessary – I thought I was hearing things. The internists, the pediatricians, the family practitioners, the social medicine people, they love this stuff. Neurosurgeons, they don't love this stuff and they were talking this -

ED HOWARD: Let me ask you to pull out the blue evaluation forms and fill them out as we go through these last couple of minutes. One other revenue related or money related question and we talked about the shared savings and the incentives to patients to participate, is there any value to the notion of letting the patients share in the savings if they are generated? That would give them an incentive to stay inside the network. And is anybody doing that?

STEVE SAYFER: It's an interesting notion, I think you would have to vet it with your lawyers and think about it pretty carefully.

GREG SHEFF: Yeah, and I think there is issues of – one of the challenges going back to Steve's comment about co-pays and carrots and sticks, is that many of the decisions even about avoidable utilization are complicated and require the judgment of the physician and so there is the risk of over incentivizing a single patient to do that. So I think some type of skin in the game is appropriate. I'm not sure that I have heard of anyone doing that particular model.

ELLIOTT FISHER: It does seem to be easier to do it in actuarially sound level of sort of joining a health plan that saves you money on your annual premiums than at the point of care. It does make me nervous and lawyers would be all over the potential conflicts of interest that might emerge.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

STEVE SAFYER: Can I make a comment? I'm just listening to the whole program, I want to step back a second. I think it's important for you all. For reasons I described and I could spend more time describing it, we went down a certain path 18 or 20 years ago and we lost serious money for the first five years and by the way, we didn't have it right. So it took time and money and focus to stay on this course. The problem with Congress and the problem with the States is public policy tends to get corrected and turned into; you gotta turn on the dime. I mean, people are counting the savings before the program is even created or minted. And if we rush this too much and under invest in it – by the way, I didn't get a dime other than the shared savings. There is a lot of people from CMMI – I mean, the reward for being a Pioneer was, you are a Pioneer. So the serious money is going out for readmission programs and all kinds of other programs coming out of here and I think that is a good thing. My point is not the opposite. This takes time and money and focus and a force field that pushes you down that field – that is the goal of government. But when you start making the savings before the program is out the door, the program won't work. It will not come to fruition and we will still have a fragmented system ten years from now.

ED HOWARD: I apologize, but we are at the end of our time. Thank [audio cuts] [applause] You deserve a hand. Let me thank our colleagues, Anne-Marie and her colleagues at the Commonwealth Fund, you again for asking good questions and keeping us going and this time I would like you to join me in thanking our panel for this wonderful discussion, a very complicated topic.

[applause]

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.