Accountable Care Organizations: A New Paradigm for Health Care Delivery?
Alliance for Health Reform
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ED HOWARD: You could look it up in your Funk & Wagnall's if you knew what a Funk & Wagnall's was [Laughter]. The shared savings program scheduled to begin next January and the Center for Medicare and Medicaid Services is smack in the middle of shaping the program, putting it in place. The overall aims for the shared savings program are not modest, improving the quality of care, improving the health of the populations served, and lowering the growth in spending. Easy list, hard to do.

So we thought now was a good point at which to look at how the implementation of these institutions was going and what some of the larger remaining issues are, what some of the options are for addressing those issues. Our partner and cosponsor in this briefing is the Commonwealth Fund. Joining me as co-moderator today is Stuart Guterman, the Fund's Vice President for its program on payment and system reform and the Executive Director of the Fund's commission on a high performance health system. Let me turn it over to Stu at this point.

STUART GUTERMAN: Thanks Ed. I want to, on behalf of the Fund, welcome everybody here and particularly welcome all the speakers we have. An issue that is extremely timely, the accountable care organization is a construct that, at the core

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of moving our health system from its current fragmented state with adverse incentives to focusing on patient-centered, coordinated, comprehensive care, and Centers for Medicare and Medicaid Services, last month, released a proposed rule for actually the end of March, released a proposed rule for its shared savings program for accountable care organizations.

We’re going to have, as speakers, I’ll set the table a little bit and then we’ll have Rick Gilfillan from the Center from the Center for Medicare and Medicaid Innovation talking about the CMS perspective and what they’re looking for from this program and where they see it going.

Then Susan DeVore from the Premier Healthcare Alliance is going to talk about the perspective of that organization, which has formed a couple of ACO-oriented collaboratives. We’ll have Bill Jessee from the Medical Group Management Association talk about some activities they’ve done from the perspective of medical groups organizing into the core of ACOs and Mark McClellan from the Brookings Institution, Engleberg Center for Health Care Reform who was one of the founders of the term accountable care organization and at the Engleberg Center has worked hard to pull together technical support for organizations who want to become ACOs.

So to start it off, we have in our current system a severe need for coordinated accountable care. We have access

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problems. We have waste and inefficiency in our system. We have poor coordination of care particularly if multiple doctors are involved, which of course, is the case for many of the sickest people in our population who account for the greatest need and also the largest share of resources.

The Commonwealth Fund does a set of surveys of the public and also of healthcare opinion leaders. In our public surveys, we found that people want more accessible coordinated and well informed care. There's very strong support for those. There's very strong support for doctors working in teams or groups as being prospective way to improve the quality and appropriateness of care, and a majority of Americans, in a recent survey we did, said that the healthcare system needs fundamental change or complete rebuilding. So there is strong support for policies, for more coordinated care, and for policies to achieve those goals.

Our commission on a high performance health system has put out a set of elements for a high performance health system including affordable coverage for all, aligned incentives to promote quality and efficiency, increase the accountability, improve coordination of care, and the need for effective leadership in the policy and healthcare communities.

The accountable care organization model fits into several of these elements or strategies for a high performance

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health system. There's a strong relationship that we pointed out between the way we pay for healthcare and the way healthcare is organized and the way healthcare is delivered.

That's what the shared savings program is focused on doing, trying to encourage folks to form accountable care organizations to meet the three-part aim that CMS points to very consistently as the goals for most of the activities that it undertakes, better health, better care, and lower cost.

The new shared savings program and the ACO initiative is consistent with all five elements above but our commission has put out a report on accountable care organizations that lays out a vision of what's necessary to make accountable care organizations a viable model for healthcare delivery both now and into the future to move our healthcare system that way but we need to remind, in all the discussion of shared savings and different programs, to provide financial incentives for accountable care organizations that the purpose here, the focus here is on accountable care.

The organization is a way of achieving accountable care but the focus is on accountable care and that's CMS' mission to be able to put together a program that encourages the healthcare delivery system to move toward more accountable care in healthcare delivery. That requires a strong primary care foundation.

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It requires a means for making healthcare providers and everyone in the healthcare system accountable for the quality of care, for patient care experiences for population outcomes and for total costs. It involves informing and engaging patients in this process. This isn't only about providers and it's not only about payers. It's about patients too and patients are the center of the healthcare system. the healthcare system is there for the patient, not the other way around.

There's a commitment to serving the community that's required that's part of the commission's vision of a high performing health system. There need to be criteria for entry and for continued participation and that's been the subject of intense comment and debate most recently. There needs to be multipayer alignment to provide appropriate and consistent incentives.

The point's been raised that we can't have Medicare moving in one direction, Medicaid in another direction and different private payers moving in yet other directions. The incentives are much stronger if they're consistent and they're more powerful if everybody is pulling in the same direction.

We need to have payment that reinforces and rewards high performance but that means that there are standards that need to be met to show that high performance is being achieved.

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We need to have the openness to innovative payment methods. We have a shared savings program that the rule applies to but the law, the Affordable Care Act, explicitly calls for the Medicare and Medicaid Innovation Center to develop alternative models of payment and organization that can meet the same sets of objectives.

We need to have a balancing of physician compensation incentives. The question gets raised aren't ACOs just another word for HMOs? We think the answer is no but the program needs to be structured to reinforce that and to make sure that evidence-based appropriate care is provided but unnecessary care and care that's not evidence-based is avoided. We need to have timely monitoring data feedback and technical support for improvement for these organizations.

So important considerations to take into account. Let me skip to the bottom bullet because I think that's the point that's most relevant to the current discussion and that is we know that there's a need for a change in the way healthcare's provided but the bottom bullet says basically for ACOs to be successful, we need to have a clear idea of what's expected of ACOs.

What is an ACO? An ACO may not be one thing. It may be multiple things but there doesn't need to be one model of organization that fits the program but there needs to be a

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consistent set of demands of the healthcare system that applies across the country and how those demands are met can be more flexibly applied.

There needs to be a strong connection between the performance of the organization and how and what they're paid. There needs to be data and technical support to help organizations be successful. This isn't a test. This is supposed to be a collaborative undertaking to help the healthcare system move where it needs to move. The challenge here is for both CMS and also private payers and healthcare organizations to build up enough thrust to escape the gravity of business as usual.

There's a strong pull towards continuing business as usual both on the part of the government and on the part of private payers and also on the part of healthcare organizations. The government is entrusted with protecting the fiscal and policy integrity of the program.

Private payers are entrusted with protecting their own financial integrity and achieving their own goals and providers need to make a margin and they need to be ensured of their own financial survival but everybody needs to work at understanding that operating in a business as usual mode is not going to get us where we want to go and in the future that's going to create big problems for all of us. So we need to build up that thrust

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and state that gravity and understand that we can't keep operating in the same old way and then we can't even do different things in the same old context.

We really need to think differently about how we all operate. So that's the challenge that faces CMS and it's the challenge that faces the provider community. We have some wonderful representatives of all of those sets of people to give their perspectives on this program and on the ACO model and how it can be initiated and how it can be sustained and how it can thrive over time. So I'll introduce now, almost now, I'll hand it back to Ed Howard to clear up some housekeeping details before we go forward with the speakers.

ED HOWARD: Yes, thank you Stu. Thank you for an excellent background setting for our panelists. I just want to note for folks that there are an awful lot of background materials in your kits and a sheet listing additional ones that you can access through our website at allhealth.org. There are hardcopies of the PowerPoint presentations of a couple of the speakers. A couple of the speakers were working on them right until the time when they hopped into the cab to come over here. So you won't find them there but they will be posted on our website as soon as we get back.

Some of you may be watching the live web cast of this briefing, arranged as are web casts of all of our briefings

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through the support of the Kaiser Family Foundation, for which we're very grateful. We appreciate their going to the extra trouble and expense of doing the briefing live on the web to accommodate the large numbers of people who couldn't fit into this room. Maybe if you're watching the web cast live, you can tweet to the people who are following you about the availability of the website and you'll share the joy.

You can find the archived website, for those of you who want to relive this experience, beginning [Laughter] Monday on the KFF.org website. You'll find a pod cast. There'll be a transcript eventually on our website and hope you will take advantage of all those opportunities.

Just one other thing, there's a blue evaluation form in your folder, which I hope you will fill out before we leave. At the appropriate time, there are question cards in your kits that you can write on and microphones that you can use to ask your question orally. That's the end of the public service announcement. Go ahead Stu.

STUART GUTERMAN: Okay and now I'm glad to hand the mic over to Rick Gilfillan who is the Acting Director of the CMS Center for Medicare and Medicaid Innovation.

RICK GILFILLAN: Thank you Stuart and it's a pleasure Ed. Thank you very much for the opportunity to be with you all this afternoon. Thanks to the Commonwealth Fund as well for

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supporting this. It is indeed a great time to be in healthcare.

It's a great time to be in Medicare, CMS and it's a great time to be in innovation because we are all coming together to take a major step in a new direction and accountable care organizations are one of those steps. At CMS, the Affordable Care Act provide us with many new opportunities to try and find ways to work with healthcare providers to redefine and transform healthcare to the betterment of all Americans. So we're happy to be here with you today and have the opportunity to engage in a conversation around ACOs.

As we thought about the accountable care organization and came together within CMS to think about creating the regulations, there were a number of aspects to the task. One we had to create a framework for a new entity and actually define a new entity that didn't exist. It's almost as if you would be saying gee let's get together and, over the next few months, define what a hospital was if you'd never seen one. that was an incredible job to face and I think folks worked really hard at doing that.

In doing that, we had to think about what the outcomes were, what the dynamics were in the marketplace. We had to think about the various components that needed to be addressed in the model itself and in the financing of the model. We

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needed to think about an overall strategy because we recognize, to some extent, this would be creating a strategy of healthcare or health delivery system transformation. There are many dimensions to it.

It was an incredible task and I just want to introduce two people who actually led the effort over the past year and maybe ask them to stand up. Terry Postman is right here and John Pelat. Stand up Terry and let everybody see you [Applause]. In years of medical school internship, residency, and practice, I've never seen a team of people and Terry, in particular, work harder to accomplish something with a more of a sense of mission. So it was an incredible effort.

At the end of the day, we were defining a new way of delivering care or offering a vision of a new way to deliver care and trying to capture it in the NPRM. We are thrilled to know that there's so many people interested in taking it all so seriously and responding so actively to the release and giving us so many comments. We are happy to have the opportunity to hear those comments today and over these past few months and right up to June 6th when the comment period will close.

So we hope today we'll get lots of input. We want to engage in conversations with you all. As Don Berwick would say, we've taken our best shot at trying to define a new way of looking at delivering healthcare and we're anxious to benefit

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from the perspective and input and thoughts from all of you and from everyone else in the industry.

So we see it as a sign of optimism that the healthcare system, providers, payers, employers, and beneficiaries are all interested in finding a new way of delivering care. Let me, if I could, just quickly go through some of the provisions of the regulations setting the stage for conversation later perhaps. I'll skip this and go right to the background. As most people may know, the program was authorized under the Affordable Care Act. It was established, the Affordable Care Act established the shared savings program using ACOs.

ACOs are eligible to receive shared savings that is savings if they demonstrate they've actually improved the cost trend and improved the quality of care for the population that they're responsible for. It's to be established by January 1, 2012. I should add that along the way of doing this, we've had numerous outreach sessions.

We've gotten a great deal of input, had listening sessions and tried to get as much input as we could from as many different dimensions as the marketplace as possible. We issued the NPRM on March 31st and we're, as I said, the comment period will close on June 6th. The definition of an ACO, as I said, it was not something that, as people would say, doesn't necessarily exist in nature.

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So we had to actually define it and we came up with the definition of it's a legal entity recognized and authorized under state law. It needs to be comprised of groups of healthcare providers and suppliers that work together to coordinate care, invest in infrastructure and redesigning coordinated care processes. They need to agree to be held accountable for quality, costs, and overall care of fee-for-service beneficiaries assigned to them.

To be clear, it's as if today if there are 200,000 Medicare-eligible people in D.C., as an example, and they're going about their business getting care the way they do here in the District going to doctors, going to hospitals that doesn't change.

Those people still have the right to do what they do today in D.C. under an accountable care organization but what's different is that the providers that are providing that care have stepped up and said even as people access care in the way that they do, we are going to change the way we operate so that we deliver a better result. We're going to deliver better care, better health at reduced costs through continual improvement in the way we provide care. That's what's going on here. It's an underlay. The Medicare beneficiaries are still doing what they do.

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Underneath that, the delivery system is stepping up and saying we're going to change what we do to deliver those new outcomes. So they agree to be held accountable and they need to establish a mechanism for shared governance. They need to be able to accept and distribute the shared savings that they are anticipating to produce.

We came up with some guidelines around who would be eligible. There was a lot of help in the legislation around this, defined in a fair amount of detail. We had to make some policy decisions but these are the guidelines we used for proposed eligible organizations. A couple of subtleties here, one was critical access hospitals.

Under a strict reading of the regulation, might have appeared that they might not have been eligible. We were able to find ways to make that happen. We're not able to find ways to make it possible for FQHCs by themselves to establish ACOs. We did find a way for them to participate with others.

It's important to note that even providers who were not listed here can participate and work with ACOs to deliver care. Big question was how are we going to pay it? How are we going to share savings? What is the financial arrangement? What's the offer to ACOs? We came up with two alternative payment tracks. Under the first, there's shared savings, one side only in the first two years. Then there is risk in the third year.

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Under the alternative pathway, there's an opportunity for greater shared savings from year one but there's also risk involved in year one or in all three years.

How do we assign patients? Big question. We need to decide how you identify those folks who are going around D.C. getting care today. How do we decide what ACO they ought to be assigned to? We decided to go with a retrospective rather than a prospective methodology for a variety of reasons we can talk about. The assignment is based on who they receive the polarity of primary care services, which was defined in the legislation, who they receive the polarity of those services from. Again, assignment does not limit where a Medicare beneficiary can go to get services.

We had to define ways of measuring quality per the legislation and we came up with a set of quality measures, separated into five domains, addressing those three major areas of better health, better care, and lower costs. We came up with a total of 65 measures. Seventeen of these can be produced through claims. Seven are produce through a CAPS survey and 41 are elements that are reported directly by the ACO providers. There's a direct tie between the amount of shared savings an ACO can receive and their performance on these quality measures.

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An important consideration was how we should think about those 200,000 people going around in D.C. getting their healthcare. Now there is no ACO. Tomorrow there is an ACO with a different arrangement. What should we do to inform those beneficiaries of what's happening under the ACO program? So we came up with some pretty specific requirements that say ACO professionals need to notify their patients, that they, the provider, are now part of an ACO. The beneficiary needs to be aware of the fact that we may share data with that ACO and they have the opportunity to opt out of that data sharing.

An important question in the marketplace was and a lot of concern was raised about whether or not ACOs, because they would bring together doctors and hospitals or groups of doctors, might end up creating more market power for these institutions that they might end up negotiating higher rates in other commercial business.

So we put in some requirements to understand the impact of ACO formation on marketplace dynamics. They're pretty specific and our attended to address new organizations that are created under the ACO framework. That is if someone is already in place, an institution just declares itself to be an ACO, they would not be subject to this antitrust review process.

So it's been an interesting response we've had to date. Many of you have probably been part of that. Folks have said

we set the bar a little too high and we feel that's okay. We know that this is a proposed rule and that the goal is to take our best shot and then work with the industry, work with interested parties to figure out what the best approach is.

So we're open to hearing suggesting and comments, as I had mentioned. I guess one question I'd ask is as you think about the rule, if you think for some reason that bar is set too high, is it too high for this year, for 2012, is it too high for forever? Are we asking too much or are we asking things that make sense if you think about us moving from a siloed, fragmented, unsustainable, financially out-of-control healthcare system to a safe, seamless, coordinated care system that's patient, people, family-centered?

Are we on the right road with what we have established? Did we miss anything? Are there other things we should add? I guess I'd also ask how does the deal look? What are your thoughts about whether or not we're meeting the industry in the right place as we ask them to transform care? So again, we're happy to hear the suggestions, comments. Don't pull any punches and we want to leave here with your best thoughts. Thanks, Ed, once again for the opportunity to be with you today.

ED HOWARD: Thanks Rick. Susan?

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SUSAN DEVORE: Thanks Rick. Rick spoke about really fundamental change in care delivery and how do we get from where we are today to a patient-centered, truly integrated, coordinated care delivery system that delivers more value and that's a fundamental and very big change? The question for providers and Premier, for those of you who don't know, is group of providers.

We have hospitals, physician organizations, nursing homes, surgery centers, all across the country. The question for them is how do we move from where we are now into this new care delivery system and how do we lead the way. It really is an evolutionary process from their perspective and it's moving from what is just evidence-based care as a process in a hospital setting or in a physician office to really being able to prove that the outcomes of the system, from a cost perspective, from a mortality perspective, from a patient experience perspective, from a safety perspective, and from an evidence-based care perspective that it's all working well and it's all coordinated.

Then the much bigger leap, which is we need to own the health of the people in our communities and how do we build the capabilities fast enough and effectively enough to be able to deliver that in our communities? I think we now have, because we've been working on this for a while, two collaboratives

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where 42 states and the providers in those states are experimenting and building various models of accountable care organizations. We've learned a lot along the way. We continue to learn.

I wanted to share with you just even the starting point before I go to the things we like about the regulations. One of the things we knew when we started was that this could not be hospital-centric solely. It could not be physician organization-centric solely, and it could not be CMS or payer-centric solely. We've actually tried versions of that.

The trick here was going to be how do we create a balance where some of the old history is abandoned and I think Stu called it thrust, a momentum for change, and we balanced the best of what payers can bring to the table, the best of what physicians and hospitals and communities can bring to the table. I would argue it's a four-part aim, not a three-part aim because what we've been learning is those partnerships in the communities and public health and those other components are as critical a part of this as everything else. Care delivery has to be transformed.

We've also learned this can't work for just one payer. So even if people participate in a CMS Medicare program, we don't want to design a system where every payer has different measures, every payer does this in different ways, and that

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patients effectively get treated differently based on which group they come to be a part of. The administrative cost of that and everything else make that not work.

There are lots of legal and trust barriers that have to be overcome. There are lots and lots of multiple models because healthcare is fundamentally local. So knowing all that and knowing that all these models either were already in place or were being built in communities, the question was how does this proposed rule look? There are some things that we think work pretty well in moving us towards that balance and that new care delivery system. The data is critical.

So having timely data, Part A, Part B, and Part D on a monthly basis so that healthcare providers can make decisions and change the way care is delivered is essential. We like that. We like the idea that CMS wants to educate beneficiaries and the ACO can educate beneficiaries and so we're very supportive of that part of it.

We did like the opportunity to have multiple payment models. We do think that CMS approached measures in the right way directionally in that they looked for consensus measures, NQF endorsed in measures that would have consensus built already around them. We've been in the measurement game a long time and we know how hard it is and how long it takes to build consensus.

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We think that some of the antitrust protections and the antitrust parts of it do allow for a more flexible way for providers to integrate. So still some work to do there but generally, we think that that's moving in the right direction. The safe harbor clearly, under anti-kickback and CMP, is very important as providers would embark upon this kind of an organizational model. The antitrust safety zones and the expedited process so that people in a variety of markets and a variety of models could move this forward are all things that we thought were done fairly well in the proposed rule.

The things that are most challenging, the highest priority one is that providers think that there's a lot of cost and investment capital that needs to be made to build the infrastructure and the capabilities to coordinate care and to change the care delivery system, IT investments, people investments, process investments, partnerships with other organizations investments.

So if you look at the proposed rule and you say yes it's a shared savings program, so right out of the shoot you know there's nothing to be shared unless there's savings obtained right? So it's a shared savings program. There's a hurdle of two to four-percent savings that the ACO has to get over before they share in anything and then, depending on the model, it's 50 to 60-percent sharing but there's this downside

risk that's very significant so that actually people could be repaying money or paying money back. Then there's a 25-percent withhold.

So if you take a provider perspective and you say we've got to invest all this money on the front end and we've got all these hurdles of financial risk, it seems like something that might actually threaten the viability of some of these systems. I know CMS wanted not the faint of heart to be a part of this and not anybody that wanted to maintain the status quo but it feels just too challenging from a financial perspective. I think the providers do think that, over time in an evolutionary way, you can build an ability to maybe, over time, have some of those elements but that in the 2012 timeframe, right out of the shoot, it's very challenging.

Although there are multiple payment models, I think the members of our collaborative would like to see maybe even more models around partial capitation and full capitation. The equalizer in this, from a cost and transparency perspective, we think and the ability to really change the way the system delivers care is moved forward pretty fast by partial capitation and full capitation models, so like to see more of that or an alternative way of doing that.

Although we liked that the measures were consensus-based, we think 65 is too many. Again, it could be a timing

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thing where you build them in over time. The PGP demo, the value-based purchasing regulations, those all started when they were new and different and we were asking providers to change the way they delivered care with a smaller subset of measures. So people could get really focused on what moves the mark. So we encouraged them to rethink that.

We also, although we liked CMS and the ACOs communicating with beneficiaries, we want to be able to add more value-added services to beneficiaries. We are concerned about the way the risk adjustment is sort of being set out upfront and not being adjusted over time when we would expect that patients may need more care. There may be more severely ill and that that risk adjustment not moving forward doesn't really reflect what might be happening.

Then I think the challenge we see for academic organizations and we do think in this country that we need to move the care delivery systems in academic organizations as well is that when all of that IME and dish is included in the baseline calculation of cost makes it even that much more difficult for any of the academics to participate.

So while we have hundreds of hospitals and health systems and thousands of physicians in multiple states building the capabilities to be accountable care organizations under the currently proposed rule, I might have a handful that could

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accept the level of risk that's associated with the current rule.

So we're pleased that CMS is open to revisiting some of it, looking at the timing of some of it, and the evolution of some of it, and the risk elements of some of it because the thing we want to do here is create momentum. The thing we want to do is create a path for our healthcare system to evolve itself and change the way that care's delivered. So those would be our comments. Thanks.

ED HOWARD: Dr. Bill Jessee?

STUART GUTERMAN: Next we'll hear from Bill Jessee from the Medical Group Management Association.

WILLIAM JESSEE: Well good afternoon. I'm Bill Jessee from the Medical Group Management Association. For those of you who may not be familiar with our organization, we're a group of about 22,500 individuals who are managers and executive leaders of a variety of different types of physician practices around the country ranging from the large multispecialty groups that are often used as prototypes for accountable care, the Clevelands, the Mayos, the Geisingers, Ed mentioned that one, down to the small single specialty groups of the three to five physicians and increasingly a larger and larger number of our members are part of integrated delivery

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systems as more physician practices are sold to, are given to hospitals.

So we wind up having about 13,000 different organizations where we have members in which something like 280,000 physicians practice. So it's a pretty good cross-section of healthcare delivery in the Untied States.

I'm going to start by talking a little bit about accountable care organizations per say and then drill down and talk about the Medicare shared savings program accountable care organization proposed rule, which is a much smaller part of that larger universe. All of you who've been in healthcare for any length of time know that we are, first of all, a very faddish industry, everybody climbs on the bandwagon and runs in the direction where everyone else seems to be running.

We also are an industry where if you don't have an acronym, you are nothing [Laughter]. As a matter of fact, about 15 years ago, the Joint Commission published a book called healthcare acronyms. That was a lexicon just to keep people up to date. They stopped publishing it because they could not keep up with the pace of change in the acronyms.

So the latest chapter in this is accountable care organizations. If you're like me, my email box fills up daily with emails advertising a webinar, the world's greatest magna summit on accountable care. All of them have the marketing

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line that If you miss this, the world as you know it, will likely come to an end.

So clearly this has been a great boom to the healthcare consultants, lawyers, and educators but so far most of the attention in my view, has been devoted to the organization part of accountable care organizations and very little to the accountable care part. In fact, there are literally hundreds of organizations that have sprung up around the country saying that I'm an accountable care organization and if you ask them well what do you mean by that?

It says well I'm a hospital and I own physician practices. I employee 135 physicians. Therefore I am an ACO but if you look at them before and after they employed that 135 physicians, you would find little difference. They have made no real efforts to change the mode of healthcare delivery in their environment. They may be poised to become an accountable care organization at some point but I would contend that they are far from what Elliot Fisher meant when he coined the term ACO several years ago.

To me, the real challenge is in how do you become an organization that provides accountable care? That is what the whole thrust of the Medicare effort, the reform bill is really about, trying to transform the way care is delivered. So it really becomes critical that when we look at where we're going

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that we be comfortable that the changes that are being proposed are indeed likely to result in more accountable care. Well that begs the question of accountable for what? In my mind, it's fairly straightforward.

There are basically four components of accountability. One is for safety that the care must be safe. We still have huge issues in this country with the safety of care. The quality of the care must be at least acceptable, hopefully more uniform than it is now and one would hope even more aspirationally that it will be improved over what it used to be.

We certainly have healthcare quality in our country that is amongst the best in the world but we unfortunately have a broad distribution with some care that is very poor and a lot care that is quite mediocre in the middle. Cost effectiveness, clearly from the payer's perspective, is one of the biggest concerns. We simply cannot, as a nation, continue to have the rate of rise in healthcare consumption resources that we have had for the last several years.

Patient satisfaction really becomes a key part of this whole process. Can you keep people well, keep them healthier, and increase their satisfaction with the services they receive and I threw one other up here because I believe that no organization can achieve any of the four aims unless they have

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a satisfied workforce that includes the clinicians and all the support personnel as well because they're critical to achieving the other four elements of accountability. Accountable to whom?

Well clearly the starting point is patients and I think CMS has emphasized that from the outset that the patient-centeredness of this whole initiative has to be continually emphasized but it's also payers, both public payers and private payers. Then increasingly, I think it's the public at large as people are looking for more information about healthcare, trying to make better decisions about where to seek healthcare services. They want to have more metrics to help them make those important choices.

How do you manifest accountability in the healthcare system? Clearly by measuring performance and that includes measures of safety, quality, cost effectiveness, and satisfaction and then by tying the revenue stream to those measures of performance. We've been talking for a long time about having more of a performance-based system. The current system is clearly designed to reward volume and surprisingly enough, the system responds with volume and that continues to drive the cost spiral upwards.

So to push Elliot Fisher's definition just a tad, an accountable care organization is, by definition, a provider

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organization that bears some degree of financial risk for the effective performance of that system in providing care for a population of patients. I highlighted provider organization because I think it contrasts with what another acronym that was coined, I think around the mid-70s by Paul Ellwood, that's something called HMO. You may remember that one.

What he had in mind when he coined the term and what actually transpired with the HMO industry was not quite the same because Ellwood was really thinking more about provider organizations creating these kind of entities that also delivered care and had a financing mechanism but HMOs largely became a for-profit insurance-driven activity that contracted with providers rather than having the providers incorporate it. Some exceptions to that but by and large that's the way it played out.

In general, higher risk payment methods have higher rewards but they also have a need for higher degrees of integration. In fact, you can put together a scale. From the provider perspective, fee-for-service is a no-risk proposition. The more you do, the more you make. The challenge for managers in organizations under a fee-for-service environment is to do as much as you can because that way you're a successful manager.

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If you're a hospital administrator, you are rewarded for keeping your beds filled. If you're a group practice manager, you are rewarded for increasing the RPU production of your physicians.

Increased throughput, the more you do, the more you make but as you move up on this scale from gain sharing or shared savings up to something like bundled payment where there's a little bit more risk on the provider side and up finally to what I call comprehensive care payment but it used to be called capitation but we decided to tone that down because that's become something of a pejorative term.

There's a lot of risk for the provider organization and some sort of a global payment to care for a population of patients. In order for that risk to be moderated, it's really essential to have a high degree of integration. If you do not provide well integrated care, it is very difficult to make it work economically in a capitated environment but it clearly is a sliding scale. The Medicare proposal is pretty much down here, fairly low-risk but not much reward opportunity and not a lot of integration required.

So let me now turn specifically to the proposed rule. I think one of the big issues we have is that the term ACO means different things to different people. One of the difficulties in communication is that two people using the same

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term to mean an entirely different thing is very difficult to find some common ground.

What I've done is refer to this rule as the rule for the statutory ACO, mandated by the Affordable Care Act and at the same time, even CMS has some difficulty because I've heard the term ACO also used to refer to many of the initiatives coming out of CMMI, which are quite different than the way they're proposed to be structured and financed. So trying to get some greater clarity and what do we mean when we say ACO that's going to help in our communication?

The statutory model has got a number of issues and I think Susan has touched upon several of them but I'll just very briefly hit some of those that are important to us. The Medicare demos that served as the model for this, we're actually about 10 years in the making. It took a number of years to get the groups that finally wound up participating, 10 diverse but all large and very sophisticated practices around the country. It took them several years to agree to even participate in this experiment.

During the course of the demonstration projects, only five ever received any shared savings. So to take a model that has had only marginal success and that expected to be adopted with a higher bar by the larger numbers of organizations seems to me to be a bit of a stretch.

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It is including beneficiary attribution, not knowing who you're responsible for until after the fact continued to be an issue. It will require significant new front end investment and the stark and anti-kickback restrictions do not give you a guarantee at the front end that if you make that investment that you will not later be told no you've got to unwind this because you've run afoul of the stark or antitrust issues.

It offers very modest incentives, includes downside penalties if we're not present in the original demonstration projects and creates significant new data recording burdens. There are estimates that it costs about $30,000 for each additional measure and there are about 65 measures in the proposed rule.

Some suggestions from our organizations, first of all, I think it could be important to make sure that we clarify terms, clarify the difference between the limited Medicare shared savings program, which is the one the rule is addressing, and the broader ACO concept, which is going on in the private sector. It's going on in potential demonstration projects from the Centers for Medicare and Medicaid Innovation and a variety of other circles.

We would suggest modifying the shared savings proposal to make it more attractive to smaller organizations by lowering the risk thresholds, lowering the savings thresholds, and

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providing better predictability regarding who the patients are and reducing the data burden on those organizations.

We would suggest broadening the fraud and abuse waivers to facilitate the necessary upfront investments. I might add that yesterday, the 10 groups that participated in the demonstration project sent a letter to Dr. Berwick notifying them that unless substantive changes were made in the rule that all 10 of them had decided they would not participate in the new program.

So I think that is sort of a telling analysis of where the provider community is. We believe very strongly that as difficult as it is, Medicare must coordinate with the private sector in each geographic area and have standard measures and standard incentives for both the shared savings program and other CMMI demos.

If any of you've ever gone down to the river between the Kennedy Center and Georgetown early in the morning, you can watch the crews rowing on the Potomac. One of the things that's remarkable is an eight-man crew really can move that boat very quickly because everyone is rowing precisely in sync.

Imagine, if you will, if those eight people were all rowing in a different direction, you would have the boat twirling in a circle and yet for many communities, physicians

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typically participate in eight to 10 different health plans. I'll give you an extreme example.

The University of Colorado Family Practice Plan has over 900 health plan contracts and if each of them is rowing in a different direction, each of them has different performance-based incentives then that result is going to be a lot of noise, not much signal and very little change. So it's going to be essential to try and make this an all-payer process.

Lastly, CMMI should be aggressive in allowing providers to accept global financial risks and be accountable for the results but let the ACO innovate in how it pays internally. All healthcare is local. When you've seen one organization, you've seen one organization. I think it's much more likely to really produce the change that we want to produce if we allow the organizations to design their own internal payment systems to allocate the funds amongst the various parties.

STUART GUTERMAN: Mark McClellan from Brookings.

MARK MCCLELLAN: Great, thanks. It's great to be a part of this with all of you and great to see this level of interest. I just want to pick up on some of the comments that have already been made around the concept of accountable care and how this is about getting more alignment between performing care in ways that make sense that keep people healthier and

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that avoid unnecessary costs and matching that up with the way that financing more works.

I think, as Bill pointed out and Susan pointed out, look at a lot of different steps that could help you get there and this accountable care organization regulation is one of those. So I want to put that in a broader context and just remind everyone here that this is not going to be solved just with this one rule or any one other particular step. The good news is that there are a lot of initiatives that are potentially moving in this same direction.

I was pleased to see a lot of the interest on both sides of the aisle and physician payment reform does more to promote better quality and lower costs and could help reinforce this effort. There are a lot of things going on in the private sector, a lot of things going on in the states. They should be initiatives that reinforce each other but no one of them is going to solve all of our problems.

Now with that in mind, I want to talk about accountable care implementation and through the lens of the recent proposed regulation and then talk about it, if I have time, a few next steps for ACOs as well. Much of this comes from our experience with Dartmouth, Elliot Fisher and his colleagues, and our learning network, which is a collaborative of now over 100 organizations as well as a number of academics and other

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experts and really people on the front lines of implementing these care reforms.

Whether they go under the name of ACO or not, they're moving in this direction of better care, lower cost. It's better aligned with payment systems, with benefit designs, with individual choice and responsibility for their care as well, all of those oars rowing in the same direction. I do want to emphasize though that the regulation is an important piece of this.

At CMS, the biggest payer, the tone that is set here is going to have a significant impact on the momentum one way or another and certainly going to shape the direction for these overall broader trends in the healthcare industry. So what happens with this regulation does matter but just keep in mind that it is occurring in the context of lots of other accountable care-type implementation activities that are going on around the country and activities with other patient populations, with other payers, and so forth as you've already heard about.

In the ACO types of activities that we've seen, I'll try to stay away from specific definitions, talk more about the overall directions and concepts, there are a number of things that seem to be common and these have implications for how the

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regulation may have an effect on what's actually happening in care delivery.

Most of these efforts or really all of these efforts start with the notion that delivery has to change. There has to be something conscious, clear that we're working on together as healthcare providers and with our patients, with other collaborators to make care better, make it different, to improve prevention, to improve the delivery of care of chronic diseases, to improve how hospitalizations are handled and rehospitalizations are prevented and so on and so on and so on, lots of opportunities to do that.

All of these opportunities are not easy to take advantage of. They require investments in the form of health IT, in the form of providers getting organized in different ways or at least working together in different ways. That takes time and effort. All of them require some new kinds of ongoing costs, hiring nurse practitioners or supporting care teams or maintaining those IT systems.

I guess I argue with the point that current fee-for-service payment is the same as no risk. Current fee-for-service payment is very risky if you're an organization that's trying to do the right things in all of these areas. What always amazes me is how much healthcare providers and community

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efforts and so forth are taking steps like this despite the fact that they're swimming against the tide and financing.

So healthcare organizations are taking lots of risks today in their efforts to deliver better care and lower costs and it's a question of how can we shift the kinds of risks that they're facing and ways to support better care and that aren't too disruptive at the same time from a regulatory standpoint.

Along with these changes in what healthcare organizations are doing and the investment cost, the ongoing cost associated with that, is a need for real measurement of performance. As you've heard earlier, if we're going to support these kinds of activities for better care and lower costs, we have to be able to measure it and thereby align the payment systems more effectively and thinking about that kind of support, what new financial streams are coming in and what new financial risks are being faced is part of the overall implementation strategy for the organizations that are trying to undertake efforts like this.

New financial support can be shared savings but it can also be recognizing that medical home payments or episode-based payments or meaningful use health IT payments or quality reporting payments all can align and can support the same kinds of investments that are needed. That's why this is an important strategic effort by healthcare providers.

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On the risk side, there certainly are some costs associated with moving into two-sided risk and things like that but again, other ways, perhaps, to mitigate those risks too. Every organization or every set of providers that is taking steps in this direction is going through this kind of planning process, both the changes in care delivery and how to finance them, the financing changes that could go along with them, and whether that all adds up. As you've heard in a lot of the comments on the—just as a big conceptual point is from a provider standpoint thinking about participation in the Medicare shared savings program or this particular version ACOs.

It's a benefit/cost analysis where the benefits of becoming an ACO include the potential for some new funding and it's shared savings for Medicare but again maybe it's a little bit easier then to get the qualification for meaningful use payment. Maybe it's a little bit easier to do automatic Medicare quality reporting too.

So maybe there's some other financial benefits versus the costs of undertaking those efforts as I was just describing. Those costs include the investment costs. They also include if it does involve new kinds of financial risk bearing, dealing with the uncertainty involving that, which

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typically means setting aside more reserves and those are some requirements along those lines in the proposed regulation.

So one of the things that we've seen in a lot of organizations thinking about how to respond to this regulation are will there be opportunities in going from the proposed to the final to maybe tweak up or increase some of those expected benefits and reduce some of those expected costs while still fulfilling the overall goals of the regulation. I think a lot of the comments you've heard already about specific changes, suggested changes in the regulation, fall into that category.

Another big area where the regulation needs to fit into this broader context of accountable care reform more clearly is the alignment or the potential for alignment between what's going on in the Medicare regulation and payments here and what's going on with other payers.

There are a large number now of accountable care-type reforms being implemented by individual private health insurance plans, by—so next slide, so I've already talked about risks and benefits and how to improve that balance and a lot of specific comments on the regulation will be in the vein of shifting that balance more.

This is the point about fitting into the broader scheme of things. Medicare's the biggest payer but obviously you can provide a lot more support for reform if Medicare is doing

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something similar to what private payers, states, and Medicaid programs are also undertaking.

One of the things that CMMI has already started to do and I think we're going to see more activities from CMMI like this is finding ways to align Medicare with what the private sector is doing. That doesn't necessarily mean Medicare just jumping on board and saying okay all of this other stuff is fine and we'll do it too.

There are differences in the population that Medicare serves that may mean a need for additional performance measures or some additional steps or considerations but having a pathway that's clear to do that especially as these efforts are really getting underway and especially so there's not too much disruption with the private sector efforts and the state efforts that are already out in front in these kinds of payment reforms as Medicare's efforts come online.

That would be really helpful and I think there's some, again some good models for that in CMMI. I would hope that that approach won't just stay in the province of CMMI pilots but could be incorporated into the broader shared savings program and the broader efforts of Medicare to move down this road more directly. I think the time is now and if we wait three or five or six more years, we're going to be in really

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bad shape from a financial standpoint and from delays in improving care.

So that brings me on to the next slide about another guiding principle here has to do with the assignment issues, notification, and data sharing. One way of thinking about this cluster of issues in the regulation is that there are some worries that creates gaps, gaps between the patients and accountable care organization Medicare is being held accountable for and the patients that they're actually treating, gaps between the benchmark that they're being held to in terms of cost savings and the characteristics of the population that they're actually serving.

We've been doing some analysis of using actual historical data on different approaches to doing this kind of attribution. In some ways, it's reassuring that there's a big debate about prospective versus retrospective attribution that, at least in sort of baseline characteristics, populations from year to year treated by particular providers are pretty similar.

We're trying to work through whether that would remain the case with these kinds of changes in financial incentives and how much change to expect there but it also, this work suggests that there may be some ways to address both the downsides of prospective and retrospective through some other

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changes in the ways that, as Susan was saying, risk adjustors or calculated from year to year. Benchmarks are updated. Populations are updated while just reducing those kinds of alignment problems so hopefully some opportunities for addressing the underlying concerns there as well.

On this slide, in terms of quality improvement, make kind of the same point you've heard from most everyone else up here, as I've said, the efforts that we're familiar with progress incrementally. It adds up to hopefully transformational change in the way that healthcare is delivered. It doesn't happen overnight because of the cost and the fact that different healthcare providers are starting from very different places in terms of the best opportunities and the best benefit costs situations for improving care right now.

That means that maybe the best way to go about it isn't through a set of 65 specific quality measures that is intended to guide this effort right away but maybe something that's more evolutionary as well where again, the efforts that are underway with other payers that are underway already in the community could be channeled into getting to these broader overall goals a little bit more over time.

So in terms of where to go from here, the regulation is a piece of this effort but there are a lot of other things

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going on too in which the regulation fits in. The further steps by private payers and states, those are moving along.

Other types of payment reforms in Medicare that could support and be better aligned with these efforts, infrastructure issues around CMS and other payers providing better data to support reforms, lots of things that can be done to help these efforts along, improve that benefit/cost ratio and hopefully, in the weeks ahead as Rick and others up here said, we're going to keep identifying ways to make this progress possible. Thanks very much.

ED HOWARD: Nice job. Our technical team should be commended as well for restoring power at the appropriate time. We now have a chance for you to ask all the questions that have been running through your minds for the last hour or so. As I said, there are some floor microphones that you can use and if you do, I'd ask you to A, identify yourself and B, keep your question as brief as you can and there are green cards that you can fill out and hold up and someone will snatch it from your hand. By the way, there is a serviceable and current, though I'm sure much shorter, acronym list in the Alliance for Health Reform Sourcebook for Reporters that you can find at allhealth.org. Okay our commercial is over. Yes sir?

KEN FEINGOLD: Ken Feingold from HHS [inaudible]. Mark McClellan briefly mentioned Medicaid, I wanted to hear more

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from him and from the rest of you about whether you think that Medicare rule will have a spillover effect into Medicaid and then how you see the potential for ACO benefits and development within Medicaid context?

MARK MCCLELLAN: Well there are already a number of Medicaid initiatives in some states that are doing accountable care and so it's not so much a spillover at this point except maybe a spillover in the other direction. I think one of the points that I was trying to make is that maybe if Rick has talked before about sort of an onramp for organizations, maybe there's an onramp for aligning performance measures and supporting our reform efforts that recognizes that the Medicaid programs share the same overall goal.

They may not be starting from exactly the same place and exactly the same measures in getting there and just as CMMI has done with their medical home multipayer pilots and as CMS has done things like these regional collaboration demonstration programs in North Carolina and Indiana, maybe there's a way to have an onramp towards alignment there too.

ED HOWARD: Rick?

RICK GILFILLAN: Yes. I should say I'm wearing two hats today. As the person representing CMS regarding the ACO regulations, I need to be careful about what I can say and not

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stray too far from what's actually out there in the broader public domain already.

So I will be cautious about that. Coming from the Innovation Center, I can be a little bit more expansive and responsive although I am still a little limited because when we do proposals or at least some proposals, we need to know that everybody heard about them at the same time. So I'll speak generally.

Number one, I'd say the Innovation Center and Terry, John, John Blum's staff, Liz Richter's staff that run Medicare and are responsible for the ACO program, are working very closely together to try and present, over time, I'll call it a seamless and coordinated ACO approach that makes sense for folks out there in the community at large.

So we are working hard to do that. I think folks should expect to see that we are thinking in a coordinated way and trying to address the various segments of the marketplace in ways that make it easy for providers to find their path to the right place.

In that context, we are working closely with Cindy Mann and with Melanie Bella in the dual eligible office, Cindy Mann being responsible for Medicaid here at CMS, and looking for opportunities and actually having many opportunities find us because states are coming to us daily with proposals for

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innovative approaches to work on with us and with other third parties.

So as Mark points out, there's a great opportunity to double down, triple down on the many things that are going on in communities already. We, from the Innovation Center side, intend to take every initiative we pursue, look for opportunities to work with Medicaid, with states, with Medicaid managed care plans, Medicare managed care plans, other payers to try and again present a rational environment within which providers can transform care to their entire populations.

STUART GUTERMAN: We have a question for Rick. It says here some criticism around the lack of a patient lock-in in the shared savings proposed rule. Does CMS anticipate that an ACO demo that comes out of the CMMI might have a patient lock-in? Cy the way, CMMI is the Center for Medicare and Medicaid Innovation that Rick is Acting Director of.

ED HOWARD: You might just sort of say a word or two about what the idea of a patient lock-in really is.

RICK GILFILLAN: Yes. Well I can see we don't use that term and [Laughter] I won't even try and define it. What I will say is again think about all those people getting care in D.C. today, 200,000 or so, I don't know what the number is, 200,000 Medicare-eligible individuals and another 200,000 Medicaid-eligible individuals going out and getting care.

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They have a lot of freedom today to choose where they're going to get care, what doctor, what hospital, etc. As we think about the ACO opportunity and as we think about most opportunities, we don't know today what's possible. If doctors and hospitals say you know, I am going to transform the way we deliver care, we don't know what's possible yet. No one's done it.

We don't know what would happen if an organization or Susan's organizations or Bill's organizations said you know what? We are going to set a population-based outcome set of goals for all of our patients, all the people we care for and we are going to drive towards that three-part aim for the entire population. We don't know how well they can do that in a world where people can go anywhere they want.

I think the challenge that we're all facing together and I think the question that is unanswered is that how much better can we do? I think we're going to focus early on, on understanding how much better we can do in a world where people have the choice to go where they want to go. People are interested in other approaches.

Patients, beneficiaries, they can choose other kinds of coverage, Medicare Advantage plans, etc. The challenge that we're talking about right now is in the fee-for-service world where people have choice, what can we, as providers, do

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differently to optimize their care? That is the big question that we're facing. So we don't see that changing early on.

STUART GUTERMAN: Let me push a little bit more on that point Rick. Suppose the Innovation Center tested some positive incentives to encourage patients to designate an ACO. We talk about lock-in. That's a negative, that's a requirement but if there are really savings to be attained potentially from tightening the relationship between the providers and patients, what if there were positive incentives like discounts on premiums or discounts on co-pays?

RICK GILFILLAN: I think there may be great opportunities to pursue those kinds of incentives for folks and they're out there. I guess all I'd say is that right now, we have a world of opportunity right in front of us and I think we think it's a good idea to try some simple things right upfront and see how well we and providers can do and then think about those kinds of opportunities a little bit further out as we get some experience knowing what's possible in the current system.

ED HOWARD: Yes? Go right ahead.

JANET PHOENIX: Yes, Janet Phoenix with the Department of Health Policy at George Washington University. I was struck by your example about the District of Columbia because one thing about D.C. is that there are some stark geographic disparities in terms of the availability of care. The RAND

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Corporation did a study that was commissioned by Children's National Medical Center and the availability of specialty care or even emergent care is not evenly distributed across the city as you may well know.

Certain sections of the city, the eastern and southern sections are not well served. One step they took to address that was to open a new pediatric emergency capacity at United Medical Center in far southeast Washington but specialty care is still largely unavailable.

My question is as we move down the road to implementing this new model of accountable care, what consideration have you given to ensuring that the implementation of this model doesn't worsen geographic disparities like the ones that currently exist here in the District?

RICK GILFILLAN: I guess I can answer a little bit from our side, we have been very conscious of the issue of disparities, access to care, as we've thought about the ACO framework and also as we thought about priorities within the Innovation Center. We have new offices within both HHS and CMS to address disparities. We're working closely with those offices.

We're thinking very hard about some programs that actually get at looking at new care models to serve those

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folks. We've got a series of dual eligible programs, which we think go at the issue of disparities and improving care.

One of the themes of the Innovation Center is in working closely with the duals, we believe, with the Office of Dual Eligibles, we believe that the time has come to actually do the right thing for the people who are in the most need and historically have not gotten the best in our healthcare system. So we think this is a great time to actually find new innovative models that deliver care in places like southeast D.C. or other inner city communities or rural communities where there's a real problem with disparities. So it's high on our list. We are thinking about them across all of the CMS/HHS programs.

ED HOWARD: Bill?

WILLIAM JESSEE: If I could, I'd like to go back to the issue earlier about choice and trying to combine choice with the issue of beneficiary attribution. I think there are some options out there and for example, in the private sector, tiered networks are very common where there are different co-pays depending upon which provider group you choose to seek. Something like that could be put into the Medicare program.

I'm not sure how far you can go in an operational program as opposed to a demo but in the bundled payment demonstration projects, there were waivers of co-pays for

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beneficiaries who chose to go to one of the demonstration facilities.

I happen to be on the board of one of the hospitals that was in that project and our whole model was driven on the expectation that we would pick up market share by virtue of beneficiaries finding it more attractive to come to our facility by virtue of the fact that their co-pay was waived.

So I think there are some ways where you can preserve choice but encourage patients to seek care in an ACO if they're in a particular geographic area and frankly I can think that if you did that, you would find more interest in the providers in becoming ACOs because no one would want their competition to have the advantage over them of being more attractive to Medicare beneficiaries.

WILLIAM JESSEE: I was actually going to make a comment back on the second question but I also agree with that kind of point. Tiered networks are almost universal now in Medicare Part D and I think the distinction there is that people really are convinced that brand name drugs are the same thing as generic drugs and that in many cases, at least, the preferred brand name works as well as the non-preferred for similar drug classes.

Seniors have overwhelmingly switched when they're able to save a lot more money than they do in a traditional

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insurance plan. There are some other examples as in Medicare, you just really need some good compelling performance measures to go along with supporting that. I'm not sure we have that yet in a lot of areas besides say brand versus generic drugs but on the earlier point, it's a very important point about disparities and vulnerable populations and accountable care.

These are the kinds of things that good risk adjustment methods and good performance measures can help address but I guess the encouraging thing is that there are a number of initiatives out there around the country that are doing this already and helping to address the problems caused by current fee-for-service systems including current fee-for-services in Medicaid with typically very low unit payment rates that result in some real access problems and a contributor to those, absence of specialists and everything else, they're really doing something about that.

So maybe probably right about Jeff Benner and his activities in New Jersey to provide better care for uninsured patients who are spending a lot of money in the form of hospital uncompensated care and emergency room visits and complications by taking some steps to implement data tracking and early intervention often in the buildings where these high-risk individuals live to intervene earlier and head off those complications. They're able to save money, improve quality and

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there's now bipartisan legislation moving through the New Jersey legislature to support that accountable care in a broader way.

Some of you may know Neal Kellman in New York City who works with a number of health centers in Harlem, The Bronx, and there's another area like D.C. that has these big geographic disparities within the region in outcomes and what they found is that by putting more money into the upfront primary care services, they have a relatively high sort of per-visit cost because their primary care physicians are supported by IT and coordination support and referral support and so forth.

They can reduce their costs for ER visits, hospital admissions, poorly coordinated specialist care, and thereby free up more money for greater access and follow-up of specialist care and deliver better care for their patients. So I actually think accountable care is probably a very important, if not, essential step towards addressing those kinds of disparities.

ED HOWARD: Go ahead Rick.

RICK GILFILLAN: A quick comment on Bill, thanks Bill. Those are great ideas and thanks for bringing up the bundled payment program, which indeed has been a successful kind of accountability at the level of an individual patient and individual entity providing care. It's a program that we folks have worked hard on that's been successful and sets the stage

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for new opportunities. We are interested in pursuing those further. We're actually going to have a meeting next week with a multistakeholder group of folks to talk about bundled premium opportunities and really care redesign at the individual level as opposed to at the community or broader health system level. So we're certainly interested in that.

I don't mean to be definitive and say we're not going to do that, any incentives for the next five years. I'm probably operating in a relatively short timeframe as I sit here thinking about what we're going to get out on the street in the next short period of time. So we remain open to any proposals, frankly, from the marketplace and certainly ones that get at using member incentives or beneficiary incentives is something that we'd be open to hearing about.

ED HOWARD: When you say we, you mean the Innovation Center?

RICK GILFILLAN: The Innovation Center. We'll even tell our friends in the center for Medicare about it and get their advice on a lot of them. We do work together very close just so you know.

DR. LARRY CHARLESTON, IV: Good afternoon and thank you for having this panel discussion. Dr. Larry Charleston, IV. I'm a legislative Fellow at Congressman Herger's office currently. I had a question that's kind of related to what you

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guys were talking about and some of the demonstration projects in the proposed rule have a requirement of 5,000 members.

I wondered if that disadvantaged solo practitioners, multispecialty practitioner, and even rural, we made some, like you guys made some inference to that, rural practitioners, I guess from participating because it seems like they have to go into a larger organization and most of these are projects that have been for primary care as well.

So getting back to that specialty that you were speaking of, the specialties and how do you propose this works with a different specialties and keeping the solo practitioners and the rural practitioners involved with this whole change in health reform?

SUSAN DEVORE: I can start there just because in our collaborative, we have a number of members from different kinds of communities and because the proposed rule allows for these joint ventures between organizations, physician hospital organizations, or physician organizations, IPAs, those kinds of things, at least what we're seeing is that the solo or small physician organizations, sometimes by themselves, don't have the level of capital or infrastructure or financial ability to take on this stuff without partners.

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So they're seeking partners either through IPAs or through physician hospital organizations or becoming part of these integrated delivery systems.

I do think given the very reporting-specific, data-specific, and capital intensive things that are required as part of this ACO thing, I think it is going to be hard for small and solo kinds of groups to do anything but be a part of other large organizations. I don't know if Bill, I'm sure, has a perspective on that as well.

DR. LARRY CHARLESTON, IV: I missed one part of my question, which is then who becomes responsible for the distribution of the savings and the reimbursement part in that as well?

SUSAN DEVORE: Well I think the proposed rule attempts to define governance models where participation by the various parties and the representation in the governance model and the ACO itself as the convener and the distributor of the shared savings program to its constituent parts. So I think that's the concept. I don't know, Rick, if you have anything to add there?

RICK GILFILLAN: No. I think in terms of the ACO, the notion is to make sure that those organizations that, you can read the language but, talks about the fact that there needs to be provider involvement in the governance and after that, as

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we've tried to make the rates as non-prescriptive as we could. That's an area that's open. People will decide how they're going to run their organizations. So hopefully in rural communities or even in urban communities, practices that are important parts of those ACOs will have a voice and be well treated.

We also are, within the Innovation Center, have a number of initiatives already and some more that we're working on that get at opportunities for folks in smaller practices or in rural areas. So we're quite mindful of that and the multipayer advanced primary care practice demonstration gets at some of that but only in eight states and we're looking at more.

MARK MCCLELLAN: Just as Rick pointed out, there are a number of initiatives already to try to help rural and small providers in underserved areas and there's some provisions to try to help with that in the regulation. It is a very different cost/benefit calculation for those providers though. I mean there are a lot of examples, as Susan mentioned, of these providers working together in independent practice associations to help coordinate care and help maybe reduce some of their costs of delivering quality care.

There also are a number of regional initiatives I mentioned briefly on North Carolina, which is how a state-based

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program that started out in Medicaid that basically was some backup service for rural, independent primary care providers to help them with managing their Medicaid patients with conditions like asthma to provide some data support and some nurse practitioner support for early interventions with the patients.

That's now been expanded to the major private payers in North Carolina and many rural counties and to Medicare and the situation where Medicare added in and added a few more performance measures that were relevant to their population but it's a very different cost benefit calculation because they have so much less infrastructure in place to support care.

On the other hand, the benefits are different too as opposed to a fully integrated organization that's already tracking in all of their patients with chronic diseases and has already implemented a lot of steps to coordinate care. There's some low hanging fruit for these independent practices and just getting some basic help and knowing who else is taking care of their patients and avoiding duplicative tests and things that are much more basic for a more integrated care setting.

One of the things that I hope the initiatives at CMMI and this regulation will address, it will keep trying to address, is the fact that there are these different starting points, all of which can mean meaningful improvements in care and reductions in cost. It's just going to be very different

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for the small, independent practices from ones that are already part of larger integrated systems.

WILLIAM JESSEE: If I could just add very quickly to that, before the rule was published, I attended a meeting in Denver probably January or so about accountable care organizations and where they're going. It's one of those, if you don't go to this meeting, the world will come to an end, but at that meeting, there were people from a 36-bed hospital in eastern Colorado with a medical staff of 22, which were bound and determined that this was a huge opportunity for them to come together and provide better, more highly coordinated care for their fairly isolated rural community.

I had occasion, after the rule was published, to talk to some of the people from that hospital and they concluded that the infrastructure requirements far outstripped their ability to even consider it. The rule, itself, was just overwhelming for them to try to think about it.

I think we sometimes forget how underresourced many of these rural communities are, the rural hospitals, certainly physician practices of two or three physicians. They throw their hands up in frustration even though they may be motivated as individuals to want to do a better job, provide more highly coordinated care.

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When the hurdle they have to get over to even begin to do that becomes so high, it turns a lot of people off. It's hard to talk about the ACO acronym without also talking about the PCMH acronym and truly much of the opportunity within an accountable care organization for savings results from better primary care coordination, which results in general in fewer specialist referrals and fewer hospitalization episodes.

So the savings opportunity is largely from reducing the volume of specialist care and the volume of hospitalizations. That has made a lot of specialists, I'm hearing now from my members who run single specialty groups, who say this ACO thing completely makes my practice a commodity. I am not being looked for by any hospital and no hospital is approaching me about how to better provide care coordination.

I am simply a commodity and I know that my income is going to drop in my practice because if they're successful in creating savings, it will come out of my pocket. So I think there are some real issues here where, to some extent, we wind up dividing the community that we were hoping to bring closer together by saying it's good for primary care physicians.

In fact, I'm thinking that perhaps the group that is best suited to become an ACO may be a large primary care network with a very small group of specialists that they refer to regularly who they can say we're going to direct even more

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volume to you if you will work closely with us in coordinated care and the hell with the hospital because they're simply a cost center and I just want to take as much savings out of the hospital sector as I can in order to do better as primary care groups. I have a lot of concern that we may wind up going in opposite direction and really dividing the community more than we unite it to try to provide more coordinated care.

ED HOWARD: Rick, did you want to add something?

RICK GILFILLAN: Yes, yes. Innovation and entrepreneurial activity in America are just wonderful. Every day in the Innovation Center, we have people coming in with wild ideas that are just brilliant and that you never would see coming and with technology, software products, etc. that overcome a problem that you thought was insurmountable.

So I think yes, it may be difficult for that small hospital in Colorado and its medical staff to find its way within what we've got right now but I got to believe that if there are opportunities out there and I got to believe that, I don't know whether it's going to be Premier or Bill, one of your medical groups, or who it's going to be but what happens in America is investment finds its way to opportunity and people find new ways of doing things and things are constantly changing and old entities change or don't succeed and go away and new ones come up.

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So I guess the challenge to all of us in the industry is to think creatively what we can do for 22 doctors in a hospital in Colorado and to make them successful at what they want to be and what they want to do. It's not the federal government saying here it is on a silver platter. It's we as in an industry saying we should find a way to help these folks be successful. We're there whether it's the Innovation Center or CM or Medicaid, we want to be there with you in the industry finding ways for people who are committed to that aim, helping them be successful. So that's what we need to find together.

ED HOWARD: We have about 10 minutes left and I just would ask that as you listen to those 10 minutes or participate in the last 10 minutes that you take the time to fill out the evaluation form to help us improve these programs as we go along. Yes Bob?

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. The literature suggests that one-third of total healthcare expenditures are unnecessary and I can see how shared savings within the provider community could reduce some of those costs if you incentivize different sectors of the provider community but I'm wondering where the savings could go to the prevention part of the problem.

In other words, how does ACOs contribute to making resources available to poor communities so that they can reduce

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the social determinants of poor health. That, to me, is the challenge of reducing healthcare costs. I don't see how ACOs are going to achieve that.

SUSAN DEVORE: It's a great question and actually when I said earlier that I thought that we needed a four-part aim with the fourth part being the partnerships in the community, we've done now assessments of all these organizations that are building ACOs or integrated patient-centered delivery systems across the country and what has become clear is that there are lots of disconnected parts but those parts, the prevention parts, the clinic parts, the public health parts, the schools, the social service parts, there hasn't been an easy or organized way of developing those partnerships.

So part of the work that these groups are doing is developing templates of contracts and partnering arrangements and if you think about an ACO program where a convener of the program builds an integrated model that includes those things and has a way of shifting payments or costs and shared savings to the lowest cost, most clinically effective environments, I think ACOs or whatever you call them, are the only way you're going to get there because I think just giving that money to that silo and giving other money to this silo over here doesn't help the problem.

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So I actually think the ACO framework is a way to do it. I think what's been missing is that execution bridge from where we are today to how we form effective contractual partnerships with shared money in the system. I think this sets up an ability to do that but there are five or six gaps that we see sort of universally across the country and that is one of the gaps is the templates for those partnerships and the ability to share money in a community.

ED HOWARD: Anyone else?

RICK GILFILLAN: Ed, just one point, going to the point Mark made and I think if people look at the Gawande article in New York, it talks about Camden, Atlantic City, and other places where folks have gone at tough populations and tough communities, there's a pathway there to actually get at this issue. As I said, the time has come. It has been there all along. We've been paying the money in Medicare and Medicaid and dual eligibles.

We're going to pay for all those people in 2014. The time has come to make the investments there at the community-based level. The ACO model will be part of that and then there may be other models and we are looking at other models to get directly at that issue of how can you affect the fundamental determinants of health within those populations as well as the medical side of the equation.

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SUSAN DEVORE: To the extent you leave it outside the ACO thing, it's just a revenue loss for whoever was treating the downstream effect of that. If you put it inside the ACO then you have a way to share the money differently.

MALE SPEAKER: Hi, how are you?, Bank Crespi. The financial liability of the ACO is critical. Without it, I see it as a nonstarter for groups to partner up. Are there any direct loan or loan guarantee programs by the federal government to reduce the risk profile or the cost of capital, to capitalize the ACO?

SUSAN DEVORE: That would be nice [Laughter].

RICK GILFILLAN: Does anybody else want to take that one? We understand, there's a lot of ways to think about it and so we're mindful of the issue and looking at a lot of the potential ACOs have very healthy balance sheets and there are some people out there interested in being ACOs that don't. So we're mindful of that and I'm not aware of specific programs that exist today.

MALE SPEAKER: Are there efforts underway?

RICK GILFILLAN: Well as I say, we're mindful of it and paying attention to it and trying to understand the significance of it and we're looking forward to getting comments on all aspects in the reg and obviously people make comments about that one too.

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MARK MCCLELLAN: I mean there are some healthcare organizations and provider organizations that are doing some debt financing. They're not getting anything from the federal government. That's not their primary line of business. They're getting it from banks or other investment sources. I think where the federal government can make a difference is in maybe some steps to reduce the uncertainty or reduce the cost of carrying that debt forward.

So again as we were talking about earlier, there are other things that can tweak up the benefits, financially participating in an ACO or reduce, as I think Rick was implying, there are different organizations that are in different financial shape and maybe depending on different circumstances, they wouldn't need to put aside as much in the way of reserves or other capital set aside to help support the financial side of risk associated with an ACO.

I always encourage though, remembering that there are lots of other places to go for financing, they may not be easy and a lot of physician groups these days are, in effect, turning to hospitals as having deep pockets and being able to support the kind of investment through buyouts that might lead to accountable care-type reforms but there are other models. There are some equity firms that are investing in these kinds of activities now.

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There are many physician-owned hospitals and other enterprises that are thinking about and actually getting into more comprehensive care using their own financial resources. There are other places to look besides the federal government and a few things that the federal government can do in this regulatory process to maybe reduce those requirements.

ED HOWARD: Bill?

WILLIAM JESSEE: I was actually hoping that Stu was going to announce that the Commonwealth Fund as the launch of the new program [Laughter] to capitalize ACOs but you do point out a real issue, which again has been a barrier to entry for smaller organizations. The vast majority of physician practices are structured as partnerships or sole proprietorships or professional corporations and they retain no earnings so that any time they want to make any capital investment, it comes out of current year income.

So it's very, very difficult for a physician group to invest in anything. It's been a big barrier to EHR purchased by physician groups is that if I'm going to spend $30,000 this year, it's $30,000 out of current year income not out of reserves. So it does skew towards larger organizations that are generally either structured as not-for-profits and have accumulated reserves over the years and haven't gotten killed in the recession or at least it's bounced back since the

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recession or for-profit organizations that have other access to formation of capital.

STU GUTERMAN: Well one thing I can say actually is that the Commonwealth Fund's Commission on High Performance Health System in the ACO report that I referred to earlier does call for the consideration of the availability of upfront loans or some kind of financing assistance to make sure that it's kind of parallel to college financial aid these days where the idea is not to have anybody not be able to go to college solely because they can't afford it if they have the potential to succeed. The key is the potential to succeed.

So a lot of small organizations you'd have to evaluate their potential to succeed as ACOs but they do call for the consideration of, under certain circumstances, particularly given the population that certain providers' organizations treat that they might be eligible for some kind of either revolving loan fund or other kind of financial assistance to be able to meet the needs so that to help them achieve the goals of the ACO program.

ED HOWARD: Let me just try one more thing that something that you just said triggered and it leads me to a green card question that ties back to what we've been talking about for the last couple of minutes and that is how you get over some of the financial or other kinds of risks that people

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are holding back because of, Bill mentioned the letter that was sent by the 10 very large, relatively sophisticated participants in the physician group practice demonstration to CMS yesterday saying that they currently are not inclined to become an ACO.

What happens if you give this party and nobody comes, if the big sophisticated folks can't bring themselves to participate, if their capital and other kinds of risk burdens to smaller groups not wanting to jump in, what are the risks that the participation level would be so small that you won't have anything to demonstrate?

MARK MCCLELLAN: As a follow-up real quick, it's Mark, which equity firms were playing in this market [Laughter]?

ED HOWARD: That's a much better question.

MARK MCCLELLAN: Well the private sector would find a vehicle to make these profitable.

MARK MCCLELLAN: Yes. I think there are different ways to do this. I mean Bill's right that most of these organizations aren't sensing, taking the heat off you Rick but [Laughter] most independent physician practices aren't set up to do this and those groups need some additional support as well to be able to do more coordinated care and I'm not going to name any names but there are some organizations that are providing some of those support services and basically taking

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an equity share in whatever gains come out of the implementation of these shared savings programs, these new more integrated contracts. So I wouldn't say it's widespread at this point.

I just would, I think one of the things that can really help on the policy side is just reducing the uncertainty about all of this. Investors don't mind taking risks if they have a good understanding of what those risks are and there are some real opportunities that everybody said here for some gains and hopefully the comments that are coming on the regulation and the process from CMS will enforce and help reduce that uncertainty and trigger more of this kind of investment.

ED HOWARD: You don't necessarily have to answer that question.

RICK GILFILLAN: I can make a comment. Yes, the PGP project is lots of things that have been written, said, and dreamed about the PGP project. So we're thrilled that it's been renewed and those organizations have a new two-year period within which they can hopefully knock the ball out of the park and show America what really happens when great organizations really put their minds to delivering the three-part aim.

I think we're confident they can do that and they can really make a difference and they've got an arrangement, apparently they're very comfortable with, and so we're happy to

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get input and advice from all quarters but we're really looking forward to seeing what they can show America this time out. We're confident that, we've got a lot of interest from folks in ACOs.

We're in this stage of our rulemaking process where there's a natural creative tension between people who like to see some difference in the ultimate regulation versus what's out there. We'll go through this period. We'll get input. We'll learn and, at the end of the day, we all think that there will be a program that makes a difference as well. So we're confident that in the future, we'll see ACOs blooming in many different fields and with many different approaches.

SUSAN DEVORE: The only thing I'd add to that is I don't think the private sector's going to wait. I mean I think yesterday, we just announced that the state of Hawaii, all the providers in the state of Hawaii and the Hawaii Blue Cross plan agreed to share common measurement systems, freeze current payment rates, set aside five-percent going up to 15-percent over four years, and pay out to providers based on their performance on things like cost and readmissions, and mortality and other things.

I think in our collaborative today, what's interesting is as upset as they are with the currently proposed rule, they're not leaving the collaborative. They're not stopping

the work that they're doing with private payers and employers and unions that they're doing in their local markets because I think people believe that we have to get to this patient-centered integrated care delivery and we need to do it with employers and we need to do it with payers.

We need to do it with CMS and we need to do it with Medicaid. So I guess I think the momentum is going to continue. I think it would just be a huge opportunity lost for the biggest program we have to not get the movement there to that different model as fast as we can but I actually don't think that the movement in this direction will stop.

ED HOWARD: I apologize to the gentleman at the microphone. I think we've exceeded our time. I don't want to impose anymore. I do want to thank you for being part of this conversation. It was an extremely content-rich, acronym-rich conversation from which I learned a lot and I hope you did too.

I want to thank the Commonwealth Fund not only for its support and co-sponsorship but for its active participation in shaping the substance of this briefing and ask you to join me in thanking the panel for an incredibly good exploration of this issue [Applause].

[END RECORDING]

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