WASHINGTON STATE HOSPITAL ASSOCIATION

CMS LISTENING SESSION:

HEALTHCARE DELIVERY SYSTEM REFORM

MEETING

December 13, 2010

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BE IT REMEMBERED THAT, pursuant to the Washington Rules of Civil Procedure, the CMS Listening Session was taken before Carmen L. Lundy, #2287, a Certified Court Reporter, and a Notary Public for the State of Washington, on December 13, 2010, commencing at the hour of 12:09 p.m., the proceedings being reported at 17620 International Boulevard, SeaTac, Washington.

A P P E A R A N C E S

JOHN HAMMARLAND, M.D.

SUSAN JOHNSON

DON BERWICK, M.D.

RICHARD GILFILLAN, M.D.

CMS LISTENING SESSION MEETING

Monday, December 13, 2010

12:09 p.m.

DR. HAMMARLAND: Well, good afternoon, all of you. Welcome. Welcome.

This is a great opportunity for us today. This is an important listening session on healthcare system delivery reform sponsored by my agency, the Centers for Medicare and Medicaid Services, or CMS, and the United States Department of Health & Human Services. My name is John Hammarland and I am the Regional Administrator for CMS based here in Seattle.

We are incredibly excited to have CMS administrator, Dr. Donald Berwick, with us today. We're equally pleased that Don is joined by Dr. Richard Gilfillan, who is the Acting Director of CMS's exciting new Center for Medicare and Medicaid Innovations.

Before I introduce Don and Rick and tell vou a little bit about the purpose and the mechanics of today's listening session, it's my pleasure to introduce my cohost, Susan Johnson, the Regional Director of HHS who will provide us with some opening remarks.

Susan Johnson was appointed in 2009 by President Obama as the Regional Director of HHS, Region 10,

serving Alaska, Idaho, Washington, and Oregon.

In this role, she serves as Secretary for HHS's primary representative and key liaison to constituencies in the region working with federal, state, local, and tribal officials on a wide range of health and social service issues.

For twelve years, she was the Regional Health Administrator and Director of the King County Health Action Plan. And I think quite a few of you in this room had occasion to work with Susan during that time.

Before that, Susan was a member of the Washington State Healthcare Policy Board. And, prior to that, she was the State Governmental Relations Director for the Service Employees International Union -- then, the largest healthcare union in the AFL CIO.

My favorite part of Susan's bio is that she loves the outdoors. And she's especially fond of one of my favorite pastimes, fly fishing. Please welcome Susan Johnson.

(Applause, applause.)

MS. JOHNSON: Anybody else here who likes fly fishing? Yes. Well, we'll meet later over there.

Thank you very much, John, for the pleasure of working with you this past year, and I welcome you all today to this wonderful opportunity to share big thoughts and

dreams in this room with harsh realities that I know we're all facing.

Before I say a couple of other things, I want to acknowledge that I believe we're joined today by some representatives of Senator Patty Murray's office, Senator Richard's office, also Congressman McDermott and Congressman Inslee. And, if anyone else is here, please give me a wave and we'll ask you to also introduce yourself.

UNIDENTIFIED WOMAN: --inaudible--

MS. JOHNSON: Thank you very much, Barbara.

We welcome you all to this opportunity to hear both from our panelists, from Dr. Berwick and Dr. Gilfillan, about the innovation center and also, for them to hear from you about the best use that you all want to make of this wonderful portal from here to our future.

It seems to me that within this region we have no shortage of innovators; for two decades now at least Washington and Oregon and other entities in the region have led the way on transforming healthcare as we knew it to what we know it and, still to go, what we want it to be. The harsh realities now of state budget cuts and your own difficulties getting from here to the future make this even harder. And it seems that the transformation of what we're doing is not just a luxury now but truly a necessity. So I know that we have the triple A leading in our minds and our

hearts, and we have the harsh realities certainly in Washington of a special session just yesterday in the forefront of our realities.

So, with that, I know that we will have a great exchange today to hear from you, to share with you, and to hear from our guests about the innovative center that will be soon a reality for all of us to use. So, with that, thank you very much for joining us and I look forward to the discussion.

(Applause, applause.)

DR. HAMMARLAND: Thank you very much, Susan. And thank you for your leadership at HHS here in this region.

All right. Now I am going to introduce you to all of you.

You are quite a formidable representation of healthcare in our region; consumers, clinicians, hospitals, health systems, insurers and payers, government officials, tribes and tribal leaders, social service agencies, employers, academics, advocates, and thought leaders all; you are the people that we need to hear from and engage with today and moving forward.

All of us want the highest quality healthcare system possible, and the Affordable Care Act allows the public and private sectors to work together in new ways to get closer to our goal.

The purpose of today's listening session is to hear from you on how CMS can best work with you to undertake the important work of reforming the nation's healthcare delivery system.

We're going to spotlight three areas of interest that represent opportunities under the Affordable Care Act:

One, the Accountable Care Organization, Shared Savings Program.

Two, the CMS Innovation Center.

And, three, the Federal Coordinated Healthcare Office.

Don and Rick will be sharing information about these three areas and our priorities at CMS. They'll be setting the table for you. And, then, we go in the listening mode. And that's what these standup microphones are for. We want you to give us your ideas, share thoughts with us and with this collective.

We want to learn from you. We want this entire community in this room and the communities and organizations and constituencies you represent to be energized by the conversation today and to help us with next steps tomorrow.

It now gives me great pleasure to welcome to Seattle and to introduce Dr. Donald Berwick, the

Administrator of CMS. If our goal is to build a healthcare system that keeps patients healthier and realizes its full potential, there's no one who has more experience or is more respected in the field than Don. In June, President Obama named Dr. Berwick the Administrator for CMS. And, in this role, Don oversees the Medicare, Medicaid, and the chip programs. Taken all together, those programs provide healthcare coverage to over a hundred million people, nearly one in three Americans.

Before assuming leadership at CMS, Dr. Berwick was President and Chief Executive Officer at the Institute of Healthcare Improvement; clinical professor of pediatrics and healthcare policy for Harvard Medical School, and; professor of health policy and management at the Harvard School of Public Health. He's also a pediatrician and has served as adjunct staff for the Department of Medicine at Boston's Childrens Hospital, and a consultant in pediatrics at Massachusetts General Hospital.

It's really nice to have him at CMS. Please welcome Don Berwick.

(Applause, applause.)

DR. DONALD BERWICK: Thank you so much, John and Susan, and thank you for your leadership out in this remarkable part of our country. It's really a pleasure to get to be here again and, so many friends, I feel like I've

actually arrived home instead of gone on a trip.

Rick and I are not here to speak very much; we're here to listen. This is a chance to learn from you about how you guide us in pursuing some of the initiatives that now are in our hands, to try to achieve for the country what we can around healthcare.

I'll just make a few introductory stage-setting comments and then Rick will dig in a little deeper on some of the things -- some of the questions we'd like to ask you, but anything is fair game today.

The Affordable Care Act is the context for our visit with you. It's the most significant piece of healthcare legislation surely in our country for decades. A very exciting piece of legislation. It has in it a primary focus on extending coverage to people who otherwise would be frightened they would lose it, and; giving benefits to people who badly need those benefits like prevention, coverage for medicine, for instance. And I won't delve into those remarkable advances for our country in making care available to people who would be frightened...

It is a fact, though, that whether or not we did that piece of work to expand coverage, we would still have in our hands a significant problem, which is that at the moment the way the healthcare system is performing, we can't sustain it in this current form; certainly not with this

level of expanded coverage and certainly not with the kinds of stress that both the federal and state governments and private payers and employers -- we all, out-of-pocket, are experiencing as costs rise out of our reach.

As I've gotten in the saddle at CMS, I proposed there that we embrace the three aims that I've referred to often in my prior life and still do now. And those are the -- my attempt to define social need; that anyone that cares about healthcare today should be rallying for it in order to create the kind of care we want and need for ourselves and for our children.

Those three goals are these:

Better care for individuals so that people in care are getting the care they want -- at least all of the care they want and need, exactly when and how they want and need as defined by the Institute of Medicine back in its 2001 report across an equality category that would state care that's effective that gives you exactly the care that will help you, reliably; care that's patient-centered so the patient is in the driver's seat; care that is timely so that unwanted delay is engineered out of care; efficient so we can reduce waste. Wasted time and ideas and resources that we have bad -- we have a strong need for elsewhere, and; equity so that we can close racial and socioeconomic disparities in healthcare, and safe effective patient-centered timely

efficient equitable care.

That's aim one, better care.

The second goal has to do with why we needed care in the first place. And, as anyone who has studied it even a little bit knows, most of the causes of the illnesses we suffer from do not lie within healthcare's reach. Only about 10 percent of the variation in health statuses is purely healthcare; the rest is due to other things -- the genetics, to some extent. They're also environmental, table choices. The factors in society that give us the illnesses. And those can be controlled but only if we invest in better health, not just better healthcare.

So the second aim is better health.

The third goal is lower cost. Lower costs through improvement, not by harming a hair on anyone's head but lower costs by improving what we do. And it's the same healthcare as any other sector of a society; doing things right in general costs less than doing things wrong. So much of our fragmented broken healthcare system today, not only does it handle for the first two rules, health and healthcare, but it also adds costs we don't need to pay.

So that brief part from me -- better care, better health and lower cost for improvement -- informs all of the strategies that my wonderful team at CMS and I are tackling now as we try to get -- use the Affordable Care Act

as a trampoline into the healthcare system that we want and need.

We're not going to try to do this alone; we can't do it alone. It has to be done in absolute full partnership in the private sector, in all the states, and of course with patients, and communities. Rick and I and our colleagues are absolutely committed to CMS being a trustworthy partner and a force to the continual improvement of health and healthcare for all Americans. But that partnership is key. And that's what brings Rick and me across the country to meet with you today. We want to partner. We want to understand what's on your minds, what you need, and what ideas you have for us, and the context of the opportunities that our country now has to get this right.

Healthcare reform -- delivery system reform, which is the topic we're tackling here is at the heart of the issue. If current systems aren't sustainable in the form it's in, not with the expansion of coverage we saw, and probably not even before that, then what is?

I'm always reminded of a story that I told for many years, and probably half of you in the room have heard this, but if you will kindly pretend you didn't, that would be polite of you.

The story is about my now 24-year-old? 23-year-old? Approximately 24-year-old daughter, Becca.

Don't tell her -- don't let that out of the room. I think it's 24. Yeah. Becca -- we -- my wife lived out here in Seattle for a few years and this had become our second city, so we often were out here hiking. It became a real passion for us. We were hiking a long trail one day with Becca, age 5. It was a 16-mile hike, frankly, and much too abusive to be right. So she was slow and she wasn't making it back in time to the car. So I, as a good father, I was yelling at her. So I yelled, she cried. And I yelled and she cried. And I yelled and she vomited.

So, Becca was moving along. It's getting dark. Finally, she stopped on the trail -- true story -- this five-year-old girl turns around, looks me in the eye, puts her hands on her hips and says: Daddy, telling me to walk faster does not make me able to walk faster.

That became always the watch word for me in my prior work. She was an expert; she knew that all improvements -- you don't get improvement by exhorting an existing system to do better. Now at whatever age she is, she outpaces me.

So, improvement and change are linked to each other. So when we talk about delivery system reform, we are talking about change. We're discussing a question, which is: What new form of healthcare delivery? Not the current one cloaked. Not the current one exhorted or stressed or yelled

at. Not the current one stabilized. But, a new one. What other form of healthcare can we construct that's capable of delivering the healthcare we want and need for ourselves and our neighbors and our posterity?

That's the journey we're on. I won't call it an expedition, national expedition, to find the care we really want to give -- and working -- because this isn't doing anything to anybody else. It's about doing for ourselves what we ought to be doing for ourselves, including those of us who want nothing more than to be able to deliver exactly the care people want and need exactly when they want it.

A lot of the innovation already exists. We are seeing all over the country inspiring examples of progress, many here in the Northwest, which show us a glimmer of that new care, the care that will do the job correctly.

Now, the Affordable Care Act resources, we have a kind of almost visionary investment in a series of assets paired with the expansion of access and coverage to care that's at the heart of the affordable care. Paired with that is a support to a search process and the inventive process. And it takes several forms. There are three we'd like to talk with you about today, but any can be in play, but:

The first is the concept of the Accountable

Care Organization. That's a new term on the landscape the past few years. Scholars have brought us that idea but it now is getting traction. It's written in the law and it's in the process of definition. We are currently writing the Notice of Proposed Rulemaking that will be out in January. Rick and I are involved as we try to shape the concept of the report -- Accountable Care Organization -- into something that you get your hands on. In fact, it's pluralistic; it has enough different forms that it can work in many of the environments around the country.

An Accountable Care Organization will help ensure patients that they get the care they want and need exactly when and how they want it -- immediately -- every time, that is affordable.

At its heart is a transition from a fragmented system to an integrated one in the context of ordinary Medicare/Medicaid services; shared savings and other supports to groups of care providers that want to come together and take responsibility for attributing populations of patients. They can do better for those people.

But that's one form of innovation with Accountable Care Organization. Now, the -- those who are performing will appear in January and you'll get a chance to comment on it. But we're here to listen now because we can take back ideas that you give us and map it into the plan

that crosses to that first -- ambitious ideas.

Second, is the Federal Coordinated Care Office. It was targeted by Congress to give us a resource to really crack the nut around the care of not going to name people dual eligibles, the neediest patients we have. These are people who are often in conditions of both social and physical need that make them extremely vulnerable. We have to get their backs. They qualify for both Medicare and Medicaid. They explain 40 percent of the state's Medicare budgets in this country. And we don't do well right now.

Their care is fragmented beyond what they really can deal with. They carry three identification cards; there are different funding sources at play; different kinds of benefit structure. But we're trying to rationalize that care as a Coordinated Care Office headed by Melanie Vellot.

And the third, which Rick Gilfillan, my colleague -- the CMS, Center for Medicare and Medicaid Innovation. It's a big fat 10 billion dollars reserved by Congress over the next ten years to invest and support, to discovery and the spread of news, to be able to support very old innovation on individual care, on integrated care, on prevention beyond anything our country has actually invested in before.

Rick is going to describe to you a little more about these three resources, these three exciting

components of the new law. But what we want your help with today is to understand how we can help you help us shape that agenda and other elements of the new context into something that will really help you create that new healthcare system that we so badly, badly need.

With that said, let me introduce Rick Gilfillan, my colleague and Director for the Center for Medicare and Medicaid Innovation. Rick is a long-standing colleague of mine. He is an experienced healthcare executive, worked at Geisinger System, and also is a physician, skilled and committed. And I know that from working with him directly. And I'm very proud to have Rick as a colleague and introduce the plan for the today.

(Applause, applause.)

DR. RICHARD GILFILLAN: Thanks, Don. It's a pleasure to be here, and it's an honor and appropriate to be working in administration, and not to be forgotten. So thanks very much for the opportunity to be here.

I'm going to step down, if I can. If this works okay so that the slides -- the slides? The former slides. Okay. Excuse me one minute while we deal with a minor technical difficulty. There you go. Okay, I don't need to be down here to see the slides because there's no slides to see.

As Don pointed out, we're going to be talking

about three, those three central topics and we're going to start with the innovation centers, (unintelligible) federally qualified for the Office of Coordinated Healthcare, talk about dual eligible population.

We do want to learn a lot today. One of the things I'd like to learn about is how we should have this conversation nationally. Because, as Don pointed out, we're interested in talking about improving health, improving care, and reducing costs. And that, as we all know, that reducing-costs conversation has been a difficult one and is one kind of loaded with a lot of potential concerns in the country.

So there's a lot of ways to think about and talk about delivery system reform but my wife said, bring the patient's voice into the room and start with the patient's voice in the room. And so this is Marie; she's from a small town in a rural state on the East Coast. And she's pictured here with her dedicated case manager who works in the medical home primary care practice that she has cared for. And Marie has the usual constellation of chronic medical problems, among them, chronic obstructive pulmonary disease and, hence, the need for oxygen that you see here.

And Marie spent a lot of time going to the emergency room and going to the hospital in prior years before she was able to connect with a dedicated case manager

pictured here. And that nurse has a hotline next to her desk that's dedicated. Marie has that phone number; Marie's family has that phone number. And when Marie has a problem, she calls that number and talks to that nurse.

And, Marie says, the idea of the program is to keep me healthy, keep me out of the hospital and keep costs down; I don't think I would still be here without this program; it has been my lifeline.

That's what delivery system reform is about. It's about getting us to a position where we can make these resources available to the people who need them. And take ourselves from that fragmented system we've talked about to a safe, seamless coordinated care system where we know we can do the best thing for Marie and other folks.

And I wonder about -- and I'd like your input on -- gee, if we had a national conversation talking about Marie and talking about her family members who can also call the nurse and know that even if you're in Florida that someone is available to take care of them on the phone.

So, Question No. 1: How should we have this conversation with the useful way of framing them? And I love to see stories -- I know there are many of you in this room who have stories that are similar to this that we could use every time we have a conversation to begin and then with a story about what a reformed process means for an individual

patient. This is the CMS condition that Don mentioned; a constructive force and trustworthy partner for continual improvement of health and healthcare for all Americans.

From that fragment, a care system to the safe seamless system we talked about; how do we measure success? It's real clear. And we think about innovation, success is defined as better health, better care, lower cost. And if people say, well, how should we think about programs? You want to think about what you might want to fund in the innovation center. We say, think about a patient, think about Marie, think about patients like that. Think about those patients' needs.

Think about why those needs aren't being met today; think about early interventions that can change and address those needs and change their lives; think about the measures of success across these three dimensions that that intervention will provide, and; think about the population -- total population of people -- that are effected and that these needs can be better met and packaged as a program. And tell us about why we should join you as partner and a supporter, if you will, or your efforts to make that -- those differences in patients' lives.

That's the way we will think about being a center of innovation. It's about innovating around delivering these outcomes, working with providers and the

delivery system in pursuit of those aims and, supporting you, not in delivering fragmented care; not delivering IPPS and OPS, not with RBI but with systems that support you as you deliver that safe seamless experience with patients.

The legislation, that's the purpose of the center to test innovative payment and service delivery model to reduce program expenditures while preserving or enhancing the quality of care first. Pretty explicit. The Congress expects us to help work with you all to bend the cost. That's our No. 1 mission. We know we can do that; we believe we can do that while improving care.

So one formulation is to provide better care and lower costs. That's the home run; that's what we're after. We know some initiatives may provide the same quality but for a reduced cost. And we want to do that, too. That's good.

We also know that occasionally we'll find something where quality and outcomes and health and the care are improved significantly. And maybe the story isn't as strong as we'd like it to be; maybe we can't speak to it exactly. We do know this: We can't live there; we can't live in that space of much improved quality at the same cost. And we know we can't live there if it's more cost. So we need to think very concretely and specifically about cost and quality together.

Ten billion dollars in funding. It gives us a clear path in many ways to do these new models of care. And at the end of it -- and this is critical -- at the end of our work looking at models, if we find that a model of care does indeed improve quality, improve -- lower costs, we can go to the Secretary and say, this is the way Medicare should pay now. This is not the old fragmented way of paying. We want to pay maybe a primary care practice, end up with per member per funds so that they can have a nurse in the office providing that kind of service.

So this is a very potent matter that did not exist before; it's the ability to change fundamentally the way CMS supports the delivery system without having to return to Congress.

Our mission then is to be a trustworthy partner with you to identify value and diffuse new models of care plan that meet those triple A outcomes.

We're going to focus this on three levels, we'd like to understand opportunities at the level of the patient care model. How can we deliver the best OB care? The best cabbage (CABG), for instance?

The second level, how we -- what are the best models for delivery and coordinating care across different locations? So, ACO's, medical homes. Other innovations in that realm of coordinated care models.

And, finally, how can we work with that community population well? Probably, doubling down on some of these other efforts or working with other community providers. Because there are lots of people working in that space. And we want to find ways to use our unique capabilities to make other programs more effective in that space.

These are the functional activities at the center that we're thinking about right now. Key pieces. We need diffusion and learning systems. And we will introduce and work with you all to develop learning systems capabilities that are far beyond what people have done in the past. And we're thinking very actively about this now and interested in your thoughts about how we might do that.

We're going to have parts of our organization focused at these three levels. We're going to be actively managing an intervention cycle. And, we want to work with you to find new ways to develop a national innovation infrastructure, support for innovators throughout the country who are interested in not the latest medical technology or not necessarily the latest drug, but how do we put all the pieces together and innovate to deliver the outcomes that we have talked about.

And the final piece of this, and I heard some interesting stuff today about health group actually, how do

we rapidly evaluate it? Because if you think about the work we're doing, we want to find out as quickly as we can what works better, confirm it, change the way we pay, and support you in new ways to diffuse that. And, to do that, we need to be able to evaluate these models very quickly. So rapid cycle evaluation would be a key piece of what we do.

We just now opened our doors; we're about three weeks old in terms of federal register notice. We're working on a strategic operating plan now. We're out there trying to capture new ideas about innovation priorities, how we should operate. We want to hear from you on that today.

We have a website where you can learn a little about what we're doing so far: Innovations.cms.gov. But we're, most importantly, beginning our work -- we felt it was important to get out there and start working with you all in the delivery system around a variety of delivery systems. These are the first four that CMS introduced a couple weeks ago.

One: Multicare dealing with primary care practice model and a PCP initiative. We're joining state-based preexisting initiatives that are multiple care. This niche will be to the creation of approximately 1,200 medical homes nationally, or support the existence of 1,200 I should say. And, we think, provide the kind of care systems we sought for Marie for about a million Medicare beneficiaries.

We also have Medicaid health home state plan option where the federal government will match 90 percent of funds sent by states on developing Medicaid-help homes.

We also announced an initiative to start building medical homes in about 500 qualified health centers. And we announced care models, the intent to develop with states' care models that would address the dual eligible population -- those eligible for both Medicare and Medicaid. We'll be awarding contracts to a number of states as the first phase to solicit from them their proposals for how they would go about better managing the care for those folks.

As Don said, this is a partnership. We know this. We know healthcare is local. We know providers need a relatively simplified set of outcomes to be pursuing. And we intend to work with you all to develop in a consistent coordinated way a common approach in local markets so that all patients can benefit.

Let me move on to the -- briefly -- on the ACO Tiered-Savings Program. It's Section 30-22 in the statute. We are currently making, as Don mentioned, we -- this program will go live January 2012. We want to emphasize, and you'll see this in the proposed rule, that ACO's are not first and primarily a financing vehicle; they are a new care model to deliver the kind of experienced care we've talked about.

There will be multiple types of providers who will be in a position to play. Being patient-centered, we're interested in ideas you may have about how we can develop what criteria should be for you to meet the notion that was in the bill that these ACO's needed to meet patient-centered criterion. They also need to be a quality where you -- your ideas talk back. We expect them to be very -- very data rich. And we understand the need. And we'd like to hear from you all about the need for data for this to be successful in the sector.

And we expect these to be continuously learning organizations. And, we expect to be facilitating that learning in major ways as we get into the new year.

Finally, on the dual eligibles, as Don said, almost 10 million individuals accounting for 40 percent of Medicaid; almost 40 percent of all CMS spending is in this population. Yet, they are cared for in ways that are remarkably uncoordinated, unintegrated. Nonsensical would probably be the most appropriate way to describe it. Because there are dramatically different incentives operating for the state and the federal government, leads to worst care for patients, poor outcomes and more expense. It's a great opportunity and we're interested in your ideas on this.

It's Section 2602 of the act. The purpose is to improve quality, reduce costs and improve the beneficiary

experience. And it's about defining new ways to coordinate across state governments and the federal government, provide entities, state governments, and; also, it's an opportunity to do something at the beneficiary level to provide new support mechanisms for beneficiaries to help them be more responsible and be able to integrate the care better themselves.

Melanie Vellot is the director of this office. And Melanie is a former state Medicaid director. She's a wonderfully, enthusiastic, knowledgeable, bright person who is just totally focused on making the lives of these patients better. She divvied up her department into two areas; one, program alignment. That is, to find ways to align the state and federal pieces of the program, and; two, she's made great progress on getting a data center available that actually gives a picture of this population that is not readily available today. So she's worked hard to do that. She's got about ten people now that are working in these two areas of her organization.

We've established a number of coordinating within HHS to get this done. We've reached out to Medipac/Macpac to kind of begin the process of thinking this through the national level, and is very interested in getting any input from different states. And, I would say, we've already had significant interest and input from the State of

Washington. And maybe they'll be some of that referenced today in the conversation.

So from Melanie -- questions, suggestions can go directly to this website for the innovation center. The website is innovations.cms.gov.

And, with that, I'd like to take one more look at Marie and remind us it's about patients, and move on to discussion. Thank you very much.

(Applause, applause.)

DR. HAMMARLAND: Thank you very much, Rick, and thank you, Don.

All right, folks, as promised, we are now going to go into the listening mode. We want you to utilize the microphones that we have now in the center of the room. And, if you can, we'd appreciate it if you could limit your remarks to a few minutes because we want to be sure that we can hear from everyone who wishes to contribute. And also, when you come to the microphone, please let us know your name and identifv vour affiliation -- a few more minutes, but it won't take long.

MR. FLETCHER: Good afternoon --(Pause due to A/V technicality). We're technologically challenged in the state of Washington.

I'm John Fletcher from Providence Health Services. We have an incredibly successful program for dual

eligibles, the Pace Program. And I'm kind of wondering if anyone from CMS has envisioned how you might extrapolate the success of the care for those with chronic conditions to the broader population. And that works under a capitating model, fortunately, but maybe unfortunately from a marketing standpoint. But I'd just appreciate your thoughts on that. Because it really is something Providence has been doing for over a decade and has really served the elderly very, very well.

DR. DONALD BERWICK: I can start the --- I can say that the Pace Program is immensely interesting. I've visited several Pace sites now. Melanie knows it well. We're using it as a template for a lot of the work -- the dual eligibles. The problem with Pace is making it scaleable. It's rooted in geriatric expertise and there are a number of other features that make it hard to replicate. But we're dedicated to learning from that model. It's a tremendous success. In fact, Rick, you're visiting on-lock, aren't you, when you --

DR. RICHARD GILFILLAN: I think later. Yes.

DR. DONALD BERWICK: -- in San Francisco.

DR. RICHARD GILFILLAN: And I think it's -- it is -- there's some other programs we've seen that, again, address very complicated populations where there are people interested in what would be a capitated model for distinct populations.

So I think it's a -- we're going to learn a lot from what was done at Pace and we're also the kind of a -- the notion of somewhat niche populations that have great opportunity to do a better job is going to be, probably, an area of interest for us in the center.

MR. JOHNSON: David Johnson from Novus Behavioral Healthcare Organization.

You know that one of your most expensive populations in this area are people with serious and persistent mental illnesses. And CMS has a history before its late incarnation of doing all sorts of things to strangle and discourage good things happening. And, particularly, with people with mental illnesses. Historically, the approach, the medical model approach, the pathology-based approach to serving people with serious and persistent mental illnesses gets it about a quarter right. There are things that we can do with medications that make the difference.

But we have found that some of the most healing things that we can do, and there are things that make people healthiest and most independent, has to do with the supports we bring forth; safe pieces of affordable housing or helping people get jobs and keep jobs, or dealing effectively with a crisis system that efficiently involuntarily commits and then brings people back into better places to be.

We have all sorts of evidence-based best

practices and emerging practices that have been very effective that, because of adherence to coding and a focus on fee-for-service and not paying enough attention to what since has been discovered and have made us not as effective as we can.

So, my hope is that when -- as you would roll out what you're doing, and we're very much excited about the integration of primary healthcare model organization partners with neighborhood health and very pleased what we're able to do with them on our campus and having us on their campus, but; as we look to Accountable Care Organization(s), I hope that we're able to structure what will allow for organizations that do housing and employment supports and the incredible healing work that happens through peer support specialists in working with people in mental illness where all of that in tandem with primary healthcare educations and so on.

If integration simply ends up being that there are social workers and psychologists at the primary healthcare clinic, you're not going to get that network of vocation, housing, peer support services, psycho education and so on. And that's so important.

So I'm hoping you'll keep that in mind.

MR. MOORE: Hi. Gordon Moore from Ideal Medical Practice. It's a nonprofit working with small private-firm

industry.

There's a lot of evidence that supports that the foundation of a high-performing health stands on effective primary care. And, primary care, if you look at the 1978 WHO definition, it's based on simple rules; be the first point of access for care, provide for relationships at the time, provide comprehensive services and care coordination.

Please note, these simple rules can be easily measured from the aggregate series of care from need. Patients can very easily and very accurately identify whether or not a practice has these attributes, and, in what degree.

I've been working with solo and small practices and lots of others from around the country. And I'm frustrated by a systematic bias against small practices in the United States. We're shutting out 78 percent of the practices in the U.S. that are five positions or smaller. A lot of these medical demonstration projects say that unless you have a significant number of patients in your practice, you can't participate.

In Farmington, Maine, Jean Antigen, she's a solo physician, has for three years in a row, zero preventable hospitalizations for her Medicaid population. She stands out in the state but she can't get in the door. That's wrong. We need to solve this problem. There are ways

to measure. There are ways to get granularity of measurement down to the individual position level. But we have to be flexible in how we understand measurement in this attribution of behavior at even small practice level. It is possible. But we have to get out of the mindset that the plethora of metrics is the only way to that end. Those are excellent metrics but they don't have granularity. Preventables don't have granularity.

So I'm hoping, especially the center for innovation, you begin to think about different measurement modes and think about actively recruiting and engaging small practice representatives so that you can hear that voice. We cannot afford to shut them out. And I don't think you want to just see them all consumed by large systems, because not all large systems treat them well if we look back into the experience of the 1990s.

UNIDENTIFIED SPEAKER: Tom --

DR. RICHARD GILFILLAN: Could I just -- you know, we are very conscious of the -- you know, kind of a distribution of care and where it's given. And we're not looking to reinforce biases. So, if there are specific ideas you have at some point about how programs, you know, we should be instituting or metrics that you think would be helpful and would give us a reasonable belief about what's actually -- or insights into what's happening as practiced,

we certainly would be open to receiving the information. And we have had a pretty open-door policy in terms of talking to people. So if there's an organization that you'd like to have us talk with at some point, we'd be happy to do that.

MR. MOORE: What's the mode of communication for that?

DR. RICHARD GILFILLAN: The website, innovations.cms.gov. And you can try Richard.Gilfillan@cms.hhs.gov as well.

MR. SAIGER: I'm Tom Saiger, Medical Director for the University of Washington Medical Center. My comments are a little bit along the same lines as the prior speaker. What I'd like to suggest is the importance of the role of CMS at the center for innovations in developing metrics and other infrastructure that will help support the alignment of organizations both within the organization and across the communities in meeting a triple A.

A number of us in this room were at IHI last week and we heard Rokawanda (phonetic) talk about the state of metrics, you know, in proper quirks, are exceeding the state of metrics in health reports in this country.

We know that if turnaround time from measurement from something occurring to a report of measurement being a tremendously long time, and, that any attempts we make to improve are going to be lagged. Any

change, we're going to tell what we did so that both handle robust metrics, that will help us assess the health of our population, the quality of the care that we're providing; the patient experience and cost will be useful to all of us across the country. Metrics that can be -- we share across organizations as well as within the organization to help drive collaboration.

And then, finally, just a comment for the number of people that I've heard mention that the Puget Sound and Washington are a unique -- in some ways, a laboratory for working on healthcare reform. We have a lot of people who are used to collaborating and a lot of good leadership in the state. And I think there's as much opportunity here in this area as anywhere to do some innovative work around healthcare reform. So thank you for again for being here.

DR. RICHARD GILFILLAN: You know, we should note that I think this -- the topic of metrics for ACO's has been one that we've spent a lot of time on. Almost more than anything else. And we are really interested in finding that next generation. We've talked a lot about functional outcomes that our patients' perceptions of their outcomes as maybe being more -- more important in something that we should be developing further. We're interested in hearing from the industry. And we'd love to see people in the industry come together and propose kind of the next

generation of metrics that really get at outcomes in a way that, up to date, we have not been able to do a very good job with. So we're very interested in hearing from you all on it.

MR. WALKER: Good afternoon. My name is Roy Walker and I work for the Olympic Area Agency on Aging. And I represent the thirteen Area Agencies on Aging in Washington state. And I appreciate having been invited to participate in your listening session today.

I just am hoping to see the openness of -- for the opportunity of working with local partners in the aging network. In Washington state, triple A's have been extremely innovative, particularly, focusing on those high-cost dual eligible claims as we support them in their home. And, I think one of the key things that we can offer all of you, as partners, is realtime information about the consumer's condition in the setting that they're in most of the time, in their home.

In Washington state, the Area Agencies on Aging have been very involved in the outcomes -- programs, including a recently piloted chronic care management program for Medicaid high-cost clients and providing supports to them for active engagement and accessing services at the right time and the right quantity.

So I'd just like to remind folks that you

have built-in community partners available to you and the triple A's in Washington state. And thank you again for this opportunity.

DR. DONALD BERWICK: Right. When you think about partnering at the community level, who are some of the -- what are some of the organizations or types of things we should keep in mind but look for partnering opportunities?

MR. WALKER: On our side or on your side?

DR. DONALD BERWICK: On your side.

MR. WALKER: Well, the Area Agencies on Aging have care managers and many of them are nurse care managers. And we're doing home visits to people, and we're helping to manage the community-based long-term care system with help from the pilot Medicaid long-term care system. Dually eligibles -- not only older people but younger adults with disabilities as well. And, as I said, we've been piloting a chronic care management for a number of years here and five triple A's, and I think we're able and ready to continue to partner and development in these activities. And I'm very proud to -- one of my heroes, Dr. Pearson, from Bellingham. And they're working on care transition models, shared care plans and many other consumer engagement strategies.

From my point of view, the biggest untapped resource in our network are consumers themselves. And when we can engage those consumers to understand their healthcare,

how to communicate and coordinate with their healthcare delivery system, I think we'll get those three aims you're looking for.

MR. KILO: Thank you. Chuck Kilo, Oregon Health & Science University. Oregon is a small state to the south of here, but we're well represented in the audience. Thank you for having us.

One can imagine when Dr. Fisher was initially contemplating the Accountable Care Organization, he was asking himself that very untenable question: How can the United States look more like Sweden where healthcare is actually accountable to its entire community? And they've delivered, as you know, at the county level. And if one thinks about that, the advantages that they have is that they cover everybody; they're accountable to the entire community. And, because of that, because they're distributing resources throughout the county, they could have rational decision making. And we don't have any of those things, including rational decision making.

So you can see that perhaps Dr. Fisher was asking himself, how do we create language that would help us get there, and thus comes the Accountable Care Organization. But everything has unintended consequences.

And one of the challenges we have now is that instead of us being accountable to the entire community,

we're being allowed to find the community that we want to take accountability for, which means that there's going to be a lot of people that nobody wants to take accountability for.

So there will be a lot of people for whom nobody really wants, presumably, if you allow us to define who our communities are. And that's going to -- that, indefinitely, would lead to a lot of challenges.

So I'm curious about your thoughts about how -- what might we do to make sure that we get everybody into an ACO so it's not just specific to an urban area? The rural areas, it's hard to hide from the population you're supposedly serving. But in urban areas it sort of ends. And so how do we fit into those three principles where we get everybody covered, we're accountable to the entire community, not just to those people that we want to serve? And, then, we have rational decision making when we have, particularly in urban areas, these big health systems, their primary objective is to kill everybody else -- all the other health systems. So that creates a level of dysfunction, and I'm wondering if the ACO is really going to help us get out of that dysfunction. So I'm just curious about your thoughts.

DR. RICHARD GILFILLAN: It would be nice to have some people accountable for a significant segment of the population, No. 1. I think we'd all recognize the challenges of difficult populations and the business realities that

exist today. And I think the way we think about it is, it's kind of a dynamic process that will take place as things -- as I think the system transitions. It would be great if system leaders said, you know, we're over here and we're going to seamless care; in five years, we'll be there; we'll be doing state, you know, seamless coordinated care and we're ready to get there. The business realities are what they are and that's not -- that transition is not a given, so.

But the interesting thing to me is that some of the people have been most progressive, have actually been people -- in coming and talking to us -- have been people from safety net situations. And I say doctors and clinics and hospitals and health systems.

So, I think there's -- you know, I think it feels like out there, there's a lot of energy in a lot of places. And it's not like it's -- I mean, a lot of it is coming from that area, at least in urban areas. And I think we need to be -- the important thing for us is to crack opportunities -- different opportunities that different kinds of organizations can place themselves within to get at those -- every population or as many populations as possible.

So maybe it's because some people find themselves in those kinds of institutions that are more -- more mission driven? We're actually hearing from them more. And so I'm optimistic that if we can -- if they can put

together proposals, we can do some very interesting things to get at accountable care for populations that might, on the surface, might not be the obvious ones. And I hope, along the way, that we find ways to create a sense of dynamist -- dynamic kind of attention in the industry so that other institutions that might not find themselves so compelled to go there would find that it might be in their business interest to do it.

MS. LAIRD: I'm Sue Laird for Enumclaw -- trustee in the hospital there in the Franciscan system out of Tacoma, and I'm an R.N. who has worked most of my career in public health.

Now, I'm really interested in the case management side of this, however, coming from a rural area I look at how are sole providers or small groups going to afford a case manager? Well, I worked in Oklahoma in the '70s, and that's what we did in public health. The local doctor would call and say, I sent Mrs. so-and-so home from the hospital, these are the problems, would you please go out and make sure all is going well?

Not every patient in a practice is going to need case management; why not look at consolidating the case management program into either a public health function or a visiting nurse-type function, so that all of the providers in the area, especially outside of the large urban areas, could

refer to this entity, whichever way you decide to do it? That would also have the social services, the housing resources that we have traditionally covered in public health but now have seemed to have gone by the wayside -- we've lost the funding for public health. But I think maybe if you consolidate some of these resources in another -- in a separate area, it might be more do-able for the rural areas or the smaller practices in the urban areas. Thank you.

MR. SECORD: I'm Mark Secord with Neighborhood Community Healthcare Center in Seattle.

One of Washington State's basic distinctions is that we're in the top three states in the country in terms of having the largest percentage of the state's population seen in community health centers. It's 11 percent in the state of Washington. So we have a very well-developed system here.

For one, I am glad to see on the list of high priorities, the idea of fostering medical homes in the FQAC. So that's great.

I'd encourage you to change your language. We, in the community health center movement, talked about healthcare homes, and I think you're aware of that. We have got to include -- offer what is often the forgotten stepchild: Oral health. Dental care as part of that. Last time I checked, the mouth is connected to the rest of the

body. And there's growing evidence that diseases like diabetes are exacerbated by oral health problems, infection of the mouth. Really beg that question.

But it is more and, as my colleague David Johnson from Novus talked about, is really knitting together the work of community mental health agencies and community health centers. Which brings me to a point about the reimbursement way that we're paid.

We watched, last year, the unfolding of a Greek tragedy, literally, as mid year last year -- really at CMS's insistence, we lost our per-member per-month payment system, as FQAC's, and moved to a per-visit reimbursement system that is in place in most of the country.

Don, I only wished that you'd been here a year ago because I have a feeling that you wouldn't have stood for it.

So, my hope is that we can both change the language and get back to a more sensible form of payment and take advantage of the power that exists in health centers.

DR. RICHARD GILFILLAN: Thank you.

MR. MOSELEY: I'm Randal Moseley, and I'm the Quality Director for Wenatchee Valley Medical Center. We're a group practice of about 200 providers with a rural health network in north central Washington.

We're very excited as a group about the winds

of change that are going. But our recent experience with CMS really also makes us very hesitant and concerned. We partnered with CMS for a demonstration project for an in-home monitoring system that was extremely successful and we were enthused about that. But the contracting process to deal with that was just incredibly complicated and left us, I think, with some significant misunderstandings. And we ended up basically with about 20 percent of the gain sharing that we were led to expect in the beginning of the project.

So, you know, my plea is not for us, personally, but in general I think if we're going to proceed with projects of innovation, that CMS clearly needs to have a more transparent and precise contracting system. Better follow-through with these kinds of payments and partnerships.

DR. HAMMARLAND: Thank you.

MR. MURRY: Hi. My name is Charles Murry. I'm a family doctor and I've worked in the Seattle area in Washington for the last 20 years. And I wanted to say, I really appreciate you being here today. My comments are about health improvement more than just healthcare improvement. And I have three points that I wanted to make about what would improve health because, as we all know, we're ranked about 41st in the world in health -- health outcomes. And we'd like to go closer -- since we've spent so much money -- to the top 10.

Now, three ways that we could do that:

Number One: Primary care, primary care, primary care. We know outcomes are much better. And there's lower costs if we emphasize primary care.

One of the reasons the CHC's do well for a difficult patient population -- why Group Health does so well -- is because they have a high primary care for the specialty ratio. And we know that England has -- 75 percent of their physicians are primary care. And, here, it's like 10 percent.

And so money going towards the pipeline to increase the number of primary care physicians is really important. And, along those lines, as long as people have a health insurance, which I know we've passed the law and I hope we continue to have that, that will protect everyone so people can get into primary care, including the uninsured.

My second point is: We also all here know that the most important outcome for the health in this country isn't what we do in medical care but in public health. We've known that for the last century -- we have reports. Public health is crucial. So, if we look at the obesity epidemic, we know that medicine -- we know that the obesity surgery, bariatric surgery, is not going to do it. It's going to take public health.

So, I know that it's not up to CMS to do that

corner, but I think we should restructure so that public health gets a much larger pie, a lot more money as well as power to influence how we do things in the health of this country. It's very important if we're going to improve health outcomes, go to the top 10 in the next 10 years.

And, third, I'm thinking more of the date we go the regional way of approaching medical care. If we can have a regional, that is, kind of styloid, where we can have the entire region work together to use evidence across organizations instead of us competing to try and get money, if we can -- if the financial incentives could be that we all do well if we follow the best evidence, we would all do better (unintelligible) as compared, physically, we see the darkness. Dr. Atlas also proved that, of course, health outcomes would be better if we emphasized evidence regionally. But there is a way that we can put -- have financial incentives so that in this area the Swedishes and the Group Healths can actually work together to collaborate.

And I know we do well in this area but with lower costs and health outcomes. But, actually, in my experience, I see a lot of differentiation between areas. And I can tell you, privately, that all the crazy stuff that I hear that some docs are doing -- it's very expensive. And we can -- and it's not improving health outcomes.

So if you do those three things the next 10

years, trust me, we'll be in the top 10.

MS. EDLUND: Hi. I'm Tina Edlund. I'm the Deputy Director for the Oregon Health Authority.

The Oregon Health Authority was just created last year as part of Oregon's overall health reforms. This is something you may all know and we've been working on this for some time now in that state down south.

We have a $3.5 billion budget shortfall -- revenue shortfall. We also have a new governor who is impatient to change the healthcare delivery system in this state. So a real sense of urgency. So I have three points:

One, I hesitate to -- after Dr. Berlick's story, I hesitate. But, the first one is flexibility. I actually think that the table is set here. That's really exciting for us. We definitely have some plans and can use that flexibility.

The second one is for speed. When we put our plans together and we come forward to you, if we could actually get responses quickly and be able to implement on a fairly rapid cycle, that would be really helpful to us.

And, then, the third one is the data. When we look at what we can do around duals and triples in the state, and we think there is huge opportunity there, we don't have a good picture; we don't have any window into the Medicare side of the spin and to actually do that analysis

and see what kind of progress we can make in those dollar amounts. We really do use the data. So, thank you.

MR. JACKSON: Hi. I'm Aaron Jackson at the University of Washington, School of Public Health, and I want to thank you for holding this session.

At the risk of being one of these people that I hate that will stand up and say some stuff that seems totally irrelevant to the topic at hand, I want to talk to two elephants in the room; one, actually, you just heard about. Sort of rhetorical, but you didn't talk about the importance of health improvement or improving the health of populations and the ability to acknowledge the relatively limited role of medical care in that. So, I mean, I think you have to -- to speak the truth that, really, if we wanted to improve the health of Americans we'd try to find a way of pulling $5 or $800 billion out of the Medicare system and put it in education, which we know has a lot more to do with health.

I know that is -- I'll accept that that's sort of a rhetorical comment, but my second one is not so rhetorical.

The other elephant in this room, I think, is that the Accountable Care Act and your role of really what you're here about is the role of innovation and promoting innovation in the healthcare system.

But, you know, if we look back over the last 60 years, if all it took was more innovation, we would surely have what some people still mythologize about the best healthcare system in the world. We have been innovating for certainly as long as I have been involved in this business. This room is full of innovators. Trulv, it's full of innovators. But innovation does not transform the healthcare system. And, you know, the one ingredient we're not going to get -- and I'm not just dreaming here -- that we're going to get that limitation on the amount of resources going into this hemorrhaging system.

But, I'm really curious about what CMS will do differently; how it will not only promote, disseminate and encourage innovation in a way that overcomes the incessant self-interest that a two-and-a-half trillion dollar a year system creates. And it's two-and-a-half billion dollars of the King County profits. And it's very difficult to overcome that, regardless of how much we put into great ideas.

I'm reallv curious and interested to hear what the new ideas at CMS will have to get over that hump. Thanks.

DR. DONALD BERWICK: Aaron, before you leave, so can you answer your own question for a minute, so --

MR. JACKSON: You know a lot and --

DR. DONALD BERWICK: Rick and I both know that the

innovation center has got to attend to the spread of knowledge, and that adoption is not just creating the new knowledge; what should we do about that?

MR. JACKSON: Well, you know, the only mechanism that -- TRE was here, I don't know, a month-and-a-half ago, talking his book and -- I'm sure you've read it, it's a great book. But the one pointed thing he said in answer to a question about this business of innovation, he said, you know, look, if we limit the amount of money going into the system people will start innovating, figuring out how to do more better with less.

Okay, so we're not going to do that -- at least in the next few years. But if there's some analog of limiting the resources available to the system -- I don't know what it is, I really don't know what it is -- but if there's some way for you to create sort of the feeling, the sense of limited resources rather than what we have now which is, you know, ever-increasing, ever-hemorrhaging system. I really don't know what it is. I'm not -- I just don't have a great idea. But it seems to me that that's the direction that you have to go. And I think if that means somehow unifying the purchasing activities of Medicare/Medicaid, the VA -- you know, whatever it is -- to really create sort of a monolith or a mammoth purchasing strategy from the federal government. Maybe that's the way to do it. But some analog

of that limited resource I think is what they have to create.

(Unintelligible - (unrelated to meeting))

MR NEFF: My name is John Neff, I'm a pediatrician at -- I've been affiliated with Seattle Children's Hospital for a long time. And, pediatrics -- somewhat of a unique situation heavily dependent upon Medicaid so that the pressure to be able to show improved costs, to be able to improve services, is really very tightly within a bind. And, then, of course the feeling that they're squeezing from the dual eligibles at the other end.

The main focus, the group that I've been interested in is the children with long-lasting chronic conditions. Not asthma or even some of the mild mental health but children that have a condition that may well be lifelong. And those children consume an enormous amount of the resources that are devoted to children and are concentrated at Children's Hospital.

We're now trying to do innovative efforts to go out and work with health plans to work with them in figuring out care management programs that would, in a sense, decrease costs. But when you're in that, and I'd love your thoughts on this, our outcome measures are very strictly limited. It's really, how do you improve costs? Which is do you decrease emergency use in the hospital, which is valid, and hospital duties? And that one should be able to show

over a period.

But there's a much, much greater dimension of quality of costs in improved care with this population. And I would love to be able to hook our information up so that we could see measured improved school attendance factors, school attendance and, also, improved employment. It's very clear that when you have a mother and father working very hard to take care of a child with so much of their resources going into that, they're severely limited in terms of that, employment capabilities in the country.

The other area -- just terrible -- is transition to adult services. It's like, for these children, they're going over a cliff. And so you may feel that in all of those systems in the pediatric care model, but once you get them to develop adult care, it's like redoing the whole thing again.

So, I think -- and I think there are other outcome measures that really show the benefit to society, but we have a breakaway from just those simple ones we all look for, the use of the emergency room and in-patient.

DR. RICHARD GILFILLAN: John, again, we're interested in specific programs that may address the population that you're talking about. So I would urge you to think very concretely about a way of approaching us with a proposal that might say, you know, this is the population and

here are the interventions we think can make a difference and we'll -- you'll see the results in the following areas.

So, we're interested. We're not going to be able to think -- we're looking out to all of you to have the best thoughts about how to kind of get at particularly some of these very specialized and small number but large-impact clinical conditions.

MR. NEFF: Thanks.

MR. KINTNER: Bill Kintner, family doctor from Port Angeles, Olympic Family Center. I have a request and a question both related to geographical maldistribution of patients. Through no fault of the four -- you up front -- I think it's the fault of Congress, for those of us in the Northwest and everybody in this room has suffered under greatly lesser Medicare coverage of our patients in terms of knowledge and, in this case, throughout the country. I think that it's true in the rural counties in Washington and Oregon, almost universally, are in the lower 10 percent -- lowest 10 percent of Medicare benefits to our citizens.

So, I know that's not the fault of you four up front, but can you please take to Congress the message that their geographic or maldistribution of traditional Medicare and the reimbursements stifle us and disincentive-ize the nation? I think the reason -- at least part, are the members' fault, is that traditionally in the

Northwest (unintelligible) and patients largely take care of themselves. But it's not fair and it's not fair to those patients.

The second question actually related to that. I didn't expect to ask this but I saw your slide there: How is it that there are up to eight states -- I saw the slide -- that are involved in the medical home funding demonstration projects? Did I not see that all of those are east of the Mississippi with the partial exception of Minnesota? How is it that none of them are from the West?

DR. DONALD BERWICK: Let me deal with the geographic variation first. There's a lot known, as you say, about variation in payment based on the current models we're using -- the Geographic Practice Cost Index, gypsy. Congress has mandated that we look at that. In the meantime, there are mitigating rules, as you know, in the Affordable Care Act, in prior legislation, to minimize the downside in rural areas. People are very worried about that, a lot of congressmen and senators.

We have a Institute of Medicine Report, one that is due in May which is taking a whole other look at the basing of those cost-input parameters to see if we can get a more accurate reading on what practice costs actually look like. And we may not have it correct now; we may be able to correct it, depending on what the IOM reports, we will be

able to put the new knowledge into the rulemaking for payments starting next year. So that's good news.

There's a longer term Medicare study -- IOM study -- funded in the law, a three-year study of geographic variation, overall in outcomes and costs, building on the controversies that are out there -- around -- with Atlas and others. Unfortunately, that study is going to take some time. But I've been talking with the IOM about ways to get early information so they can begin to do more accurate basing of the actual costs.

Do you want to comment on the --

DR. RICHARD GILFILLAN: Yeah. On the MAPCP. This is an activity that's actually going to come out of the traditional ORDI group at CMS that has done evaluations in the past. It was underway for a long time. The solicitation had been done. The evaluation package for the applications had been done, and the selection process. And there were actually a number of states that you would have thought would have been kind of right there. And I think it was more a function of who in the state decided to apply. And so it was surprising both from a geographic standpoint and also some usual suspects who you would have thought would have been there.

So we're going to continue working, continue looking for opportunities to make sure we get a good

selection of medical home models to get started, or to support and to evaluate so that we're sure that we're -- we come up with the right answer at the end of the day about which -- what the right medical home model is -- or models are so that we can take the opportunity to maybe support them more directly through that program regulation process that I described. So it's not over yet but, hopefully, it will be more expansive next time around.

DR. DONALD BERWICK: I took a very strong personal interest in this once I arrived and looked at all the applications. And we did expand that. It was supposed to be six states but we went to eight states but, as Rick said, I hope we can revisit this, so.

MR. PIERSON: I'm Marc Pierson, Whatcom County Peace Health.

I want to suggest what I think may be one of the most highly-leveraged innovations we could work on, and that is: Governance. The community watch-out for limited resources.

I'm pretty sure that the government's models we have out there, they are not going to work. Eleanor Austin has spent most of her life and got a Nobel Prize for sort of documenting how communities have been able to do this. And I think a lot people would think that's too Harry Caray. We need to replace this broken fad, fetishness, as

others have pointed out. But some innovation is going to increase the cost. This issue, someone brought up, how can a small practice play a game with the big practice? I think Eleanor Austin gives us some ideas about this and so forth, and there are eight simple rules. And I really think that's going to be the cheapest, perhaps biggest payoff that we could improve in playing -- figuring out how to do this.

DR. RICHARD GILFILLAN: You know, that's a very interesting suggestion. And as the conversations have -- or the questions and comments have gone around here, that thought came to mind. The real interesting question is, okay, here we are in Seattle, in Washington state and, you know, we're -- folks have collaborated a lot and worked in a very progressive way around a lot of care delivery approaches. And if that's the solution -- or if that's an important part of the solution, it would be great to see an opportunity to evaluate a community coming together and looking at that. Looking at the total span, looking at the commercial, Medicare/Medicaid, other payers spend in the community and say something like, we are changing the rules of governance for those of us who are part of this community in a way that -- because that is so -- we'd sure like to be part of an initiative that gets at that. What better place than right here in Washington?

DR. DONALD BERWICK: If even a single community in

the country, one household per region, took that seriously and built the all-payer regime that would allow the three aims -- better care, better health, and lower cost -- to really, really be there and measure over time, not just starting where they are, that would be groundbreaking to the country.

MS. ROWE: Good afternoon. My name is Cheryl Rowe, I'm the Executive Director for the American Indian Health Commission in Washington State.

And, as you're thinking about these innovations, I think we'd -- we would like to encourage you to really take a look at those tribal health delivery systems that are already in place so that, by design, they are -- you can look at those systems' medical homes. And they're very innovative because of serious underpinnings of the Indian health service. (Unintelligible.) Tribes have become very creative in financing in how to provide services to their people.

So, as you do these, I'm just hoping that you'll be inclusive with tribal health organizations in the effort.

MS. SMITH: Hi. My name is Jeanene Smith, I'm from the state of Oregon, Office of Health Policy, the health authority. And, in your request for ideas about the Accountable Care Organization, I want you to look at what

Oregon has done in its usual public process, developed patient-centered primary care home standards reform. We recently just updated it with a look at from children as well as adults. And I think one of the things that emerged from our discussions was how to change the language that's patient-centered.

So one of the first things we did was, we took the six attributes, what we thought it should be, because we felt the NCQA definitions were more a process checklist, and we really wanted outcomes that really change the culture inside the clinics. And what came out, you know, instead of saying the third next available appointment means access means be there when my family needs you to be there for us. It says maybe help me be -- I am the most important partner of the medical team and how can you help me and my family do that?

So we revised sort of the key elements to get us to think that way and to really apply the thinking about it from the patient perspective. I think those could be applied to overall Accountable Care Organization perspective if you think about all the things you want in a patient-centered primary care home. That's exactly what you want that entity, the ACO, to be able to provide for those patients.

So maybe if you could mirror that language up

from the clinical site and the surrounding health community needs that need to partner with public health and social services; to achieve it all the way up, I think would be the most effective decision to achieve that new language coming down as a definition for accountable care.

DR. DONALD BERWICK: Jean (sic), is this written up?

MS. SMITH: Yes. I can send it to you.

DR. DONALD BERWICK: Would you, please?

MS. SMITH: And Susan has it as well.

DR. DONALD BERWICK: Thank you.

MR. MARTIN: I'd like to draw your attention to an infrastructure that already exists in rural communities.

My name is Tom Martin, I'm the Superintendant of the Lincoln County Health Hospital District in Eastern Washington. We operate a critical access hospital and three rural health clinics. We also operate emergency ambulance service, a nursing home, and we partner very closely in a structured way with public health.

Reality is that in these rural communities you already have the infrastructure for a medical home. Primary care base.

In Washington state, we've got a history of working collaboratively among the rural hospitals to look and measure the quality of care. The issue has always been, do

we have statistically significant data? And, many rural communities, we just don't have the numbers. However, we can demonstrate that we do have best practices, scientifically-proven methods of practice of the medicine. And that's, I think, an option for us to be able to demonstrate quality. If someone comes through our emergency room and we apply the best practices, then the outcome should follow. I think that's a way that we can actually demonstrate quality to our populations rather than being hampered by the statistical-significance issue.

The other aspect in Washington state is that we have been very effective in working together as a community of hospitals, small and large. We've implemented some emergency protocols with the help of the Department of Health, looking at trauma for cardiac and stroke. And we've been able to achieve some pretty significant integration of care between the rural communities and the urban communities, coordinating care of our emergency rooms into those cath labs in the large urban areas.

So my point is that I think we already have an infrastructure that's already been put into place. The policy at CMS, it says we need to have an infrastructure rural community's support for quality of life. And the State even sanctioned that community. The cost base for those resources are extremely important. We can certainly

demonstrate that we can maintain the quality of care and we can maintain the status of people's health. We can do that in a primary care-based organization.

We can also manage the referral process to assure that we're making appropriate referral so the utilization of the specialty and critical level of care is being used appropriately.

So I think we have a good structure that we can bring forward -- demonstrate to CMS that you already have good partners in rural communities that can actually achieve efficiency, patient safety and all of the six goals that have been identified.

DR. DONALD BERWICK: What's your organization?

MR. MARTIN: We are Lincoln County Public Health.

DR. DONALD BERWICK: Lincoln?

MR. MARTIN: Lincoln County Public Health -- excuse me -- Public Hospital District Organization. And we work together in Eastern Washington, Critical Access Hospital Network, that is going to be coming forward with a proposal to CMS that will integrate all of what we just talked about as far as the pieces that are in both communities. So I wanted to give you a head's up of something that will be coming forth from that.

The other point I want to make is that we also have an organization that's unique on the national

scene, that is, the Rural Healthcare Quality Network. It is an organization that represents all of the critical access hospitals in the state of Washington. And we work on a collaborative basis to identify safety issues, quality issues. We're looking at the stemi programs, the stroke program, and making sure that protocols are applied in all of our rural communities.

So the point is that I think you already have an infrastructure that you can achieve what you're after. And in the rural communities. We just need some flexibility in how we measure how we make those benefits.

DR. RICHARD GILFILLAN: We'll look forward to seeing that.

MS. SMITH: Laura Smith, Washington Dental Service Foundation.

As you approach ways to integrate healthcare services and address the reputation that's out there, I think you have an unprecedented opportunity to put the mouth back in the body. Better care, better health. The evidence is that you won't get there without good oral health.

We have worked a number of years here in Washington to include the delivery of preventable oral health services through Well Child Checks. And we're making progress with that.

We're working nationally to increase the oral

health education that happens during healthcare professionals' education. We really think the fact that oral health, for the most part, and oral disease, is preventable. This means that there's some real opportunities to lower cost. Most people really are surprised when they find out how much dental care is delivered in operating rooms and emergency rooms.

So I really would second Mark Secord's admission to really think about how oral health can be included in county care organizations and as you think about innovations. Thank you.

MS. GOODWIN: Thank you. My name is Dawn Goodwin and I represent two organizations today; I'm in charge of operations for a large home health and hospice agency in Eastern Washington, Family Home Care & Hospice. I'm also the current President of the Home Care Association of Washington.

And, I would just like to remind you all that you already have a solid element in place and, that is, the Medicare home health benefit. So while I'm very encouraged to hear about the care organizations and the like, but I think what's missing is a discussion about home health within those organizations. So I would encourage you to remember that home health is here and has been around since inception of the Medicare benefit. We are a outcome data-rich organization and we've always been patient-centered.

So I would just encourage you to do home health, any sort of innovations that may develop down the pike. So, thank you.

DR. RICHARD GILFILLAN: Just to be clear, most of the ACO work is kind of anticipating -- ACO activity -- we're anticipating the opportunity to use current -- some current Medicare reimbursement mechanism. So there's -- the expectation is that those benefits will be an important part of ACO's meeting their mission.

MS. JACKSON: I'm Joyce Jackson, CEO, Northwest Kidney Centers.

I'd like to talk about what you termed earlier, perhaps a niche operation. People with kidney failure. Because of a law that passed in 1972, this is an almost universal entitlement under Medicare if you have kidney failure. So it's a population that represents point six percent of Medicare beneficiaries but six percent of the Medicare budget. So something that I think, we all have high interest in improving health and lowering costs.

For the center of innovation, I really encourage you to consider innovative projects relating to the ESRD dialysis population. There's an epidemic of kidney disease due to diabetes and high blood pressure, for the most part. So we've got an increasing number of people facing the need for these intense services. But because of payment

policy, for instance, there have been a lack of innovation; in fact, for 30 years our field has hardly changed at all. An example is home dialysis.

We now know, through research, that people who have treatment in their home five, six or seven times a week instead of coming to a center three days a week -- actually have improved outcomes and lower hospitalization costs. But because Part B is where we're paid for and Part A is hospital, we've been prevented from really innovating in that area.

So I really encourage the center for innovation in recognizing 40 percent of our patients are dual eligibles as well to consider ESRD-related projects. We'd love to work with you. Thank you.

DR. DONALD BERWICK: Joyce, any other innovations besides home health -- home dialysis that you just -- popped in mind?

MS. JACKSON: Well, the new bundling payment system that goes into effect next month is also part of -- brings with it the quality incentive pay system. Like "P," which I believe is the first pay-for-performance system within pay-for-service Medicare. I think that's a very good innovation, and it's forcing us all to think about what are the most key measures of outcomes that we should be monitored by and, in fact, pay based on -- and I think more is to come

in that area. And I applaud CMS for moving us forward in that area.

DR. DON BERWICK: Thanks, Joyce.

DR. HAMMARLAND: This is my way of signaling that we'll have to draw this to a close in a little while. So we'll take those who are standing in line and anybody who just zips up right now to get in line, and then we'll have to close out.

MS. SOSNE: Thank you. My name is Diane Sosne and I'm a Registered Nurse, and I am President of SEIU Healthcare 1199 Northwest. And, two points.

The first is -- at first I want to say, we really appreciate the opportunity to have a forum like this. And it's great to see you taking notes, so we appreciate that.

I wanted to tag on to something Aaron Jackson said and the colleague from Oregon regarding the State's budget deficits and what we're seeing as a result. And I'm sure this is not anything you don't know, but we're actually seeing, because of these cuts, a dismantling of some of the innovations and a sliding backwards. So when cuts -- whether it be mental health, behavioral health, internal, child, public health, we're just seeing money poured into a deep black hole. And so if there is a big CMS idea, this is a time that would be really important to think about an

initiative related to what's happening to the states.

The second has to do with work force. And, when I think about the large number of unemployed in this country in our state, what happened in the last election around the top issue being jobs for people, I think about how can CMS put resources into helping get unemployed trained as healthcare workers, outreach workers, community health workers, educators, and how we -- and how you could help really drive mobilizing an army of registered nurses and these other types of innovative workers into communities. Not just into existing healthcare system as we know it on a regional and state basis.

And, you know, I was thinking the other day that if we, hypothetically, could think about, let's just say Washington state, where we have -- roughly we're going to hit one in six unemployed -- I mean uninsured -- in just a short fifth year, if we could do some kind of pilot where we could deploy a lot of healthcare workers regionally or statewide and say we're going to show results in six or twelve months; we're going to have everybody screened on this; we're going to have everybody immunized on this; we're going to do education on nutrition and smoking cessation; we're going to do something really big on diabetes and prediabetics that -- again, I really like the idea that you've talked about and showed in your slides about how can we really move the dial.

Thank you.

JEFF GROSHONG: Thank you. My name is Jeff Groshong. I'm a pharmacist and work with the Washington State Pharmacy Association as their CEO.

I just wanted to thank you for this opportunity to speak at this forum and I really urge you to consider the role that the current infrastructure within pharmacy settings has to offer. And there's differentiation -- I speak to pharmacists but the pharmacist within those settings, whether it's in a community setting, within the hospital setting and coming from the like -- currently, I have a skill set that is typically not underutilized or up -- really not utilized. And that's in the area of medication management.

We know that there is a tremendous amount of resources put into medications and therapy, yet there's no support for the quality and the outcomes of the appropriate use. Non-appearance costs us $290 billion annually by some reports. If you know that there is a huge issue with regard to the perfect storm, then these are patients.

When we are in the care of patients, when they're with us, we do a pretty good job taking care of them, and then they go home. And when they go home they decide not to take their meds. They read on the Internet (unintelligible), they have poor health literacy or language

barriers. They've got 300,000 over-the-counter products to work around, and they may have four or five doctors reported by a pharmacist working with this.

So the work that's been done regarding heart disease medications, therapy management is a step in the right direction. I certainly think and hope that you'll consider where pharmacists within the Accountable Care Organization will fit -- and the medical homes. That is crucial, I believe, and I think it is something that might not be considered. And the reason I think that is, currently, the services provided by the pharmacists are uncompensated for. The product is what these contracts and the pharmacies are based on. And, without that service model, and the services are central, then we have an industry where chronic disease stage will continue to cause the biggest money drain in our system. And pharmacists are perfectly trained to help with that.

So I'm hopeful that in this effort to have better health, better care and lower costs, that it utilizes the role that the pharmacists could play to help manage that. Thank you.

DR. HAMMARLAND: We're down to the final five.

MS. BUELT: I'm Madeline Buelt, Chief Executive and the Vice President of Operations at the Seattle Cancer Care Alliance. And I would just like to state that I would

hope that within this healthcare discussion is the role of the drug companies come to play because they are a huge part of costs for cancer care. And how do you look at ratcheting down those costs without looking at the cost of drugs? Especially cancer. Thank you.

MS. MOODY: My name is Robin Moody with the Oregon Hospital Association.

And, in Oregon, we have one of the highest penetration rates of Medicare advantage products that approaches 40 percent. There's been some concern and consternation about whether Medicare-managed patients will be eligible and able to enroll in the ACO's and Shared Savings Programs.

So if you haven't made that decision, you know, we're hoping that Medicare advantage patients will be able to be in those products.

Secondarily, both Oregon and Washington has eluded to today -- are low cost states. We tend to be, you know, very efficient on the hospital side. And so, you know, it is somewhat of a concern, I guess, that some of the costs that you might be able to bring out of higher cost systems might not be available to a lot of those needs. When you look at other states -- might not be available. Because I think, you know, CMS took a big step forward with the value purchasing and may want to, you know, consider that as you

construct the payment models or the shared savings models for ACO, keeping in mind that there are people that come in on a lower benchmark, such the healthcare quality coalition has submitted comments' fees. So, some suggestions and I would encourage you to take a look at those. Thanks.

DR. RICHARD GILFILLAN: Thank you. Just one quick point on the ACO's and the MA plans, and there's certainly nothing that would limit MA plans from being able to pursue contracts with ACO's, and; we are interested in looking for opportunities to get as much -- kind of momentum behind a particular model as we can, and get multiple payers involved for ACO's, medical homes -- whatever -- in the issues we're pursuing.

MS. JOHNSON: My name is Carrie Johnson. I'm a home health hospice and community education programs manager. I have two comments.

One, that you have really good chronic disease case management and cardiac rehab, pulmonary rehab, and diabetes education done by nurses right now. And I'd encourage you to strengthen that, if possible. And we added a chronic disease exercise program that goes for years after their initial episode. And that's been a really positive self-pay program that I think is really good in communities.

The other thing, and I haven't heard it and I guess I was a little surprised is that, it's because of

hospice work but it's not in hospice that I think primary care and other providers need to be educated about how to have that conversation with people when care is futile and we're spending thousands -- millions of dollars on care that doesn't give quality and it really doesn't allow people to end their life with dignity.

DR. HAMMARLAND: Thank you.

MR. VIGDOR: Greg Vigdor, Washington Health Foundation, healthy state and nation campaign.

We've been innovated on a number of concepts in our campaign for about the past six years. I think the one I'm most intrigued with -- because, actually, I work in a health home. The use of that term predated a lot of the applications right now. I think in terms of innovation, the one thing that strikes me to listen to this conversation -- that I don't think has come out -- has been the importance of relationships that we've found when we talk to people about how to form, broadly speaking, health homes.

And I think what we've found is the truth, that most people, and probably an awful lot of people, their primary health relationship is not with the medical community, not with the physician, but with their spouse, family member or friend, or someone who they met online because they came down with some disease they didn't know anything about.

And what we've found that's really active in health homes in the way we were doing things -- really it's important just to reach -- reach into those relationships and somehow try. I know that CMS mostly pays people -- we're not suggesting that you do that. But I think somehow working with the provider community to help make sure those relationships thrive rather than be hindered would be an important innovation to consider somewhere in this platform of work that you're doing.

DR. JOHN HAMMARLAND: All right.

DR. RICHARD GILFILLAN: Thank you.

MR. FISHER: Thank you. My name is Mark Fisher, Olympic Community Center. I want to just ask the question of the role of the innovation center and what service they can provide to us who want to use it.

I want to mention a problem that I think that may resonate with many people in the room, particularly, providers. I work in a semi rural community. And I've actually accumulated, personally, sort of a difficult series of complex patients over the last year-and-a-half, where there's been substantial ball-drops in transfers from tertiary medical center back to their care in the community. And I've looked at myself in the mirror many times and thought that issue, to see what I could do on my end to try to help that issue. By the way, these case names that I'm

referring to come from all the amazing superior medical centers that you've heard many people represent today.

My question is: In this era where we're all on a different trajectory for EMR's, we have disparate communication systems -- is there a role in this public/private process that you're talking about this morning for establishing some type of standard communication or continuity that may help a region until the blooper-Alice (phonetic) enterprise, EMR, becomes a reality?

DR. RICHARD GILFILLAN: That's a great, great point I think. A couple things; one, we are very interested in the whole issue of care transition as much as the nation has gotten very interested the industry has gotten interested in care transitions over the past three or four years it seems like. It seemed like it was a blind spot for all of us.

So we are going to be very interested in looking at readmissions and opportunities to improve the way we do care transitions, and opportunities to improve patient safety in hospitals which would include, we think, that transition. So that is going to be a major area of focus and interest for us in the near future I think.

I know systems I've seen in the past have had -- provided access, or tertiary systems can provide access to rural physicians or doctors who are not necessarily

on the medical staff. And I'd be interested in a proposal or in an initiative that maybe looks at somehow doing that in pursuit of improving transitions as we get into doing some of the transitions of care work that we see coming up.

DR. JOHN HAMMARLAND: Thank you. Well, you know, when you throw a party you're always afraid folks won't show up. I think, given the guests that we have here today, given the criticality of these topics and given the commitment of the people in this room, you folks definitely showed up. You taught us -- you inspired us. And we thank you very much for joining us today.

If you did not have a chance to give your comment to us, this is just the beginning of the conversation; you can reach us at aco. -- aco@cms.hhs.gov. That's if you want to give comments about ACO's. And with respect to duals, fchco@cms.hhs.gov. Those are the two ways.

You can also get ahold of me, my office is right here in Seattle; I'll make sure I get the comments back East. And, as Rick mentioned earlier, the innovation has its own website at: www.innovations.cms.gov. They've got information, and it's also a portal into CMS.

To my cohost, Susan, thank you so much for joining today and giving your leadership.

Let's, once again, thank Don and Rick for coming to Seattle.

(Applause, applause.)

They set the table very well for us here in this community. Thank all of you for your participation today and for the hard work that I know is to come. We really appreciate your engagement. Thank you all for coming.

CERTIFICATE OF NOTARY PUBLIC

I, Carmen L. Lundy, do hereby certify that pursuant to the Rules of Civil Procedure, the witness named herein appeared before me at the time and place set forth in the caption herein; that at the said time and place, I reported in stenotype all testimony adduced and other oral proceedings had in the foregoing matter; and that the foregoing transcript pages constitute a full, true and correct record of such testimony adduced and oral proceeding had and of the whole thereof.

IN WITNESS HEREOF, I have hereunto set my hand this 22nd day of December, 2010.

Carmen L. Lundy

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