MEDICARE and MEDICAID

HEALTHCARE SYSTEM DELIVERY REFORM

CONFERENCE

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

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

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

have them here.

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

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

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

Before assuming leadership of CMS, Dr.

Berwick, as many of you know, was president and chief executive officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School and Professor of Public Policy and Management at the Harvard School of Public Health. All wonderful credentials for the new role he has undertaken. He is also a pediatrician, which I'm sure he will say, is his first and most precious credential of all. He's a provider of services to people. He served as adjunct staff in the Department of Medicine at Boston's Children's Hospital and consulted in pediatrics at Massachusetts General Hospital.

We are very fortunate this day to have Dr. Berwick here for an important summit, a listening summit, as we strive to make Medicare/Medicaid leaders for the kind of change we want to see across our entire health care system. Please be candid with him. Show him your spirit and welcome to Dr. Donald Berwick.

(Applause)

DR. BERWICK: Thank you, Judy, and thank you all for the chance to join you out here in this wonderful part of our country. I also want to say a

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

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

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

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

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

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

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

These who in medicine labeled six

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

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

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

Inequity, closing the gap in socioeconomic

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

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

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

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

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

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

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

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

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

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

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

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

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

So we have answers upon us. Others we

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

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

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

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

There are answers throughout this law.

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

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

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

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

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

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

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

for better care, better health, and lower cost. Integrating care, coordinating it, helping it be seamless.

I was recently in Atlanta visiting a group like in a senior center, and one of the seniors there was a very worried woman. I said, what are you worried about. She said, I have five doctors. I'm on six medicines and I go to four places to get care, and I don't think they talk to each other. I'm worried. I'm worried doctor number 1 is going to prescribe a medicine that I couldn't take with medicine prescribed by doctor number 2, and neither doctor will know it. That was what she was worried about and that's an eloquent explanation of what happens with care for seniors. She might not understand the term accountable care organization or health home, home attainment. Those are meaningless to her. But the idea that doctor 1 talks to doctor 2, that they share common information, could be rewarded and supportive to cooperate around her, that she's the center and everyone weaves a net for her. That's what she wants and that's what all of those innovations that are now a cost for us, accountable care organizations, medical health line, that's what all those mean, based on the data on the

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

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

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

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

lead your future and ours.

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

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

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

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

as partners, providers, other stakeholds in the industry to really get at the issue of the care that we have today and creating the care system that we have tomorrow, and I -- that we want to have tomorrow.

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

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

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

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

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

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

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

We can deliver the same quality of care at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Let me turn the mike over here to Melanie,

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

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

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

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

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

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

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

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

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

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

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

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

AUDIENCE: Sure.

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

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

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

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

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

Second is to improve the coordination

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

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

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

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

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

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

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

But an understanding office needs to know

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

last five years.

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

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

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

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

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

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

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

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

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

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

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

Thank you.

MR. GILFILLAN: Okay. Is that live.

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

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

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

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

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

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

to come up with an approach.

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

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

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

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

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

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

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

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

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

For instance, in order to provide the

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

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

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

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

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

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

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

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

talking about ACOs?

RICHARD HELLMAN: Sure.

MR. GILFILLAN: And it was pretty broad. And I think there's ample opportunity for providers in all settings to find their way to another pathway. And there'll be a lot of talk about exactly what those pathways are, but I think the intent is we understand that the world is not filled with, you know, integrated medical -- large integrated health systems or medical groups. We know the majority of care is provided by people in a very different setting.

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

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

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

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

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

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

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

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

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

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

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

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

MR. GILFILLAN: That'd be great.

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

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

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

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

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

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

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

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

MS. BELLA: Yeah.

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

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

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

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

BILL APPLEGATE: No. I'm way over my head.

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

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

MS. BELLA: Oh, yes, I know.

BILL APPLEGATE: And no count.

MS. BELLA: Yes, I know.

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

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

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

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

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

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

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

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

That being the case, for the record, I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. BELLA: Thank you all very much.

MR. GILFILLAN: Thank you.

(Applause.)

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

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

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

world.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HERB COON: Herb Coon with the Missouri

Hospital Association. Thank you for being here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

regulations that will follow.

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

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

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

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

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

MR. GILFILLAN: Rick.

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

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

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

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

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

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

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

The contract health services, you know,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

comes to those considerations.

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

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

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

I think there are low technology that

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

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

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

Be interesting to see how much gas you can save.

MARTIN KENNEDY: My name's Martin Kennedy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This is the first time that I've heard

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

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

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

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

themselves immediately.

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

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

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

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

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

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

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

MR. GILFILLAN: So, Jim, what would you

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

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

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

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

going to let it vary more than 20 percent.

MR. GILFILLAN: Right.

JIM: Just the 80 percent sensitivity on that.

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

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

MR. GILFILLAN: I see.

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

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

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

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

MR. GILFILLAN: Yeah.

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

MR. GILFILLAN: Yeah. No, I understand.

Yeah.

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

MR. GILFILLAN: I see. Right.

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

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

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

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

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

that are in primary care -- moving them forward, and that's not just the little family guy. But I think that's an incredible effort nationally to try to make a difference. And it's really quite farsighted and so congratulations on that.

And I just want to thank, Judy, Nancy, the team for just an outstanding visit here. You guys are very together. We're very impressed. You have set a very high standard for the other visits we're doing. Thank you very much for your participation and spending your time. I know you're all busy. This has been very helpful. It's our first, I guess, of five or six we're doing around the country. And we really appreciate your thoughtfulness and your interest. I go away thinking, again, most of us, not all of us are interested in doing great things for patients, so thank you.

(Applause.)

MS. RIOS: And on behalf of CMS, the regional office, I thank you for being here, being so engaged, so participatory. We appreciate your partnership with us and we look forward to working with you over the next amount of time and pulling all this together. Thank you.

CERTIFICATE OF REPORTER

I, NAOLA VAUGHN, the officer before whom the foregoing meeting was taken, do hereby certify that the testimony that appears in the foregoing pages was recorded by me and thereafter reduced to typewriting under my direction; that said meeting is a true record of the proceedings; that I am neither counsel for, related to, nor employed by and of the parties to the action in which this testimony was taken; and further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

_____
NAOLA VAUGHN
Notary Public in and for the
State of Missouri

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