



Medicare Delivery System Reforms: What Do We Know?

**Alliance for Health Reform
Kaiser Family Foundation**

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Marilyn Serafini: We are going to go ahead and get started. I am Marilyn Serafini. I am with the Alliance for Health Reform. And I would like to welcome you to today's briefing on payment and delivery system reforms in Medicare. So today we are going to be looking at the evidence behind numerous experiments that are going on across the country to pay medical providers based on quality rather than the quantity of services. I would like to thank our supporter in this event, the Kaiser Family Foundation and in particular our long time partner Tricia Neuman.

I wanted to let everybody know that you can Tweet with us live with this event. You can Tweet your questions. You may Tweet your comments for both the people in the room and also those who are joining us live on C-Span. The hashtag is Medicare demos. And also, if you would like to access our speaker presentations and you are not in the room with us, you can find them on our website at www.allhealth.org. So I am going to turn this over now to our partner, Tricia Neuman, who is going to tell us just a little bit more about why we are here today.

Tricia Neuman: Thank you, Marilyn. It is great to be here. Before we get started, I just want to congratulate you, Marilyn and Sara Dash, where you may be, for taking over the helm of the alliance. We miss Ed. But it is great to see you both, the new co-CEOs. So welcome. And, of course, you have been here for a while. I want to thank all of you for coming here today on behalf of the Kaiser Family Foundation. I am excited to be here. I think we are going to all learn quite a bit as we focus on the progress of Medicare payment and delivery system reforms.

It was not long ago that people talked about Medicare as a fairly static program. But things are changing pretty rapidly in traditional Medicare. The longstanding concern as the main problem with Medicare is that it only encouraged more and more care has really been changing and changing at a fairly rapid clip as Medicare is instilling more incentives for providers to do more, provide better care, to manage care and even potentially at a lower cost.

So I am here as you are all here to learn more about the progress of these demonstrations. I think it is fair to say that we all have a lot to learn, not just about how they are today, but how they will progress. Sometimes these things do take time. But it is exciting to see so much change happening and so much energy behind the ongoing effort to improve Medicare for the program, but more importantly for the people who it covers. So thank you.

Marilyn Serafini: Great, okay. So I am going to introduce our speakers. To my far right, we have Cristina Boccuti. She is going to kick off today's discussion. She is associate director of the program on Medicare Policy at the Kaiser Family Foundation. And she has held a number of government positions at HHS, the Medicare Payment Advisory Commission and the Government Accountability Office.

Next to her is Marilyn Moon. She is institute fellow at the American Institutes for Research. Marilyn is an economist. And she has analyzed the Medicare program in various capacities including for the congressional budget office. She has also served as a public trustee for the Social Security and Medicare Trust Funds in the 1990's.

To my immediate right is Patrick Conway. He is acting principal deputy administrator at the Centers for Medicare and Medicaid Services. And he is also the director for the Center for Medicare and Medicaid Innovation, CMMI (you will hear that acronym a lot today). And CMMI is overseeing the payment approaches that we are going to be talking about today.

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Eric De Jonge – of course, next to me is Tricia Neuman. And to her left is Eric De Jonge. He is director of geriatrics and co-founder of the Medical House Call Program at Medstar's Washington Hospital Center. Eric will give us a glimpse of the Independence at Home Program that is getting so much attention and that Medstar is planning to expand to its other facilities.

To my far left is Jim Garnham, Director of Contract and Payment Innovation of University of Rochester Medical Center. He leads Rochester's Bundled Payment Program. And he also has a hand in its ACO-like and risk-based models.

So we are going to start off at the far end with Cristina Boccuti who is going to talk about the recent work that Kaiser has done and what evidence we have on hand.

Cristina Boccuti: Thank you. Let me see. Okay, good. So I am going to start with just a little context for delivery system reform and Medicare. And then I am going to go over a very brief summary of three of the models and conclude with a few thoughts on ongoing challenges and opportunities. So to get right to context, I will mention a few items. Although CMS had already been running some new models on delivery system reform, the Affordable Care Act really brought in a large multi-pronged effort for delivery system reform.

It created some permanent changes to the way hospitals are paid, for example, the Hospital Readmission Reduction Program. It created the office called the Medicare-Medicaid Coordination Office, which is looking at ways to align payments for people who are dually eligible for Medicare and Medicaid. And the ACA also established ACOs through what is called the Medicare Shared Savings Program, which we will get into in a little bit. And the ACA created the Innovation Center, which of course we call CMMI because we love acronyms here in D.C.

But CMMI was really marking a significant investment in testing new payment models. And the ACA gave it unprecedented authority to expand models that achieved certain specified performance on quality and spending.

I would also mention that underlying delivery system reform in Medicare was the passage of MACRA, which was the law that repealed the SGR, which was, of course, many former Alliance briefing topics. But MACRA has within it financial incentives for physicians to be paid a bit more if they are participants in what is called alternative payment models. And this will be coming in future years. So CMS is planning to release some regulations in the near future, some proposed rules on what exactly will be used to define the alternative payment models. So that should be coming out soon.

Then a final piece of context is, of course, HHS's overarching goals to shift more of traditional Medicare payments toward value instead of volume based reimbursement. And perhaps Dr. Conway would be talking about that. So I am not going to.

But I will move on quickly to this slide, which shows on the left hand side three models of delivery system reforms that we cover in the primer that is in your handouts. And I am going to talk about some of the individual models that are there on the right hand side.

So starting with medical homes, to distill it down, medical homes are really based on the concept that investing a bit more in comprehensive primary care could lead to lower overall spending due to better health outcomes when you invest earlier in primary care. All three of the models on this slide here involve care management fees to the medical homes. And the first two specifically have a focus on

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coordinating Medicare care management fees with other insurers like private insurance and Medicaid. And you can see on the map that they are clustered a bit for this reason. The lighter blue is the MAPCP model and that has more involvement with states. You can see the whole states colored in. And then the orange dots represent the CPC participants and in those models, CMMI is playing a greater convening role with those insurers.

The evaluation reports for the medical homes are starting to come in. I think that at this time net savings are not very high, but more results are coming. And the CPC model is showing some gains in quality. But again, the others are awaiting more results.

I will move on just for a moment to the Independent at Home model, which is also a primary care model. But, of course, we have an expert with direct experience. So I will just give you a couple of teasers that show what is unique about this morning. And one is that its focus is on home visits to address the care needs of frail patients. A second unique feature of this primary care model is that it does not involve care management fees. And in fact, has within it the opportunity for the Independence at Home practices to share in savings if they have lowered spending. Then we will say the early results from Independence at Home are showing some promising savings.

So then moving on to the ACOs, these are entities that have agreed to be held accountable for both spending and quality for the beneficiaries that have been assigned to them. They can contract with hospitals, physician groups, help post-acute care facilities. The model that accounts for the most beneficiaries by and large are the MSSP models. They account for about seven million beneficiaries across over four hundred ACOs. The MSSP model with the most beneficiaries is the one is that is called Track One. And in that model the providers do not take on financial risk with Medicare. But they can share in savings.

There are new tracks that are coming up. But perhaps Dr. Conway will mention them. So I will not. But then there are also nine pioneer models, which are required to take on financial risk. I would say that while about one-quarter of the MSPs I just mentioned shared in savings as results came out for 2014; about half of the pioneers were able to share in savings. And that model did get certified to be expanded.

Then the last little model I want to note is the bundled payment model. Bundled payments, of course, we are again lucky enough to have someone here who can talk about direct experience. So I would just characterize this model as one that focuses on a whole episode of care rather than payments that are made to individual providers for the individual services that they themselves provide.

The BPCI demo has four different payment models. They are triggered by a hospitalization. But there are many details. So I am really not going to get into them, but to say the results are very preliminary.

So finally, I will just close with a few comments on ongoing challenges and opportunities. We see here that CMS has launched a lot – to be fair, a large number of payment models in a very short period of time and in a changing healthcare environment. We can note that while we are all sitting here wanting results, Congress, providers, CMS for sure, it takes time. And so there is certainly a tension between what we want and letting these models be fully implemented as they are being tested.

I would say that the ability for CMS to change these models while they are ongoing based on early results and based on unforeseen circumstances presents great opportunities and great challenges for the evaluators certainly. And finally, I would note that a key consideration that CMS and Congress will be

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considering as results come in for these models is how Medicare beneficiaries are really faring in these models and particularly with high healthcare needs. They are the ones that we think some of these models were designed to help. So let us learn about them in particular. Thank you.

Marilyn Serafini: Thank you, Christina. That is actually a great transition because Marilyn Moon is now going to talk to us about how consumers are faring under these models. Marilyn?

Marilyn Moon: Thank you. I am going to be relatively brief because I may be talking about a one horse pony idea here and that is that consumers matter. And you really need to take them into account in these kinds of models. Some of the earliest innovations that occurred and some of the earliest thoughts about innovations really were often done without even thinking very much about consumers. Imagine an ACO that is getting organized, an accountable care organization that is thinking about steering patients into different other providers and slightly different models and approaches.

But the beneficiary often has no idea that they are in an ACO. They may or may not have gotten a letter. They may or may not have known they have gotten a letter. And in many cases, they are not quite sure why the physician is doing that. If it is for good purposes for both improved quality of care and lower prices that is all for the better. But you are going to get a lot better cooperation, a lot better cooperation, a lot better engagement and involvement if the beneficiary actually is engaged and knowledgeable about that.

I remember when people were talking in an early event I went to about medical homes, which you think would be particularly consumer sensitive, people were talking about patient centered care and going on and on. And after mentioning patient centered care the term patient never arose again in the rest of the conversation including when someone was asked about it. And the individual said well the physicians have the patients' best interests at heart and therefore they can take care of that problem.

I think we need to change everyone's minds and attitudes in the healthcare world. You are not going to change the healthcare system if you have a raft of patients who are heavily resistant to the change. None of us like to change things that we become familiar with and comfortable with, especially when it is something as complicated, uncomfortable and important as healthcare.

So it is very important to get people on the same page. AIR where I work did a study a number of years ago that I was not involved with, but I thought was really fascinating where first they interviewed patients and then they interviewed doctors and gave them the same exact specific scenarios about healthcare, trying to get people interested in quality. And what they found was the reaction of the patients and the physicians were totally different. The patients' reactions when they were being encouraged, for example, to look at quality measures to decide where to go to deliver a baby, the reaction was well why would I want to do that. I would just ask my neighbor.

And in the case of the physician, the reaction was why would I do that? Why would I even want to take this patient because he or she is going to be litigious if they are out there looking at quality measures and trying to steer me to a particular hospital. They were not only resistant to quality, but they were on a different page. So there is a lot of education and activity that needs to go on.

Now I will note that as mentioned in the primer and elsewhere, the new generations of models that are coming out are getting much better at that. They are trying to think of ways to encourage and involve patients. So I think that it is important to keep in mind that this may be a little bit of a dated

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comment. But it is something still to keep in mind because it is easy when people get focused on all the tough technical things to do to leave the consumer out of it.

One of the important pieces that needs to be part of all of this is to ask the question what do patients really want to achieve. And when designing goals, for example, for complex care, let us say post-acute care, it is very important to know what the patient wants to achieve. I can give you a personal example.

When my husband was first out of the hospital and on home health after a stroke where he could not read numbers and he was very confused about a lot of things, he had a therapist who insisted he needed to learn how to dial a telephone. And I kept telling her no, he does not really need to do that. All he needs to do is push this button because we have technological advance that allows him to just push this button. But nonetheless, she was bound and determined that he was going to dial the telephone. And after about five sessions we essentially told her she did not need to come back. But she never asked him what he wanted to achieve. And there were plenty of things that he could have achieved that she could have helped him with in that period of time rather than the frustrations that he went through.

So whether it be to climb a set of stairs to sleep in your own bed if you have health problems, whatever it is, the patient often has a goal. And getting them involved very early on is really important.

Finally, it is important that it is an opportunity to build in consumer issues from the very start to make sure that that gets baked into a new healthcare system rather than added on at the last minute. I think this is part of the reason why it takes time to achieve savings because everybody is adjusting to a new environment. And before we either give up on new innovations or before we say that they are not working, we have to make sure that everybody who is involved, physicians, other providers and the patients are all on board before we really judge whether or not it has been successful. Thank you.

Marilyn Serafini: Great. Patrick?

Patrick Conway: Yeah, so thanks for having me here today. I really appreciate it. And thanks for allowing me to be two minutes late. I apologize. I was coming from another speaking engagement. So it is actually a great Segway.

I think the reason we do this work is the people and the patients and families we serve. I will hit on some highlights. But at its core, we think we can have a system that achieves better health, smarter spending and help your people. And to get there, I do think patients and families have to be at the center of care. We have policy principles we use at CMS. One of them is around patients and families first. So these are the goals that were alluded to just briefly.

The president and secretary announced in early 2015 that we wanted to move at least 30 percent of payments by the end of 2016 in alternative payment models where the provider is accountable for quality and total cost of care such as an ACO or a bundled payment by the end of 2016 and 50 percent by the end of 2018. Then in March we actually announced that we reached that goal ahead of schedule, approximately one year ahead of schedule. And it really is a fairly dramatic shift in the delivery system. Lots more to learn on what works, why and what is scalable and expandable, but a major shift in how we think about paying for care.

Goal number two included value-based purchasing. So it includes things like hospital value-based purchasing and other programs that tie payment to quality and/or cost. And the goal there was 85

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percent of payments that Medicare would link to quality and cost. We actually reached that goal ahead of schedule as well.

Importantly, this is not just a Medicare issue. It is Medicaid, it is states, it is commercial payers and etcetera. So we launched the Healthcare Payment and Learning and Action Network to try to collaborate across the public and private sector. We did not only achieve these goals, but ultimately achieved that better care on behalf of patients.

We have now got eight of the ten largest private payers engaged in this network. We have got over one thousand providers who got consumer and patient organizations, large employers. And really, the focus of the work is how do we agree on goals, which we have, agree on payment definitions which we have, agree on how to report on those, which we are starting to do now. And then maybe most importantly, work on alignment in many of these models. So if we are talking about an ACO, can we agree on basic constructs around risk adjustment, quality measures or attribution models or how patients might do voluntary attribution?

So we are doing that work now. This is, I think, a long term journey. But I think we have set up the structure for effective public and private partnership. I was just at the guiding committee. And a number of the folks around the table said this work that they thought was some of the most meaningful public-private partnership work they have done in a very long time. So that is the goal to do this in partnership.

The Innovation Center, which has folks here today, we are not going to go all through these models. Interestingly, we chose a lot of the same models to highlight. The ACO model, as we said, almost 480 ACOs serving about almost 9 million beneficiaries now. We do have increasing numbers in risk bearing arrangements. So 64 now and counting in risk bearing arrangements. So you are seeing this both in the public and private sector, increasingly prevalent.

Pioneer ACO that was alluded to improved quality, 28 out of 33 quality measures year on year, improved patient experience and lowered costs. So it was certified by the actuary. We brought many of the Pioneer ACO components into what is called Medicare Shared Savings Track 3.

We also learned Pioneer was designed so organizations could exit, but nobody could enter. By definition then, your numbers go down over time. So our model now is a much more flexible construct where people can come in or out in a much more flexible way.

Next Generation ACO, really building from some of the learnings in Pioneer. We are going to have a couple years of adding ACOs. The first year was actually a very tight application cycle and had 21 come in. They also have opportunities to exit and others will have opportunities to enter. A few key points, one, patients can voluntarily say this is my ACO, this is my choice. And then they are in the attributed population receiving enhanced services and can even receive financial rebates for certain behaviors like staying within network. It rewards quality. All of our models focus on quality first. There are waivers around Tele-Health, skilled nursing facilities. So we are really trying to enable those provider organizations that are ready to partner with patients in their communities to move to a much more advanced – this is can be fully population based in payments. So totally moving away from free for service. So we are excited about this model which just started in January. Applications are open now for new participants.

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Comparative Primary Care, I have an update as of 9:00 a.m. this morning or today and this morning. So this was our first model on this slide that did show decreased hospitalizations, decreased emergency room visits. We are going to release the next set of results soon. And we announced this morning what we are calling Comparative Primary Care Plus, which is really building what we learned in this model. It has got two tracks. And I will talk more about those estimated 20 states and regions, multi payer, similar to the previous Comparative Primary Care model where we agree on quality measures and basic approach could be 20 thousand physicians and clinicians in the model and 25 million patients. So it is the largest primary care model in United States history and we think very exciting.

Track one is similar to CPC, but has a couple important changes like having the financial incentives at the practice level and more real time delivery of incentives and payments to practices on a monthly basis. Track two, they can move to population based payments. So greater than 50 percent of payments coming from population based payments and a compensatory reduction in fee for service. So it really opens up the practices so that practices can deliver care the way they want to and patients can receive the care where and when they want to whether it is Tele-Health, at home, low monitoring or care management. I am sorry to talk about that one a little longer. But it is exciting, just in time delivery from this morning.

Independence at Home, I am going to let others talk about it. But it is also still incredibly exciting. And I will let others that know the model better than I speak to that. Bundled payment, which you will also hear more about, we have actually now got over 15 hundred what we call episode initiators. So these are physician groups, hospitals or post-acute care facilities taking on two-sided risks in 48 or 1 of 48 various episodes. So these are things, everything from surgical conditions like hip and knee replacement to medical diseases that are complex where we are redesigning the payer system, building those connections between hospitals, physicians and post-acute care providers. And early results are promising in terms of improved quality and lower cost. And we are actually working on releasing some more results here as well.

That led to our Comparative Care for Joint Replacement model which in 67 markets we are saying we are testing. This is how we are going to pay for joint replacement. It improved quality, lower cost and better care coordination. It actually includes testing patient reported outcome measures. So directly hearing from patients about their functional status and outcomes, which we think is incredibly exciting and important.

We heard from patients in these type of procedures. So we think an exciting development. I will end on time. Since I have 20 seconds, I will say a few more sentences. I am still a practicing physician. This is exciting work. I think we are in exciting times. I think we have made significant progress over the last three to five years improving our health system. And collectively, I think though we have to view this as a long term journey. I always want short term results as well. But we need to continue to evaluate, to learn and rapid cycle to scale what works. And I think look forward to the rest of the panel and discussion, but I think exciting times.

Marilyn Serafini: Fantastic. Thank you, Patrick. So this is the part of our program where we turn to the on the ground perspective. And we are lucky to have with us today two gentlemen who are right in the middle of these experiments. And so we are going to hear from them. Before we do that though, I want to remind anybody who is following us on Twitter that our hashtag is Medicare demos. You can comment. You can ask questions. Which brings us to the point that after Eric and Jim speak, we are going to turn to a question and answer session.

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For those of you who are in the room, you have two options. There are two microphones in the room. You are welcome to ask your question at the microphone. You also have green cards in your folder that you can write a question on and our staff will be around to pick it up. So we have two more presentations before we get to the question and answer. So get your questions ready. If you want to start writing questions, feel free to go ahead and do so.

If you are watching at home on C-Span, you can Tweet us your questions. We do take Twitter questions. And we will try to answer as many as we can. Again, hashtag is Medicare demos. So now I am going to turn it over to Eric De Jonge who is going to talk about his house calls, Independence at Home Program.

Eric De Jonge: Thank you. Can you hear me? Thank you very much. I am going to start off with a disclosure which is on my front slide. I just want everyone to know I am going to be talking about home-based primary care, essentially a house call clinical model of care for frail elders and how that has kind of led to the IEH Independence at Home model and demonstration program that has been quite successful in the results announced so far. My disclosure is at the bottom of my slide. My presentation does not involve CMS sponsored analyses. It is my responsibility and there is no review or verification by them although hopefully Patrick will be okay with it. The next slide?

I am going to talk first about the patients that we serve. I would like to do a brief survey of the room and ask how many people in this room have an elder in their life who is sick and has trouble getting to the doctor's office. Just raise your hand. All right. So it looks like more than one-half of the room.

So Independence at Home and Home-Based Primary Care is the model of care for those people. Seventeen years ago, Dr. George Toller and I came to D.C. And we decided to set up a clinical model of care for those folks who are sick elders, very frail and have trouble getting to the office. Essentially a house program, but more than that, a home-based primary care program that would follow them across all settings. And we will talk more about the details of that model.

We then wanted to look at the effect of that kind of model, a mobile team-based approach to care in the home on quality of care, the patient's experience and ultimately the cost of care, which is, I would say, a secondary outcome. Most importantly, what is the impact on the patient and the family? And we will talk about some of those results.

Then I want to close with talking about what is next. How can allies and policymakers both here in this room and across the city help us expand this program?

So who are the patients? It is actually a highly targeted clinical service. In contrast to some of the other demos, it actually targets less than five percent of the Medicare population. Roughly two million of the Medicare population could be eligible if it was expanded nationwide. In our practice, they age 66 to 110. The 110 year old just recently passed away. She was actually born on January 1, 1900 at the beginning of the century. So these are the kind of folks that we take care of.

The service, the intervention is really simple to describe, but hard to execute. It is interdisciplinary, mobile, primary care teams, 24-7 availability across all clinical settings. So it is not just about making house calls. You take care of the patients wherever they are. And you coordinate all services that they need: medical services, social services, sub-specialty, transportation or whatever they need.

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The goal ultimately is to enhance the health and the dignity of these frail elders, bring peace of mind to the caregivers and families. Those are the two primary goals. A happy side effect of this kind of care is that it has a dramatic impact on per capita Medicare costs, which we will talk about in a positive way.

The Independence at Home model, which was based on home-based primary care systems across the country allows home-based primary care teams to be scalable. In some ways that is the major take home point for the day. The Independence at Home, both demo and payment model, allows it to be scalable. And the reason for that – we will talk about it more. But these are the main points. There is very strict criteria for eligible patients. You have to be frail, disabled, have had high costs in the past year. And there is a high bar for service quality in the program. You need to have all of the resources in place to really take good care of these very complex patients.

You only receive savings only after you have achieved five percent reduction in per capita Medicare costs. There is no upfront payment to these programs. And there is no payment until you have exceeded statistically a greater than five percent reduction. And you have to link the savings to six relevant quality metrics. Providers would get 80 percent of savings beyond that first five percent if they meet all six quality metrics.

This is a CBO study. But it highlights the focus on the top five percent and why that is such a big impact. So orange at the top on the left is the number of beneficiaries. But they expend nearly 50 percent of the budget. And this is similar now in the current Medicare-Medicaid population as well as in commercial payers. But this is the population you focus on to have the greatest impact on costs.

I am going to talk about a patient briefly. This is a 69 year old who had liver and heart failure, depression, falls and a lot of caregiver burden. The year before she moved to D.C. she had six admissions to the hospital in Colorado and Arizona. That is six admissions per patient year in health services speak.

The daughter moved her mom to D.C. zip code in order to gain entry into a home-based primary care IEH program. And for the last four years, she has received over 150 house calls, many social services, coordination of these, a lot of home x-rays, EKGs, echocardiograms, wound care, many urgent visits by our team, has a terminal diagnosis of liver cancer reversed by subspecialty care at the hospital center. She had a life-saving radiology procedure where she was having massive hemorrhage internally. We thought she was going to die. We used the hospital high level, high tech care to do a last minute procedure and it actually worked. And she has now been home again for the last 18 months.

In the last 4.5 years now, she has had 2 admissions or .5 admissions per patient year. She has been four years older and four years sicker, but has not been in the hospital more than twice. And she had one emergency room visit in four years. I have to change this. Just two days ago she actually had another emergency room visit. So in transparency, I want to say it is two emergency room visits in two years.

So how does this work? This is a busy slide. But I just want – I will not read it all other than to say the home-based primary care team has to coordinate everything. It is a direct team of people coordinating everything the patient and family need over time until the last day of life. We coordinate routine and urgent visits. Today, actually from the weekend, we had about ten unstable patients. And there are nurse practitioners all around D.C. today making house calls to prevent emergency room visits and keep people at home.

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We coordinate emergency room care and subspecialty. We direct the hospital care ourselves so we can manage the discharge back to home. We are available 24/7 as all the IEH programs have to have a 24/7 availability. We manage rehab and hospice.

Then the next six bullets are just all the things you can do at home. What is really possible? The hospital really is only for intensive care, surgery, procedures and complex level of things. You can do almost everything else at home from radiology to blood draws to EKGs to echocardiograms to equipment to intravenous therapy to intravenous fluids. And as long as you coordinate all those services, you can have a dramatic reduction in costs.

This is a quote from Sylvia, the daughter of that patient about how the house-call program saved her mom's life and mine. It restored her faith in the system and gave them encouragement and support every day. And the good days, hours and moments she has are a result of the excellence, tireless passion and commitment of those who created the program. And she gave us permission to give this quote.

I am going to close with some of the results. This is the VA study that came out in 2014. The highest rated program in the VA showed a 12 percent lower cost. The study of our program in 2014 showed similar mortality, a high mortality of both controlled cases, but a 17 percent reduction. And finally, the Independence at Home year one results. Our Mid-Atlantic Consortium had a 20 percent per capita cost reduction. It was about one thousand dollars per patient month, close to 12 thousand dollars per patient year. Nine of the 17 programs were paid savings ranging from 6 to 31 percent savings. And in year one, 25 million was saved and about 12 million was returned to the providers.

I am going to close with just what are the challenges going forward. Finding the scaled workforce is probably the number one goal. It is very doable. The people are out there. But you have to have a financial model that will support them. You have to build a lot of practice capacity to support these teams and all the other service partners. And then you have to have a health system that will really commit to doing value-based care. And fortunately, Medstar Health here in D.C. in the Mid-Atlantic is now building a new team in Baltimore based on the Independence at Home results and both the quality and the cost savings because they have faith that CMS and other payers will reward this kind of care.

So finally, how can you all in this room help? We are working currently with Senate Finance, House Ways and Means and Energy and Commerce to IH into a national program, a permanent part of Medicare that will be available in all 50 states and D.C. And I am glad to talk with you in the question and answer about how that is going or afterwards. Make sure you link savings to relevant quality metrics for this population, for people who are in their last couple of years of life. Their sugar level does not really matter that much when they just have a year or two left of life. It has to be within parameters. But you have to make sure it is relevant for the population. And finally, CMS to their great credit have been working hard on Independence at Home to target the right patients who have persistent high costs, use fair and very rigorous criteria for new practices as we roll this out across the country that will preserve the quality and the impact. And then use really good fully risk adjusted methods when you do the outcomes analysis so the results are fair to both the government and to the provider.

Here is a picture of our team. This is the most important thing that we do that we have every day. This is a team of 20 people who are here in D.C. who do this work. And finding the right people is the key to success. Thank you.

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Tricia Neuman: I just have to say that I had the privilege of sitting in on a team meeting and shadowing George Toller who is your partner in crime. And this is the work you hear about. This is team-based approach. It is collaborative. It is using people to do what they do best in different capacities. And if I had someone who was old, sick and impaired in D.C. I would be thrilled to give you a call.

Eric De Jonge: Thank you.

Marilyn Serafini: Great. So we are going to move now to Jim Garnham who is going to give us his own perspective from the University of Rochester Medical Center where they are trying out bundled payments. Jim?

Jim Garnham: Thank you. I appreciate the time to be here this morning or this afternoon. I do just want to level set understandings of what bundled payments are. So in the simplest of terms, it is a single budget for an episode of care. And we think about episodes of care. We have had a little bit of a definition around that. It starts with, in our case, an inpatient admission and what we call the anchor admission. And it goes out beyond discharge, out to again, in our case, 90 days. There are options for less time than that. And it includes, if you think about it, really everything that happens to the patient after they are discharged from the hospital, inpatient, outpatient physician, nursing home and those kinds of things.

There was a term that was used earlier today about patient centricity and what Marilyn said was that the patient comes first. And if you think about a patient-centered approach to care, I think first and foremost about bundles not just because I am the director of the bundled program. But if you think about someone who has knee replacement surgery and that is how I conceived it. If I have knee replacement surgery or if I need knee replacement, I think bundle starts. So the episode starts when I go to my doctor and I say the injections are not working anymore or the medications are not working and it ends when I get to go back to golfing. And now I have a better excuse for how badly I golf.

But that is the totality for me. That is the concept of what knee replacement is. And that is how patients think about it. But it is not how we deliver it. It is not how we finance it. It is not how we pay for it.

So that is why I am very excited to be part of this program because I think it very much is a much more patient-centered viewpoint. So as you can understand then, if we are at risk for all of that care, then there is a huge incentive for us to reduce unnecessary care and reduce and reduce unwarranted variation.

So that is what we started with. We started with do we have volumes here that would indicate that it is worth doing? And do we have variations that would say that there is something that we can do to reduce that variation, standardize care, improve care and reduce cost? But while this is a financial arrangement and it is a contracting arrangement and that is why I am involved, ultimately, first and foremost, this is a clinical practice. It is a clinical program.

So we had to go to them. We took the data, which is all great. And we went to the leads of our service lines and said look. Here are some opportunities. Here are some potential opportunities for us to improve care, reduce cost and really dip our toe into value-based payment. What would you do differently? What would you do to go after this opportunity? What resources would you need? How much would it cost? How quickly could you get there? And what kind of outcomes could you achieve?

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That really then, not only did it give us do we think we can actually get this done? Do we have the clinical knowledge to get this done, but ultimately, do we have the clinical leadership that can actually get it there? So this brought us then down to the major joint replacement as one opportunity and then congestive heart failure as the other. And you will see these are very different programs. So this is just a little bit of the data that we have started with. This is our baseline data, some of it. And each vertical line is an episode. And the colors indicate where the dollars are being spent. And it does not take a rocket scientist to figure out gee, green is probably where we need to focus.

And for major joint replacement, it is skilled nursing facility based rehab. We started out at 74 percent of our patients were going home with skilled nursing facility or to a skilled nursing facility for their rehab. And we said we can probably do better than that. We can get it down to 25 percent we think within a year.

Congestive heart failure - a completely different story. There is some skilled nursing facility. But again, I look at that and I go what is red and how can we eliminate it? And red is readmissions. The whole thing about congestive heart failure is keeping people from coming back. And if any of you have anybody in your life that has congestive heart failure, you know this constant revolving door.

So all right, so we have nailed down what the objectives are. Now we got to have a plan to get it there. And so we start obviously with the inpatient side, the hospitals that are at risk. We have the right folks in the room. But this is not just about improving care in the hospital and handing it over to the post-acute side. So we actually brought the post-acute folks into the facility and said look, work with us. Help us understand these patients. Help us figure out not only what we do here, but also what you do on the post-acute side. And let us coordinate and let us have a unified plan of care across this continuum.

Then once we figure that out, we need a place or a way that we can keep track of those folks across that continuum. So we have a couple of resources. One is a dashboard, which is really simply just a way to – a place to put people. It is a software package that we can keep track of people.

But the real key is the care navigator, one person who has specific focus and responsibility to watch these folks across the continuum of care not just in okay, here we are done over at the hospital. Here you go. But it is continuing that process all the way through the end so there is a single point of contact both for patients and for providers. And then the other major resource we applied was enhanced home care.

For joint replacement, clearly, it was getting rehab done in the home with homecare and not in a SNF. For congestive heart failure - totally different approach. It is all about applying those home care resources in a rapid environment so that instead of picking up the phone and calling for an ambulance, going to the emergency department and back up to the hospital, it is you call the nurse navigator or the visiting nurse service and say come out, do an assessment and they can actually bring telemedicine resources so we can do a consult with cardiology onsite and even administer intravenous medications if that is what is necessary to keep folks from coming back into the hospital. So results, we all care about results, right.

So this is major joint replacement. Green line is SNF rehab. You see it was 74 percent at baseline. We set a target for 25 percent. We have already blown through that. But that is not enough because we want to make sure that we are not doing that and then people are coming back into the emergency department or back into the hospital. Because instead of being in a SNF where they are getting good

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care, they are at home. And maybe they are not getting the care they need. Our emergency department visit rate actually went down. So not only did it not go up, the emergency department rate went down. So we are very encouraged by that. And we did bend the cost curve. We did achieve what we were looking for. We think we can do better.

Congestive heart failure, completely different population. We have not bent the cost curve. We have not yet really solved the readmission problem. But there is one shining star in this. So remember, we said we had this clinical pathway. And part of that was home care, enhanced home care services for this population. And so if we look at just the population that went home, did not go to a SNF. The people who went home with no home care, which means they were offered and they refused it, they came back at least 40 percent of the time. At least 47 percent of the time, they came back at least once. If they went home with a home care agency that was not one of our partners, they came back 43 percent of the time. If they went home with our partner home care agency that was committed to applying those rapid resources and doing telemedicine and intravenous Lasix administration (Lasix are the medication we use to control fluid retention) 17 percent of the time they came back. So there is a glimmer of hope here. And I think if we just keep focusing on that model, I think we will do better.

In the 30 seconds I have left I want to just say there is one piece of this that I am really excited about and sort of the spillover effects and the lessons learned. And that is you would expect the clinical leaders would all be about hey, let us apply these resources, these great resources to more than just the Medicare bundled payment folks. And so we have had that. We expect that. What I did not expect is I have just as much attention from the administration of the hospital saying how can we leverage this to other patients. We have a unique opportunity here to really improve the quality of care that we are delivering, reduce the cost that we are delivering. How can we figure out a way to afford this to broaden it out to other populations? That is a really exciting place for a policy wonk like me to be. Because usually, you are trying to drag along the culture. And instead, I am seeing the culture change before our eyes. So I will end with that. And we will take questions.

Marilyn Serafini: Well great. Thank you for that very, very specific information about these on the ground programs. It is incredibly helpful. So we are now open for questions. I invite folks who are in the room to come up to the microphone. I invite anybody who would prefer to write a question on the green card and our staff will be around to pick up your questions and bring them to us. If you are at home watching this live on C-Span, please Tweet a question. Anybody in the room can also Tweet a question. Again, the hashtag is Medicare demos. So while we are getting folks set with their questions, I am going to turn it over to Tricia to kick us off.

Tricia Neuman: This is a question for Patrick. We did some work a few years ago that looked at people who lived in nursing homes, so people who live on Medicare who have very high rates of emergency room use. They go in and out of the hospital. They are high Medicare spenders even though we do not think of Medicare as a place for Medicare spending for nursing home residents. I think there may be two demonstrations, a new one and an older one. Could you tell us a little bit about how they are moving and what the early evidence might be?

Patrick Conway: Yeah, there are two. So they are both managed by the Innovation Center and our duals office that was alluded to focused on beneficiaries on Medicare and Medicaid. The first was around evidence-based practices and implementing those to decrease admissions and readmissions. We did see early evidence of a decrease of admissions, readmissions and higher quality early in that program. Then we overlaid a financial incentive on top of that model. So to really reward financially as well if we were able to prevent admissions and readmissions. So this is a population that we care about

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deeply and two models that have not been certified for expansion yet. But the early results are promising.

Marilyn Serafini: Great. So let us move the microphones.

Caroline Poplin: I am Dr. Caroline Poplin. I am a primary care physician. I have a specific question for Dr. De Jonge and then a more general question. The specific question for Dr. De Jonge is home health visits. My understanding is that Congress has been cutting the amount of money on home health because they think there is a lot of fraud in the program. The fraud that I have seen, because I am also an attorney, is for profit home healthcare provided to people who do not need it while avoiding the people who do need it because it is expensive. My question for the panel is along the lines of Marilyn Moon is value for home. I know value is supposed to be quality over cost. But are the patients involved in the quality measures? And I do not mean patient satisfaction surveys because for a healthy patient that is parking and ability to schedule and to call the doctor at night. And for a sick person it is time with the doctor to ask all the questions, get the explanations and get some empathy.

Eric De Jonge: Yeah, so I heard two questions there. One is just kind of about home health care. The medical house call home-based primary care model taps into skilled home healthcare as needed. And we have found many very good ethical, high integrity home healthcare agencies that we work with. We use them when we need for episodes of care. But they are part of the team in the IH model. And then in terms of – could you just restate your second question?

Caroline Poplin: The second question has to do with value. When we talk about substituting value for volume, I guess you are talking about quality over cost. But value to whom? Value to the system...?

Eric De Jonge: It is my perspective and the Independence at Home looks at this as well. It is value to the patient and family as well in terms of their goals, their outcomes. In fact, one of the six metrics in Independence at Home that is directly linked to savings is whether the patient and family's goals and preferences for end of life care are documented, whether they receive a house call within 48 hours of going home. So it is value for the patient and family first and then value for the payer in terms of being able to afford the care. I think it has to be both.

Caroline Poplin: But I would like to hear Dr. Conway's impression or some of these other people who are involved in the program setting the quality measures whether patients are involved in the quality measures. I mean frankly, I do not care how many mammograms my doctor has ordered.

Marilyn Moon: I think you are making a good point. And I think one of the things that makes most sense to me when you look at these models is to think about whether or not there is actually both flexibility and coordination that goes on. Because then you are talking about the patient and you are getting involved in what the patient wants. And it seems to me that in terms of cheating those goals, the kinds of things that we were hearing about both in terms of the bundled payment and the Independence at Home have a better opportunity to do that than ones that are really focused on or are more technically focused and do not involve the patients as much.

Patrick Conway: And we do have patients on the various quality measure development teams and committees that review quality measures for implementation and various programs. That is critical.

Carolyn Serafini: So let us move to the other side here. If you could please identify yourself?

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Joanne Lynn: Hi, I am Joanne Lynn from the Altarum Institute Center for elder care and Advanced Illness. I am delighted that we are on this journey. I feel like we are sort of Lewis and Clark and their first winter knowing where they are headed sort of and having no idea how far away it is or what they will encounter. But I think that really continuing to work on what it is we are trying to get to is an important part of the endeavor. Because some of what we are now doing may make it harder to get to where we hope to go. And in that light, let me invite folks to weigh in some on where it is we are going. We talk about total cost of care as if that is an obvious idea. We are only talking about total cost of care in Medicare.

The big issue is long term services and supports and especially family caregivers. So when we cut out all those SNF days and we are terribly proud of it and we are sharing our profits with the providers, we forget that that means that some families have to take people home much sicker, still with their wound clips in, still unable to do a two person transfer and someone has got to cope with that. Someone loses work. The caregiver – the average woman, family caregiver, lose one-quarter million dollars toward her own retirement by taking care of her mother. That is big. But we do not account for that. The big issue is not – it is a big enough issue just what we are going to do within Medicare. But Medicare has this huge kind of semi permeable barrier with long term services and support.

And it is even bigger, especially if you start counting the family caregiving. And if we start giving quality measures in that arena, we get into things like people not wanting to be bankrupt, not wanting to lose the ranch, not wanting to be a burden on their kids or their grandkids. It seems that the vision, like Lewis and Clark trying to imagine the Pacific, has to include some real endpoint that is not just paying providers for what they ought to have been doing 20 years ago. Eric and George started their effort 20 years ago. We knew then what we needed to do.

It seems that we really have to start planning these modifications in light of where we hope to get to. And that, it seems, might require thinking in terms of small localities, at least for these very sick people. It does not matter....

Marilyn Serafini: Are you going to answer the question or...?

Marilyn Moon: I want them to weigh in on whether this seems to be where we are going.

Marilyn Serafini: Okay, great.

Marilyn Moon: One of the directions for the movement would be to really take account of the seriously disabled, seriously frail elders in a geographic community and build the capacity more broadly there. Much of what we are now doing makes that harder to do because we are building financing and quality measure lines that do not support that endeavor.

Marilyn Serafini: Okay. Let us see if we can get a reaction from the panel here. Anybody?

James Garnham: I can actually take a little bit of that. You bring up a really good point. And I think it deserves a lot more than I have the time to address today. But let me just give you just a small sliver of what we are doing. So we do not simply turn people over to their home and say here you go; good luck to you. It actually starts well before the surgery when we are talking about joint replacement. We actually go out to the home, meet with that person, meet with their caregiver and plan their discharge with them and their caregiver jointly. So it is not just our decision to say you are going to go home and not to a SNF. It is a joint decision with the patient, their caregiver and the providers. So you are

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absolutely right. We cannot just kick people home and expect that the family is going to pick up the slack.

Marilyn Serafini: Great. Let us move to the other mic here. Oh, did you have a comment, Patrick?

Patrick Conway: We obviously talk a lot. So I will not give a long answer. But I think we are trying through accountable health communities through some of our Medicaid transformation work including on long term services and supports and some of our state innovation work to start to address more of these issues in the wholistic care paradigm including out of the provider system and really testing models at the community level to improve health and health outcomes. I think it's a fair point that we have more learning to do in this arena about how to do that the best way possible.

Marilyn Serafini: Okay, great. So thank you. Let us move to this microphone.

Amy Gibson: Thank you. My name is Amy Gibson. I am with the Patient Centered Primary Care Collaborative. I want to build on some of the comments, Marilyn, you were making about how we get by and why buy in among patients is so critically important. And one of the things that we have come to realize is we really need to have them involved as partners in the design of the program from the very beginning. We just heard from a panel of patients in a conference in Chicago from a patient who reminded us that quality is assumed by patients. So when they are going to get advice on where to go to get their best care they are not necessarily looking for a four or five star rating that shows them that the quality is good. But rather as you address that they are going to their friends to find out if your doctor really listen to you. What was your experience in care?

So I think if we have the conversation with patients around improving experience of care and they also absolutely understand value of care. Dr. Conway, I certainly want to first and foremost applaud CMS for all that you have done to demonstrate how important those collaborations are from the very beginning. I mean our organization is funded as a support and alignment network within TCPI specifically to facilitate these collaborations and meaningful partners with patients and families in clinical redesign.

Dr. Conway, I just want to kind of have you talk about that and some of your learnings and how CMS is starting to evolve those relationships. And even through the expansion of programs that are successful and new programs that you are developing, what are you doing to better assure that there is that collaboration, meaningful partnership with patients from the very beginning?

Patrick Conway: Yeah, so thank you for the question. It is a critically important issue. So a few things we are trying to do. One, which was talked about earlier in the quality measures and what is the quality focus. We think patients and caregivers are the most important voice in that equation. And I think we are doing this now. And I appreciate the positive comments. I think we need to continue to do it better. How do you engage patients and families really in the design, as you have said, and the life cycle of the model?

I think this is something. We have met with a number of groups thinking through this and how to do it more systematically. So stay tuned for even more. But I think we agree with the concept that you want patients, people, consumers, families and caregivers to use all terms to be as inclusive as possible to help design these models to be co-creators both at the start, through the evolution of the model as we try to improve models and in aspects of evaluation such as the quality measures in the model.

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Marilyn Serafini: Great, thank you. So let us move to a question from one of our green cards.

Tricia Neuman: We actually have a few questions on the issue of how well does all of this work in rural areas. So several of the demonstrations we have heard about are sort of well suited for areas where there is a concentration of people and providers. I think there was a story in the paper this morning about some of the challenges that people in rural areas face, especially seniors. I think one-quarter of all people on Medicare are living in rural areas. So this is really for anybody in the panel. We have talked about scaling of things that work. Do they work in rural areas?

Eric De Jonge: So I think Independence at Home and Home Based Primary Care can work in every state in the country: rural, suburban and urban. The challenge will be how do you staff it. In Arizona and New Mexico, there is an IH like home-based primary care program that uses more tele-video. It uses slightly different staffing. The doctors are sometimes more consultants. But you can achieve the same goals of keeping people at home using mobile technology with a slightly different kind of staffing mix. But I think this can be done in any geography.

Patrick Conway: Just to build on that briefly and then others. This is an issue we focus on significantly. I think the primary care models and Independence at Home can be done in rural areas. We did advance payment and other methods, which in our ACO program, which had the vast majority and the last round of participants were small practices or rural practices to help with the transformation work. We also are engaging with a number of states that are thinking about population based payments for rural areas and what that might look like. So I think more work to be done. But I think a number of these models can work successfully in rural areas. And then it is how do you make that even more common.

Marilyn Serafini: Okay, yes, with the mic.

Jennie Boyer: My name is Jennie Boyer. I am with the Health Net Federal Services. We are the contractor that manages Tricare in the East.

Marilyn Serafini: Could you just pull the mic a little bit closer?

Jennie Boyer: Sure. So my question especially to those of you who are involved in making policy, all the pilots are great when it is a well-known and high quality facility for a small area. But how do you scale that for the whole country? And what happens when the quality inevitably deteriorates?

Patrick Conway: I think that is me. I think it might be me again – so a few thoughts. One, the majority of our pilots are voluntary. They are community, state or provider pilots. You are seeing a number now like the joint replacement which are testing in the geographic area including all providers in a geographic area. The sequence there was we saw early positive results in the joint replacement model from the BCCI, the bundles model that was talked about. Now we are testing a geographic area to learn what you just described. Will the results be the same in a diversity of providers? We do have monitoring. We are trying to minimize unintended negative consequences and try to eliminate them if possible. So we have monitoring. We have the ability to pull people out of models. We have other tools we use when we have major issues. But I think you need an array of testing strategies. You picked up a lot of the early adopters and now we are moving to the big middle. And we are sort of shifting the curve as was alluded to.

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So how do we now learn in this sort of big middle of transformation and what works with the big middle if you will? How does context – sorry to answer long. I will try to be brief. It is a good question. The context of the providers really matter, etcetera. And so we are trying to structure this now in a sort of stepwise progression that picks up and increasing number of states, communities and providers across the country including ones that maybe historically were not high performers, but want to be high performers in a population health construct. And lastly, (sorry) supporting people. So we are making major investments through transforming clinical practice, which was alluded to in other initiatives to support various providers, states and communities to improve.

Marilyn Moon: Marilyn, can I just add that I think that not only do you see in the beginning that high performers. But you often see the highly motivated and ready to change folks. And it is the not so ready to change people that you are worried about than bringing these two. So I am glad to see Dr. Conway talking about the importance of then providing additional resources and providing education and information to people. Because the leaders already are motivated to change in many cases. And it is the folks who are just not sure that is what they want to do or are skeptical that you need to bring along. And I think that is a really important aspect in the next stage of all of this.

Jennie Boyer: Okay. Thank you very much.

Marilyn Serafini: Okay. We have another question at the mic.

Carl Pulzer: Hi, I am Carl Pulzer, Co-Chair of the Long Term Discussion Group. And I really enjoyed the presentation about the Independence at Home program and the savings to Medicare and the quality of the care. But I thought of this question before the other two questions. But it is sort of a follow up. What do we really know about the incidence of long term care, Medicaid costs and the burden of unpaid caregiving around – and if you do not have specific studies, what is your sense? Does it also save an assisted living nursing home and home care long term care services or does it not? And what about the needs – the pull on the unpaid caregiver?

Eric De Jonge: Sure. Thank you. So in our practice here in D.C. we have a less than five percent incidence of nursing home placement per year. So about 95 percent plus of our patients stay at home long term. And that is much lower than the benchmark around the country for this population. We have not done the Medicaid cost analysis. There is actually a number both at Penn and I know within CMS I am interested in doing that. Our experience is that if you have social workers on the team as we do and you have the true interdisciplinary approach and get the care for the caregivers and the patient in place that the amount of both nursing home placement and then therefore Medicaid costs are significantly less.

Marilyn Serafini: Okay. Do you want to ask this one?

Tricia Neuman: I am afraid this one might be for Dr. Conway too. But maybe anybody else want to join in that would be terrific. Everyone including presidential candidates is talking lately about the problem of rising drug costs. How will these demos address the problem and are there any particular demos that directly address this issue? And I think I know where you were speaking this morning that you have a specific demonstration to talk about.

Patrick Conway: Yeah, so a number of the models, before I talk about a specific one, do include drug costs, typically B costs. But Next Generation even includes the possibility of organizations bringing in

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D costs. Our Oncology Care model, which we had robust interest in, we look forward to announcing the participants also includes both A and B costs. So it includes drugs.

We do have a Part B model, which I spoke this morning about that directly focuses on paying for value and better patient outcomes in Part B. I want to say clearly it does not limit access. We do not believe that the proposal limits access for any patient to get any drug they need and any physician to prescribe any drug that they think is warranted. If there are examples that people could provide around limiting access, we would want to know about those. Because access and folks having better patient outcomes is a core principal for us. But we do think the Part B model is a proposal that we are seeking comment on that could directly be aligned with paying for value in the drug arena.

Marilyn Serafini: Great. We have another question at the mic.

Christine Grossman: Sure, hi. This is Christine Grossman at the Alliance for Specialty Medicine. I actually had a question. Hi, Patrick. I have a question actually for Jim. I used to work at CMS actually up until quite recently. I had a question on your bundled payments portion. So you talk about the episode of care lasting until 90 days post services. And I wanted to know. I have heard from several doctors both now and in my previous position in the past at CMS having issues in terms of following up with patients and getting information past 90 days. So I wanted to see if you all account for that and what you do in terms of if a patient does not follow up and how that computes into bundled care.

James Garnham: Patient follow up is a huge issue for us particularly for the congestive heart failure. I will tell you a little bit of a story. And this is only tongue and cheek. One of the medical directors of the congestive heart failure program said that if he could find a way to combine the oral Lasix medication, which is the drug we use for fluid retention, with crack then we could get our patients to be compliant. And he was only half kidding. So when you talk about patient follow up, I mean we have care navigators that are constantly calling and visiting folks to try and get them to come into those follow ups, which is one of the reasons why we have initiated tele-health services through the visiting nurse service. So if they cannot get back to the clinic for their follow up appointment, we will go to them and so they can have that visit wherever they happen to be. But patient follow up is one of the hardest things to do in this population.

Christine Grossman: Thanks.

James Garnham: Yep.

Marilyn Serafini: Okay, thank you. So to follow on that, let us talk about additional implications for patient involvement. So there are some pros and cons associated with passive enrollment in these models of care. So what are the implications of more or less patient beneficiary involvement?

Cristina Boccuti: I can comment a little bit more as an analyst looking, like you said, at the pros and cons. I would say while some models are being introduced in the future that allow more patient engagement; some of the ones that we have results about now have more of the passive attributes from which you note. And I think some of the thoughts behind that are that in the one hand it does not – it is not very disruptive to the patients. This is going behind the scenes through claims based analysis. And then it in fact places a greater role for the providers to really engage the patients and work on the care. And also, it eliminates some of the selection issues that I think Marilyn sort of brought up where although this is more of the patient selection where patients, whether they be recruited or not recruited.

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So some of the passive enrollment form an analyst perspective has some merit. But on the other hand, you are losing by this passive attribution. You are losing patients volunteering to be part of this model and then being proactive and listening to the care decisions and making choices about which providers might in fact be higher quality and lower cost. So I think there is a push and pull. And I imagine that the future models that are coming are going to be assessing both that push and pull about selection issues versus patient engagement and patient involvement.

Patrick Conway: For some it could be both. There is both passive populations plus active choice populations on top. So we do want to learn how to do this best and what is the deepest level of patient engagement necessary. And I think just to build on the answer, which I agree with, in some models it may be both.

Marilyn Serafini: So I want to note we have 15 minutes or so to get through more questions. But I want to point out that in your package you have a blue evaluation sheet. And we would be very grateful if you would take a moment to fill it out. We have actually made it a little bit shorter so it is easier to fill it out. So we would be grateful if you did that. But this is not an invitation to leave. So I would actually like to ask Patrick and the others up on the dais to look into the crystal ball into the future into the next year, into the next two years to give us an idea of what is coming next whether it be an expansion of some of the programs that we are already seeing in demonstration projects whether we are expecting to see some new kinds of programs that are bubbling up that are not necessarily part of the demos, but they are starting to come about in the private sector. What will be the focus? What do you all see coming down the road if we look ahead?

Patrick Conway: I can start on this. So great question. First, at a high level, I think I actually see the level of transformation accelerating. And my prediction is that may continue in a positive direction. I think I am seeing a cultural shift. Three or four years ago I talked to big group CEOs about this. And I could tell it was like yeah, yeah that may happen someday but I am not that worried about it. Including a very tangible example where a person said I will never be in one of your models and now they are in a bunch of our models. And it is because I think you have seen a cultural shift that people know this is where we are going. It is the path we are on. We need to learn how to get there. So I think the progress will continue regardless. Delivery system reform I think is truly bipartisan.

Then on the details, I call out three main things. I think you will see increasingly announced certifications in diabetes prevention program, which we have not talked about today – a few weeks ago. I think you are going to see increasingly the results that meet the bar for expansion and therefore expanding of the program. You are also going to see us take learning from programs even if it is not formal expansion, and propose them into various programs.

Two, I think you will see continued models that fill gaps like the Conference of Primary Care Plus model today. We are actually working on some direct consumer-oriented models that are really complicated and hard to get right. But we have worked on health plan innovation, which we have not talked about much today. The drug space, you have Part B model. It is proposals. So I think you will see gap filling.

Then three, I think this private sector-public partnership aspect you are going to see accelerating. Increasingly, when I interact with private payers, states and Medicaid programs, there is agreement on this is where we need to go. There is actually agreement on a lot of the high level payment models. So I think you will see a shift across the public and private sector, which will actually make it – I have been on the provider side and have had to deal with various – makes it much easier to succeed if you are

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getting a common signal across your payers from your state and etcetera about moving to this alternative payment model.

Marilyn Moon: I would like to talk about consumers from two perspectives and how this will affect things. I think the argument for increasing impetus for change comes from the demographics of the baby boom population turning 65 much more accustomed to questioning authority, much more accustomed to being skeptical about being told something by a physician, for example. And with all of the attention and publicity around change, I think recognizing that change is not only going to be coming but that if people want to have a role in it, they need to be fairly active.

The passive side or on the more troubling side, we will have an increasing population of diverse people on Medicare program than we do now as increasingly the number of Latinos and African Americans increases the share of the population on Medicare. That increased diversity means that you have a bit more of a challenge in reaching out to those people who have different cultural backgrounds, particularly on the Hispanic side where we know from a lot of research that people behave differently, respond differently, interact with the healthcare providers differently. And that is going to mean that unless we reach out and really try to provide good outreach and education that then there will be some problems there. So it can be on the one hand or on the other hand I guess. But I think there will be some positive things. And there will be some additional remedial work that needs to be done.

Cristina Boccuti: I will add one more change that I feel like I see that has come up here and come up on the panel, which is about health workforce. And I see that changing a bit where we have the navigator with the bundling that is mentioning in Rochester. And we have community health workers involved in hospitals in the paper today. And in the rural areas, which came up as a question, there are different workforce models that I think may have the ability to coordinate care across settings even better. And I think that might go hand and hand if the payment incentives continue to find ways to marry those into the workforce. But that needs to be cultured. There are other systems to develop that.

Tricia Neuman: I have a question, which is we are talking about changes in traditional Medicare and really learning from different models in order to improve the way care is provided. I am wondering how all of this relates to what is brewing in the Medicare Advantage world and whether or not some of the lessons learned from Medicare Advantage are being applied into traditional Medicare and conversely, are the things that are working in traditional Medicare being injected into the Medicare Advantage space? And how would a beneficiary know?

Patrick Conway: Yeah, so I will start. Others can jump in. So we are having this bidirectional learning and approaches and then those scribed briefly further. So one, there are examples of models. For example, value-based insurance design which we launched in Medicare Advantage. We had seen much of that work from the private market. So it is bringing those learnings and then testing them in the Medicare Advantage market.

I interact routinely, as do many of us, with the Medicare Advantage, their various clinical quality and innovation leaders. So we are learning from them on some of the consumer oriented work they are doing as well. I think likewise, we have had examples in ACOs, bundles, Independence at Home and primary care where we are sharing directly what we are doing with other payers encouraging them because often we can encourage, but not require, which is appropriate. And encouraging the various Medicare Advantage plans to adopt or consider adopting these various new payment models. And we are seeing that happen. So I think you are going to see the way that Medicare Advantage plans pay providers and traditional Medicare paid providers I think increasingly converge over time.

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Tricia Neuman: So just as a quick follow up, for something like Independence at Home, which is focused on the frailest high cost people who are living in the community, is that something that is a part of the care system that Medicare Advantage plans are providing as far as you know? And is CMS working with Medicare Advantage plans to be sure that these best practices, if they are best practices, are being replicated for beneficiaries no matter which delivery system they choose?

Eric De Jonge: Can I just mention that actually Medicare Advantage companies are taking up Independence at Home model, home-based primary care and there are multiple states. Both New York and Oregon already are having programs or contracts with Medicare Advantage companies to be paid under a per member per month that covers the cost of the program and gets them into the black. And they are now doing that care as we speak.

Marilyn Serafini: Okay, great. Oh, go ahead.

Patrick Conway: Conference of Primary Care Plus, which we announced today, we want Medicare Advantage plans, we want Medicaid plans, we want commercial plans at the table.

Marilyn Serafini: Great. Question at the mic.

Marion Grant: Hi, I am Marion Grant, Policy Director of the Coalition to Transform Advanced Care. These models are great. And hopefully they will continue to be successful. But how will we coordinate these models into the future? So if you were a frail elder who needs a hip replacement, are you in an ACO but you are also part of Independence at Home and then it is a bundled payment. Can you speak – I know that the demos are individual projects, which they need to be from an evaluation standpoint. But how is it going to come together?

Eric De Jonge: I will just say from the doctor perspective on the ground, I think that the patient population has to drive the financial models, the payment models and not vice versa. So you have a lot of silos of all these different financial models. But ultimately, in our program, we take care of the patient from day one until their last day of life. And all of that care for now is with Independence at Home. We right now are not in an ACO because right now they are mutually exclusive. And we do not participate in bundles either because that would interfere with the shared savings model. So for right now, IH is a standalone, all the way, fully coordinated program. And that is the way I think for now it needs to work.

Patrick Conway: And we have other examples. You could be a bundled payment entity plus an ACO. And then we have mechanisms on the back end if you will to ensure we are not double paying but also align the incentives across programs. And we will continue to work on those issues.

James Garnham: I will just say that what we are going to find is that as some of these things fall out and we really find financial mechanisms that are working they will become the industry standard for how care is paid for and organized. And so we are going to have to work through those issues. But I mean we did this 20 – 30 years ago with DRGs. The hospital stopped billing for every little bit and we bundled the care together in that. And now that is the – Medicare did that. Medicare started that. And the industry fell in line. I think we are going to find that as well with these models.

Marilyn Moon: I think we are going to need some help from consumers for a long time to come. And the whole idea almost of ombudsman or support is really important. And there is an area where I think The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

you also have to worry about again the relationship between Medicare and long term care type – long term supports and services. And in fact, I think one of the things that would be good for Medicare to be able to do over time is to provide not only some of those ombudsman kinds of services, but potentially even a structure to help people manage the long term services. That might be an add on program that people would enroll in and pay a modest income related payment for in which they could get additional help in managing that system. But I think the whole idea of managing it to think of managing it by yourself if you are sick is pretty scary even if you are managing it with the help of a family member. So I think that is an area where we really need to think about, maybe even a model onto itself in terms of an innovation.

Tricia Neuman: So I think we are wrapping up because while we do have more questions, I do not think we can get to all of our questions. I want to thank the Alliance for this really interesting discussion and the panelists. I want to give applaud for our primmer, which at least two of our panelists worked on, Marilyn and Cristina Boccuti. If you have not learned everything you needed to know about payment delivery system reforms under Medicare, here is your cheat sheet right here. I want to thank you and thank Marilyn and everyone else.

Marilyn Serafini: So for those in the room, you have that in your packet. For those not in the room, you can find that on our website, www.allhealth.org. Please join me in thanking our panelists for a really exciting conversation. And one more applaud to please fill out the shortened, streamlined evaluation form. Thank you very much.

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