

## MARK McCLELLAN

Hello everyone, and welcome to the Learning Action Network's Spring Virtual Forum. I'm Mark McClellan, I'm the co-Chair of the LAN Guiding Committee. We are pleased that you have joined us for this event, and we are also pleased to bring everyone together at a midpoint in the year between the summit that we help last October, and the summit that we are planning to host again in the fall. I see that there are over 900 people who have signed up to participate in this event online from all across the country. Welcome and thank you for being with us.

If you are new to the LAN, we are glad you are here. If you have already been engaged with the LAN, you know that this public/private partnership is an important collaboration for working together to advance effective payment reform, with the goal of healthcare that delivers higher quality and smarter spending. The LAN's work is about developing a shared understanding of how we can be better in supporting actions that accelerate effective payment reform.

As we all know, there is an ongoing debate right now about how to make health insurance coverage more affordable and available to families, companies, and people who need extra help. But there is more agreement that it is increasingly difficult to make healthcare coverage affordable, unless we can reduce the cost of healthcare. And there is broad and bipartisan agreement that our traditional healthcare payment systems often get in the way of more efficient and effective ways of delivering care, such as using more personalized approaches or telemedicine and less costly care settings. Or, better coordinated and team based care, or care that better integrates medical with behavioral and social services. Payment reform is challenging, and it needs to keep evolving, but developing and implementing alternative payment models remains a vital part of improving our country's healthcare and health.

In the LAN, we are working with clinicians and other healthcare providers, patients and consumers, health plans, purchasers, expert advisors, policy makers, and others, in this challenging work. We are seeing promising new directions, in addition to important federal initiatives in the Medicare program. We are seeing more innovation and leadership from states, and from private health plans and regional collaborations, we are seeing promising approaches to engage patients, including those with serious chronic diseases and high expected cost. These position new directions are bolstered with more evidence on what works to make payment reform better and less burdensome for healthcare providers and patients, as well as more evidence on how healthcare providers, large and small, can succeed in improving care. Together, these trends are helping to provide momentum toward higher value, more effective care, that works for patients and families.

And you are going to have a chance today to join with is in the discussion about some of these challenges and about opportunities for further progress. Now, in addition to these developments in the LAN, and around the country, we are looking for other ways to build on and compliment the LAN's work. I want to briefly mention a couple of those. The PFPTAC, or the Physician Focused Payment Reform Technical Advisory Committee, is now accepting proposals for physician focused payment reforms. It's reviewing a range of approaches that aim to help physicians deliver more patient centered care in ways that do not yet have good financial support, and it will make recommendations to HHS. And the Payment Reform Evidence Hub, based at Duke with a national network of evaluation experts, is working on identifying and filling gaps in evidence on payment reforms, especially private sector and state based initiatives. And there are a lot more examples of how collaborations like these, can help transform the payment reform landscape, working with the LAN and all of you. We are looking forward to making more progress together.

Right now, continuing on this topic of leadership to improve health outcomes and reduce costs, it is my great pleasure to introduce Miss Seema Verma, the new administrator of the Centers for Medicare and Medicaid Services, one of the most important leaders in healthcare reform. Miss Verma is bringing a new emphasis on state flexibility and local leadership to CMS, to support innovative approaches for improving healthcare and health across the country. She was confirmed by the U.S. Senate on March 14<sup>th</sup>, so she is still very new in the job. Her experience in policy and strategic projects goes way back though, involving Medicaid, insurance and public health, and spans state and federal government and the private sector. For more than two decades, Miss Verma has been involved in guiding health policy. Throughout her career, she has worked to put patients in charge of their healthcare, working with states on the redesign of their Medicaid programs, and supporting the development of new ways to meet the diverse and complex needs of the populations that they serve. As the architect of the historic Healthy Indiana Plan, she helped create and implement the nation's first Medicaid program with a central emphasis on consumer directed care. Before becoming CMS administrator, she was the president, CEO and founder of SVC, Incorporated, and National Health Policy Consulting Company. Miss Verma is committed to empowering patients to take ownership of their healthcare and making sure they have access to the information and resources they need to be effective consumers. She is working to reduce burdensome regulations, so doctors and providers and focus on providing high quality healthcare to their patients, and as the CMS administrator, she will enhance support for states to develop innovative solutions, including new payment models that focus on improving quality, accessibility and outcomes, while driving down cost. She completed her master's degree in public health with a concentration in health policy and management from the Johns Hopkins University, and a bachelor's degree in life sciences from the University of Maryland. Seema, we are very glad that you are here with us, to join us in kicking off this LAN summit. Thank you.

## **SEEMA VERMA**

Thanks, Mark. Thanks, Mark, that was a great welcome. I think you actually had down my whole mission, so I could probably just stop and let Mark have the final word there.

Well, it's great to be joining LAN and all of the organizations that are focused on improving quality and providing patient centered care. Today marks seven weeks that I was confirmed by the Senate, and we have hit the ground running and are focused on putting our agenda of putting patients first.

We are empowering patients and doctors to make decisions about their healthcare and ensure patients have the information they need to make choices as they seek care. And creating a system that fosters innovation, market competition, while it increases quality, access and efficiency. It is important that as we move forward to drive efforts towards quality and outcomes over volume, that we do not create undue burdens on our providers. Heavy reporting requirements and regulations can drive out small providers and reduce access for patients and ultimately increase costs.

President Trump and Secretary Price have made a commitment to the American people to reduce regulations, and we will fulfill this promise. We will continue to support innovation at every level, especially with our states. As we understand that a one size fits all model does not work, communities must figure out how to drive quality and value at the local level. Dr. Price and I recently sent a letter to states, promising them increased flexibility to design programs that work best for them and their citizens. Likewise, we will be encouraging providers to develop new and innovative payment models to advance quality, outcomes, value, and ultimately market competition. The challenges that we face in healthcare today, are far too great and complex for individual sectors of stakeholders to tackle on their own. We will not be able to achieve these types of outcomes that we want to see in our systems, unless we break down silos and work together. I appreciate LAN's convening of payers, providers, patients, states and other stakeholders. The LAN provides a springboard for collaborative efforts to increase adoption of value based payment and alternative payment models, so that our system better meets the needs of patients.

You stand as a testament to the fact that stakeholders across the public and private sectors are deeply invested and want to find ways to improve care. The good news is, there are many examples of success. An estimated 30% of Medicare payments are now tied to alternative payment models, and we look forward to partnering with more providers on alternative payment models in the future. We appreciate the opportunity to work with all of you, to work on innovative solutions that improve quality and outcomes in the most cost effective way. Thank you for having me here today and I wish you the best of success. Thank you.

## **MARK McCLELLAN**

Thanks, Seema, thank you very much for joining us, and clearly these issues of improving value and care, taking advantage of innovative ideas that are percolating and developing around the country, is very important to the new administration and very much connected to the work of the Learning in Action Network.

Now I would like to invite the LAN guiding committee co-Chair along with me, my good friend Dr. Mark Smith, to highlight some of the ways in which the LAN is working to support the implementation of alternative payment models. Mark?

## MARK SMITH

Thank you, other Mark. As many of you know, LAN's mission is to accelerate the transition to alternative payment models or APMs. And we thank all of you who have contributed your stories and lessons learned, your expertise and your leadership. All of your efforts are making a difference, in fact, today's event coincides shortly after the two-year milestone of the LAN, and there are many accomplishments to celebrate. So, I'm going to talk about a couple of them.

Through collaborative workgroups and public comment, the LAN has produced seven white papers outlining recommendations for designing payment models, and these are being tested and implemented in efforts around the country. The LAN is currently updating its APM framework that was first published a year ago, and it's been helpful in conversations across the field, and you will hear from Sam Nussbaum later about the details of the update, later in this program. The LAN is also tracking APM adoption on an annual basis, and has launched this year's data collection effort, where we expect to see expanded participation by payers across the country. We look forward to releasing the 2017 report at the LAN summit, later in the fall. We are currently supporting two action collaboratives for advancing knowledge and adoption of solutions that work. One for changing maternity outcomes, and one for evolving multi-payer primary care payment. Resources from these efforts are posted on the LAN website.

I would especially like to single out the leadership of the LAN's 138 committed partners, whose organizations have committed to tying payment to quality, and have set their own goals for APM adoption. These partners represent a kind of a hot bed of innovation and we applaud their leadership. To highlight just one example, Community Health Plan of Washington, which is a Washington based not-for-profit, Medicaid managed care plan. It has 72% of its Medicaid payment tied to value based arrangements that are in category 3B, according to the LAN's APM framework. And CHPW continues to evolve its role in supporting providers in capacity development, enabling them to take on value based payment arrangements, and achieve the best and highest quality care for their members. And we applaud CHPW and all of our committed partners in this work.

I also want to commend and encourage the increasing instances of regional collaboration that are going on around the country. This is very important as healthcare quality is generally generated at the local level by partners sharing data and coordinating their care. And I will note here that Washington Health Alliance is hosting a regional dialogue around this question, following this national broadcast, and we thank you for doing this, and encourage others to continue the regional work and look forward to hearing from your discussion about this event.

These kinds of collaborative accomplishments have set the stage for what we want to work on in the next couple of years. We know that both sides of the aisle agree on core tenants. Coordinated care is better than uncoordinated care, and cost of care have to be brought down, if the cost of insurance will ever be affordable. We know this isn't easy, and this kind of change takes time. It also takes resources and collaboration and often profound culture shifts. And the evidence for the change is not always there at the beginning or even within a few months, but there is no question that we are making progress, and it's vital to keep at this challenging work. Whether you are just getting started or working on a more mature initiative, we commend you for the reform work that you're doing, and I hope that our program today inspires you to double down on those efforts, by hearing from others experiences in the trenches.

In a moment, I'm going to introduce you to a speaker who through her own personal story, will remind us of the ultimate impact of working towards quality care, which is the care that patients get. Before I do that, let me preview the rest of the program for you.

After the next speaker, at about 1:45 east coast time, I will introduce a panel of stakeholders who will share their stories of their own APM implementation and launch a dialogue on successes, challenges and how we can take the best learning from those experiences, to keep moving forward. Toward the end of that panel, we will also invite you to submit your comments and questions online and here in person, so stay tuned for that portion of the panel. And after the panel, we will hear about how the APM framework, which was first adopted a year and a half ago, is being revised and updated, based on feedback and developments in the field, before we wrap up at 3:30.

So, as you can see, we plan to cover a lot of ground, so we hope that you'll sit back and enjoy the conversation, and also participate in the conversation. And we thank you for that participation. Before introducing our next speaker, I invite my co-Chair Mark McClellan to engage our audience, by gathering some information through an on-line poll. Mark?

## **MARK McCLELLAN**

Great, thanks, Mark. We thought it would be great to use this opportunity to get a little bit of information from you all, about where you are and the journey toward alternative payment models and what role you see yourselves playing in this process of reforming payment to support better healthcare.

I'm going to ask two questions right now. One of them, the first one, is directed to those of you all who are actually implementing alternative payment models right now. After that, a question to those who are supporting the implementation of alternative payment models. The first question is for providers and for healthcare payers who we know from the forum registration, represent a quarter or so of the audience that is joining us online today.

If you are, or represent a provider or a health plan, please take a moment now to respond to the poll that you see on your screen. For those of you who are here in person, if you represent a provider or payer, you can access the poll on your mobile device and again, we would like to get your responses right now. You can follow the instructions there with you. If you are not from one of these two groups, hang on, the next question is for you. So, on this first question: Are you participating in an alternative payment model in whole or in part, and for how long? And you see the range of choices. They include: Being at it for a while, three years or longer, less lengthy time periods, down to people who are thinking about joining a payment reform effort, or not participating at this time. For those of you who are online, you will see the results appear in just a moment. We are going to come back and talk about these a little bit later in our program today.

Now, for all of those who are not direct implementers right now -- that is not people who are in healthcare organizations or health plans that are implementing these payment reforms, please respond to the second question that we have up on the screens now, for those of you who are here in the audience on your mobile devices. Look at the ways in which you can support advancing alternative payment models. So, these include: Advocacy and consulting, providing education and resources, expertise, serving as a convener, or other roles. Again, we are looking to get a sense from you of your interest and background and we will come back to these results a little bit later on in the event this afternoon.

For right now, it looks like we do have a whole diverse range of expertise and perspectives with us. Mark, I would like to go back to you, to introduce our next speaker.

## **MARK SMITH**

Thanks, Mark. I'm really looking forward to hearing our next speaking, who was planning to be here, but circumstances being what they are, is going to be speaking to us from home, so we really appreciate her being able to do so.

Nancy Michaels has a very compelling story to tell, which reminds us all that the point of payment reform is not payment reform for its own sake, but to improve both the affordability and the quality of care that patients actually receive on the ground every day. In 2005, she had it all as a published author of several books, a sought-after business speaker with Fortune 500 companies as clients, and a Tom Peters Wow Project Personified Award, and the mother of three small children. In what seemed like an instant, Nancy found herself in the hospital for an emergency liver transplant and cranial procedure with significant medical complications that would twice nearly end her life, and left her in a two months' coma in the intensive care unit at a major Boston medical facility. She made it through this long health crisis, miraculously, with no residual problems. Today, she consults on strategies, tactics and tools, to increase patient satisfaction, engagement, and safety. She is going to share her perspectives on what matters most to patients and our collective efforts to move our system towards paying for quality and value, rather than volume. From Concord, Massachusetts, we are grateful for

your being able to be with us by audio. Welcome, Nancy. Nancy, can you hear me? The stage is yours.

## NANCY MICHAELS

Okay, thank you so much, and I'm sorry I couldn't be there physically. Today, I am doing a better job of listening to the cues that my body gives me and I knew heading to Washington D.C. today wasn't a good idea, when I got in the car. So, I turned around and came back, but I'm so happy that I can be with you here in this format.

I want to share with you some things that were incredibly important to me during my hospital stay. It was now 12 years ago. I had an emergent liver transplant that literally -- it seemingly happened almost overnight, where I went into complete organ failure. Fortunately, by the time I -- within a few days of entering Beth Israel in Boston, they had reversed my kidney's functioning, and they were functioning again, but my liver definitely needed to receive a transplant. I've learned a lot about organ donation and all of this after the fact. I never expected to be a recipient, but I'm so grateful that modern medicine can do the things that they can today.

I wanted to share a couple of things that still remain very memorable, in my mind, about things that were done, and maybe some tweaks to things that might have made my situation a little bit more optimal in terms of my care. I'm not taking of the care I received for granted, in any way, because I know that ultimately, these people at that hospital saved my life, and I am forever grateful for them and for all of the work that people in the medical field do. It's really just overwhelming to me at times to think about the things that they did in order to maintain my life. I just wanted to start off with that. I think oftentimes we absolutely pay attention to more technical expertise. We want the best surgeon or nurse, or medical team for our family members or ourselves. But I think we also want other things that are maybe more softer kind of topics, I guess, or items that mean a lot to us, that I don't think would cost a lot more. I think that the biggest issue, obviously, is time, but hopefully some of these ideas will not be overly taxing, because I think that a lot of it is just how we approach certain things.

I wanted to just share an example about years ago, my son, when he was born, I realized something was very wrong, and for a long time, I was told that, you know, I must be crazy, there was nothing really wrong with him. He wasn't maybe developing as quickly as his sister, but boys might be a little bit slower in certain areas. And I just -- my gut instinct just confirmed all along that there was something wrong. He was diagnosed at the age of three with having Asperger's Syndrome. One of the things that was incredibly frustrating as a parent, was in the mornings, every time I would feed my son his breakfast, he would literally through the eggs off the table and it would hit the wall. It was just overwhelming to him for whatever reason, I just couldn't figure it out. We ended up bringing in a behaviorist to work with us. She observed this happening one morning, and she turned around and said to me, Nancy, make him breakfast again, and just tell him that you are going to give it to him, before you put the plate down. So, I did. I made the breakfast again, and I said, Noah, here are your eggs, and I put them down. He picked up

the fork and he started eating. I looked at her like, this could not have been this easy. What was I missing? That's all I had to do, was tell him that I was giving him his breakfast, and he would pick up a fork and start eating it? And she explained it to me, that this concept is called, "previewing expectations", and she said that because my son had sensory integration issues, that receiving that without being told, was very affrontive to him. That this actually -- this theory of previewing expectations, would work with anybody in my life. She said, you can do this with your daughter, you can do this with your husband, you can do this with friends. If you let people know ahead of time what to expect, everyone wants to be more in compliant when they know what is happening.

I have thought about that so often, since my own experience as a patient, because I think oftentimes, I didn't know what was happening. I think that when you are patient, you are at your most vulnerable. I felt like my modesty, my humility, everything had been stripped from me. When I woke up from a two-month coma in ICU, I was trached, so I remember, I really [inaudible] of that time, I think because I couldn't speak, as they were dialing me down off that respirator. And I often thought of that example. I wish that people would talk more to me about what was going to happen. Even in that day. So, obviously, that's not -- it doesn't add any cost to this experience. It might cost a little bit more in time, and I'm not sure whose role, if not everyone's, is to contribute, to help alleviate a lot of the stress and anxiety that patients and their families have in those situations. That would have been something that I would have loved more of. It did happen, but I don't think that it was incredibly consistent and I just think it would have gone to addressing a lot of my anxiety and fear in those situations. Especially to being in the ICU where you have ICU psychosis and those things are absolutely real, and I thought at different points in my stay that my nurses and doctors were almost trying to kill me, or taking my medication. I wasn't thinking clearly at all. I really felt, getting off that respirator, I almost felt like I was going to die of suffocation, because I just wasn't aware that the harder it was for me to breathe, it was actually a good sign and they were weaning me off of this. But it really wasn't communicated. It was very, very fearful for me as a patient. Especially not being able to speak as well.

I do want to say that I think that really what patients want, are what I would call the four C's. That is compassion, communicative, consistent care. In compassion, I want to share a story of something that a nurse of mine, who I just reacquainted myself with, last October, who I hadn't seen in about 11 and a half years. His name was Frank, he was the first nurse that I had seen when I was brought from my local ER to ICU at Beth Israel. There was just something about him, he just had a very kind way about him. When I woke up from a coma, he was one of the people I actually did fear and I thought he was not -- I thought he was enemy, when of course, he wasn't. He did one of the kindest things for me, and I had been asking, or mouthing out, to my doctors and nurses, that I really wanted to go outside. It was August. It was actually late July, or mid-July, when I woke up from a two-month coma, but I knew it was summer out. I was very thankful and very much aware of what had happened. I just really wanted to be outside. They kept tell me, and I'm sure for all the right reasons, that I was much too immune suppressed and probably wouldn't be able to do that. One day, he came in early to his shift and he offered to take me down for a routine CT scan. We did that, he waited outside for me, and he



took me to an area in the hospital that was very unfamiliar to me. I had just mapped out in my mind, where I was going based on the hallways that I was being carted to, and this was not very familiar. He opened these two big, black, double doors, I will never forget it, and he brought me outside onto the loading dock of Beth Israel Deaconess Medical Center, and pushed my stretcher into the sunlight, and just stayed there for five minutes. Didn't say anything to me. And it was just one of the kindest things that he could have done. Now, it did take him time to do that, obviously. He probably did something that maybe wouldn't have been encouraged by my entire team, but it's one of the best memories I have of being in a hospital and having -- and having that experience. That really was just a very small act of compassion that I felt that he had for me, that again, I'm talking about it now, 12 years later. It certainly had an impact on me then and continues to.

In terms of communication, a lot of that ties into what I said earlier in being proactive, or previewing expectations. I don't think there is ever a fear that you could overcommunicate with a patient or a family member. I think that it's far better to say more than say less. One of the people that my parents, who were in charge of my health, unfortunately, [inaudible] my illness and they were my healthcare proxies. They were dealing with this doctor consistently, who was really part of my entire team. I had infectious disease involved, because they weren't sure what was causing my organ failure. I also had a transplant team, I had a liver doctor on board. So, I had many different people as part of my team. He was really very familiar with everybody and everything that was happening, and he would meet with my parents almost daily, and tell them, you know, what was going on. So, it was very comforting for them to know that they could call on him and that he would be up to speed on my case. They went in one day and they asked to speak to him, and they were told that, oh, gee, you know, he actually just moved to South Carolina. He got a job there, but somebody else will be coming by and they will give you an update. And my parents were really devastated. I was not conscious at the time, but I can only imagine how that must have been for them to suddenly have the person who they had complete faith in, to suddenly go away and not be told that. Or not been able to say goodbye to him, or who might be taking over? Were they really up to speed on everything? As it turned out, that did happen, but there was no communication around what was going to happen, what was about to happen, that I think would have alleviated a lot of stress from their perspective.

Consistent care, I think, is really about -- you know, I absolutely love my doctors and nurses. I would do commercials for them. I am so grateful to them and for the things that they have done. I remember one nurse in particular, Erin, who was there at the very beginning. She just actually switched jobs, and it was her first week when I entered BI. She was my nurse practitioner from that day forward, until about, I would say, five years ago. And suddenly I was told I had a new nurse practitioner, who was a lovely person, there is nothing at all wrong with her, except that I really wanted to be seen by Erin, because Erin knew me, she had that history with me. I know that can't always be done with staff changes, et cetera, that obviously would be impossible, but I think in this case, Erin could have remained my nurse, because she had been with me all these years. But they had a switch in the hospital system to take patients by the first letter of their last

name, and somehow “M” didn’t make it onto Erin’s docket, it was given to someone else. I think in those cases -- and I still see Erin when I go in there, but I think that is an easy thing to shift, if somebody wants that, or should just be maybe more aware of the fact that you actually do -- I think -- get very attached to people who have taken care of you. Erin was one of those people, and I remember vividly going in with my parents at one point, after being [inaudible] for six months. I had gone to Spaulding Rehab for six weeks, and then I went back to BI with a failure to thrive diagnosis. And after I was finally discharged after six months, I went back in 11 more times over the next six months with various complications. I had [inaudible] in my lungs, I had high potassium, I had two rejection episodes. It was a very complicated case, obviously. But I remember going in for a visit with my parents and Erin was there. And I looked at her and just said -- because I really felt like I was never going to get better. I asked her, I said, Erin, will I ever get better? And she looked at me, and I think she was shocked and she just looked at me, almost like a deer in the headlights, for a second, and said, yes. Yes, you will. And it was so powerful for me at that moment, because she really gave me hope, when I really didn’t have a lot. So, obviously, I’m very attached to Erin and would still like for her to be my nurse, and she is someone who if I can’t get through to the person I’m assigned to, I do call her and she gets right back to me. We have that history, that I think is just really reaffirming in terms of our relationship and this continuity of care that I think we all want to receive.

I think those are really my big takeaways. I mean I think the art of previewing actions and obviously, we want our doctors to be very knowledgeable and capable, but we certainly want them to be -- to have some compassion, to be very communicative, and offer that consistency of care whenever possible. So, I would be happy to take questions, if we have time for that, but I am just so grateful that I could do this for you today, virtually. And I’m so sorry, again, that I couldn’t be here physically, but I knew it was better to listen up and pay attention to myself. I have been known to ignore that in the past. So, no longer.

## **MARK SMITH**

Well, that is terrific and we thank you very much for sharing the story, it’s a reminder of the fact that all of us at some point or another will be patients and at some point, or another, the things that will be important to us, include technical competence, but a whole lot more, including understanding the path that we are walking on, which is something we are going to talk about today. So, it’s a really great reminder and we appreciate your participation.

## **NANCY MICHAELS**

Thank you so much.

## **MARK SMITH**

Thank you. Thank you, for being here virtually and putting up with this.

The next portion of our program is a panel discussion encompassing multiple stakeholder perspectives, and we are going to launch this dialogue by hearing from two providers and a regional payer, about what it takes to do the nuts and bolts of changing from a system in which people are rewarded for the number of things they do. The number of procedures, the number of visits, the number of hospital admissions. As opposed to the achievement of some pre-arranged, pre-determined quality level, including the things that are important to patients, that is to say, value over volume.

First, let me ask the director to put up the results of our first poll that was done when Mark asked. We asked, how long people have participated in APMs, for those that are implementers. And if we could put that up on the screen. And the answer is, 26%, or a little more than a quarter are three plus years, 24%, one to two years. So, about half are a year or more. 14% less than a year, 14% would like to participate, but not ready at this time, and 22% are not participating. This is probably a good sign that we have people at different parts of this journey.

The second question was, what is your role in advancing APMs? Here we have 11% advocacy, 28% consulting, 30% education and resources, 9% expertise, 14% convening, and 8% other. So, we are going to talk about the need for all of these roles as we hear from the panel, but I think it's worth pointing out that for anyone who is implementing APMs, there are lots of nuts and bolts stuff to be done, and it's not easy, because we are changing a culture that is deeply imbedded in both the economic model of everybody in healthcare, and the cultural presumption of everybody in healthcare including patients about the way the thing works.

So, let me introduce our second poll, which is to ask this question: For those of you who are implementing APMs, what is it that is a problem? What are your obstacles in instituting value-based payments? Leadership support, organizational culture, technology and infrastructure, legislation, financing, access to implementation tools -- that is playbooks about how to do things -- other, or none. You are off to the races, and everything is going just swimmingly. Probably not many in that category, but if you are in that category, by all means, check that box.

As we said, trying to do this involves nuts and bolts, changing the way we do things and we are very lucky to have with us a number of people who have been on the implementation side of this work, so let me introduce them to you now. Brian Bourbeau is Director of Practice Operations for Oncology, Hematology Care in Cincinnati, Ohio. Karen Johnson, Vice President for Healthcare insights and partnerships in Blue Cross/Blue Shield in Kansas City. Emily Brower, Vice President of Population Health for Atrius Health.

Each of you has about six minutes -- that's six minutes, to share your implementation story and then we will hear from responders. So, Brian, let's start with you. Then Karen, then Emily.

## BRIAN BOURBEAU

Thank you, Mark. Oncology, Hematology Care is a community cancer practice in Cincinnati, Ohio, with 53 providers across 13 locations. We are in Ohio, also in Indiana and Kentucky. Four years ago -- actually, five years ago, we began a strategic planning exercise and one of the opportunities arose to improve our care model. We adopted a medical home that we call the Oncology Medical Home Model, and many of the ideas that we put on the board five years ago, survived. Some did not. But they centered around wanting more comprehensive care for patients, and better navigation, working through psychosocial support, and financial support. A second stream was evidenced based care, really focusing on what drugs are most effective. Best side effect profiles, and then starting to focus on a new subject called "financial toxicity". Third, was access. Many of our patients were ending up into the ED, and were admitted to hospitals for conditions that we knew we could treat either in extended hours or weekends, Urgent Care visits, or maybe even triage and education at home. We shot a couple of supporting strategies for that. First, was accreditation. There wasn't an accreditation program for Oncology Medical Home five years ago, but there is today. We are one of ten practices that helped found the Commission on Cancer, accredited Oncology Medical Home. That gave us an outside perspective of whether or not we were doing the right thing. We also sought payment reform. We knew that the current payment model did not support what we wanted to do, and so we found partners with Medicare and with private payers to help support this new care model and change how we do oncology in the country.

In 2012, we were 94% straight fee-for-service. We had a small quality and value program with a private payer that represented about 6% of our business. We set goals for 2016 upon joining the HCP LAN, to hit 63% quality and value, ranging across different categories in the framework, by the end of last year. We actually hit 64%. So, we met goal number one. Goal number two is to reach 90% by 2020, and it ranges from some simple pay for performance programs, to more advanced, bundled, and shared savings and risk models.

Our latest model is the Medicare Oncology Care Model. It is a five-year project, supported by the Center for Medicare and Medicaid Innovation. There are 190 practices across the country, ranging from one office community centers, to large academic health systems. It blends together redesign and quality improvement, with a change in how oncology is paid for. It involves shared savings and risk for practices that performed well, or made to improve their performance in the model. Each practice has its own work stream that it knows it needs to improve upon. I may perform well in one area, and you may perform well in another, and the Oncology Care Model gives us the freedom to work on what we need to improve. For us, we came down to some of the three work streams that we saw back in 2012. First, was evidence-based medicine. We have applied both treatment pathways, and what cancer care we give you, what drugs and radiation, as well as triage pathways and other evidence-based medicine strategies to improve the quality of care. We are also surrounding our patients with 20 nurse navigators and, I lose count, I think I'm up to 11 financial navigators today, who help patients through their journey with all the psychosocial and financial support needs.

Finally, we call it ED avoidance, because we find out our patients end up in the ED. But we have dedicated now a triage unit that does great work in getting the patient the care they need either at home or through urgent visits and used as an evidence-based medicine approach to accomplish that.

In our first year of the program, we have received one quarter of results and over multiple quarters here, you see leading up to June of 2016, even adjusted for inflation, we see a rise in Medicare expenditures per beneficiary for cancer care. In our first quarter, July through September of last year, we saw the first downward tick. I'm not here to claim success yet, but we liked those early results. One of the benefits of being a part of this program is quarterly feedback to let you know how you are doing as a practice, and how the model is doing overall. So, we hope to see another quarter of great results here soon. Thank you.

## MARK SMITH

Great, thank you.

## KAREN JOHNSON

Thank you. I am delighted to be here to share with you the story of CPC Plus in Kansas City. We are one little region, made up of five counties in two states. Lots of great clinicians and one payer. Fingers crossed for round two announcements.

So, to understand our story, you really have to go back to 2009, when the medical director at that time started looking at the early results coming out of the national demonstration project and other patient centered medical home pilots and said, this is a good idea, we should do this. So, in 2010, we launched a pilot with about 161 physicians, caring for about 40,000 of our members, and it went well. By 2012, we decided to go from pilot to program. At that point, we had a substantial number of physicians involved and then in 2012, you may recall, there was something else going on, called the Comprehensive Primary Care Initiative, which we were quite excited about. We enthusiastically submitted our application, which was not to be. So, undeterred, we soldiered on, we continued to grow momentum for our program and our little market.

In 2016, we had over 800 physicians, caring for over 200,000 members in our 32-county service area. We were getting really, very good results and very encouraged. But, it is not without its challenges. So, here to talk to you about a few that we see as important in addressing head on, because we think that if you do, they will lead to successes, no matter how small or incremental those successes might be.

I think the first is really, as a health plan, we really have to reimagine what our role is in member health. As an industry, we have invested substantially in direct to member programs like wellness and disease management. We also know that members prefer to get their healthcare from their providers. I think that with the right financial incentives in

place, with the alternative payment models, we have to reimagine our role in supporting providers differently. And you will hear me often say, it's not just about the payment. It's about how we support them with other resources and information.

One of the things that we did at Blue KC, is we redeployed a number of our disease management nurses, as primary care nurse coordinators, and they are working actively with the care coordinators and our medical home practices, learning and growing with each other.

Another important piece of this is talking to employers. They shoulder a substantial burden of the cost in our healthcare system today, and we have to bring them on the journey with us. It's hard conversation, employers want to know how their dollars are being spent for their population. Unfortunately, it's hard to tie results of alternative payment model pilots and programs to specific employer groups. So, what we are left with sometimes, is health plans making the decision to leave self-funded employers out of the conversation. At Blue PC, we took a very different approach. We had everybody at the table and we choose to be very transparent about the costs that we were paying. The new payments to medical home providers, which were actually on top of fee-for-service. So, we know -- I spent actually 20 years as a broker before I joined on the health plan side, and we know don't like to talk about added cost on the employer's side. I think the fact that we brought everyone to the table, and we are very transparent about the conversation, we actually even came up with a name for all of these payments that we report with claims costs each month, quarter, however frequently the employers are reported. Medical Value Payments, or MVPs, is what we call them. And happy to report that at this stage employers are for the most part on the journey with us. It's going to continue to be a challenge to have these conversations, but they are important conversations to have.

I think we all know that engaging providers as partners is very different than contracting. And what is really challenging, is we are still contracting with them, because we are still built on a fee-for-service infrastructure, but we are also engaged with them as partners in very many different ways, and I think that it's just really important that we understand what the provider experience is like. In CBC Plus, we talk a lot about how we have to align quality measures or exchange data and methods that don't burden the providers. I think it's important to step back and look at even the nuts and bolts. Some of the administration that was in place long before alternative payment models, which gives us opportunities to better serve providers, and we know that that's really where we get what we all want out of this.

So, we kind of know how the story ends. We, in 2016, when CBC Plus was announced, Blue KC was once again at the table saying, we really want to do this. We think this is important for our community, we think this is important for providers. We also knew that we might be the only payer to apply, but we worked closely with our providers, we rallied as -- we tried to rally support for other payer applications, but at the end of the day, we knew that we might be the only ones applying. So, we also looked at the numbers and that's how we ended up with a little five county region. We knew that market density

could be achieved with just Blue KC and CMS if we focused on that market. And it has been significant. One of things I hope we talk about is the community collaboration that is required, and CBC Plus has given us a platform for that, whether we have other payers officially at the table or not. Oh yes, of course, we were in.

One of the things that we were asked to do as part of this panel today, is be inspiring, which is kind of a tall order. But I have found that as we have engaged with the LAN and others on a national and regional basis, that I'm often inspired by others. So, I want to share with you something that inspired me, and this came from Dr. Cunningham, who is the Chief Medical Officer for the Blue Cross/Blue Shield of Oklahoma plan, and it was in the LANPAC webinar -- and that's the Payer Action Collaborative, if you are not familiar with the acronym. They were asked, to what do you attribute your success in what is now known as CPC Classic, and he started this with something like, you know -- it sounds much better with his charming Southern drawl, but it's really pretty simple, pretty straight forward. "We always put the patient first and don't let our organizational baggage get in the way."

With that, I will close and look forward to the conversation.

## **MARK SMITH**

Thank you, Karen. Emily?

## **EMILY BROWER**

Thank you, so pleased to be here. I'm going to talk a little bit about Atrius Health's participation in alternative payment models, a model that we believe is best suited for providing those strong relationships, supporting strong relationships with providers and patients, and hopefully delivering that compassionate consistent communicative care that Nancy was talking about earlier.

Because I'm going to talk about our experience and our Medicare ACO model, I have my disclaimer here, so you know the views and information are my own. So, Atrius Health provides care and coordinates care for 675,000 patients in Eastern Massachusetts. We have been in that market for a good long time. We embrace value based payment models, alternative payment models, really focused around, as I said, that meaningful relationship between the patient and the provider in our patient centered medical homes, and we have 29 practice sites in Eastern Mas. Then going out from there, coordinating care across the community. We will always raise our hand to participate in those kind of payment models, and so as a result, about 80% of our revenue is in total cost of care or value based models. So, we have a lot of the tools and infrastructure that gave us a strong foundation to participate in the Medicare ACO models. It also enables us to perform very well on delivering quality outcomes that patients deserve.

To speak a little bit about why participating in the Pioneering ACO in 2012 was important to us, it was really about getting all of our Medicare patients into one model of care. So, we had about 50% of our Medicare patients in the Medicare Advantage model and 50% still in Medicare fee-for-service. So being able to wrap our arms around the other 50% meant that our delivery, the way that we take care of patients could be consistent across the entire population. It also gave us some experience getting into risk -- financial risk, for PPO models -- Medicare being the largest PPO in the country. Then, furthering our mission to work with others in a very collaborative manner, to transform care nationally, hence our participation in the LAN, the Healthcare Transformation Task Force, and as a Pioneer ACO and now a next generation ECO.

So, our Population Health Approach is one, I think that will not be unfamiliar to most, which is really bringing a comprehensive patient-centered approach to patients who have the most advanced illness and really need us to wrap around the patient, the family, and their community resources, to make sure we are delivering exquisite care for them in the manner that they have communicated to us they would like to be cared for. And then, going down the pyramid, those patients with multiple co-morbid diseases, very much focused on preventing acute exacerbation of those diseases, and then preventing the development of chronic disease in the first place.

We focus, we say, on our highest risk patients and those highest cost events. That's our biggest opportunity that then translates success down the pyramid for other populations. Many Medicare ACOs, we would start that process, or a process with any population really understanding the population and what their gaps of care are. Then bringing the folks in our organization and in our community, focused on improving care. So, those are the clinicians and others to redesign the system to deliver that care. We have seen some great results. Atrius Health, because of that long history, providing care in these kinds of models, was both a foundation for success, but also a challenge, because we started out the model as a low-cost provider. Those patients, even though they were in fee-for-service in Medicare, often had been our patients within HMO and POS models, where we had been caring for them, for generations, for decades. So, for us, really had to work hard to deliver savings coming out of a historical low cost for efficient provider, but we have been able to do that year over year. Haven't quite gotten our results yet for 2016, but looks to be even better. So, continuing to drive value for that population as part of delivering results as a whole. Again, within payment models that at their essence are about supporting the relationship between the primary care provider and the patient, starting from there and then going out in our concentric circles to manage the total cost and total care.

## MARK SMITH

Thank you. So, we have now heard three examples of people who have been implementing different advance payment models, alternative payment models, and you will note that in each case, they decided the kind of partners that they needed to get this done. It might have been employers, it might have been state or federal government, and



certainly patients. We now have four responders who will speak to their own perspectives on their alternative payment models.

We've got Phillip Bergquist, who is Manager of Policy and Strategy Initiatives from the Michigan Department of Health and Human Services. Linda Brady, who leads Healthcare Strategy and Policy for the Boeing Company. Debra Ness is President of the National Partnership for Women and Families and a member of the Guiding Committee of the LAN, and Patrick Conway, another Guiding Committee member, is Deputy Administrator for Innovation and Quality for the Centers for Medicare and Medicaid Services. So, love to hear from each of you in terms of your perspectives on this work and the work that you yourself are doing around alternative payment models. Phil, let's start with you.

## PHILLIP BERQUIST

Great, thanks, Mark. It's interesting to hear the sort of stories of the three of you as we all work forward in this payment reform journey. I'm somewhat new to state government, and I'm learning that lens in that perspective each day. One of the things that I have come to appreciate about our role as a state government and in particular our role as an insurer in the Medicaid program, are the layers of integration and the layers of partnership. So, as a state Medicaid program, as a state Health and Human Services Department, we come together with providers, we come together with payers, we come together with patients and community members and advocates, and really pulling the pieces together to lead a strategy and also to have some vision.

I think one of the things that we are most excited about right now in our work as a state, and in particular as a Medicaid program, is the alternative payment methodology partnerships that we are working on right now with our Medicaid Managed Care organizations in the state of Michigan. Using the LAN APM framework as a guide and as a way to have started that conversation, partnering with each of these managed care organizations, who are then partnering with their provider networks, and the patients that are served by those providers to figure out not a one size meets all strategy for our entire state, but a menu of options and really a shared framework in talking about goals. So, setting a structure forward where each of our Medicaid health plan partners becomes accountable for a goal, has the opportunity to look at multiple payment methodologies to meet that goal, to work with payment approaches that support providers at different stages of readiness, and different abilities to engage in a pretty complex -- as you guys said, a pretty complex system of things that are being undertaken right now.

In looking at those goals develop, we are still early on in our process, but at looking at those goals develop, it's really exciting to see payers coming together in thinking about proactively engaging providers and providers thinking about proactivity in engaging their patients and the communities that they serve to think about how we can do it better and how those goals can shape the work that we do together over the course of the next three years. With that lens in place and that sort of collaboration happening at multiple levels, it can be a complicated thing to take on, and a complicated opportunity to realize -- and I

think one of the strengths that we have going into it, is the opportunity to work with lots of different experts and lots of different folks that are doing this work across the country.

We have adopted that LAN framework as a way of not only to help us set goals, but as a way to talk about payment. That's been helpful, but we also are able to use things that we learn, to use expertise from people that we meet, to tap into things that we may not have directly, or to share things that we do have directly, to help others. And that's been a really wonderful thing thus far. I think one of the pieces that is most interesting to see evolve today, and you guys all hinted at it in your comments as well, is that we are never done. Everybody has taken a step and a journey.

Michigan has taken many steps over time as a large commercial program that have been really wonderful for our provider base in participating in the multi-payer advanced primary care demonstration and in advancing health information exchange, and we have had the beginnings of payment reforms, much participation in Medicare shared savings programs. Our next step as a Medicaid program, is coming through this alternative payment methodology strategy, but there will be a step after that. That's interesting to see that component evolve, and it was interesting to hear it from the three of you as well, and see that evolving in different ways. Each of you taking a different step, we are taking many steps in Michigan and many steps at the same time. But to see all of those pieces come together and play out with a supportive environment around each other, is really rewarding.

I think we have a lot of work ahead of us. It's great to hear different organizations taking different perspectives and accomplishing this work. I think that we have a lot to learn from one another in doing that, and to see which one works for different populations. That's my favorite thing to remind myself of, is that as we try different things, and as we test different things, especially when it comes to payment, and how payment impacts the way that we deliver care and best serve our patients, that we have many answers for many populations and many needs. It's exciting to see those things come together and looking forward to the conversation.

## **MARK SMITH**

Thanks. Linda?

## **LINDA BRADY**

I'm delighted to be here.

I'm with the Boeing Company and for the last several years, we have been direct contracting with multiple health systems in four markets. So, we have two health systems in Puget Sound. It wasn't our original intent to go with two systems, but it seemed to fit the need of our population, which is where our largest employee base is. Then in 2016,

we launched in St. Louis with Mercy Health Care Alliance, and then in Charleston with Roper St. Francis. Then this year, we just launched with Memorial Care Health Alliance.

With each one of these arrangements, it's been a direct contract. Directly with the health system and with the providers. It's not a situation where we have the contract settled in and then we walk away. We are actually talking to every single one of these systems multiple times in a month. Not just quarterly or annually, it is every month. We gather together to talk about the challenges. You asked a question earlier about what are some of the obstacles that our systems or our initiates face? And there was no option to say, all of the above. I did note that to myself, thinking, well, we could classify it. We are challenged, and are learning so much, the fact that we've got two systems in the same market in their third year. They also take care of two cohorts, so it isn't just cohorts that actually enroll and decide that they want to be part of the ACO model, but it's also for employees that use these systems, but didn't enroll. They stayed with a more traditional healthcare plan. So, that has posed some interesting challenges to our systems.

I would say a key theme for us right now, we've got a number of them: One is, one size does not fit all. One of the advantages of being in multiple markets and working with very different systems, is we are learning a lot, but it's very unique. Each market has its own personality, its own needs. The culture in the market of our employees and how you want to engage them. What their health risks are, are very, very different. And, the reputation of each of the markets, of the different systems. So, that's been a fascinating journey.

We have been able to take forward some lessons learned in Puget Sound. They are kind of our leaders out there with no blueprint. Sort of making the blueprint as they go forward. But we have learned from some of our newer players, some of whom are differently shaped. In Puget Sound, our two systems are made up of multiple partners, not just one primary health system, it's multiple partners. In St. Louis, for example, it's a primary partner. A partner that had experience at one point as a health plan, and that has brought in an interesting perspective to what we are trying to do. Universally, all of them are challenges with data. Data, data, data.

I was listening to you talk about what something is inspirational, and for us, it's always about family first, patient first, member first. That and it's hard -- it's not supposed to be easy. That's a famous line in some movie about that. But it is about the patients first and I think we are still trying to crack that -- what we call the \$64 million question: How do you engage our members in a very powerful way, an important way, to get them invested in their own healthcare? As employers, we are coming behind our health plan partners, often the community, to try and fill in the gaps. By doing that, we've added sort of one off or some might describe it as boutique solutions, both in wellness as well as in healthcare. And in working with our ACO partners, what we are learning is, all of these solutions -- two things, our employees get confused and aren't always sure about what's available. The second thing, our other theme is, are these solutions taking member's eyes away from the PCP? So, we have a very heavy emphasis, without exception, across our markets, about the importance of the primary care physician and the role they play in the

member's engagement and care. So, we are looking at how do they differentiate in their market? How do they make the experience for the members so unique and so helpful, that the member wouldn't want to go anywhere else but there? And that is a big problem that we are trying to -- "problem" isn't the word, it's "challenge", that we are trying to address. We see each of our systems taking the steps to do something unique and new and it's a very exciting time to be in healthcare. Every day I pinch myself, thinking, how lucky I am to be part of this, to be working with people who care so deeply and intensely, about changing the way care is delivered.

## MARK SMITH

Thanks. Debra?

## DEBRA NESS

Thank you. I'm Debra Ness and I'm with an organization called The National Partnership for Women and Families, which for four and a half decades, has been working to improve health, equity and economic security for women and families. I, as an advocate, view this work to move toward alternative payment and to move us away from fee-for-service, as being in the service of achieving that mission. Of improving the well-being and the economic security of women and families. I think it's why, at the end of day, I ask myself always, "Are these models that we are building, really providing better care for the patients and families that use them?"

So, I would like to touch on three things that are particularly important to me, as I answer that question for myself and as I advocate and as I listen to the panelists here. The first is, this idea of co-creating the outcomes that we want. We all want better outcomes, we all want people to have better care experiences, we all want to lower costs. I think we all -- at least intellectually, agree that we can only get there if we do it together. That getting to that ideal state is something that we have to co-create. I think we do that -- I think we say that intellectually. I think payers and providers and other stakeholders try to do that, but we often fall short when it comes to engaging really collaboratively with two of the key players -- the clinicians and the patients. I think a lot about the conversations that physicians are having today about the amount of change that is coming at them, the burden, and there is lots of talk about burnout.

Then I was very encouraged by listening to some of your stories about what is going on in Kansas City, the fact that Karen talked about the fact that collaborating with clinicians is not the same as contracting with them, really resonated with me, because of course you are going to have a very different kind of engagement if folks are there at the table helping to create the system they think will work the best.

I want to encourage us to remember that that is also true with patients. At the end of the day, we all talk about the fact that we want a system that's patient-centered. And in fact, administrator Seema Verma started us out, saying, we want to be patient-centered in our

healthcare. Well, how can we get there if we don't have patients with us at the table, from the very beginning, in the design and the development and the implementation and eventually in the evaluation of these new models of care.

One of my questions for everybody here is, how are you involving patients and gauging them to make sure that the new models you are designing are really going to meet their needs? My second point is really going to echo what Linda was saying about the importance of primary care and how important it is that we build these alternative payment models on a strong foundation of primary care. And I say that for really two reasons. One sort of, quite plainly, the primary care clinician is your gateway to other care. And in some estimates, I have seen, 90% of other use of the healthcare system is determined in some way, shape or form, by PCPs. For patients, there is an enormous opportunity for good relationship with their primary care clinicians to really guide them in the way that they use and engage with the rest of the healthcare system. We talk a lot about the need to change culture, the need to engage patients differently. We need to understand that the role of the primary care clinician -- and that relationship between clinician and patient, are really at the heart of how we will probably most engage patients and most change the way that they interact with healthcare system.

Finally, I want to urge us to think about the ways that we are assessing the value of these new payment models. Yes, we are looking at whether they lower cost. Yes, we are looking at clinical outcomes. But are we really looking at whether or not, at the end of the day, the patient had a better experience in this model, then they did in that model? Or in the old way? I think we haven't quite figured out how to get at that yet. Is the care better today than it was yesterday? That is the question that I hope we all can work together to figure out. Thank you.

## **MARK SMITH**

Thanks, Debra. Patrick?

## **PATRICK CONWAY**

Yeah, so it's an honor to be here today with the panel, and I was reflecting back on the panel and my over six years on this tour of government service, which feels like 42 in CMS. I had the honor to serve now three different presidents and four secretaries of health. I think importantly, an honor to partner with people like we heard here. I will reflect on five things briefly.

One, I do think the federal government has a role in partnership. You heard about it in Pioneer ACO and CPC Plus, and the Oncology Care model. All of the examples here, the federal government had a role to play. The Innovation Center in particular at CMS, we now indirectly affect over two thirds of Americans, over 200 million, directly have over 18 million people in various payment models like we heard about today. Over 200,000

providers, and over 30% of payments in alternative payment models. So, I think a partnership that we need to continue to develop, but I think can be a catalyst for change.

Two, I think we heard about public/private partnership, and their critical nature of public/private partnership. You heard about the Primary Care Plus initiative, I would also say, some of the work that LAN is doing now, on alignment of these payment models. So, ACO's or bundled payment or primary care, things like quality measures, risk adjustment, attribution, et cetera, as aligned as possible. So, if you are a provider, you are getting a common signal, much easier to be successful, I think, when we have alignment across public and private sector, including with states as well.

Third, and related, I think we still need to tap into ideas and innovation from across the country, and tap into what I will call state and local innovations. So, certainly in our state innovation models, but also broadly. You know, how are we going to innovate in various states? What models make sense for those states and communities? How are we going to do catalytic investments like state innovation models or accountable health communities that really focus on a given geography and really tap into the resources, the partnerships, the potential collaborations of that state and local level.

Four, and Debra said most of this, so I won't resay it all -- but, patients and consumers first. I do think co-production. We are doing some work in co-production, but I think we have opportunities to improve. How do you really co-produce with patients, with consumers, with providers as well? How do you really have true co-production mentality? I still practice as a physician who mainly takes care of children with multiple chronic conditions. In my clinical practice, I'm able to talk about goals of care, not just for that hospitalization, but long term goals of care. We still don't have a reliable system to measure that, to achieve that at a real patient centered level, in my opinion.

Then lastly, how do we have a true continuous learning system? So, I think we made progress here based on data and evidence, but at a macro level, how do we learn what works and scale that? I think we are doing better today than we were three or five years ago, but we still are not as rapid cycle in our learning, as I might want. And then also, at the more micro level, you know, I used to have to manage within a delivery system, you know, how do you get the data and the information and the evidence at the point of care to that primary care clinician or that patient and family making a decision about surgery - whether to have it or not. How do we really get the data and evidence at the point of care as much as possible, to drive care change?

So, I will just close with thanking the panelists and really look forward to the discussion today.

## **MARK SMITH**

Thanks. So, what we are going to do now. First, I am going to report on results of our second poll, and then I have a question for each of our presenters, and then we will have a conversation. So, if we could put up the results of the second poll, that would be terrific.

What are your obstacles in instituting value-based payments or APMs? Leadership support -- I think all of the above probably most people would say that. But leadership support, organizational culture, technology infrastructure, which I will include, data. Legislation, financing, access to implementation tools and actually fairly small numbers for both other, and none. So, it sounds like we got the main obstacles and it sounds like most people have some version of all of them.

Let me say first to our audience that is online, here is an opportunity for you to submit questions to the question box on your online engagement tool. We will get to some of them, as many of them as we can. I think for those of you who are in the audience, you have ways to do that as well. Write them on a card, give them to the other Mark, and we will get to as many of them as we can also.

I have a question for you, Phil. We heard our patient talk about previewing expectations. Jemma Internal Medicine has this long-standing feature called “less is more”, which kind of gets at the point that many of us, not just providers, but patients, often start with the presumption that, the more the better. More tests, more procedures, more drugs, more everything. I said Phil, I apologize -- Brian, sorry. You’ve laid out this very impressive re-organization of care for patients with cancer. Where one might pressure that they would presume that more is better. It turns out, I suspect, that less of somethings -- perhaps chemotherapy, perhaps other things it’s better -- how is it that you’ve talked to patients to preview the expectations for this journey that you’ve now reorganized? As opposed to the old days, where people would page us to do stuff, you have thought through what their pathway is for a certain kind of cancer. You should be in a position to preview expectations, but also in some ways, change their expectations, because you have changed the model of care. So, how do you talk to patients at the beginning of this process, about both what they should expect and how do you involve patients in this co-production that you have heard Debra and Patrick talk about?

## **BRIAN BOURBEAU**

Well, I think a great example is end of life care. It’s the realization that you are treating a patient, not a tumor. Not a disease. And you and I, as patients -- if we were patients of the same physician, let’s say of Dr. Conway’s, we have different life impacting us, we may have different desires for end of life care. I may want an aggressive approach. You may decide that you don’t want to have your last days spent in the hospital receiving more therapy. So, we need to have conversations with our patients and really explore, you know, what their values are, what their desires and goals of therapy are. And we do that up front. So, as part of the oncology care model, advanced care planning is one of the redesign activities that we are pushing in organizations across the country, to make sure we are having conversations early, understand the patient’s values and then apply them to their care.

## MARK SMITH

So, I have a question for you, Karen --

## LINDA BRADY

Are providers having that conversation or are other care leaders having that conversation with patients?

## BRIAN BOURBEAU

It's a team based approach. So, it starts with our physicians, and then we also compliment that with more specialty trained care team members. So we sent all of our advanced practice providers, our nurse practitioners, clinical nurse specialists, the course of many years ago, on that subject, and so they are available to really help with care planning and a team based approach.

## MARK SMITH

I want to speak up for doctors for a minute. There are a lot of things that drive doctors crazy. In a lot of ways, doctors drive other people crazy. But one of the things that drives doctors crazy is getting different signals, different metrics, different instructions from different payers, and nobody seems to think it's either ethical or particularly efficient to have doctors practicing to different standards for patients based on who's paying for them. And, yet, a lot of people from the left and to the political spectrum to the right seem to think that competition between health plans is the key to reducing costs, so you talked a lot about how you're engaging with providers, but most of those providers have patients who are paid for by other payers and apparently, the other payers haven't yet drunk this Kool-Aid. So, help me understand where you think the role is for competition between versus collaboration between providers, between health plans, in trying to engage providers to provide one standard of care for all their patients, no matter who's paying.

## KAREN JOHNSON

How much time do I have? [Laughter] So, I think this is a huge challenge to us, as health plans, is to figure out where we compete and where we collaborate, and I do think that's one of the great outcomes of this whole movement toward a new form of payment. It's really causing us to have a conversation that we should have been having a long time ago. So, like CPC Plus, for example, we are in regions collaborating, and I always, in the regional meetings where we come together with – who am I collaborating with in my region because I'm one payer? Of course, CMS, you know, and our folks there, but we, in Kansas City, decided that we didn't need to wait for a formal program, so a couple of years ago we launched something we called at the time the Blue Ribbon Advisory Panel, which was intended to be a conversation in the community about the best interests of the



community and how do we move forward knowing times are changing, and what does that mean for all of us? So, it started with 22 healthcare leaders that were asked to come to the table for their perspectives and their experience, and that program has evolved, or I shouldn't call it a program, that group, that community conversation has evolved to the point today where we have probably 100 people in the community involved in this conversation. We've had work groups started, one around community infrastructure and technology, one and all-payer work group. So even though we don't really have an official convening of CPC Plus in our market, we're saying let's just come together and talk about what we can do together. So, in a CPC Plus platform, we talk a lot about focus on quality measures and the new things that we need: data exchange, clinical data exchange, and quantum measures. I'm saying let's back it up. Let's talk about all the payer-specific stuff that we ask of providers that we could collaborate on. Something as benign as provider demographic data, and we know physicians move and change practices and when they do that, they have to submit forms or use logins on different portals for every 7 to 10 payers that they have, and if the doctor is moving within one system, from one location to another, they do that twice. So, we're just not making it easier on providers and I think it is up to us, as payers, to start looking at each other and having those conversations and let's start with the easy stuff.

## **SPEAKER**

Mark, could I jump in for a second?

## **MARK SMITH**

Absolutely.

## **DEBRA NESS**

Because this comes right back to the first point that you raised, and this whole idea of co-creating. If you are beginning to take some of that burden off the doc's, then the doc's also have time that they didn't have to spend with their patients, which, if you talk to most doc's that's what they feel like they least have and they feel like all this other stuff is getting in the way of patient care. When the doc's and the patients are able to form a relationship, the problem of more is better goes away because, when a patient has a relationship with someone they trust, a trusted clinician, they're much more likely to feel like they're getting good recommendations in their best interest. They're not going to want the more and the more. The kinds of conversations that we're talking about are conversations where you can talk about why maybe you don't want to go that extra round of chemo, or you don't need that extra diagnostic test, or whatever. But I think we're underscoring the importance of coordinating across the board to reduce burden, but also that also creates more time with patients, and more time for that relationship and what you can change the way patients, then, engage with healthcare.

## BRIAN SMITH

Great.

## PHILLIP BERGQUIST

I think Karen made one other point that's really worth stating explicitly, which is it's not just the "what" it's the "how", so you know, it's easy, the first thing that comes to mind for me, when I think administrative version is quality measures, right? Different payers, different measures, I'm measuring 60 different things, or I'm being graded on 60 different things. It's 60 different things, but it's also 60 different things reported eight different ways. And the how in all of this conversation is really important. So it's, you know, is it a different portal, is it a different format, is it a different file, and that the details of that, they seem to matter a lot, just as much as the conversation around what and what that burden is, itself, it's how do we go about doing those things and is there a way for us to not only, you know, center in on the things that can be made the same across expectations, whether that's a regulatory expectation or a payer expectation, but also how do we go about getting those things because the space between the two, you know, the 50 things measured eight ways and the 50 things measured one way, that's a big space that gets at exactly, you know, Debra's point, as well.

## MARK SMITH

That's terrific and we'll come back to that point, I'm sure. So, I want to ask you about culture because you saw from the results, and I think from most of our experience, the way in which providers are paid doesn't go back a month or a year or even 10 years, it goes back decades. It's deeply embedded in everybody's business model, it's deeply embedded in everybody's way of operating—staffing levels, capital commitments, etcetera. So how did you deal with the culture question as you've been trying to transform the organization from one that has done well in a volume-based world, to one that can do well in a value-based world? How do you tackle that culture question?

## EMILY BROWER

So started out with, I think, some advantages, some of the precursor organizations to Atrius Health were staff model HMO's and they were groups of clinicians who came together very deliberately to try and deliver a better model that matched what they believed was the right care. So, payment and care coming together, so, so much a part of our DNA. We were able to hold onto that when the market moved away from managed care in the '90s and back into fee-for-service, hold onto some of that culture, that commitment to delivering care that best supported the patient, and then when the payers and CMS were ready to kind of get back into that game, we were right there and trying to advance that in our community. So I think, really starting out with understanding from the clinicians what they believed the right way to take care of patients is and building around that, because all of us in healthcare, we're all working for a purpose, and that's a

very strong sort of core piece of the solution that everyone can gather around. We're all trying to improve the experience of care, the outcomes and transform people's lives. So starting there and saying, okay, so what's the system, the delivery model that is going to advance that, and then working with the payers to say what's the payment model that's going to support that delivery model.

## **MARK SMITH**

Terrific. Anybody else have any comments on culture?

## **SPEAKER**

Well, I do think that it starts with leadership, too, and the willingness for a system to be bold and be disruptive, because that's often a good way of changing the culture. I would also say, back to an original question, an original point, the last thing any of us wants is a provider saying, okay, you're with this plan with this employer so I'm going to treat you this way because this is my check list. That will never get changed. We're wasting our time and we're in a hamster wheel. The sooner we get to all patients are treated the same when they walk in the door, the better chance for us to really show that we're making progress, and that's real success.

## **MARK SMITH**

So I note we don't really have any hospital people on the panel. [Laughter] Hospitals are a big part of care. They're a big part of the economics of care and moving from volume to value based care inevitably involves changing the role of the hospital, the centrality of the hospital in care, and kind of reevaluating that. I wonder if people have lessons they'd like to share, since we don't have someone who actually comes from a hospital-based system, but they're very much a part of this issue. Do you have some lessons you'd like to share about what it means to be working with hospitals in a value-based environment? Emily.

## **EMILY BROWER**

Sure, I could certainly speak to that. Atrius Health, to do the work that we do and get the kind of results that we get we have to partner really well with the hospitals in our community. And one of the great things about all the focus on readmissions as being a real failure mode, is that we can approach that from all sides, so engaging our hospital partners in improving the discharge, really creating a tight discharge plan, and experience for the patient, and having those hand-offs work really effectively and smoothly and not confusing patients with too many messages and too many people. So that's a place where the physician group and the hospital can partner really well together and we both benefit. The hospitals want to improve those measures, that's part of their value-based payment, and that reduces the total cost and improves the experience. In those moments of

transition is where there's just tremendous opportunity for the whole community to come together.

## **MARK SMITH**

Okay. Patrick, and then Debra.

## **PATRICK CONWAY**

A couple quick comments. I think we're working with hospitals in a number of ways and sort of meeting with them where they are on some level, so one is state-based, we're in Maryland, Vermont, and now Pennsylvania for rural hospitals, we have population-based payments for hospitals, and the other is, you know, just before this, with the next generation ACO with about 20 hospitals, and their CEO spoke very eloquently—and this goes back to culture—that they knew it was the right thing to do. They had been in this a while, in fairness, working with physicians in their community but they're in a full population-based model in making that shift, and she knew it was the right thing to do for their community, and their hospitals had a focus on serving their community. So I do think you need more leadership in culture like that. I think the last thing is, we also have hospitals that may not be ready for population-based payment models but are willing to partner with us and bundle payment in an arena, or think about admissions and readmissions. So we're trying to meet – our health system needs to move through this trajectory, including hospitals, and so we're trying to meet with hospitals at different stages of change, if you will, and help them make that shift in a way that's financially viable but also delivers the care we would all want for our loved ones going through that hospital.

## **MARK SMITH**

Debra.

## **DEBRA NESS**

So I was just going to note the connection to the earlier conversation about culture change, as well. I mean, we're asking hospitals, and actually everybody, to really rethink their role and go through a lot of change and one of the major pieces of culture change is making it instinctive to actually talk with patients and communities about what you're trying to accomplish. So the number of hospitals I've engaged with who've tried to change the discharge process or reduce readmissions based on what they know, but without ever really engaging with patients who've been discharged from their facilities, or talking to folks in their communities, you know, they're not going to be as successful. Nobody can probably tell them better what's needed than the patients and the community folks themselves. And so, again, I think part of hospitals making this transition is being

willing to make that same kind of culture change to involving patients in the design of – in the redesign of what they’re doing.

## **MARK SMITH**

Terrific. Yes.

## **KAREN JOHNSON**

I agree with all this leadership rests in a belief system that you start with and, you know, it’s just that when you see a market with stark contrasts in that and in our own community I’ve seen hospital leaders say things like, “I want to be a part of this community conversation,” that I was describing which is now known as the KC Health Collaborative, I don’t know if I added that or not, but they ask why they came to the table, one of the hospital CEO’s said because there are so many win-win, win-win-win opportunities out there that we all have to be a part of this. For that, I’ve also heard, when we were talking about advancing alternative payment models in a different form, a hospital leader also said, “What’s wrong with what’s going on today? I don’t think it’s broken.” So it’s interesting when you have that in a given community, but you really do start to understand where your collaborators are, pretty quickly.

## **EMILY BROWER**

And that’s really where that voice of the patient comes in so strongly. I think that the last time we decided we’ve got to do even better on re-admissions, and I said we’re partnering with the hospital center community, we went to talk to our patients and we were looking for the patients that had been readmitted 4 or 5 times in a year. So those are not patients who are likely to be able to easily come work with our model where we do pull patients into the care model redesign, so we went to them. I sat at kitchen tables talking to patients about what was their experience, what happened, so that they could tell me in their words what does it mean to have, what we call, a readmission. What was that? Why did that happen? And having both us and our hospital partners hear about some of those, what we would call failures, definitely failures, that is where, when the patient tells you, you can’t ignore that. You can’t say, oh, this is working great for us now, fee for service, when you have the people that are experiencing the care tell you otherwise.

## **BRIAN BOURBEAU**

A few years ago we saw patient feedback on how educated they felt they were, how supported they felt they were in their care. And what we found was a surprisingly high number of patients who believe, or who expressed that we did not educate them on side effects and symptom management. And we looked around and thought, well, we did really great at that. You know? Obviously, you know, they must have misunderstood the question. [Laughter] So it happened that they didn’t and they expressed that feedback a

year later, too, and so last year we completely redesigned how we did patient education, did more team based care, spent more time with patient, rewrote our patient education materials and so on, because we certainly have our perspective and our background and we may understand certainly the vernacular of healthcare, but we need to speak to the patient where they are and find the best way to get through to them. And, thankfully, you know, I've gotten some early feedback this year that we have improved in that area, but it starts with seeking that patient feedback.

## **MARK SMITH**

Alright, so I'm beginning to get actually a number of questions from our far flung Internet-based audience, and I'm going to start to kind of throw them at you, one by one, if that's alright. So this one's for Brian. Can you say a little more about that financial toxicity domain that you talked about?

## **BRIAN BOURBEAU**

Oh, yes. So we were actually discussing this over lunch. We have been discussing a contrast between two different treatments that we have for a particular symptom of cancer care, one of which costs \$1,000, the other costs \$40. Now the \$1,000 does show marginal benefit on effectiveness, but it's also \$1,000, and so we must consider that whole financial toxicity, and what does that mean to the patient. A study published in Journal of Clinical Oncology last year, showed that patients who declare bankruptcy have far higher risk of mortality than patients who do not declare bankruptcy. All the social detriments of health. And so when you consider do I treat with \$1,000 drug that may be marginally more effective, or the \$40 drug, also have to consider what impact that has on the patient financially, and therefore, bankrupting our patients, certainly that impacts their health just as much as any disease.

## **MARK SMITH**

And I think it's probably fair to say that in the old world, a lot of physicians wouldn't have had the slightest idea how much a patient actually costs and it's not that they don't care, but it's not one of the things that people have available to them typically, and right.

## **BRIAN BOURBEAU**

Well, I have to thank, actually, Patrick's team for sending us millions of lines of data, and saying, well, here you go figure it out. You know, thankfully, we do have some smart people who have been crunching those numbers, and then our physicians have been very receptive. You know, after that education, you know, we spent five minutes on the subject and physicians began raising their hands saying, "Well, we need to talk to every single patient," and, you know, and that's just a great response. That's what we wanted, but it starts with that data.

## **LINDA BRADY**

You shared with us, too, that statistic where before the providers were having financial toxicity conversations, particularly with this one element, it was about 50-50, the use of these two drugs, and after they were educated and started talking to patients it went from 90 to 10, where 90% were using the most cost effective treatment plan.

## **BRIAN BOURBEAU**

Yes, we're fairly conservative in what we're trying to tackle, right? You know, we have hundreds of treatments out there, but we're focusing on about a dozen and we've seen great shifts just through educating our providers in the use, and it goes far beyond anything you could attempt to accomplish with prior authorization, for normal techniques of trying to change practice, education has been the key here.

## **DEBRA NESS**

Brian, have you provided any training for your clinicians in shared care planning, because you mentioned shared care planning being part of what you do, and that's when you would be sharing all of this information with patients. Because that's part of the culture change, too. How do you actually engage collaboratively like that in a conversation with your patients?

## **BRIAN BOURBEAU**

What we found is that our nurse practitioner and clinical nurse specialist programs do great preparation for those providers, and so we tap into them as part of that care planning process. So, you know, the physician, of course, is starting that care plan and then the psychosocial assessment, and that type of work, is done by our nurse practitioners, clinical nurse specialists, and RN's, working with the patient. And we do it in a team based care where, as a patient, you would come to our office and after the physician and you have decided kind of goals of care and what you're going to be receiving, you also, then, go through a series of consultations with an advanced practice provider, with the nurse navigator, and with the financial navigator, and often we uncover things that maybe weren't originally considered. You know, I had a patient, one of the first ones I shadowed, lived in a hotel and had to get rides from friends. And here, we had the patient in for 36 fractions of radiation therapy and had to consider how she was going to travel to the office. So that, then, makes you rethink the care plan. Is there any way we can do a hyper fractionation? Is there anything that we can do with their chemotherapy treatment to address this travel issue that we felt was a more detriment to her health than the actual treatment selection.

## MARK SMITH

So let me channel one of our Internet viewers and press down on that, because one of the concerns that's been addressed in some quarters about moving from volume to value is whether some patients, who already face disparities, will actually be harmed by this, whether providers who take care of patients who are less affluent, who may be less likely to speak English, who are physically isolated, either in urban or rural areas, if they're held to the same outcome standards as other providers will actually wind up making those disparities worse rather than better. I wonder if anybody on the panel would like to speak to both how you feel about that question and what steps you've taken to monitor whether not just for a given patient, but systematically, whether or not the payment reform that you're adopting may have the unintended consequence of making things worse for some patients rather than better.

## PHILLIP BERGQUIST

Mark, I think one of the things that we really try to embrace about value-based payment, especially for populations experiencing health disparities, is that, to be frank, our system today isn't working and that's part of why the health disparity exists in the first place. What we know, and I think what probably everybody watching knows, is that there are ways that we need to provide care differently, and that care may mean something else in the future. You know, we've talked about team-based care, and I think everybody has referenced a team member who isn't a physician at some point in today's conversation, and you know, one population that experiences significant health disparity is our low income populations; near to be because of a large enrollment in the Medicaid program. We also know about that population, that their health is significantly influenced by social and economic factors and that while a physician is a really important part of their care and their health outcomes, it's also really important that they have help in ensuring stable housing, that there's nutritious food to eat, that there's transportation not just to a doctor's appointment but to other places, that there's child care for somebody to work. There are many other factors. I think what we can have the opportunity to embrace through value-based payment is payment that's flexible enough to adapt when the primary health challenge isn't healthcare or isn't something that we can prescribe to, or isn't something that we can treat in a traditional sense. That value-based pay has the real opportunity to give us flexibility, to give communities flexibility, and care teams working together to say, what's the right way for us to serve this population, and that it's okay that it looks different than it does today because different might get us a better outcome than what we have right now.

## KAREN JOHNSON

This is a perfect example of how CPC Plus has become a catalyst for community conversation and potential action in Kansas City. So the track 2 practices have a requirement to do a psychosocial needs assessment of their patients and connect them to community resources. Sounds like a good idea, but when you are a small primary care practice, which we are fundamentally a nation of small primary care practices, unless



you're a safety net or a Medicare only population focused practice, you don't have the need in your practice panel to build out that level of resource at the practice level. So one of the conversations we're having at the KC Health Collaborative is: could we build at the community level some kind of a shared services model that really leverages what already exists in the form of things like United Way 211, and, you know, information that the practices should be engaging their patients in the dialog about what are your non-medical healthcare needs. But to put that burden of addressing all of that directly on them without any additional support or resource is probably unrealistic. So I just think there's a lot of opportunity in these models to really engage differently.

## PHILLIP BERGQUIST

Very similar approach happening in Michigan. We have the community level infrastructure through our state innovation model work, not only looking at can we help support community infrastructure for adjusting social need and providing additional resource to practices and resolving those needs and creating deeper connections, so partnerships in the way that, you know, you've become partners with your providers. Those providers having partnerships that deep with community institutions, but also to look and see if there are ways for large provider organizations to support one another, too, and be on, you know, a journey that is similar in social and economic factors to the journey that they're on when it comes to their day to day business in quality improvement and payment reform.

## MARK SMITH

Debra.

## DEBRA NESS

I think the one other point I want to add, because what I'm hearing is we need to move toward these payment models that allow this kind of whole person, whole community care, I think the other thing is we have to be able to look at the impact of care through measures that allow us to stratify and see where the disparities exist, and without getting into a debate about risk adjustment, I think there is definitely a role for the right kind of risk adjustment at the right times, but we also need to be collecting the data and ensuring that, at the end of the day, when we're looking at outcomes, we can assess whether or not we are eliminating or perpetuating disparities.

## MARK SMITH

Agreed. So I have a question addressed to the Michigan representative. One writer says: Well, a lot of people in Michigan spend much of the year in Michigan but part of the year in Florida. [Laughter] And I suppose some people spend some of the year in Kansas City, Kansas and others in Kansas City, Missouri. [Laughter]

## PHILLIP BERGQUIST

Or the day. [Laughter]

## MARK SMITH

So we've spent a lot of time talking about kind of focusing on integrating work within a community, but there are lots of people who either go back and forth for the time of year, or work in one community, live in another community, have family. Do people have examples of kind of collaborations across state lines, or perhaps, across county lines or beyond the usual regional things that might serve the needs of not only wealthy people from Michigan who live in Florida, but workers who migrate from one part of the country to another. People have some comments on that?

## PHILLIP BERGQUIST

Michigan is home to a very large migrant farm worker population, in addition to folks that go to Florida. When it gets cold in Michigan state, I think that there are quite a few good opportunities. One of my favorites is actually more related to that migrant and seasonal farm worker population in Michigan where safety net providers in Michigan, Texas, Florida, and a few other places, have come together to say, is there something that we can do to coordinate the care for that person or for that family when that person is with us? So to make sure something like care isn't interrupted when the change across state lines happens, or if it's a person who's enrolled in the Medicaid program to see if there is a way to very quickly recognize when a state resident's change has happened and re-enroll that person in the Medicaid program in the new state so that there isn't a gap in coverage. I think that really successful examples of that can be seen, but through strong collaboration between providers. I think it's equally true, and maybe you can think of an example for this, that large payer organizations, particularly payers at the regional level and, in some cases, even Accountable Care Organizations at a regional level have started to look at community in this broader sense and maybe, you know, another word that I hear kind of substituted, it may be even more appropriate, is population and sort of taking ownership of a population, regardless of how that population moves. It's very common for folks that, you know, transition back and forth between Florida and Michigan to maintain that relationship with providers in whichever state is their most prominent state which, for many people, is Michigan [Laughter] – and to maintain that relationship so that provider sees the patient as part of their population, regardless of whether or not they're physically located there right now or maybe, you know, consulting through an e-visit, or e-mailing, or using telemedicine, or, you know, many other ways, e-consults, different ways to maintain that relationship as well. But it all starts with the willingness to have that collaboration and also kind of a look at this concept of I've taken responsibility for a population, regardless of how they're moving around. I don't want to make it seem like it's not challenging, though, because that physicality and the moving and, you know,

migration patterns really do pose that challenge. We've come a long way but have a long way to go.

## LINDA BRADY

And this is where technology, I think, can also come in and play a big, big role in being very creative in how you can kind of take your doctor with you.

## EMILY BROWER

I was going to say the same thing. So one of the wonderful things that is happening because we are embracing this shift as a nation, is that we're starting to share the same tools. So one of the things that enables us as really a practice based delivery system to coordinate the care all across our community is event notification, admission, discharge, and transfer notifications, so historically, we've built that sort of in a point to point technology, so Atrius Health, hospital 1, Atrius Health, hospital 2. Well there is a piece of technology on the market now that is national that we just sort of all point – we kind of all point there, I mean, it's building out, and because in multiple communities it's worth it for multiple systems to pay a small amount for each transaction, but then we all see it. So all of a sudden we're participating, and this is called the Patient Paying; I'm sure there are others. We participate in this now and our case managers now see when a patient is admitted to a skilled nursing facility in Florida so that we can use that other really effective piece of technology and call the nursing home. [Laughter] Seriously! I mean, that's, I know we get – there's a lot of blocking and tackling in just the day to day care, but when we all do this together through collaborations and broader national models, that's where you get the payoff.

## MARK SMITH

So we have about five minutes left. I want to ask a couple of more provocative questions. It's all very well to say we want to adopt value based care that will save money kind of over the course of a year, or maybe two; the course of a pregnancy, the course of a cancer diagnosis, but so many of the interventions we're talking about may have their economic and clinical payoff a decade or more from now and the chances are that a patient who's your patient now will be Patrick's patient 10 years from now, or will be somebody else's patient. So I guess, do people have thoughts about how we even keep track of, let alone, reconcile the issue of value based payment in a truly longitudinal way, given the volatility of people's eligibility for different government programs and the fact that, to the extent that health insurance is still largely employment based, people cycle on and off a given insurer. What implications does this have for collaboration among payers, public and private; collaboration among payers, private, even though that are competing with each other at the same time. What are your thoughts about this kind of more longitudinal sense of value as it relates to patients' clinical and financial outcomes? Patrick.

## PATRICK CONWAY

Maybe I'll start on this one. In 2013 or '14, I wrote a New England Journal paper on this sort of health trajectories and modifiable and compoundable over time, it's called a life-long health system, but so Medicare, the average Medicare beneficiary we now insure for more than 15 years, at the age of 65, so the longer time frame than a few. I'll let my colleague talk about Medicaid, but you have people insured for very long periods of time on Medicaid. I do think this gets to the public-private partnership point at the state and community and certainly there's going to be people that exit and move around payers, but if you have a common framework around health and health trajectories over time and you execute on that across the public and private sector, whether it's at a national level, state level, or a community level, there's strong evidence you're going to have a population that not only has better health and health outcomes and lower cost, you know, better educational outcomes, lower justice payments, etcetera, and I think this, as a nation, is one of the big opportunities for us. How do you collaborate to really impact health trajectories that we know are modifiable and compoundable over time and reap those benefits as a nation? And it is a classic problem with the comments. There's a reality that, because of some of the insurers, and other issues, people have trouble sort of managing and wrapping their head around it, but I think you can – we've seen this in some states and communities and other places where it's done well, so I think it's how do you learn from that and scale it more broadly.

## KAREN JOHNSON

This is one of those places where I think health plans really have to start wrapping their minds around what their competitive advantage is and, in my mind, that's fairly clear and that's really they're our members, so what's the member experience? It's enrolling easy. It's making benefits understandable. It's helping you tie your benefits to how I get care. It's all of the things that happen outside of the direct care delivery environment and, then, I think, then it becomes that, what you are talking about, Patrick, which is really creating a common care delivery framework that benefits everyone. And I do think, though, is payers – one of the things that Linda said earlier that I think is really important is that patient experience, which you don't see in outcomes as much, and I do think payers have a role in sort of incenting that. I don't think we can create that because I think each provider's going to create their own unique experience of that, but I do think there's a way for payers to really support that. But I think we have to get really clear about the member versus the patient and what's our role in each of those strategies.

## MARK SMITH

And it does, I think, go, as you said, to one of the core things that the LAN has been about since its inception which is kind of typified by this panel—the need for public-private collaboration, the need for state-federal collaboration, the need for collaboration between, frankly, different parts of the same agencies, of federal and state government, to the extent that the system has longitudinal rationality, to the extent that providers need a common set of quality metrics, targets, patient experience measures that can't be

achieved by any given agency, any level of government, or any payer. It has to be the kind of collaboration that we've been trying to do.

I'm afraid that our time is up. Thank you very much for a very thoughtful panel of both your experiences, your reactions, your insights, and your wisdom, and I'll now turn this back over to Mark.

## **MARK McCLELLAN**

Mark, thank you, and my thanks, as well, for everybody who joined us on the panel and contributed to this discussion, also, all of you who sent in questions and comments.

I'd now like to introduce Sam Nussbaum. Sam has been leading efforts on the LAN's alternate payment model framework for over two years now. Back in 2015, when we were just starting up, he led the LAN's first work group which was tasked with developing the framework that was published in January of 2016, and we know that the framework has been very helpful in discussions all across the country for shaping how organizations move along a continuum, the value-based care. And you heard about some of that earlier today. Since that time, of course, there have been evolving ideas of what constitutes an alternative payment model, and how they best can work together.

Sam is currently leading the Framework Refresh Advisory Group for the LAN that's taking these developments into consideration for an update on the framework, and Sam, thanks for joining us this afternoon, to talk about the framework update.

## **SAM NUSSBAUM**

Good afternoon, everyone, and thank you, Mark. It is so important that we're here together today to learn and see the progress that we've made. I think this panel has been spectacular in both identifying the areas of achievement, whether it's in oncology or primary care, but also in giving us that inspiration for how we build to the future. In fact, there's nothing more important that we can do as individuals in healthcare, as communities, and as a nation, as providing a foundation for truly healthier people, for better care, and for smarter spending. And, as you've just heard, it's that smarter spending part of it that will enable us to invest very much in the future of social determinants of health, of education, and infrastructure, and all that we need to do for our nation.

So why are we working through a common framework? What is our focus? What is the framework about? And I think it is so important to recognize that the common framework is to have a language that we can all speak. We talked about measurements having their common ground, but this framework that we're all adopting today enables that. It's a system for classifying value-based models of care, but as equally important, a set of principles, principles that outline the goals for better care, for payment reform, and for innovation that we all need to invest into our health delivery system.

So it's a rationale that says: how can payment be an underpinning? How can an undergird be a foundation for the fundamental changes we need, and you've heard about, in the delivery of healthcare? It really is, in so many ways, our path forward.

Now, let's see where we are. And the framework that we're using today is one that includes a trajectory of categories. Category 1, where most payment lives today, is really fee for service. And while we've seen increasing links to quality, and that is good, it is not going to get us to this promised land that we all seek in patients getting coordinated care and communities being involved in care. But we see, across this continuum, these categories, a progression to Category 4, which are population-based payment models. Now, each category includes important subcategories. So, for example, if we look in Category 2, we have 2A, which were payments to help physician practices, to help care management organizations build infrastructure, so payments for infrastructure. In addition, Category 2 had pay for value, pay for performance, so quality payments. As we move to Categories 3 and 4, population-based models, we were seeing different approaches taken to bearing financial accountability; financial accountability that allowed for better patient care.

What's important that we discuss this framework is to understand also what it's not. The framework is a model for categorizing payments, but it is not a tool for establishing delivery systems because delivery systems can exist within each of these four categories. Some are better prepared to move to advanced payment models—Categories 3 and 4—but a patient-centered medical home can give superlative care within each of these categories, but it's our goal to move along this continuum, to have providers be where they can most effectively deliver care.

So it wasn't really our work group's intention to determine which model is the best to follow. Each organization and each community will determine that best model to follow, but it's to allow for evolution, for innovation in a field while driving payment reform.

So why would we, a year after the payment categories were articulated, we published this in January, why would we, a year and a half later, come back and want to refresh the framework? We believe it's vital because this framework enables us to see where we are as a nation. And independent of this debate that we're now having about the future of healthcare in the country, delivery system reform and changes are essential, no matter who the payer is and who the patients are and who the individuals are. So to remain relevant, we believe it must reflect the passage of new legislation and the issuance of new regulations, so MACRA is very relevant here, and we'll talk about that in a moment. But equally important, the learning that took place on this stage moments ago, and for the thousand of you watching this event, it's about learning from best practices in the field. In that way, we can make a more profound difference.

So what topics did we address? When we first established the Framework we believe the principles were enduring, but have they changed? Are they still foundational? We wanted to clarify the relationships between advanced alternative payment models under MACRA

and the categories of the LAN APM Framework. We do not want 60 different categories, each one identified by individual financing organizations. Very much to the point that Mark Smith was raising, we wanted to identify where safety net providers can participate in APM adoption and also where small rural providers can also find their common ground in their home. In addition, with the growth of integrated financing and delivery systems, we said should there be a new category, or a new subcategory where this velvet revolution that has gone on of providers having insurance models, and insurance companies aligning and, in some cases, building provider capabilities, we wanted to make sure there was a way of identifying these advanced approaches. And we wanted to both expedite the measurement and understand how we can simplify the entire tracking progress while reducing burdens for all of us.

So, most importantly, to start, we said let's convene a representative group and it was not only this group that made significant input into the process, in fact, meeting for much of the last several months weekly, but they also reached out beyond to gain additional information. So I had the privilege of chairing this group, but included were Reid Blackwelder, and Reid had been former President of the AMA, a family physician, so AMA, the American Academy of Family Physicians, excuse me, but a family physician; Tim Ferriss, who's a leader of Population Health at Partner's Healthcare; Aparna Higgins, who leads Performance Measurement and has helped get us to a common ground on performance measures through AHIP; Dorothy Teeter, who leads the Washington State Healthcare Authority and has accountability for Medicaid as well as the employees of Washington; Keith Lind, at the AARP Public Policy Institute; and, Alexander Billoux, who represented a real talented group of partners at CMS, and I do want to call out CMS here in the most engaging and positive way. Under Patrick's leadership, the public-private partnership, the flexibility and willingness to work across the communities, has been extraordinary, and the innovation has been extraordinary.

So what were our initial principles and where did they change? One of the important elements was to understand that payment is only a driver. Let me back this up a moment. That payment is one of the many drivers of patient-centered care. As I said, an enabler foundation, it can make a huge difference but it is only that enabler. We wanted to establish goals for APM adoption and you know that the original goal was to have 30% of CMS payment and advanced payment models by 2016, which was achieved, but the private sector LAN also was looking at 30% and we fell a little bit short of that, about 25% but there were some areas, such as in Medicare Advantage where there was a 40% adoption. We wanted to identify those distinguishing characteristics of APM's and the conventions for classification and we also wanted to give recommendations on how to structure and distribute value-based incentives. Those principles are largely unchanged. But what are the changes to the foundational principles?

Those include, this first point I want to make is that payment reform is that vehicle. It's not a goal in its own right. So if we go out there and achieve 50% by 2020 but we are not delivering more patient-centered care, if we're not delivering better quality, better performance, better health then we will not have met our goals.

Our second point, and this is vital also, is that, for some providers, the final place to be is in Category 2. That can be the vehicle for delivering high quality care. Not everyone has to get to Categories 3 and 4, although we do believe that many, particularly larger integrated organizations will get there.

The third point and the one, again, that is vital for all of us to understand, is that we want financial incentives to be in place, but they should be balanced. We can't have physician organizations become insurance companies bearing inappropriate financial risk, so those were some of the elements that we wanted to avoid the unintended consequences of payment reform.

So let me share with you now, what some of those classifications are. First, we established a new Category 4C for Integrated Finance and Delivery Systems. We surveyed a lot of these organizations to see whether they behave differently if they have the combined responsibility of both financing care and delivering care. All of you know Kaiser as sort of a benchmark for what an integrated financing and delivery system would be, but, over the past years, we've seen lots of models emerge where health plans that own provider organizations, such as Highmark owning West Penn Allegheny, and working closely there; Anthem owning CareMore; and, Optum United having a very, very large physician presence. We've also seen the opposite—provider organizations that sell insurance products. Two great examples are Intermountain and Geisinger. And what we wanted to understand is do these organizations invest differently? Do they invest differently in an information platform? Do they invest differently in their communities? Do they invest differently in those issues involving social determinants of health? And we believe that they likely do. This is all to be studied, but we believe that this integration of financing and delivery offer unique opportunities for transforming care delivery beyond where just paying in a fee for service environment does. We think that they can more effectively engage other components of the communities and other professional caregivers. Over time they will touch transportation and housing and those models.

So let's look at one other part that we looked at, which is the expanded definition of Category 3. Early on, we said that cost performance for Categories 3 and 4, against a financial benchmark, was the key characteristic of Category 3, so against a global budget, against a medical trend, but it was a financial performance. But we're seeing more and more, in certain circumstances, and the specific one is the one you heard about today: primary care for Medicare population. Comprehensive Primary Care Plus, Track 1, is a great example where you can see that there can be effective proxies for generating cost efficiencies and total cost of care. So, for Medicare beneficiaries, approximately 40%-45% of all spending is spent in the hospital, in the emergency room. So if your measure is reducing inappropriate or unnecessary hospitalizations through better coordination of care or ER visits, then you can see how that can work very, very effectively as a model in which there are shared savings that would benefit those physician organizations within this Category 3.

So we have some concerns about this, of course, and we need to be mindful of them. So reduced hospitalizations may not be fully reflective of improved care. We want to be sure



that care remains appropriate. We want to have more and more quality and performance requirements and we certainly don't want to reward physicians or anyone for reducing appropriate and necessary utilization. This is really about how we deliver a better outcome of care.

Let me now, also talk about one more classification change before I close; and that is, an additional requirement for Categories 3 and 4, and this is about being patient-centered. This new requirement is an accountability for appropriate care. Because there are strong incentives to reduce costs, we want to make sure that this is a result of removing unnecessary care, not essential care. We want to strongly encourage reductions in wasteful care by evaluating providers on the basis of what's appropriate. Here are some examples of appropriate care that we want, and there are many national benchmarks that have been achieved here. There's already been good progress in preventing hospital admissions and re-admissions that are unnecessary; unnecessary imaging; documentation of shared decision-making; appropriate use of medications; rates of "never events"; adherence to clinical guidelines, even issues you heard shared today in terms of oncology care and making sure that that remains patient-centered; preventing pre-term labor and delivery. All of these will make a profound difference in care. This is what we want to measure over time and support over time.

So here's what the new model will look like. First, let's look at this bubble chart on the right side of the screen. Today, we have, as I said, most of our care in Categories 1 and 2 with growing amounts in 3 and 4. The future, we believe, will have far less care in traditional fee for service, but there will always remain fee for service care with strong incentives for quality, but more and more care will be in this future state. And, as you notice, on the vertical axis, this is a critical vertical axis because it is about patient engagement and patient-centered care. It's about accountability for delivering better health and better health outcomes. It's about the information architecture that we need and, it's in this way, in advancing care along this continuum that we believe we can make a profound difference.

In closing, I want to share with you the next steps. The next steps are actually your steps. We believe that this Framework is a compelling one. It will address the changes that we're seeing in our healthcare ecosystem, but we need your participation to measure this and to build on this. So during a public comment period that will occur within the next weeks to months, we will be issuing this white paper in a preliminary way. We want to hear from you. Last time around, we had, you know, literally hundreds of organizations and comments—you make this better for us, and we welcome those comments.

We also welcome another journey and that is your participation as a nation, as communities, as physicians, as health professionals, as health plans, as government, as payers that we work together. The theme of today's meeting and what you heard is about collaboration and building together a better healthcare system. Let's continue on that journey. Thank you.

## MARK McCLELLAN

Sam, thank you very much for those comments, and I'd like to thank all of our presenters today, also all of our participants here in the room with us, all of you who are online who joined us in today's discussion, and Mark, a lot to think about, from what we've heard. It does seem like we're in the midst of a journey, even though the principles may seem pretty simple here: better care, lower cost, and finding ways to work together to use the payment systems as a means to an end for that. Boy, implementing this is a lot of work, and one of the things that I took away, though, was despite the challenges, we're finding some better ways to do it and we're also finding some ways to expand and improve the efforts that have been underway.

## MARK SMITH

I think that's right. I think the other thing that's worth noting is that the kind of efforts that we heard cited, everybody had to give at least a little bit. Collaboration doesn't mean I get to do exactly what I want and you have to adapt to my standard. It means everybody kind of has to give at least a little bit to achieve some common goal. And so, whether it's a health plan, or a hospital, a physician group, the Feds, the state government, trying to unite around a shared goal and vision of the way we'd like to see care delivered requires everybody being willing to concede at least a little in order to get the kind of collaboration that we heard several examples of today.

## MARK McCLELLAN

It sure does, and we heard, as you said, a lot of examples of how to do this, both collaboration at the level of the individual patient, provider, health plan relationships, that's where a lot of this begins in patient-centered care. I was impressed by how much is happening at the regional and state levels where, to find ways to put together different resources, whether it's social services that you heard about from a number of our participants, or just getting organizations that need to build trust to work better together, a lot of opportunities for collaboration at the local and state level; and then, finally, a recognition, I think, as Emily put it, that, you know, there are a lot of tools out there that we can use wherever we are and that we don't always need to reinvent the wheel when it comes to quality measures or methods for calculating benchmarks, or data sharing, or even figuring out which tools are most relevant for particular local circumstances.

## MARK SMITH

I think that's right, and I was actually quite impressed by the diversity of participants and where they come from. Cincinnati, Michigan, Seattle, St. Louis. And so, I think part of what we've tried to do with the LAN is to give people examples and actual context, like people's e-mail and phone numbers. Here's who you can contact to figure out how they did X or Y or Z, and I think trying to move from setting out a common vision towards

actually incenting collaborative action together is a lot of where we'll be placing our emphasis in the next two years.

## **MARK McCLELLAN**

That's right, and we are going to move forward from here. We want to build on foundations like the APM Framework that you just heard about, like the outputs and tools that are coming from all of the LAN Work Groups, but we are aiming to increase our impact with a new focus on helping healthcare organizations implement important and effective payment reforms. This has started with LAN's Maternity Multi-State Action Collaborative, and the Primary Care Action Collaborative that you heard referenced earlier today. They were launched at the end of 2016. It also includes an upcoming collaborative to support effective ACO implementation, so stay tuned for opportunities to be involved in this upcoming work and to hear more about the resources that we're developing that support faster, smoother, and more effective implementation of payment reforms all across the country.

## **MARK SMITH**

So, thanks to all of you who tuned in. Thanks to all of you who joined us here in person. We want you to stay connected to what the LAN is doing so please go to the website, send your friends to the website to have them register for the website. This program will be archived and available on the website for those of who weren't able to see the whole thing or who'd like to refer other people to it, and we want to also make sure that you understand that last October there were about 900 people who gathered at the Fall Summit to have more and more intensive discussions like this. We'll be announcing soon the time and date and place of the Fall Summit upcoming later on this year, and we'd be pleased to have you with us for that.

So this concludes the 2017 LAN Spring Forum. It'll be archived on our website. We really appreciate your attention to it and appreciate everyone who came here in person. Thanks for being with us, and enjoy the rest of your day.