IPRO

Moderator: Sara Butterfield
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12:00 PM ET

Operator: Good day, ladies and gentlemen, and welcome to the IPRO Learning and Action Educational Session. At this time, all participants are in a listen-only mode. Later we will conduct a question-and-answer session and instructions will follow at that time. If anyone should require operator assistance, please press * then 0 on your touchtone telephone. As a reminder, this conference call is being recorded.

I would now like to introduce your host for today's conference, Sara Butterfield. You may begin.

Sara Butterfield: Thank you so much, (inaudible). Good afternoon, everybody. I'm happy that you'll be spending your lunchtime with us. I welcome you to the Care Transition Statewide Learning and Action Network Educational Session. And as we've shared before, these are educational opportunities that we provide to foster an environment of shared learning and to hopefully facilitate some cross-setting partnerships to address care management of the Medicare seniors across New York State.

The impetus for today's session was really based upon a request from our Hudson Valley Care Transitions Coalition, one of our TRAC 2 communities. Our team has had the honor of collaborating with them over the past 2-year time period. And with all of the events that are going on with the health care arena related to bundled payment pilots and accountable care organizations, the Affordable Care Act, really keeping up on how this ever-changing environment impacts health care delivery at the community level is really proving to be quite a challenge for everyone.

So the information that will be shared with you today will hopefully increase that level of understanding on how all of these pieces of the puzzle really fit together and to assist you in strategizing a proactive approach for your organization as far as how this all fits together. Those of you who registered for today's webinar were forwarded via e-mail a copy of the slides that will be referenced during the presentation, and then your input and participation will also be part of the program. We'll have some polling questions that we'll ask you to respond to using the Webex tools that you have on your screen in front of you, and we'll prompt you when those polling questions will occur. And we're going to ask you to respond to those during the program to provide some context to the information being shared.

The webinar is being recorded. It's going to be posted to the Care Transitions webpage in the Past Events section on the IPRO Care Transitions website. We'll send you all a link out when that's posted. And it's usually about 7 days before it's posted there -- maybe sooner -- but we'll certainly notify you when that occurs.

As mentioned, all of your lines are currently muted and following the presentation we're going to be opening up the lines for your questions and comments and further discussion. If you prefer, you'll note on the bottom right-hand side of your screen a little box that says Chat, so if you prefer to put your questions in that Chat box and you want to send to all participants which is automatically up there, I'll be looking at the questions and putting them together for our speaker to address at the end of the presentation.

And mentioning our speaker, we're very fortunate to have with us as our guest speaker Dr. Kimberly Rask. She's the Medical Director for the Improving Individual Patient Care and Integrating Care for the 10th Scope of Work at Alliant Georgia Medical Care Foundation, the Centers for Medicare and Medicaid Services Quality Improvement Organization for the State of Georgia. Since 2008, she has provided direction for patient safety initiatives, including health care-associated infections, and quality data reporting, including value-based purchasing and readmission reductions. She also holds joint appointments as the Associate Professor of Health Policy and Management in the Rollins School of Public Health and Associate Professor of Medicine in the Emory University School of Medicine. Dr. Rask is a magna cum laude graduate of Bryn Mawr College. She attended the University of Pennsylvania School of Medicine. And after completing her residency in internal medicine, she was a Robert Wood Johnson Clinical Scholar and concluded the doctoral program in Health Economics at the Wharton School of University of Pennsylvania. She's a faculty member of Emory since 1991. Her research into teaching focuses on quality improvement and outcomes measurement, and she has published book chapters and peer-reviewed articles on primary care practice, cost effectiveness, quality improvement and outcomes measurement. And we welcome her to the call today.

And with that, Dr. Rask, I'll turn the call on over to you.

Kimberly Rask: Alright. Thank you, Sara. Well, thank you all for joining us today. There is no question that we live in interesting times in health care. There's a lot going on. And what we're going to talk about today is sort of some of the new kinds of organizations that we're seeing in health care and, specifically, talking about ACOs and patient-centered medical homes. But also, I think it's important to think a little bit about how we got here, and having some understanding of what these forces are that seem to be changing and reshaping the way health care is delivered in the United States really makes it a little easier to understand what's going on and a little clearer about what we might expect to see going forward over these next couple years.

So I'm going to cover a couple of topics today and then I look forward to your questions at the end. First, we'll look at kind of what's driving change in health care, what are the things that policy makers and people who are making decisions about how we deliver health care -- what are the things that they're focusing on. We'll look at what the public sector's doing and the private sector. Sometimes it's very similar; sometimes it's not. We'll talk about some of these new health care models that we're seeing out in the marketplace -- the ACOs and the PCMHs. And then think about, with all this transition going on, what does this mean to you all and what does it mean to your organizations and what are the kinds of things that you want to be focused on to be successful in health care going forward?

So if we first try and look at what is driving all this change which seems to have accelerated in the last couple years, it really comes down to costs. Health care spending continues to rise. We know that we had a little bit of a dip with the recession that costs were not rising as fast as they'd been in the past, but we still spent an awful lot of our money as a country on health care, and there are many people who are concerned that it just -- that rate of growth just can't continue without crowding out everything else that we need to spend money on in our country.

Another thing that bothers a lot of policy makers are the large cost variations that they don't seem to be able to explain away. Certainly there are people who are sicker who would have higher health expenses, but when you look at different areas across the country, it doesn't seem to match very well with severity of illness. There also is a belief that the way that we currently pay for most of our health care -- whereby you're paid for doing something -- just encourages health care providers to provide more care without necessarily providing better care, and there is a belief, I think, across both sides of the aisle that the way we pay for health care ought to be changed so instead it incentivizes providers to provide high-quality care and to do it efficiently at a lower cost.

The geographic variation across the United States has really been one of the things that's gotten a lot of folks attention, trying to explain why health care should be so much more expensive and so many more services used in some parts of the country rather than other parts of the country. And some of these high-cost areas seem to stay high-cost so it's not just a random variation from year to year. And when they look into where these cost variations are coming from, the drivers are really different depending on which payer you're looking at. If you look at Medicare, the majority of the variation in Medicare spending per beneficiary comes from post-acute care. And for that reason, Medicare is paying a lot of attention to what's happening with home health use, skilled nursing use, rehabilitation facilities, long-term care hospitals and hospice, because even though those providers are not necessarily the highest cost to Medicare, they seem to be the biggest differences across the country. There are some communities that use a lot more or more expensive post-acute care than other communities.

In the private sector, the private health insurance markets actually see something different. Most of the variation that they see is due to different prices. So the way that they are able to set premiums and pay providers across different parts of the country influences that. Now some of that certainly is the difference between the Medicare population and the privately-insured, generally younger and still working population. But given those differences, we'll see that -- what the private insurers are trying to do in restructuring health care is a little bit different than what Medicare is trying to do.

So first, before we get into the rest of this discussion, what I'd like to know now is have our first polling question and to have you tell us what type of organization you are from. And Sara, maybe if you could explain how to do the polling?

Emily: Okay. On your screen on the right-hand side bottom quarter, you're going to see some questions about what type of organization are you from. And all you need to do is to click on what particular organization you're from. You'll have 45 seconds to do that and then we'll tally so we know what today's audience is representative of. So go ahead and click what type of organization you are from. And you have about 30 seconds to do that at this point and we'll just wait for that to come up on the screen.

Kimberly Rask: Alright. Well, it looks like we have our -- most of the folks who are on the call are in a hospital setting or a skilled nursing facility, and a nice range of people from other facilities, too. So this is great. This'll be very helpful as I talk through this about being able to highlight some of these aspects that are particularly important for your organizations. And it's nice to have such a mix of folks from different health care settings.

So now, moving on then to what is going on in health care reform. Well, we know these last couple of weeks we have heard a lot about the health insurance exchanges and how the website's working, but there are a whole other areas that are really important that were also part of the Patient Protection and Affordable Care Act besides the health insurance exchanges, and a lot of those initiatives which were part of the Affordable Care Act have a lot to do with why we are -- what we are seeing today in terms of value-based purchasing, in terms of penalties, in terms of increased public reporting, pilot programs trying to bundle payments. So instead of paying for every individual hospitalization, bundling payments for an episode of care that might cross a hospitalization and include pre-hospitalization as well as post-hospitalization services. And then also a real push promoting the development of ACOs and PCMHs.

And in looking at where we came from and how we got here, it's always been the case that the way we pay for health care really influences how health care is delivered. When we pay for health care individually for individual events or individual services, we encourage individual providers to develop and produce the one service that we're paying them for. What we're seeing now is an interest in bundling those payments, and what that leads to is increasing the integration between health care providers so that instead of paying every individual provider separately, many of these payers want to be able to pay one group of providers and let them distribute the funds and let them determine exactly what services should be offered. And that's where we see the big transformation coming.

Public reporting is viewed as one of the very important first steps to be able to get health care quality information out in front of patients and their families, and hospitals have faced public reporting for a while. Skilled nursing facilities have also. Physicians will soon be seeing physician quality measurement being made available on the websites for people to look at and to be able to look at cost as well as quality outcomes.

If we look at the Medicare program, there are four different programs that are already kind of incentivizing hospitals around quality in different ways. The annual payment update -- for those of you in hospital settings, you're very familiar with the core measures. That's kind of what we call pay for reporting. That's been going on for many years. A significant potential impact on Medicare revenues if you don't meet the reporting guidelines. We now have the value-based purchasing, whereby you are not just paid to report your quality outcome, but you actually will be paid in part on what those quality outcomes are. And I'm going to talk a little bit about how that is increasingly going to impact providers outside of the hospital setting also. We have our new readmissions reduction program. We've had the second year of that going into the third year. Increasing the impact of that potential penalty every year. And then finally -- we won't talk about it for today's purposes, but the health care-acquired conditions penalty programs, which will also be starting out next year.

If we look at value-based purchasing, again, that's really trying to move health care providers from reporting quality measures to actually making them accountable for what those quality measures are. As I mentioned earlier, it is part of the Affordable Care Act.

It is a pool of funds, so no one -- there's no money that's handed back to the government. The money is pooled and high-performing hospitals will get extra money and lower-performing hospitals don't get their money back. What's especially relevant to the rest of the community is that increasingly some of these outcome measures that are being included in the hospital value-based purchasing program are going to focus on the aspects of care that happen outside of the hospital setting. So even under value-based purchasing, hospitals are going to find that it's important to be coordinating with other providers in their community.

And this slide sort of shows what kind of goes into the value-based purchasing score that a hospital would get. And if we start on the column to the furthest to the left, you see the first year it was 70% clinical processes of care. So that's the core measures -- a lot of what has been publicly reported for a while. And 30% of that is patient experience. What do patients say about their experience while they were in the hospital? How do they feel that the physician treated them, that the nurse communicated with them? Did they know what they needed to know before they were discharged?

And then, as we move to the right on the table, you see every year that proportion changes, and what was just -- what was initially a big chunk of the score -- what clinical care is being delivered in the hospital -- is going down to be less and less of the score. And the patient voice is still a critical, and will remain a large, component going down to 25%, but (inaudible) be 25% of the hospital value-based purchasing score. And then if you look at outcomes, hospital infection rate -- 30-day and 30-day mortality rates -- will be an ever-larger part of the value-based purchasing score. And then new starting this year we have actually a cost measure, which is a cost per episode of care, and that's moving up to be one-fifth of the value-based purchasing score all the way to one-fourth of the value-based purchasing score.

So if we look at these outcome measures -- and again, these are currently being applied to hospitals. We have infection rates, adverse events, but we also have the 30-day mortality rate for acute MI, for health failure, for pneumonia. So what a hospital is going to be ranked upon -- 30% of it will be not just what has happened while that patient was in the hospital, but what happened in those 30 days after they were discharged from the hospital. So increasingly paying attention to post-acute care is going to be important and will impact hospitals and their value-based purchasing.

If we look at the efficiency measure, this is a new measure. It looks at the cost to -- per Medicare beneficiary for the care that was delivered 3 days prior to the hospitalization, up to 30 days after the hospitalization. So again, the hospital is going to be responsible for that total episode of care cost, and if that hospital is working with community providers that are high-cost, it will impact what the hospital gets paid under value-based purchasing. So again, just an example that even under value-based purchasing, we're seeing Medicare trying to move towards a broader community-based focus.

The other penalty program -- the penalty for excess readmissions -- really, even more clearly, links the hospital payment to what is happening in the broader community. In the first year of that program, there was a potential for a 1% penalty, this most recent year -- 2%, and this next year it'll be up to a 3% penalty on Medicare revenues.

When the program was initially started, they only focused on three conditions -- heart attack, heart failure and pneumonia. If you look at where sort of -- how the -- how this excess readmission penalty is calculated, it is calculated using a very well-recognized methodology that was developed by an independent party, not Medicare -- an

independent party that develops quality measures. The other interesting thing is they set a 3-year rolling time period with a minimum of 25 discharges, and what this meant is that this measure now applies to the vast majority of hospitals. What they were trying to avoid was not being able to include a hospital in the penalty program because there were too few discharges. By making it discharges over a 3-year time period, a lot of small to medium-sized hospitals became eligible for that -- to have that penalty assessed to them. What's happening going forward? Well, now we're increasing the number of conditions that are -- that a hospital is eligible to be penalized for. The readmissions penalty is different from the value-based purchasing program in that this is money that actually does go back to the federal government. So you cannot get an incentive from the readmissions. You are at risk of losing money. And in the first 2 years, roughly two-thirds to three-fourths of hospitals nationwide face that payment penalty, which has made readmissions a really high priority and a high-focus area for hospitals. Also, the other important thing about this measure is that you are always being compared to the national rate. So a hospital is always being compared as to whether or not it's doing better or worse than would be expected nationally. And what that means is that if people are -- if hospitals and communities are improving their care for patients and reducing readmissions rates, then it's important for everybody to be also reducing their readmission rates because it's possible that you could reduce your readmission rate and still face a penalty because other communities reduced their readmission rates even more than you did.

Next, I want to start talking about ACOs -- the accountable care organizations -- and patient-centered medical homes. But first, I wanted to ask you a polling question about what the status is for accountable care organizations in your community. Is there an active ACO already? Are providers talking about it? Has there been no discussion yet or are you just not sure? And again, if you look to the right of your screen in the polling session, the question is put up. And if you could just click on whichever response is closest to what you see going on in your community right now, that'll give us a nice sense of where everybody is.

Sara Butterfield: And again, just click off which is most appropriate and click Submit.

Kimberly Rask: Alright. Interesting. So the more common -- most common answer is "Providers within our community are having discussions about forming an ACO." There are some communities with -- that already have an active ACO. And there are some of you that aren't sure. And I am not surprised that people are not sure and I think this reflects what we're seeing everywhere. There's a lot of discussion. Some places have leapt into this two feet in and some communities are just trying to sort out what is going to be right for them and do they have the right partners in place to be thinking about accountable care organizations. So thank you for sharing that.

And now let's go talk a little bit about accountable care organizations. The first thing about this is that the word was not even used and the concept was not even known until 2006. So one of the reasons why it can seem so confusing and unclear about what an accountable care organization is or why we should want them or what it is they should do is that we're really talking about a very new concept in health care. I found one definition. There are a lot of different definitions out there, but this definition, I thought, was relatively clear. An ACO is an integrated health care system that commits to provide full spectrum of care to a defined population meeting specified quality standards and benefiting from cost savings. So conceptually, what an ACO is trying to do is to bring together the providers in an area and contract with a payer -- it might be a private insurer, it might be Medicare -- to say, "We will provide all of the health care needs for these

1,000 people and we will do it for X number of dollars, and if we spend more than X dollars, we have to lose the -- swallow the difference. If we spend less than X dollars, we get some of that shared savings back. And we have to demonstrate that we're providing high-quality care by meeting certain quality indicators."

Back in 2010, when ACOs were first included in the Affordable Care Act, there were only 16 of them across the country. Not surprisingly, after the ACO, but January of this year, we've got 428 Medicare or private payer ACOs across the country, and there are more coming every day.

So what kind of defines an ACO? Again, there's not a strict definition, except for under some particular programs, which I'll talk about in just a minute. But conceptually, what is an ACO trying to do? It's basically trying to get physicians, hospitals and post-acute providers to have their incentives aligned. All those various health care providers have to get together and financially integrate well enough that one organization can get the money for all of the different partners and then have a mechanism for distributing it internally. In return for being willing to do that and become financially integrated, then the health care providers have the ability to organize the way they deliver care in ways that were not feasible or not reimbursed under a fee-for-service program. So you can do things like telephonic care that, in the past, perhaps were not reimbursable, but if you think, as health care providers, this is an effective and a cost-effective way to deliver services, you can do that. You can decide how you want to spend the dollars that you're given to care for that entire population.

The -- part of what makes it difficult to get a handle on, though, is that within that sort of general concept, there are a lot of different ways to do it. And the quote I put up there (inaudible) here -- If you've seen one ACO, you've seen one ACO. They do not all look the same. Medicare has their Medicare programs -- their initial group of 32 pioneer ACOs, which were kind of organizations that were already integrated and were really ready to take this on, and then they have their new group, which are the shared savings model, and both of these only deal with Medicare populations. And the Medicare populations that they define are not required to only get services from that ACO. So it's a little bit of a hybrid mix. But if an integrated health care delivery system decides to go after the shared savings model for Medicare, then again, as I mentioned earlier, if they're able to provide care to those Medicare beneficiaries for less than what would have been expected, they are able to share in that savings. And by doing so, they are able to join together and provide services that maybe would not normally be reimbursed under the Medicare fee-for-service program.

Commercial payer -- the commercial or private market insurers can do things a whole lot of different ways. Some of them are doing selective contracting, doing pilot programs with certain health care systems to kind of help start this process and help everybody learn how to make it work right. So some of them are more expansive than the Medicare program and some are much less expansive than the Medicare program.

And as I mentioned, thanks to the Affordable Care Act as well as the concerns about rising health care costs, we've seen a lot of these ACOs that are brand new just within the last year or so. So to look at the new ones that formed in 2012, they can kind of give us a flavor of who's trying to form these accountable care organizations. We know they have to have all the partners included in there, but sort of what are the organizations that are bringing them together? Well, over half of the new ones in 2012 were sponsored by physician groups, and there are a lot of leaders in the health care field who feel that physician-driven organizations are going to be most successful long term. Not everyone

agrees with that, but we're certainly seeing that the people who are setting up ACOs seem to favor that model. About a third of them have been sponsored by hospital systems -- often hospital systems in partnership with their employed physicians. A small number are being started by -- directly by insurers, and then an even smaller number by broader community-based organizations.

ACOs -- both because they're new and because they're trying to be a very different way of delivery care -- are facing a lot of challenges. One of the big challenges for ACOs right now is trying to provide this integrated care where you're paid in bundled payments for some of your patients but yet have the rest of your patients still be paying -- be reimbursed through fee-for-service, which may not cover some of these same services. In a fee-for-service model, if you decrease the amount of services you provide, you lose revenue. In a bundled payment model, if you decrease the amount of services you provide -- assuming that you've kept quality intact -- you gain revenues. So it can be challenging for an organization to figure out how to kind of have one foot in the boat and one foot on the dock. And in some communities, organizations are just kind of going whole-hog and saying, "I think this bundled payment ACO is the path of the future, so we're just going to get on it and understand that we might have some short-term losses, but in the long term we think we'll come out ahead."

The other direction that ACOs are going somewhat differently is that some ACOs are taking a very holistic whole view that they want to capture all of the care within their network. So they want to include all kinds of providers, all post-acute care, all primary care, tertiary care, referral care -- and provide it all to a defined population. There are some other integrated networks that are forming ACOs, carving out areas or service lines that they feel that they have a particular advantage in. So sometimes an ACO may be integrated across everything. Sometimes an ACO may just be focused on cardiac care, for example, or orthopedic care, and try and just segment one part of the market but have everything that orthopedic care would require.

And then the last (inaudible), which I'm sure would not be surprising to anyone in health care, is how hospitals and physicians are going to figure out this balance. There are very few physician groups that have the kind of capital that's required to set up something like an accountable care organization. There are more hospital systems that have that capital, but a lot of the decision-making around what services are delivered are still driven by physicians. And so you really need a strong partnership and a shared vision for that to work.

So what are the impacts we're seeing on hospitals? More and more hospitals are joining health systems. There are many who believe that the day of a single -- of an independent hospital remaining independent and not aligned in any network is going the way of the soloist physician practice and it's just something we're not going to see. We are seeing what one term (inaudible) as an integrated practice units where, again, you've got a group of providers working together across specialty to be able to provide one-stop shopping for particular conditions. And then everyone's pretty sure that the number of hospital beds that we have is going to decrease. And even in spite of -- in addition to more people having insurance through the health insurance reform, there is a belief that more care is going to be provided outside of hospital settings, and hospital census are going to drop and hospital beds per population are going to be going down.

And with all this, there's clearly a downstream impact on nursing homes and home health. Federal agencies and different health care policy groups are already tracking readmission rates from nursing homes and home health agencies. Hospitals are doing

that kind of tracking themselves and considering whether or not they want to use selective referrals because if they have -- if they're being faced with payment penalties like the excess readmissions reduction, then it matters to them what the readmission rates are from their post-acute providers. But also, if they're going to be increasingly integrated or joining those ACOs and being put financially at risk, then if they partner with community providers that have high readmission rates, they're going to be doubly penalized for that.

Next, let's talk about patient-centered medical homes. A lot of the patient-centered medical homes are tied to or related to ACOs. A lot of ACOs want a patient-centered medical home as part of their primary care practice, but they're not necessarily the same and they don't have to be together. The patient-centered medical home is a vision about physician practice, usually a primary care practice -- though there are some specialists who are working on this model -- where the idea, again, is that as a practice -- as a physician group -- you would provide care for a defined population of either Medicare beneficiaries or private insurance enrollees, and you would be paid a bundled payment which would let the provider then put together whatever multidisciplinary team feels like the right mix of services for the patients that they are taking care of. And they're not -- we're not subject to the previous concerns about what is and is not billable and who can provide services and bill for them, as opposed to some providers who cannot bill for those services.

There is a certification program from NCQA. And for those of you that are familiar, NCQA is the same organization that accredits health plans through the HEDIS program, where there is a certification program for patient-centered medical homes. And then, as I mentioned, we are seeing that a lot of the integrated delivery networks are interested in having that kind of model be a part of their ACO. And it's because the fundamental vision for the patient-centered medical home is very similar to that concept of what we were just talking about with accountable care organizations. You're emphasizing continuity. You want good access to your providers. You're trying to have coordinated team-based care. You're going to focus on population health and you're going to really invest in informatics to be able to do that, and achieving those goals are very much in alignment with what ACOs are trying to do.

In order to do this effectively -- in order to be able to manage populations effectively, there's a strong belief that the patient-centered medical home has to have the ability to really measure and monitor health outcomes. And again, this is where we're seeing a lot of the IT involvement with patient registries, with reminders and recalls, to really try and put that up to a level that a lot of primary care practices have not done before. There is -- we have had a little time to look at these patient-centered medical homes. There have been some that have been very successful, some that have not. They require a real culture change in practices, and it's -- the cost savings -- some have done very well. Some have not been able to show much in the way of cost savings.

And the impact then that we're seeing on physician practices is, as we make this move then towards bundling payments to thinking about populations, that we are changing the way that physicians are practicing. We're going to -- we are seeing more and more employed physicians, physicians joining larger groups that can afford to make the kind of investment that they need to do in infrastructure to be able to do this monitoring.

And we also, similar to what hospitals have been facing with the public reporting -- physicians also will be facing public reporting and (inaudible) to as hospitals had pay-for-reporting and then value-based purchasing. We're seeing physicians now enter the phase

of pay-for-reporting, and I don't have a crystal ball, but I'm pretty sure that pay-for-performance is going to be coming down that road, too.

And we're seeing that Medicare is now even proactively figuring out how they're going to pay for non-face-to-face care, and this really in an effort to try and increase the integration between providers and being sure that home -- the appropriate home and community-based services are being made available to beneficiaries.

And then one point to make often is, as we hear all the politics in Washington and concerns about the health insurance exchanges, I just want to note that, for these kinds of quality and ACO and PCMH discussions, there's not a lot of discord in Washington. Even if you look at the Republican proposal to reform Medicare payments, they're fully on board with quality measurement, with financial consequences, with physicians who perform well on quality to be rewarded if they provide lower-cost care, and if physicians participate in ACOs or PCMHs, that they can opt out of those payments. So they can automatically not be subject to penalties. So whichever the way -- whichever way the winds blow in Washington, I don't think it's going to change these trends for ACOs or patient-centered medical homes. I think this is what we will be seeing increasingly in the future.

And it's not just the providers who are going to face these different incentives. If you look at what private insurers are offering in their health insurance plans, we're familiar with the high-deductible plans, really focused on making people very cost-sensitive, but what we're also seeing now is insurance plans that will guide how you use health care to encourage people to use high-quality, low-cost care. So the amount of cost-sharing that someone would have to put out, the amount of deductible that they'd have to pay -- even which locations they went to -- might well be determined by whether or not they got health services from an approved insurer -- an approved provider according to that insurer's quality metrics.

So all of these things together mean that we are going to be seeing less of what we have in the past, which is the fee-for-service to individual providers and more and more of bundled payments, which means that health care providers are going to need to work together to provide care for patients across different sites of care. And just as -- we kind of said at the beginning that we think that the fee-for-service program has really led to -- really encouraged the development of individual providers and individual health care providers delivering services to individual patients, beneficiaries, enrollees -- increasingly, it's going to be a group of providers together that will be paid a lump sum to provide all of the services required for a defined population. And what that means is they're going to have to be coordinated, talking to each other, working together. And it's not going to happen overnight. It's not that we suddenly go from point A to Z immediately, but what we're seeing is every year a little bit more, more incentives to work together and be integrated, more penalties for not doing so. And my word of advice to the health care organizations that I work with is this is the future, this is the way it's going, figure out how to do it well, how to do right by your patients, find the partners in your community, find the health care providers who look at things the way that you do, and organize yourselves to be successful and deliver the high-quality health care that you have been and that you want to continue doing going forward.

And those are my remarks for our conversation. I'd be happy to answer any questions.

Sara Butterfield: Thanks, Dr. Rask. (Inaudible), could I ask you to give instructions to the attendees on how to ask questions?

Operator: Ladies and gentlemen, if you have a question at this time, please press * then 1 on your touchtone telephone. If your question has been answered or you wish to remove yourself from the queue, please press #. One moment for questions.

Sara Butterfield: And while we're waiting, Dr. Rask, I just -- you have -- listening to you today, many of the folks on the phone are -- as referred to as the choir, so these are folks that are already within community coalitions that are moving towards and working collaboratively with the hospitals across different settings. And it kind of rang true to me when you were talking before about how to best promote their value in the outcomes that they're really achieving within each of their organizations, for lack of a better word, to be able to market that or share what they actually are doing with those other folks within their community, other health care providers, to show the value of the -- and the efficiency of the care delivery that they're providing. And I think that really seems to be driving -- one of the driving forces for folks to get together and work on a (inaudible) level on care transitions and care coordination within each of the communities.

Kimberly Rask: Yes. Absolutely. And I think that's -- it's a great opportunity because you have -- if you're a community provider, your hospital's attention should be increasingly focused in these areas, and this is an opportunity to demonstrate your excellence in what you've been working on and why you're the right partner and you would be a good partner to them. And same on the hospital side. If you want to partner, you want to partner with a hospital that has recognized these issues, is working on them, and so you want to choose your partners carefully.

Sara Butterfield: Absolutely. So (inaudible), what questions might we have?

Operator: I'm not showing any questions, ma'am.

Chris Stegel: Dr. Rask, this is Chris Stegel. I have a question. You said or made the comment that Medicare is the seeing the variation in post-acute care -- in the post-acute care provider setting, but I haven't seen -- most of the APOs I've seen are partnering physician office practices with hospitals. And I don't see -- and with patient-centered medical home, I see physician practices adding case managers to their practices, instead of incorporating some of the community services or post-acute care providers like home health agencies, skilled nursing facilities, into their integrated model. I just wondered if you maybe have an example or could comment related to that.

Kimberly Rask: Yes. That's a very good point. And I think -- what I -- on the patient-centered medical home side, I think that the reason -- my explanation for why a lot of that has happened is a lot of that innovation has been happening in the private insurance market where the private insurers don't see as much of their variation in cost coming from the post-acute setting, so they haven't been very laser-focused on that. It's more of an issue for the Medicare population. And I think that Medicare is working in steps to try and tackle that coordination piece, and the first step seems to be more around making sure that long-term care settings have the same financial incentives that hospitals do around things like readmissions and the penalty programs. But they're finding it more challenging to think about how to really redefine payment rules in a way that can cross all of those different providers and do it fairly, and so I'm seeing them move just with smaller pilot programs to try and sort that out. So I think that it's moving in that direction, but because it's such a big change, I think we're not seeing as much movement as you might expect. Yes. But I think it is coming.

Chris Stegel: Thank you.

Sara Butterfield: (Inaudible), any questions?

Operator: Again, ladies and gentlemen, if you have a question at this time, please press * then 1 on your touchtone telephone.

Sara Butterfield: And Dr. Rask, it's Sara again. I just -- it also struck home with me about the opportunities for all the provider settings to kind of look at what's happening with patients. You noted the pre -- looking at the efficiency pre and post-hospitalization to look at the overall outcomes, and I think -- again, when folks are trying to identify what are the strengths within their organizations, that that is one additional area -- the pre -- that a lot of times folks don't focus in on.

Kimberly Rask: Right. That's a very good point. And really trying to think about that -- what's being done and are there ways it could be done more efficiently. And certainly, we've seen some of that already just on the physician side in terms of surgical payments, but now this is going to be something broader that really -- and again, it's -- as you said -- and I (inaudible) the other question the sort of frustration that we're in the transitional phase, and that's what makes it kind of difficult because it's not fully-bundled so that we can -- as health providers, we can set all these systems in place to address all these issues for all of our patients. Instead, we've got some patients that we are ready to do this kind of work with and we've got some patients that -- if I'm a hospital CFO or I'm a nursing home administrator -- if I don't have that person in my facility, I don't have revenues and you're going to have to make a difficult case to me about why I should change what I'm doing. And so these next couple years -- I think all of us in health care deserve an extra pat on the back because it's going to be challenging, but I have a lot of optimism that I think it's going to move us to a place which is really a better health care system where we can focus on what we want to do as health care providers, which is take great care of people, instead of how do we take great care of people in the financial constraints of our current billing system which doesn't let us do what we'd like to do.

Sara Butterfield: Excellent point.

Chris Stegel: Yes. I agree. This is Chris again, Dr. Rask. I agree and I tend to be an optimist also. So -- but I wanted to ask, is there something that a home health agency or a skilled nursing facility or a hospice or whatever could do to kind of get involved in a local APO? How would they, I guess, broach the argument to involve them --

Kimberly Rask: Right.

Chris Stegel: In the model?

Kimberly Rask: Sure. Great question. Usually what I see is that (inaudible) go and speak to your local regional hospital and look at your own data, demonstrate -- be able to affirm -- and I've been on the side of some of these conversations where there -- often sometimes as providers, we think we are doing the right thing and it turns out that when we actually look at our data, we are not doing as well as we thought we were. But by actually working at that data, we can identify the problems and fix things if they need to be fixed. And then share that data with the hospital, with the regional health system, and say, "I could help you and I should be part of your network and I should be one of your preferred providers because we are doing the right things by patients, we are getting the good patient outcomes, we will take better care of your patients." And that's -- kind of

developing that linkage and being able to do it based on your outcomes is one of the strongest ways to open that door.

Sara Butterfield: Excellent advice.

Chris Stegel: Thank you.

Sara Butterfield: And I'm thinking also of those folks that weren't sure about the accountable care organization activity within their community. You can go to the Medicare website or you can actually just Google Medicare accountable care organizations. That'll bring you to the CMS website option, and they're listed there by state so you can see if there is an accountable care organization, on the Medicare side at least, within your particular community to give you some perspective. It'll tell you which organizations are involved and give you a little information on each of the different ACOs.

(Inaudible), I'm going to check once again with you to see if folks have any questions.

Operator: So far we have no questions, ma'am.

Sara Butterfield: Okay. Great. And Dr. Rask, I want to thank you for a very informative presentation and helping us make sense of all the different pieces and the activities that are going on in the health care environment. It was very informative. And if folks have any questions that they didn't feel comfortable asking, you're welcome to e-mail myself, Sara Butterfield, and we'll be happy to get some answers and address those questions. I thank all of you for joining us, and again, thank you, Dr. Rask, and thank you, (inaudible) and Emily, for helping us with the program.

Operator: Ladies and gentlemen, thank you for participating in today's conference. This does conclude today's program. You may all disconnect. Everyone have a great day.