



Accountable Care Boot Camp HIGHLIGHTS (September 12, 2011)

Attendees (34)

Joe Cramer, MD, new medical director for Medicaid), Todd Wood (SelectHealth), Mark Briesacher, MD (pediatrician w/Intermountain Healthcare), Maureen Henry (E.D., Utah Commission on Aging and ADRCs), Lincoln Nehring & Barb Muños (Voices for Utah Children), Sheila Walsh-McDonald (SLCAP), Michael Siler (American Cancer Society), Tom Metcalf (American Academy of Pediatrics-Utah & UHPP Board), Sylvia Rickard (Hispanic Health Care Task Force), Joyce Dolcourt (Legislative Coalition for People w/Disabilities), Andrew Riggle (Disability Law Center), Russ Elbel & Vicky Wilson (Healthy U), Randy Bates & Kevin Eastwood (Weber Human Services), Lisa Nichols (Midtown Community Health Center & AUCH), Brooke Osterland (National MS Society), Scott Horne (Utah Hospital Association), Leena Sharma, Renee Markus Hodin & Jen Lemmerman (Community Catalyst), Elisabeth Arenales (Colorado Center on Law and Policy), Fahina Tavake Pasi (National Tongan American Society), Gina Pola-Money (Utah Family Voices), Korey Capozza (HealthInsight), Andy Curry & Darice Aslett (TriCounty Center for Independent Living), Danny Harris (AARP), Brent James, MD (Intermountain), Chuck Norlin, MD (Utah Pediatric Partnership to Improve Healthcare Quality), Shelly Braun, Judi Hilman, and Kim Myers (UHPP).

1. Welcome (Judi Hilman, UHPP)

Our purpose: to explore the full horizon of possibilities for bringing accountable care to Utah Medicaid. This concept may have had an abrupt beginning w/Senate Bill 180. That started us down what we expect will be twisted path, starting with a problematic Medicaid 1115 waiver application. Yet, the concept of ACOs presents an exciting opportunity to deliver higher quality cost effective care at lower cost, along with better health outcomes for beneficiaries. This waiver is very much under negotiation. In the meantime we'd like to learn what ACOs have meant in different states—especially for consumers. Later we can use this insight to circle back and re-examine the waiver—is it the right first step?

2. Introduction to Accountable Care (Renee Markus Hodin, Community Catalyst)

See slides: http://www.healthpolicyproject.org/Publications_files/Medicaid/FINALBootcampSlidesCommunityCatalyst9.12.11.pdf

[Community Catalyst](#) is a national nonprofit consumer advocacy organization that works on health care issues. We work to ensure the consumer voice is an active part of the discussion and provide support to local organizations (about 40 states): legal, technical, and policy/strategizing support. For today the relevant CC project is the [Campaign for Better Care](#). This focuses on the portions of ACA that relate to improving care for older and vulnerable populations and implements these in the best way for consumers. Right now we work with MA, OH, PA, NC, NJ, and ME on state-level campaigns with emphasis on comprehensive affordable and accountable or integrated care and on training older adults and caregivers in advocacy.

2 crises led to the Campaign for Better care:

- a) **Crisis in quality:** we have a fragmented system. Older, dually-eligible, people with disabilities use the system a lot, and it's not always to their advantage. Chronic conditions worsen, behavioral health not addressed, poor discharge instructions, not linked to community resources, more ER use (*slide 3*). Related to that is the...
- b) **Crisis in cost:** impact on Medicare spending—also in private market, but vulnerable population is on Medicare/Medicaid). 2/3 of Medicare spending is for folks with 5+ chronic conditions= 20% of Medicare population. Top 5% of enrollees accounted for more than ½ of Medicaid spending (*slide 6*). The dual eligibles also have disproportionate spending (*slide 7*).

AC (Accountable Care, *slide 8*): It's not ONE thing. Like the unicorn, it's what stakeholders want to make of it. From consumer advocacy perspective, it's positive as long as it meets the needs of vulnerable

groups and specific to sub-populations. There is a template being designed as part of ACA- Medicare ACO process, but it is definitely not the only one being developed.

3. Opening Remarks by Dr. Mark Briesacher, Intermountain Healthcare

-Dr. Brent James will join us for lunch-

Slides come from Joe Mott, CEO of Primary Children’s Medical Center, who has been tasked by Intermountain to lead accountable care working group (see Joe Mott present similar slides at upcoming annual conference of the Utah Association for HealthCare Quality: <http://www.uahq.org/Annual-Conference.html>. Leadership Team member Russ Elbel is President of the UAHQ).

From opposite ends of the political spectrum, Heritage Foundation and Center for American Progress are saying the same things about health care: “Medicare/Medicaid costs are unsustainable.” Promises to our population are also unfunded obligations: Medicare at 37.9 million and Social Security at \$7.7 million. Dante: “Abandon Hope All Ye Who Enter HERE (*slide*)” – it’s a big task that will take conversations like this, with all stakeholders.

The ACO concept comes from Medicare, which has been running demonstration projects showing significant savings. The one group that did well on reduced spending was the Marshfield Clinic (met 2% threshold of savings). Why? It’s an ACO like group of clinicians surrounded by a lot of clinicians not coordinated. But every group improved quality, saved money. 500 pages of proposed regulations came out of these projects- <http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html>).

ELEMENTS OF COST OF CARE—WHERE ARE WE SPENDING MONEY???

Formula we use: Episodes per person x process per episode x cost per process = cost per person (for a specific condition). Or: Population utilization x intra-case utilization (DRGs) x efficiency = cost.

From [Jack Wennberg’s](#) work ([Dartmouth Atlas](#)): care by hospital geographies.

This table shows the significant variation around accepted care standards—note how Utah’s variation is lower than national...

	Utilization	Intra-case	Efficiency
National	140%	40%	25%
Utah	50%	25%	15%

SAO or Shared Accountability Organization, the preferred term at Intermountain:

We prefer “SAO” to address the shared accountability of patients. We are holding Open Forums about this program/concept—UHPP will share details.

Q & A

Sylvia: what about help for English-challenged, minority populations where decision making on care may be happening more at the family level? Some cultures make all medical decisions as a family as opposed to the patient making all decisions. What about navigators? Also we have very little data on minority populations—what about data collection?

Dr. B: The regs cover this—and we agree on these areas. We are struggling with that—when do you ask the questions and collect the data in a way that is safe and appropriate?

Waiver point (Judi): in the stakeholder process we found a strong appetite, esp from UHA, for better consumer/patient engagement or personal responsibility (carrots and sticks). Let's come back to this.

The [proposed ACO rules](#) were posted for comment on March 31, 2011. Medicare ACOs will be online January 2012. We have many issues with the regs, including anti-trust, how do you coordinate, how do you share savings, millions of dollars just to implement it. "Pioneer ACO" LOIs (Letters of Interest) for advanced entities like Intermountain, Geisinger, and Mayo Clinic were due by 6/10; application thru the Center for Innovation by 7/18.

TOM: what is the private and uninsured health care obligation (cost)? Is anyone thinking about applying ACO to these populations. In terms of cost to the nation, sense is that cost is reasonably significant.

JUDI: Sen. L would like the model developed for Medicaid to spread to rest of market.

DR. B: also—cost shifting. 15% "tax" on the health insurance premium. Agree, this cannot be a Medicaid only model. Can't have 10-15% of your population be in a capitation type system and the rest in FFS—too hard to operate that way.

TOM: politically it's a huge move to go from Medicaid to private market.

Dr. B: but companies cannot handle high single digit increases.

MAUREEN: is no-one on board with the March 31 ACO rules?

Dr. B: People say the concept is spot on, but the rules are troublesome, especially anti-trust. That barrier alone is too high.

MAUREEN: so is the direction at federal level to tinker around with edges and put everything else into innovation center?

Dr. B: plenty of places in the country where there's no coordination of care, so much waste. If you brought those people into ACO it would work! You're compared to your own performance. UT re-admission rates are 10%, in Florida is 40%. So UT is already doing well.

RENÉE: overall we thought the regs were going in the right direction, there was a lot of patient centeredness, which is positive, engaging consumers in the governance. Won't be scrapped entirely but will be modified. It's our job to take the elements and make something work in Utah.

Current Activity @Intermountain

- Medicare Advantage: Select Health dev product for Jan 2013 enrollment (Milliman helping)
- Medicaid: SB180; Waiver to CMS, target to launch July 2012
- Medical Group is implementing a patient centered medical home (personalized primary care)
- LEAN capabilities in Urban North Region
- Shared accountability model - Urban South Region + Primary Children's
- Bundled payments- Rural Region w/BlueCross of Idaho.

Bundled payment: system gets one check and has to decide how much to pay whom. If the group performs efficiently and at less cost than payment they get to keep the difference. Great concept, but no one has described: how do you unbundle it for payment to the different docs, depts., etc.

TOM: so shouldn't the variety of providers become an ACO then?

Dr. B: tough thing—some of the providers are private contractors.

"it's better to do things all the same than do things right" if you come together and decide to do it all the same way, even if only 80% there, because together you can collect data and make quality adjustments, and get to 100%. "Go for good to get to perfect."

RUSS: what quality measures do you recommend?

Dr. B: start with nationally accepted measures. The problem w/quality measures is how you actually measure. It won't work to simply rank from best to worse because this gives you an arbitrary line. Choose a quality threshold high enough to ensure quality improvement is taking place but not too high to exclude those who are working hard on it!

JUDI: Greg Poulson of Intermountain uses a helpful metaphor: until the 1950s, some airplanes would crash on descent because pilot would forget to put down the landing gear. Then they figured out how to engineer planes so that a signal goes off once you hit a certain altitude: PUT DOWN THE LANDING GEAR! Now there may be a valid reason to *not* put down the gear at that point. The alarm signal functioned as a cue to the pilot: if you are not planning on landing, there better be a valid reason. Is this an apt metaphor for the decision making process that ACOs should strive to support amongst their providers?

Dr. B: Yes, we have this for many conditions, but not all. The point is to have data on how you're doing—*while you're doing*. The human mind remembers things by sign-posts, so need data. Intermountain's EHR (electronic health records) are designed to collect data, not to report on quality measures.

CHALLENGES

- A culture change is what's called for: Intermountain is successful because of its culture (of continuous quality improvement).
- How to address structural barriers
- Definitions of success must change over time, as we learn more about how the decision making process works for different entities.
- Managing timing/transitions
- Transitioning the financial model
- Transitioning the care delivery model

JUDI: what do you (or Intermountain) think about the Medicaid waiver...is it the right first step in Utah's transition to accountable care?

Dr. B: where's the safety net in this? Providers will be required to deliver the same quality to all segments of population? Where is the financial accountability—is there evidence the cost sharing changes will work? I am reminded of Daniel Pink, author of [Drive: The Surprising Truth about What Motivates Us](#). If you take an extrinsic motivator (like money) and try to apply it to an intrinsic thing (health) it usually makes things worse. So, docs are insulted to be paid to do quality because they already do quality. What they need are DATA so they can see how they are doing and go from there. Same for healthy behavior—we need a walking community, to pay someone to walk.

SYLVIA: our populations came from areas where we walked all the time. Here it's dangerous on the streets, dangerous for the kids. We're all worried about things. Need to also do cultural change in the dynamics of the community. In Hispanic community we have "fatalismo" (fatalism) to contend with. But when death is close, the patient might well switch to "let me live!!" Need to change mindset!

RENÉE: please talk about structural changes to engage patients and families.

MARK: We're moving toward patient-centered care. 2 years ago it was the doc and medical assistant. Now we're adding nurse (RN), care manager—embedded in the clinic. This can get expensive! Added into cost (not FFS). Using MAs as health advocates. This dyad screens for mental health issues (vital in chronic care), updates medical list, and then follows up after doc appt with education. The most the patient retains is 9-50% of what doc says. So if we do the education separate from the doc appt and it WORKS!

TOM: any data collection on population level to control obesity, *before* they come to doc office?

Dr. B: no but we need this! Need a support structure in place to manage chronic conditions. As the teams are built and embedded then we can begin to address these important challenges.

40% of health is choices we make (food, drugs, exercise), then genetics, then 20% environment; **only 10% of our health is impacted by medical care.**

4. **OTHER STATES (Leena Sharma, Elisabeth Arenales, Renee Markus Hodin)**

North Carolina (Sharma)

CCNC (Community Care N. Carolina) is a statewide public-private sector medical home care management system. Information is collected, shared, and used to improve quality.

Slide 12: How CCNC works (slide 13)—enhanced fees for certain populations. FFS (Fee for Service) Medicaid rates are 95% of Medicare rates. Each network has a team: director, pharmacy, medical management committee. NC has significantly reduced ER use and inpatient admissions and improved chronic condition outcomes.

Savings: retained by the state in Medicaid (slide 15).

Next steps in NC:

- Expanded to duals in 2010
- “one touch rule”
- Managing multiple chronic conditions
- Informatics Center and Provider Portal to become shared resource for all communities.

Success of CCNC based on statewide visionary leaders working together, local and statewide docs. The NC experience demonstrates that cooperation works.

Q: what was the driver for less ER admissions?

Leena; team of medical home steers people to clinic, not ER

Q: how are savings used?

Leena: not sure. See their [tool kit](#), which has been useful for other states.

Colorado (Elisabeth Arenales, Esq.)

See slides: http://www.healthpolicyproject.org/Publications_files/Medicaid/ColoradoAccountableCarePresentation.pdf

Colorado’s project, which is focusing on quality improvement and efficiencies, is underway, in process. It is based closely on the NC model! The medical society began the discussion. Medicaid Director (Dr. Sandeep Wadhwa, now at 3M in Utah) really took the ACO concept and ran with it as a hybrid model: ACO + primary care case management to improve quality, increase access, decrease cost.

In CO the intent is to enroll all beneficiaries in a very short time (a concern for advocates like us).

The changes are happening through state plan amendment, 2 tiered, passive enrollment w/opt out. (Slide 3)

Payment structure is FFS (fee-for-service), participants get additional incentive. Option for shared savings not defined yet. Goal is to enroll everyone.

RCCO (slide 5+)= Regional Care Collaborative Organizations:

- Care coordination and practice support
- Develop provider networks and contracts
- Facilitate referral process
- Data (to dept and/or SDAC)

ISSUES:

Do you want to build on systems already in the state or make new ones?

How do you design a network if there is no disincentive for going out of network?

Real emphasis on DATA—feedback loops from the beginning. Regular stream of data for RCCOs and providers on the measures they will be held accountable for.

How long does it take to ramp this up, how much does it cost?

Primary care providers can belong to more than one RCCO—how will that work?

How do providers balance a 10% Medicaid system with their other patients?

Special assistance for behavioral health needs or dev. disabilities?(slide 6)

ANDREW: does this just address medical needs or also community supports and long term care?

E: not yet, down the road dual eligibles and more than medical needs will be addressed

Colorado is waiting to pull in harder populations until figure out how to do this well and work the kinks out. Doing a waiver for adults without dependent children (can cover up to 10% FPL!). They have big medical needs and would like to pull into RCCOs right away.

But 120K enrollment is target goal by June 2012 and then the fragile populations—probably too fast!

Most providers would like to look at data. Reasons include budget cycle and state has promised to provide savings of over \$4mill and cover the costs.

Budget cycle is a problem but unavoidable. CO must make more general funds cuts in near future.

TIME FRAME (slide 10)

Already have 45K assigned to ACO. Using claims data to primary care codes, and assigning people to last source of primary care .

COMPENSATION (slide 11)

Higher in initial phase and then goes down in expansion phase.

Level I and II target goals = different compensation. Have to hit target in each area to get \$0.99 extra PMPM (per member, per month).

Dr. B: What's primary care access to start, what are the ER and re-admission rates out of gate? It would be helpful for Utah to know where we start and what interventions will work.

JUDI: Health plans must file these quality/access reports every 3 years. Do we have enough primary care providers, is there adequate access? These reports say YES, but less clear anecdotally.

RUSS: Access is measured through HEDIS now. Not perfect. Going forward with APD (All Payer Database) will help us get better access to data.

E: Colorado just implemented an APD, so will be a few years to get results. WE expect APD will help.

ANDREW: noticed that the PMPM for the RCCOs is much higher than rate provider receives. That strikes me as the reverse of what it should be. Can you talk about who the RCCOs are and how they are structured in the different regions of the state and what their responsibilities are to justify this?

E: we have the same question! When you look at NC their rates are different than ours. Based on feedback from national colleagues, this seems to be a higher allocation than anywhere else. This balance between achieving savings while providing sufficient funds to get the programs off the grounds is tough. RCCOs are non-profit to do Medicaid managed care. Being asked to do a lot, no question. I honestly don't know if compensation is justified or not.

Dr. C: how are physicians part of 2 RCCOs— because they aren't geographical, they're statewide networks. And, Medicaid is not yet a part of the APD in Utah.

E: would like to see uninsured counted in APD.

SYLVIA: how do you pick your consumer advisory committee members? I've been on IRBs (institutional review boards), for example, and its frustration to see someone's wife on a committee because he donated!

E: it's interesting. The RCCOs are not necessarily as familiar with how to achieve consumer engagement. It's been hard to figure this out... consumer advocates have showed up at some RCCOs and have been gratefully received. There's often a disconnect because consumers haven't had a formal role. This needs to be established.

SYLVIA: is there any process for educating consumer to be effective advocates? So they know it's about the whole system, not just about "me."

E: This remains to be seen.

DR.M: how do you include primary care providers?

E: still stuff to work out. Can opt out if your doc isn't in the RCCO, RCCOs are supposed to reach out.

CONCERNS FROM COLORADO EXPERIENCE (SLIDE 16)

- Process of attribution: how to assign someone to a RCCO and how they choose a provider. 45 K people enrolled now, but lots of kinks to work out. Do the people understand what it means to be part of a RCCO? It's confusing.
- Provider/RCCO/state relationship—this can be confusing. Is payment incentive too much or not enough?
- Data and reporting—making sure this is adequate to do the job—and useful. Accurate and timely data is crucial.
- How much does it cost to start this up? IT infrastructure is significant investment.
- What about the grievance process and complaint resolution? The office that deals with this for the state got only \$3000 additional to deal with RCCO transition!

IN SUM, RECALL LESSONS FROM NC TOOL KIT

- Avoid top-down approach.
- Don't do it alone.
- ACOs take time and up-front investment.
- Supports and systems must be in place.
- Feedback and accountability are essential.

New Jersey (Leena)

Started by one provider in Camden (population=79,000) and expanded to the state. Highest crime = poverty in the USA.

Biggest issue was lack of primary care providers.

1st step: collect data from hospitals; then identified "hot spots" (residential areas that had the costliest, highest utilization). One was low income housing, one was residential area.

Developed *community engagement model*. Worked with residents on solutions on how to address health care needs.

They learned what needed

- Collaboration between providers
- Collaboration between providers and community
- Build public will for change
- Directly engage the residents in the hot spots
- Train local residents to participate in decision making over health care resources

Solutions

Nurse practitioner-led clinics onsite in hot spot buildings! Outreach teams, home-based care coordinators, and more open-access scheduling—same day.

Early successes: (slide 26)

- Decreased ER, boosted primary care.
- Will replicate model in other communities.
- Now moving to Medicaid—so this community can serve state as ACO model and participate in “gain sharing.”

JOYCE: is mental health included? What about co-pays?

RENÉE: yes, no co-pay for primary care and there are mental health SWOT teams.

Dr. B: what is uninsured rate for NJ? 15%

MASSACHUSETTS (RENÉE)

Senior Care Options (SCOs) (slide 28): This is active enrollment (voluntary) for dual eligible seniors with blended payments.

Commonwealth Care Alliance (CCA, is part of SCO) (slide 29): non-profit comprehensive care system. Official founding members are Boston Center for Independent Living and Health Care for All (UHPP’s counterpart)—two consumer advocate groups.

Boston Community Medical Group serves dual eligibles with complex disability.

Structural elements of CCA: (slide 30)

- Selected hospitals and specialist networks. Have to be disability competent and have training in geriatrics.
- Multi-disciplinary care teams with same day access, home visits, care coordination out of the box (like air conditioning or a chair!)
- Members are engaged in meaningful relationships with care givers and active participation in care plan. (slides 30-32).
- Very hands-on approach and very personalized.

[Stanford U. Model of Chronic Disease Self-Mgmt program](#) is offered to members, a 6-week course.

RESULTS (slide 33)

- Fewer hospitalizations
- fewer nursing home placements,
- and reduced projected costs.

WHAT’S NEXT?

SCO (Senior Care Options) is informing what’s going on cost & quality-wise in MA reforms. Remember that MA health reforms increased coverage first; now MA is tackling cost + quality.

Payment reform commission recommended & moving to global payment—still exploring this. Will have a new bill for next session—debate is happening now!

[Health Care for All](#) (which hosts the MA Campaign for Better Care) has developed a set of principles to use as a measuring stick for proposals. At same time Mass got a planning grant from the [CMS Center for Innovation](#) and Office on Duals to redesign a system for non-senior duals. Rich conversation right now, lots of public forums. SCO needs to be modified—what about disability competent care, for example. Ad hoc coalitions forming around this now. See 2 products from this exciting new collaboration:

- [Using the Opportunity of Health Care Reform to Improve Care and Manage Costs for People with Physical Disabilities](#)
(Disability Practice Institute)
- [A Health Care System Designed to Serve Adults with Disabilities](#)
(Community Catalyst & Boston Center for Independent Living)

5. LUNCH PANEL- SHELLY MODERATING: LOCAL PERSPECTIVES ON ACCOUNTABLE CARE

1. DR. CHUCK NORLIN, PEDIATRIC PARTNERSHIP TO IMPROVE HEALTH CARE QUALITY, U OF U.

My work is related to quality improvement and medical homes. See [HANDOUT](#) on results. Healthcare crisis is the result of high costs, access issues, primary care provider shortage, etc...and this is what led to landmark legislation, the ACA.

The ACA supports innovative ways to pay for healthcare while taking into account (the crisis issues), potential of learning from innovation, and the fact that it takes time to produce change in care. Right now payment is provided for doing procedures with no or little value as opposed to paying much less for education and other things that can produce better outcomes.

Medical home is a model of care to improve continuity, coordination of care- especially for those with chronic conditions. Lots of opportunities to incentivize systems to provide high quality care with a focus on outcomes. Also worried that there are so many experiments going on that the outcomes will be difficult to share widely.

2. GINA POLA-MONEY, UTAH FAMILY VOICES

My and UT Family Voices' role in above medical home projects has been to facilitate family and consumer involvement. It is exciting to see where we are going, but we still need to clarify WHO we (and ACOs more generally) are accountable to. The cost containment focus makes us nervous because children with special needs are big cost drivers.

In the medical home demo projects the family needs to be at the center--especially in pediatric projects. This is so much more than just surveys about satisfaction. A care coordinator makes the biggest difference, but too often the elements of care seem to operate in silos. Our families use public and privately funded care, but also transportation. Mental health integration is essential. In terms of ACO and waiver, we have to take into account all these issues. I am concerned about the waiver' proposal to start rationing care- for our kids these are not 'optional benefits.' Coordination of care, with family at the center, is the key! Without buy in, the consumer may not share in "accountability."

New numbers from data resource center: used to think that about 10% of children have special needs- now it's more like 15%. Almost 120,000 Utah children with special health care needs (short term, long term, physical, behavioral, mental). If you have cultural or linguistic difference, it makes an already difficult system, even more difficult.

SHELLY: Can you address the idea of creating an ACO around a specific condition or population as opposed to a general ACO?

GINA: It becomes problematic because one person may have more than one condition to manage, so every ACO should be able to manage multiple conditions.

Dr. N: It depends on the design...of the unicorn. If ACO is structured so it can serve a large and distinct group, like children with special health care needs. This brings a lot of expertise and value to the table. If this can be a wide net, it may work, but we also want families together, in the same ACO.

3. SYLVIA GARCIA RICKARD, HISPANIC HEALTH CARE TASK FORCE, BREAST CANCER NETWORK

I am wearing different hats (community-based organization, minority woman, and someone soon to be on Medicare), my first question is: who are ACOs accountable to? Providers, hospitals or to patients? Accountability should be towards patients, as opposed only to saving funds. This is critical especially for vulnerable populations...ethnic minorities, non-English speaking, people with disabilities, mental illness, etc. From what I can see so far, the state ACO is provider centric. I would like to see one based on consumers, on quality for them as well as equity. To start, all ACOs/medical homes must have the ability to collect data on these different populations.

Medical homes can be positive and negative. I have a place to call medical home, with a well respected and admired PCP (primary care provider). But I probably have this because I am an educated and empowered consumer. What if you're not?

On **navigators**: there is a need for patient assistance to help families navigate system. It is about educating family--not just patients. And remember that family can be defined different ways! My point is it must be defined by the patient.

Medical **interpreters** are also critical: who is going to absorb those costs, for qualified medical interpreting? This includes the ability to translate or mediate cultural thoughts on illness at different literacy levels.

On **access to appropriate care** at appropriate time: the PCP must partner with patient on these decisions, including access to specialists and second opinions.

What about **long term care**? We need community watch dogs—UHPP, CAP, AUCH for example—to protect consumers and communities. What about out-of-pocket expenses like deductibles? I am concerned about the disenrollment provision in the waiver proposal- there are a variety of reasons people may not follow directions such as cost, cultural beliefs, etc...the waiver needs better protections for patients.

Access to PCP is so important, and trust and relationship within this context. I am concerned about bundling. There should be something like a warranty on healthcare- for example mistakes on mastectomy. This kind of thing just shouldn't be happening! We need safeguards to reduce medical mistakes. Care coordination, working together across systems helps bring down costs while improving safety and quality for patients. Grievance process- we also need this for system to work.

BARB MUNOS: at 16 my husband was taking care of his elderly aunt...he took her to E.R. There was nobody to translate that she needed a pelvic exam, it was traumatic for everyone for him to try to translate for his own aunt! Patients are scared and alone and need the comfort and clarity of communication in their language.

DR. TOM: HMOs were a recent failure in health care system. These seem similar to ACO in many ways. What lessons are we learning so we don't repeat mistakes of HMOs?

DR. BRENT JAMES: Right now providers are paid more for providing unnecessary care and for harming patients. ACOs are responding to this. The operative factor for ACOs, in contrast to HMOs, is aligned

payment generally through a shared savings model, with these processes aligned to reward for quality outcomes. The main difference is aligning or tying payment to quality outcomes.

HMOs, by contrast: from 1993-2000 the cost curve *was* actually bent by HMOs by putting insurers in charge of care. This made it fail because insurance doesn't know how to make all the decisions about care.

To summarize the failures of HMOs:

1. Financial incentives to inappropriately withhold care (studies say there was a slight increase in care!);
2. Choice- patients want to be free to go to any doctor.
3. California examples. I don't like for-profit insurance personally—talk about perverse incentives

Now the primary goal of ACO *is* also to get cost under control. Put in this model providers are also at financial risk for care. Now there are financial advantages to providing the right care.

And that care will be organized and coordinated through better process management. This forces you to provide patient-centered care along a continuum of care.

In 1994 Intermountain did a key process analysis (of treatment decisions) on 1,400 conditions in our hospitals. 1st we ranked them by clinical risk and internal variability. 104 of them added up to 95% of all care delivered. Intermountain has had success with this. 11% of system volume is pregnancy related- 2nd is heart related (10%). In medical home demo- 1 is diabetes, 2 is depression.

Two big changes since HMO: Data systems are much better and so care is massively better. We think that care will not suffer. On the issue that seriously ill patients will be turned away: if we focus our resources on them, then there is no incentive to turn them away. In this transformation, we're not asking insurance to manage care anymore—providers will be managing care. That's the main difference between HMOs and ACOs.

LISA NICHOLS: Midtown Community Health Center and representing AUCH's Medicaid Reform Group

Serious and persistent mental illness is a major cost driver and siloed in care delivery. So Kevin/Weber Human Services and I are working on this together since February and supporting a co-located clinic and sharing resources. Midtown provides primary care and mental health care for the uninsured, and Weber County serves Medicaid. Anecdotally this is working very well. We're seeing compliance in those who have never been compliant. These folks used system in most expensive ways, showing up in E.R. 75% had a PCP, though this may have been a psychiatrist. This was not efficient in controlling costs. CHC provides a range of services under one roof with coordination and a patient-centered medical home model. We have structures and processes in place to improve care delivery over time: patient portals, email visits, after hours visits. We have a lot of patients who come for social visits.

KEVIN EASTMAN, WEBER HUMAN SERVICES

Funding is a huge barrier in our system and state. We are working on serving the community in most efficient ways possible or funding limitations will be our demise. Medicaid dollars were available to re-invest in care for the uninsured under the old capitated system. Now this service is partially funded through a pre-paid health plan with cost-settlement at the end. This creates disincentives in the system, for example Medicaid will pay well for inpatient costs, but not residential treatment at a much lower cost.

We need to start talking about mental health in terms of physical health. We need to prepare our Medicaid system now to be prepared for Medicaid expansion in 2014.

RUSS: How do you (Dr. James) see flow of funds in ACO?

DR. JAMES: Through a shared savings model, capitation is structured so that savings are the result of better care—not withholding care. Intermountain is now sorting out how this could work using payment. Going into this, the pressure to control costs is intense. There are 2 key ways

1. Ration care or

2. Managing care *processes* and improving care. For this the key factor is an effective team and organizing care around patient needs. Big change from revenue model to cost centers...which is why coordination is so important. When PPACA passed we knew that, if we don't find a way to control costs in next 10 years, the system will implode.

Adding to the cost pressure is the coming Medicaid expansion: where is care going to come from? Wait times will increase, but low-income people can't wait as long as wealthy. This is to say: insurance is no guarantee of access to care. We need to focus on increasing access in terms of placement of care delivery, streamlining of care delivery, etc.

DR. METCALF: Can this work in current terms in Utah Medicaid. What about payment of doctors?

DR. JAMES: Call it what you want- shared accountability, organized medical homes, etc...Yes, it can work in Utah. Any practice not partnering or streamlining with other practices will probably fail in the future. Most will have to be part of a group to survive. Big groups have harder time turning away Medicaid.

6. STRATEGY DISCUSSION (Jen Lemmerman, facilitator)

Update on waiver negotiations (Dr. Joe Cramer)

Michael Hales, Gail Rapp, and I sit on calls weekly waiver negotiation meetings.

The changes in cost sharing for kids (and pregnant women) are off the table. One question related to prescription drug pricing still under consideration: can we impose a \$5 charge for non-preferred drugs and no charge or less for PDL-listed drugs? The timetable is still uncertain, but perhaps sometime around Jan 2012. Political realities want this resolved before 2012 legislative session. We are still aiming for a July 2012 implementation date, though are uncertain if can reach that. The premium subsidy proposal has not been discussed yet.

RUSS: has there been any discussion of the time table at all?

DR. C: federal-state partnership means "they haven't told us yet" The Feds don't want one, state is pushing for one.

Next Steps for Leadership Team Strategy

JUDI: From what we learned today about other states' experience, ACO have been years in the making, yet Utah is going fast (July 2012).

DR. CRAMER: but "implemented July 2012" might mean anything. While the waiver is there, that's not where the action is. The action is with the people who will actually create the ACOS in practical and logistical ways. That's where conversation needs to be—w/insurance companies and physicians. It's about a massive culture change.

JUDI: What do we need to keep an eye on, who needs to be at the table, what do we need to do, what are the mechanisms, the brain for all of this? We had a stakeholder input process, thanks to Senator Liljenquist—but where did all of this input go? It's not reflected in the waiver proposal really—when or where will this thoughtful input show up? Our input needs to be tied together in a way that makes sense and sets benchmark for the state and...keeps consumers at the table.

DR. METCALF: UHPP should be the frontal cortex

JUDI: OK, but probably with HealthInsight as neutral convener of the providers and insurers, who really need to be co-driving this.

DR. CRAMER: do you see any help coming from the [Governor's Sept 30 Health Innovations Summit](#)?

JUDI: That's only part of one day...we need something more permanent.

DR. CRAMER: I don't know yet what the Governor's commitment to this looks like.

JUDI: Gov Herbert wants to create a 5 year plan on health care in Utah, is forming workgroups now.

DR. CRAMER: will that guide what DOH is doing on Medicaid reform? It's up in the air.

JUDI: that might be one opening—we should maximize the Sept 30 process.

Jen: So the Governor is starting a 5-year plan, what about opportunities for **immediate savings**?

RENÉE: what can we do now to improve care and reduce cost? The waiver reminds us that our timeline may be too slow. Here are a few well-tested ideas for the group:

- Reduce hospital readmissions and complications. Join the HHS-sponsored [Partnership for Patients](#) to reduce complications/readmissions by 40% thru adjustment to the rates. What has the discussion in Utah been around avoidable readmissions/complications?

Dr. C: I can follow up on this, at least from the Medicaid standpoint.

JH: maybe Scott (UHA), Wu Xu (from DOH), and Dr. Cramer could present at next meeting—is there something we can do in next leg process?

Dr. C: work more closely with medical community. How do they make decisions, what is their environment to make changes and move away from defensive medicine. We have a new Medicaid inspector general who is good and competent but has a mandate to save \$30-40 million.

JH: where are we on fraud prevention? Is there something else we can do like qui tam? (whistle blowers.)

RENÉE: Is there room to improve on our prescription drug purchasing strategies?

Dr. Cramer: Yes! Legislature has said hands off on including psychotropic drugs on the preferred drug list for whatever reason.

JUDI: we've been having discussion with county mental health leaders about mental health on PDL etc.

KEVIN: a lot of exploration here, but I think there's common ground.

DR. M: With the exception of NAMI, which is dead set against compromise, other participants would like to see a bill again this year. Can we strike a compromise w/NAMI? Hard to say. Without NAMI anything we put forward as legislation may be doomed.

JUDI: we'll report back.

KEVIN: We're also looking at the Medical Home planning grants for integrated health homes.

LISA: just some dialogue on how to increase the flexibility of MEDicaid... just dialogue.

ELISABETH: Getting back to fraud prevention, it may be worth asking whether your definition of fraud is broad enough to maximize 3rd party recoveries, for those who have Medicaid and private insurance/ or Medicaid and Medicare.

FAHINA: we need to work bottom up to identify needs and issues that are keeping costs down, especially with ER.

SHEILA: we know the impact of 2014 w/Medicaid expansion. Most data shows those who will be coming on have pent up health care needs (multiple chronic care)...thus the more models we can set up and the more resources we bring in the better off they will be. This needs to be the year of education

DR CRAMER: 17% of Medicaid applications are denied at DWS for process reasons. We need to make sure they get enrolled!

ELBEL: To reduce traffic to E.R., we will need a community education effort. We talk about access problem, we need to know more about that as well. This community education effort will help with reducing ER and understanding access more. ANDREW: Yes, we need public awareness campaign, but that is focused on getting attached to a primary care provider. I heard 2 things today—that for cost and quality reasons, mental health should be integrated with primary care and working with education and providers around extended hours of care.

PRINCIPLES: let's get these started for the broader ACO transition. Need to recruit people to part of a smaller group—see below.

Preliminary brainstorm (Workgroup can build on these) of Principles and/or Next Steps

- Recruit people to be part of group to recommend principles with help from Community Catalyst.
- Consumers at table/integrated into ACO's
- Data populations/subpopulations/usable
- Involve provider community
- Flexible to meet Utah needs
- Learn from other states (NC has been doing this for 15 years)
- Implementation should be seamless for the consumer

PRINCIPLES WORKGROUP:

Judi (UHPP), Lincoln , Andy, Andrew, Fahina/Ivonne, SelectHealth (Pat, Sean, Todd), Russ, Tom Metcalf

ACCOUNTABLE CARE BOOT CAMP: FEATURED SPEAKERS

***Elisabeth Arenales** has directed the Colorado Center on Law and Policy's Health Program since January 2000. She is recognized as an expert on public health insurance programs and works to protect, preserve and expand access to healthcare, particularly for lower-income Coloradans. She served as a consumer representative on the Colorado Blue Ribbon Commission on Health Care Reform and was the founding board chair of the Colorado Consumer Health Initiative. Prior to working for CCLP, Ms. Arenales was staff attorney for the Colorado Lawyers Committee, where she focused on access to education, particularly in rural areas of Colorado. Ms. Arenales has been recognized by many organizations including the University of Colorado (Law School Alumni Award for Distinguished Achievement) and Trial Lawyers for Public Justice (Trial Lawyer of the Year). In 2006 Ms. Arenales was recognized as a community health leader by the Robert Wood Johnson Foundation.*

***Mark Briesacher MD** is the Senior Administrative Medical Director for the Intermountain Medical Group and Medical Director for the Medical Group's Central Salt Lake Region. In these roles he is responsible for implementation of the patient centered medical home, quality improvement and reporting, and other related projects. Mark joined the Medical Group in 1995, began working at the Bryner Clinic in 1996, and then moved his practice to Holladay in 2001. He served on the Intermountain Board of Trustees from 2005-2008 and is currently a member of the SelectHealth Board of Trustees and Intermountain Medical Group Board. He received his Bachelor of Arts in Chemistry at Central Methodist College and his Doctor of Medicine from the University of Missouri-Columbia. Dr. Briesacher then moved to Salt Lake City and completed his internship and residency in Pediatrics at the University of Utah and Primary Children's Medical Center.*

***Kevin Eastman** is a Licensed Clinical Social Worker with the State of Utah. Kevin earned a Bachelors degree in Social Work at Weber State University in 1992, and his Masters in 1994 at Our Lady of the Lake University in San Antonio TX. Kevin has been employed at Weber Human Services for over 18 years where he has worked as a clinician with both Mental Health and Substance Abuse clientele. Of those 18 years, he has been in a supervisory role in various programs and capacities such as the inpatient liaison at McKay Dee Hospital, day treatment supervisor, case management supervisor and as a supervisor over an outpatient substance abuse outpatient team. He also created and supervised a residential substance abuse treatment program which was known as "STOP" (Substance Treatment Options Program) in the Weber County Jail. Kevin served as the Chief Operating Officer at Weber Human Services for 4 years and most recently is the Executive Director at Weber Human Services since his board appointment in July of 2008. Kevin believes strongly in the principle of partnering with other entities to create*

better service opportunities for the public system and that was the impetus to work with Midtown Community Health on an integrated health clinic located at Weber Human Services.

Renée Markus-Hodin is Director of Community Catalyst's Integrated Care Advocacy Project, where she leads efforts to ensure that the voices of our most vulnerable populations are well represented in state and federal efforts to redesign the U.S. health care system. Renée also serves as the Director of Community Catalyst Legal Action, an effort to challenge unlawful practices of private health care entities which hurt health care consumers. Renée's expertise extends to other areas of health care including hospital free care and community benefits and health care conversions. Before joining Community Catalyst, Renée served as a Special Assistant Attorney General in the Civil Litigation Department of the Vermont Attorney General's Office. She holds degrees from the State University of New York at Binghamton and the University of Maryland School of Law. Community Catalyst is a national non-profit advocacy organization working to build consumer participation in the health care system.

Brent James, M.D., is known internationally for his work in clinical quality improvement, patient safety, and the infrastructure that underlies successful improvement efforts, such as culture change, data systems, payment methods, and management roles. He is a member of the National Academy of Science's Institute of Medicine (and participated in many of that organization's seminal works on quality and patient safety); He holds faculty appointments at the University of Utah School of Medicine (Family Medicine and Biomedical Informatics), Harvard School of Public Health (Health Policy and Management), and the University of Sydney, Australia, School of Public Health He is the Chief Quality Officer, and Executive Director, Institute for Health Care Delivery Research at Intermountain Healthcare, based in Salt Lake City, Utah. (Intermountain is an integrated system of 23 hospitals, almost 150 clinics, a 700+ member physician group, and an HMO/PPO insurance plan jointly responsible for more than 500,000 covered lives serving patients in Utah, Idaho, and, at a tertiary level, seven surrounding States). Through the Intermountain Advanced Training Program in Clinical Practice Improvement (ATP), he has trained more than 3500 senior physician, nursing, and administrative executives, drawn from around the world, in clinical management methods, with proven improvement results (and more than 30 "daughter" training programs in 6 countries). Before coming to Intermountain, he was an Assistant Professor in the Department of Biostatistics at the Harvard School of Public Health, providing statistical support for the Eastern Cooperative Oncology Group (ECOG); and staffed the American College of Surgeons' Commission on Cancer. He holds Bachelor of Science degrees in Computer Science (Electrical Engineering) and Medical Biology; an M.D. degree (with residency training in general surgery and oncology); and a Master of Statistics degree. He serves on several non-profit boards of trustees, dedicated to clinical improvement.

Lisa Nichols, Executive Director for Midtown Community Health Center of Northern Utah, has over 16 years experience working in non-profit health care with medically underserved populations. Lisa currently serves as the. Since 1998, she has built the organization from 4,800 patients and one service site to an organization with seven service sites and 28,000 patients. Lisa is currently the chair for the payment reform group with the Association for Utah Community Health Centers. Lisa has served as an adjunct faculty for the University of Utah and Westminster College, teaching health services administration. She has a Masters in Social Work. She is also the recipient of numerous awards for her work with the medically underserved.

Chuck Norlin, M.D. is Professor of Pediatrics and Adjunct Professor of Biomedical Informatics at the University of Utah School of Medicine, where he practices and teaches general pediatrics and served as chief of the Division of General Pediatrics for 17 years. Since 2001, Dr. Norlin has directed the Medical Home Portal (www.medicalhomeportal.org), a web-based information resource to support primary care clinicians and families in caring and advocating for children with special health care needs. He has served as co-director, in collaboration with the Utah Department of Health, of three medical home/integrated services implementation projects funded by the U.S. Maternal and Child Health Bureau. Dr. Norlin serves as director of the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ), established in 2003 to improve the health of Utah's children by promoting and supporting quality improvement in primary care practices. He is also medical director and principal investigator of the Children's Healthcare Improvement Collaboration, a 5-year project funded by a CHIPRA Quality Demonstrations grant (Centers for Medicare and Medicaid Services) aimed at developing a system to improve and support quality in children's healthcare for Utah and Idaho.

Gina Pola-Money is the proud mom of five wonderful children two of which had a rare disorder. Gina is the Director of Utah Family Voices Family to Family Health Information Center at the Utah Parent Center and works with the Utah Bureau of Children with Special Health Care Needs, the Utah Leadership Education in Neuro-developmental Disabilities for multidisciplinary professionals and the Utah Medical Home initiative with University of Utah Department of Pediatrics. Key activities and passions include incorporating family involvement at all levels of healthcare systems of care, advocating for Utah's children with special health care needs as well as helping families effectively navigate the complex system of care.

Sylvia Garcia Rickard is currently serving as President of both the Hispanic Health Care Task Force of Utah and the Women's State Legislative Council of Utah. She is also serving as a Community Representative on the National Cancer Institute-sponsored steering committee of [Redes En Accion \(National Latino Cancer Research Network\)](#) and on the National Advisory Boards for the National Cancer Institute's Consortia's The High Risk Breast Cancer Familiar Research Study and the Post Genome Wide Association Research Study. A 2-time 18 year breast cancer survivor, Sylvia is in her 17th year serving as a Legislative Advocate and Utah Field Coordinator for the [National Breast Cancer Coalition](#). In these capacities, she lobbies' both the Utah and the Idaho congressional delegations on legislation and research funding for breast cancer research and has worked to pass several pieces of Federal legislation to improve the health of women. Sylvia is serving on the Board of Directors of [Image Reborn Foundation](#) here in Utah, which provides free retreats for women dealing with breast cancer. She formerly served as Chair of the Utah Department of Health's Ethnic Health Advisory Committee and served 5 years on the Governor's Hispanic Advisory Council. She has served on numerous boards and committees engaged in improving the health of Utahans.

Leena Sharma. As a Field Coordinator at Community Catalyst, Leena Sharma works on the Integrated Care Advocacy Project's Campaign for Better Care. She provides technical assistance to state-based organizations including: policy analysis, strategic-advice, coalition-building, advocacy/outreach tools, and campaign strategies. Prior to working at Community Catalyst, Leena worked at the Greater New Jersey Chapter of the Alzheimer's Association, where she served as the Public Policy, Advocacy & Volunteer Coordinator. There she worked on advancing the public policy advocacy efforts on behalf of those who struggle with Alzheimer's disease and their family caregivers. In addition, she also managed the volunteer program, from recruitment of volunteers, to training them and placing them in a volunteer position.