

February 25, 2015 Workshop Transcript:
Examining Healthcare Competition

Hosted by the Federal Trade Commission and
U.S. Department of Justice, Antitrust Division

February 25, 2015

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[START OF WORKSHOP, DAY 2]

WELCOME REMARKS AND ANNOUNCEMENTS

- **Caroline N. Holland, Chief Counsel for Competition and Intergovernmental Relations, U.S. Department of Justice, Antitrust Division**

CAROLINE HOLLAND: Good morning. My name is Caroline Holland, and I'm chief counsel for Competition Policy and Intergovernmental Relations at the Antitrust Division at the Department of Justice. On behalf of my colleagues and the Antitrust Division and the Federal Trade Commission, I'm delighted to welcome you to the second day of our workshop examining health care competition.

We appreciate all of you being here in person today and we thank the FTC's tech team for enabling the webcast to make the program accessible to a much wider audience. Staff from the Antitrust Division and the FTC have put together another excellent round of panels today to examine recent developments related to health care provider organization and payment models. Thank you to our panelists for sharing their deep knowledge and understanding of health care and competition. We appreciate the time and the effort you put in to making this workshop possible. And we look forward to hearing from you.

The public record for this proceeding will remain open through April 30, and we encourage interested parties to submit public comments, especially if the workshop triggers new ideas or discussions. In addition, all the workshop materials will be available online. Before we get started with our substantive program, I need to review a few administrative details.

Please silence any mobile phones and other electronic devices. If you must use them during the workshop please be respectful of the speakers and your fellow audience members. Please be aware that if you leave the Constitution Center building during the workshop you will have to go back through security screening again. Please bear this in mind and plan accordingly, especially if you're participating in a panel so that we can do our best to remain on schedule.

Most of you have received a lanyard with a plastic FTC event security badge. We re-use these for multiple events, so please when you leave for the day return your badge to event staff. If an emergency occurs that requires you to leave the conference center, but remain in the building, please follow the instructions on the PA system. And if an emergency occurs where we need to leave the building an alarm will sound, and everyone should leave the building in an orderly manner through the main 7th Street exit.

After leaving the building, turn left and proceed down 7th Street across E Street to the FTC emergency assembly area. Remain in the assembly area until instructed to return to the building. If you notice any suspicious activity, please alert the building security. And please be advised that this event may be photographed, webcast, or recorded. By participating in this event you are agreeing that your image and anything you say or submit may be posted online indefinitely at the ftc.gov or justice.gov, or any of the Commission's or Antitrust Division's publicly available social media sites.

We've provided a table outside where speakers and attendees are able to leave copies of handouts

or any other materials that might be of interest. Please note that the FTC and DOJ do not endorse these materials. We're just providing the table as a courtesy. Restrooms are located in the hallway just outside of this auditorium, and as a reminder lunch is on your own both days. The Plaza East cafeteria is inside this building. It's open until 3:00 PM with a brief closure from 11:00 to 11:30. No food or beverages are allowed in this room, so please plan accordingly.

I'd also like to say a quick note about our use of webcasting, social media, and our Q&A process. We have done our best to get speaker materials loaded ahead of time. So they're available for webcast viewers. If any materials are not accessible we'll post them as soon as possible after the workshop. For those of you on Twitter, FTC staff will be live tweeting today's event at #FTChalthcare. We also have comment cards here in the conference room, and audience members will be able to submit questions or comments for each panel.

During each session workshop staff will collect cards and bring them up to the moderators. We'll also monitor Twitter and the workshop email for any additional questions that you'd like to submit. Time permitting, moderator's will select some questions for the panelists. In the unlikely event that we get to all of the questions, please still submit them so that we can review them and continue our research and inquiry. If anyone has any questions throughout the day, please feel free to ask any of our conference staff, including our wonderful paralegals at the registration desks.

And now to open today's workshop, I am honored to introduce Assistant Attorney General Bill Baer. Bill was sworn in as Assistant Attorney General on January 3, 2013. Prior to his appointment he was a partner and the head of the Antitrust Practice Group at Arnold and Porter here in Washington D.C. Earlier in his career he was the director of the Bureau of Competition at the Federal Trade Commission. Please join me in welcoming Assistant Attorney General Baer.

[APPLAUSE]

OPENING REMARKS

- **William J. Baer, Assistant Attorney General, U.S. Department of Justice, Antitrust Division**

BILL BAER: Good morning, everybody. Caroline, thank you. I know because you now work for me as Chief Counsel for intergovernmental relations and other things, having joined us recently from Senate Judiciary Committee, she needs to say she's honored to introduce me, but I like it nevertheless. And I appreciate it. Look, thank you all for coming here. I know Caroline was saying just as I came in I take it that in addition to terrific attendance yesterday and today that we've had as many as 1,300 people accessing the webcast. The IT guys were telling me on the way in. It's fabulous. I want to thank those folks at DOJ and FTC who planned it, and the FTC folks for making sure we broadcast this out to as wide a network as possible.

These workshops which FTC and DOJ have done jointly really help us step back and take a look at the evolution of policy and competition policy in particular areas. In health care for us to act effectively as enforcers and advocates we need to understand. We need to step back on occasion.

This workshop provides us an opportunity to hear from a number of experts, practitioners, experts about the challenges the industry is facing and about the role of competition policy. And, helping sort this all out.

Yesterday I know a number of people talked about the importance of health care that we're close to spending that will top \$3 trillion when we total up the numbers for 2014. We talk about the rising cost, and while we have seen, I think- and I've got a chart or two in my prepared remarks- a nice decrease in the average annual increase in the cost of health care, those numbers in terms of the annual total cost keep going up, and at 16 percent or 17 percent of the gross domestic product, it is something we will need to continue to pay close attention to.

The Affordable Care Act, passed in 2010, has accelerated some of the changes you were talking about yesterday. And today stakeholders are working to focus on cost and ways of improving health outcomes while disciplining costs. Yesterday there was a lot of discussion about the health insurance markets, specifically in the marketplaces the Affordable Care Act created. There appear to be some promising developments in competition as people develop and strengthen their networks. We're seeing new entrants.

We're seeing expanded choice, increased competition and new alternatives provided by third party payers. Insurers have also been working to develop innovative plan designs, including narrow networks and tiered networks. These developments, as those in the audience know as well or better than I do, encourage providers to compete on price and quality in order to be included in plan networks at the most favorable level or tier.

According to one report about one half, 50 percent of insurance offerings on health insurance exchanges would qualify today as narrow networks. And again, we learned yesterday that, when these plans are well structured and transparent to consumers, these new networking practices have the potential to drive competition and to benefit patients in many different respects. Well, we understand the need for the health insurance industry to evolve to address new challenges. We as antitrust enforcers need to pay close attention to the potential for the development and abuse of market power.

For example, to contracting practices such as anti-tiering, anti-steering, most favored nations clauses that do threaten competitive harm. Earlier in this administration the Department of Justice challenged the Blue Cross Blue Shield of Michigan's efforts to insulate themselves from competitive forces by employing most favored nations clauses. We filed a lawsuit. Ultimately the Michigan legislature became convinced that that practice was abusive and anticompetitive and passed a law banning it.

Last week we were reminded in another context of the anticompetitive potential of anti-steering practices by the district court's decision affirming the DOJ challenge under Section 1 of the Sherman Act to the anti-steering rules imposed by American Express on merchants. Those same concepts, anti-steering and the potential for them to have anti-competitive effect, obviously have implications in health care markets as well.

Both agencies, both the FTC and the antitrust division remain committed to challenging anti-competitive and mergers in health care markets. As the FTC has done on a number of cases in

recent years, most recently the successful challenge to Saint Luke's, acquisition in Idaho in the Ninth Circuit affirmance of the FTC approach in that. In 2012 the Department of Justice took a hard look at Humana's proposed acquisition of Arcadian management services.

We ended up negotiating a structural settlement that preserved competition in 45 counties and parishes in five different states where the merger would have resulted in the combined company controlling anywhere from 40 percent to 100 percent of the patients who take advantage of Medicare Advantage plans.

We also see innovation by health care providers, in addition to the third party payers, to improve quality and cost through better information and management of patient care. These include reimbursement models designed to align incentives for efficient care across provider groups, such as accountable care organizations. We support those efforts. That's why the DOJ and the FTC in 2011 issued a joint statement explaining our antitrust enforcement policy regarding ACOs participating in the Medicare Shared Savings Program.

This joint statement provides guidance to ensure that ACOs are able to innovate in both Medicare and commercial markets and not run afoul of the antitrust laws. The guidance was timely. The numbers I have, and I put them into the chart here, that the number of ACOs in the US were in the fourth quarter of 2010 less than 100. By the fourth quarter of 2013, the most recent stats I've seen, they've gone up by 600 percent too, from under 100 to 600.

We also provide fact specific guidance where we can. The FTC has an advisory opinion process. We have a comparable process where we'll provide business review letters for those who have innovative ideas for improving patient care and want to make sure they aren't running afoul of the antitrust laws. We did this a year and a half ago working with the Greater New York Hospital Association issuing a business review letter saying we did not intend to challenge a proposed gain sharing program that was intended and designed to provide a framework by which participating hospitals can measure physician performance against certain benchmarks, and or bonuses to physicians for improvements in quality and efficiency.

So we will work on the front end to help provide guidance where we can. At the same time on the back end, which is where you never want to be, we will challenge provider conduct that enhances market power, that stifles pro-consumer innovation, and that risks leading to lower quality and higher cost health care. And, we have challenged agreements among competing providers that eliminate competition.

A chiropractic association contacting on behalf of its competitors, conduct by a dominant provider to insulate itself from competition, such as United Regional Health Care systems, which had contract provisions that inhibited insurers from contracting with competing providers. In the provider area we've also seen a wave of vertical integration as hospitals acquire physician practices. Industry participants and observers have offered varying and sometimes conflicting views regarding these transactions.

Proponents argue that this integration enables providers to provide better care, to better coordinate the provision of care, and to reduce costs. And, there are situations where that is clearly a legitimate perspective on these vertical transactions. In other cases though, folks raise concerns

that these transactions create conglomerates with the market power and bargaining leverage to adversely affect competition. Part of the challenge of yesterday and today, part of the ongoing challenge for the FTC and the DOJ is to sort out which of these transactions do have an overwhelmingly dominant procompetitive affect and which have the potential to adversely affect competition.

We're not going to take on transactions, whether vertical, horizontal, or otherwise that improve the delivery of care and that pose no threat of increased prices, or reductions in competition. But obviously, we stand ready. Both agencies stand ready to take appropriate enforcement action where necessary. Perhaps, most importantly, and obviously very significant to both agencies, when we do challenge anticompetitive activity in the healthcare area consumers are entitled to meaningful relief.

Our strong preference, a preference shared by the FTC and the DOJ when challenging horizontal mergers in the health care sector, as in any other industry, is for structural remedies that maintain competitive markets and remove restraints to competition. This issue, as many of you know, is front and center in Massachusetts in the recent Partners HealthCare matter, where a state court, a couple weeks ago, rejected a consent decree urged by Massachusetts, a decree between the Mass AG and Partners HealthCare, that would have allowed a potentially problematic hospital acquisition in Massachusetts in return for commitments by Partners to certain behavioral remedies.

When Attorney General Maura Heale, who I met with yesterday came into office, she took a hard second look at whether that behavioral set of remedies really would fix the problem. She filed a pleading in state court which the state court judge relied on in issuing a very thoughtful opinion rejecting the settlement, because of the uncertainty about the ability, the behavioral commitments, which I'm sure were made in good faith, to actually be implemented in a way that we could trust that the citizens of the Commonwealth of Massachusetts would benefit.

Subsequently, after the court rejected the settlement, and Maura Healey made it clear that she would challenge Partners' acquisition of a hospital in southern Massachusetts, South Shore, Partners decided to abandon the transaction. And, I think that is a good outcome for the citizens of the Commonwealth of Massachusetts.

So just to sum up, DOJ, the FTC, and our colleagues, like Maura Healey and State Attorneys General Offices, play a critical role in protecting and promoting competition in health care during this time of extensive dynamic change. Through antitrust guidance and through advocacy, we can help stakeholders direct their creativity towards procompetitive innovation—innovation that benefits patients while preserving competition.

I wanted to thank the folks who were here yesterday, the distinguished panelists. I want to thank those who were on an impressive schedule that we've developed for today. You are helping us increase our knowledge of this industry, and that is so critical, as I said at the beginning of our remarks. You're helping us administer competition policy effectively in an area which is not at all short of its complications and unique dynamics.

I know many of you had to travel a long way to be here. We thank you for that. I also want to thank the FTC and DOJ staff members who worked hard to make this event. Thanks to you, the audience in person and those on the webcast for your participation. I hope I haven't discouraged you from continuing to watch as I invite up the first panel of the day, which will discuss accountable care organizations. Thank you very much.

[APPLAUSE]

So first panel, why don't we come on up and get going? Thank you.

EARLY OBSERVATIONS REGARDING ACCOUNTABLE CARE ORGANIZATIONS

Moderators:

- **Ellen Connelly, Attorney, FTC, Bureau of Competition Health Care Division**
- **Matthew C. Mandelberg, Attorney, DOJ, Antitrust Division, Legal Policy Section**

Panelists:

- **Alison Fleury, Senior Vice President of Business Development, Sharp HealthCare**
- **Kristen Miranda, Vice President, Strategic Partnerships and Innovation, Blue Shield California**
- **David B. Muhlestein, PhD, JD, Senior Director of Research and Development, Leavitt Partners, LLC**
- **Hoangmai Pham, Director of Seamless Care Models Group, Center for Medicare and Medicaid Innovation**
- **Terri L. Postma, MD, Medical Officer and Advisor, Center for Medicare at the Centers for Medicare & Medicaid Services**
- **Simeon A. Schwartz, MD, Founding President and CEO, WESTMED Medical Group**
- **Chapin White, PhD, Senior Policy Researcher, RAND Corporation**

ELLEN CONNELLY: Good morning everyone. I'm Ellen Connelly. I'm an attorney in the Health Care Division here at the FTC. My co-moderator today is Matthew Mandelberg. Matthew is an attorney at the Department of Justice, in the antitrust division, in the legal policy section. We want to welcome you today here to our first panel of the day which is entitled "Early Observations from Accountable Care Organizations."

As you probably know, Accountable Care Organizations are a type of organizational structure intended to bring health care providers together to deliver higher quality, more efficient, and more innovative care. But have they succeeded at doing this? And if so, how? And are there implications for competition? As you've just heard, we here at the antitrust agencies, at the DOJ and the FTC, have put a lot of hard work into considering this last question, the competitive implications of ACOs, and worked alongside our colleagues at CMS to develop the 2011 joint FTC-DOJ policy statement to provide guidance to organizations wishing to form ACOs.

I know that the impressive group of panelists we've assembled here today have also put a lot of hard work into thinking about and working with ACOs. I'm going to turn it over now to my co-moderator, Matthew Mandelberg, to introduce our panelists.

MATTHEW MANDELBERG: Thank you, Ellen. Today we'll have the opportunity to hear from Dr. Mai Pham, Director of the Seamless Care Models Group at the CMS Innovation Center. Dr. Pham will discuss the Pioneer ACO Program. Next, to discuss the Shared Savings Program, will be Dr. Terri Postma. She is the Medical Officer and Advisor at the Center for Medicare at CMS.

Our third speaker will be Dr. Chapin White, Senior Policy Researcher at the Rand Corporation.

And he will be followed by Dr. David Muhlestein, Senior Director of Research and Development at Leavitt Partners. Doctors White and Muhlestein have both researched ACOs in the health care system.

We will then hear from two panelists who can speak to on the ground experience running ACOs. Joining us by phone we'll have Alison Fleury from Sharp Health. She is Sharp HealthCare's Senior Vice President of Business Development. And here we have Dr. Simeon Schwartz. He is the Founding President and CEO of WESTMED Medical Group.

And last, but certainly not least, our final speaker is Kristen Miranda. And she is Vice President of Strategic Partnerships and Innovation at Blue Shield of California. And she'll give us the health plan perspective on ACOs. She leads Blue Shield of California's ACO program. So more detailed bios of all our panelists are in today's materials. So, with that, let me turn it over to Dr. Pham to start us off.

DR. HOANGMAI PHAM: Good morning. I apologize for being late. Thanks very much for having me. When will we be able to see my slides? OK.

So I'm going to walk you through a quick overview of the ACO initiatives that the CMS Innovation Center is sponsoring. And then Terri will explain to you how it is that we are just the baby sister to the permanent ACO program in Medicare, the Medicare Shared Savings Program.

At CMS, we work very hard to try to present a unified strategy on Accountable Care Organizations, specifically, and improving care coordination and traditional Medicare, more generally. Our ACO portfolio currently includes, as I said, the permanent program, the MSSP, the Pioneer ACO model, which is what I'll be focusing on today, two kind of ancillary models – the Advanced Payment Model, and its successor, the ACO Investment Model, which are really targeted at MSSP ACOs, a subset of them, which, by virtue of being some combination of small, rural, physician-led, we believe are in need of additional capital support to make the infrastructure investments they need to do population care management. There is the comprehensive ESRD Care Initiative. This is an ACO initiative focused on just dialysis beneficiaries, and it's our only condition specific ACO model. And I'm happy to answer questions about that. And then we do have other models in development that hopefully you'll hear about in the near future.

So CMS's vision for ACOs in general is that we very much want to grow participation in the program and retain participation among those who have already entered, to gradually shift those organizations from the baby steps and shared savings – what we refer to as one-sided shared risk arrangements – to two-sided arrangements where they also face potential downside risk and losses, because we believe that that really gives them the optimum motivation to really put pedal to the metal in their care coordination efforts. We strive to use the Innovation Center's authority to test what we believe might be six, seven, eight steps down the road in terms of the evolution of this construct. We work very hard and invest a lot of resources in creating a shared learning environment for participants to work with one another, and also with us. And that's both to improve their performance and to improve our performance in terms of program implementation.

The Innovation Center's specific role, as I said, is to anticipate with the rest of the agency. OK,

where would this construct likely to go? Where would we like to see ACOs evolve to in terms of their capabilities, in terms of the program design elements, that we aren't quite ready to put into the Medicare Shared Savings Program, but that we need to test out? We need to work out the policy kinks, the operational kinks; the ACOs need to give us some feedback. That's the Innovation Center's job, is to test those elements. And in the testing of those we also, as part of that overall ACO strategy for the agency, strive to offer different options to ACOs than is offered in the MSSP. So we're trying to be informative to the MSSP and complementary to it. And then it is the Innovation Center that sponsors, resource wise, all the shared learning activities, although, Terri spends an enormous amount of time on that as well. And not least, we also co- invest with our partners in the Center for Medicare in the CMS infrastructure necessary to run these programs, which are non-trivial.

Specifically, on the Pioneer model, to distinguish it from the Medicare Shared Savings Program, which Terri will go into greater detail, the payment arrangements, as I mentioned, differ from the MSSP. Pioneer ACOs are exposed to higher risk, but also have access to higher opportunities for reward. So if you think about sharing savings or losses, their share percentages are higher than in the MSSP. They also have the option to convert a part of their fee-for-service reimbursement – what they would expect to be paid based on claim submissions converted to a monthly population-based payment – is what we call it. And this doesn't affect how much risk or reward they get. It's really a cash flow mechanism. So if you imagine physicians on that hamster treadmill, one fee for each service, we're trying to remove some of that treadmill effect. Say here's a dollar amount. You know you have it every month. You work with that to invest in care management. Worry a little bit less about generating the service value.

The Pioneer model also uses prospective alignment to define the population of beneficiaries that the ACO is responsible for. As Terri will explain that's a little bit different than in the MSSP. And we're also piloting in Pioneer a mechanism for defining that population, that we refer to as voluntary alignment, and kind of government speak. Beneficiaries, patients, may experience it as oh, you're asking me if you're my doctor? You're my main doctor, the one I expect to coordinate my care? Yes. I think that's true, or no, I don't. I won't sign this piece of paper. But if you sign it, then Medicare gets that signal. And we give that greatest weight when we define the ACO's population. So if the claims data say you're not in the population, but you say you are, the beneficiary's voice trumps.

The Pioneer model is also testing various other design elements, again for operational and policy kink working out. One of those is a waiver of the current payment rule that says a patient has to be in an inpatient facility for at least three days, three nights before they can qualify for skilled nursing care. And that sets up some perverse incentives for use of inpatient facilities when it's not necessary. So, in a trial, we are allowing Pioneer ACOs to waive that rule and admit directly to SNFs. And then, as I said, an extensive shared learning system, which admittedly works differently when you have, you know, a few dozen Pioneer ACOs as opposed to a few hundred SSP ACOs.

We accepted 32 organizations initially. Nineteen remain. Most of those that have left have transitioned to the MSSP. This illustrates a really core principle at CMS, several core principles actually. One is that we want to acknowledge that one size does not fit all. Two is that we have no

interest in moving providers off a financial cliff. So if they try higher risk, and they decide that their organizations are not ready for that, we would rather that they move to a risk level they were comfortable with. And so we want to build in that flexibility for them to move.

The Pioneers came in with extremely varied levels of experience in managing total cost of care. We required a large population size for them to qualify. And they started in 2012, so we are now in the fourth performance year. This gives you a sense of the states. The ones in red are representative of where the ACOs that remain in the program are. As you can also see, they were quite diverse in organizational structure.

We've been really gratified to have seen the early results from this model. Total savings over the first one, two performance years: \$372 million. In 2013, which is the second performance year, 11 of them, this last year, earned shared savings payments, and they actually lowered overall per capita Medicare spending by 1.4 percent, which may not sound impressive until you realize that overall Medicare cost growth has been at historic lows the past few years. At one point it was somewhere south of one percent. And to be able to generate savings in that environment, we think, is really impressive. As if not more importantly, they managed to do this while not only not reducing the quality of care, but by enhancing it. And this gets at another CMS principle is that we firmly believe that you generate savings and value through care improvement, not through care stinting. So their mean quality score across 33 metrics increased by 19 percent between the first and second performance years, and that is on, sorry, a baseline that was very high already.

Summarizes the results for you. Qualitative lessons, and I wish I had a little more time to delve into these. Happy to answer questions. But it takes a lot of work. And it takes a lot more time. When providers tell you they are ready to do this, it means they roughly know where the hardware store is. Comprehensive data is absolutely essential, especially when you are taking on downside risk. As I said, one size does not fit all.

We have learned that it's very important for us to be transparent with them. And for us to be as straightforward as possible in our methodologies. They have to pivot and explain all of those to both their internal clinicians and their Boards and CFOs. Physicians, in particular, need a really clear and compelling clinical and financial narrative to engage. And they're putting in a chunk of money on their own. All the Pioneers that earned shared savings, the vast majority of them would tell you that they barely, and some of them did not, cover their investment costs.

Beneficiaries are responding positively, we believe. We've have had calls from beneficiaries asking indignantly why they are not aligned to an ACO. Some common priority areas that we've seen them engage in, definitely post-acute care, definitely chronic disease management, care transitions. And some of the low hanging fruit are those unnecessary tests and procedures, which they really tackled in year one. We've been also gratified to discover how generous they are in helping.

I know that this entire crowd is all about competition, but within that legal regulatory framework they have spent an enormous amount of time and energy sharing with one another, passing best practices, helping one another. And we believe that in combination with the competitive forces, when you have a first mover in a market doing something like this, you don't want to be left

behind. And that generates positive spillover effects on the local market. Thanks.

ELLEN CONNELLY: Thank you, very much, Dr. Pham. We're now going to hear from Dr. Terri Postma about the Shared Savings Program.

DR. TERRI POSTMA: Thanks. Thanks for inviting me and thanks to all of you for attending. My name's Terri Postma. I'm a Medical Officer in the Center for Medicare at CMS. And I've been privileged to join CMS just a couple months before the passage of the Affordable Care Act. And so have had the privilege of leading the development and implementation of the Shared Savings Program. So my comments are going to be fairly brief, but I'm happy to answer any questions about the program that you might have. OK. Great.

So I think Mai did a really good job of articulating the CMS's overall strategy for ACOs. This slide just drives home the point that fee for service Medicare tends to be, for patients, very fragmented care, and inefficient care. And so we really view the Shared Savings Program and ACO initiatives as a way of incentivizing providers to think more thoughtfully about the journeys of care that their patients are taking, and to do that in a very patient centered way.

This just reemphasizes what Mai talked about, sort of the way that the programs interact at CMS. The Shared Savings Program is a national program. It's a voluntary program for providers, under which providers continue to receive fee-for-service payments as they normally would, but then we assess them at the end of each year. And if they have demonstrated improved quality and reduced cost compared to their benchmark, then we share back with them a lump sum shared savings payment at the end of each year.

We were absolutely delighted when the Innovation Center took up testing of the ACO model. We're learning from it. We're looking forward to implementing some of the things that are learned that are proven to be working to improve quality and reduce costs into the national program over time. The national program, of course, has to go through rulemaking, unlike the testing models.

You've heard a couple of times this morning about the interactions that we had in developing the program rules, both with the antitrust agencies as well as with the IRS. And a joint waiver was developed with the OIG and CMS for addressing CMP kickback and referrals for ACOs.

Participation in the program has been growing very rapidly. We have, as of January of this year, over 400 organizations that are participating. Again, it's voluntary. These organizations have to meet certain eligibility criteria, and after which they're accepted to the program. Most have chosen to enter in a one-sided model. On the slide previously it showed the Shared Savings Program has what's called track one and track two. Track one is a one-sided model where ACOs agree to become accountable for their assigned population and have the opportunity to share in any savings that they generate, but not be held accountable for any losses. Track two, however, is a little more advanced. There's a higher reward rate. They're offered a higher shared savings rate, but in exchange, they agree to become accountable and pay back any losses that they demonstrate over the course of the agreement period. We accept applications annually to the program.

This map, unfortunately, I don't have a new heat map that reflects this year's group of 90 or so

organizations that joined, so this is just the first couple of years of the program. And it shows where those organizations are interacting with fee-for-service beneficiaries. And, again, these are only the beneficiaries that become assigned to ACOs that CMS assigns. And we do that by looking at where the fee-for-service beneficiary chose to receive a plurality of their primary care services over the past 12 months. So beneficiary choice is retained. And so these are the beneficiaries that received a plurality of their services with the ACO, enough so that we can say the organization could reasonably be held accountable for their quality and cost of care. So the point that I wanted to make was that these organizations touch and influence many, many, many more fee-for-service beneficiaries than actually get assigned to the organization.

We completed our first performance year with the organizations. We had some starting in 2012 for a partial year and some starting in 2013. And those organizations completed their first performance year at the end of 2013. They reported quality at the beginning of 2014. And we calculated their cost and quality results for their first performance year in the summer of 2014. So basically it's very early in the program. And it's just gotten started. That being said, as Mai indicated, we've been seeing that these organizations are improving quality of care over the course of time. They're also improving costs. In the first year, roughly a quarter of the ACOs shared in savings.

I personally think this is a pretty remarkable achievement, given that, as Mai said, these changes in health care processes take time to implement. And it takes time to see results. And moreover, in order to share in savings, the ACO not only has to demonstrate that they've achieved a reduction compared to their benchmark, but they also have to pass a confidence interval – 95 percent confidence interval – which is called the minimum savings rate. So the fact that a quarter of them were able to achieve that – exceed that confidence interval in the first year – is pretty remarkable.

ACOs are engaging in a variety of innovative care activities. And I want to skip ahead to some anecdotal information that I've been hearing. I've talked to almost all the organizations that achieved shared savings in their first year or two. Sort of get to know them, get to understand their organizational culture a little bit better, understand what processes they put in place in the first year that they really point to leading to their first year of success. And, demographically, these ACOs are really diverse. About half of them are physician only ACOs. The other half have facilities involved in their organizations. But nearly all of them reported to me that it's very important to have strong clinical leadership in their organization. Communication and transparency was reported to be very important. In fact, a lot of these organizations are developing internal dashboards of cost and quality for the practices and the providers that are participating. And share those in a very open way, which they tell me is driving friendly competition between providers. When they look and see that the provider next to them is achieving a 90 percent influenza vaccination rate, and their practice is only achieving 50 percent, it generates conversations about what they're doing differently in their practices. And that drives practice change, and ultimately improves quality of care for the beneficiary.

The other thing that they're really focused on is that practice redesign – to make practices more efficient – and in turn more efficient and better collaborations between sites of care to improve that journey of care for the patient. They also are saying that it's really important for organizations to think thoughtfully about how they're going to approach these changes, and pick a few things,

and build on them, build on that success rather than trying to tackle the entire elephant, bite off pieces one at a time.

Looking ahead, again, we're prepping for our annual application cycle. We're also in the midst of improving the rules through rulemaking. We published a proposed rule in December and received comments by February 6, that we're currently going through. And are working on then developing the final proposals.

OK. With that here's some contact information if you have additional questions. We have a wealth of information on our website. I invite you to look at that, including a lot of data on the organizations that are participating. I'll turn it over. Thank you.

MATTHEW MANDELBERG: Thank you. Dr. White?

DR. CHAPIN WHITE: Great. Thank you. Jeez, I sound really loud to myself. I don't know if I'm loud to you all. OK. So thanks very much for inviting me to be here. Let me give you a thumbnail sketch of where I'm coming from. I'm a health care economist. My official title's a Senior Policy Researcher, but basically I focus on prices and financing and spending issues. I worked at the Congressional Budget Office from 2005 to 2010. And I feel some personal connection with ACOs. I was actually one of the people scoring one of the very early versions of ACOs, which we called bonus eligible organizations. I don't know if that sounds familiar, but back in 2008, there was this idea of ACOs. And CBO thought, you know, Accountable Care Organizations, that sounds too fuzzy and nice. We're going strip that down. CBO is where good feelings kind of go to die, so we relabeled it bonus eligible organizations. There's a score you can look up. And then, obviously, the ACA propelled ACOs into reality. I've been fascinated to see how reality is playing out. At CBO we spent our waking hours trying to imagine what the world would look like this year. And it's incredible to see.

Let me also say I'm not going to use slides. I'm going to try something different. I'm going to talk to you. And if you want to follow me on Twitter, I'm @chapinwhite, and I have tweetdecked some tweets that relate to this presentation. There are some little tidbits. If you follow me, I don't know if it's a reward or punishment, but you'll get some tweets from me around the time this talk ends if it works.

OK. So the motivating question, we're in FTC building. The question to me is are ACOs increasing consolidation among providers? And is it undermining private plans' ability to negotiate prices? That's question number one. Question number two is are ACOs spurring broad based increases in the efficiency of the health sector?

So the short answer to that is, we don't know, or at least I don't know. I think it's too soon to tell. But I'll give a little bit of a longer answer to that. The Assistant Secretary for Planning and Evaluation in HHS has funded Rand, and Brookings, and a couple of other groups to do work in a bunch of areas. One area that ASPE is focusing on is exactly this question. Where are ACOs emerging on the Medicare side as well as the private side? What impacts are they having on negotiated prices? So ASPE is latching their teeth into this question. We don't have results yet, but watch this space. ASPE and Rand and its partners will be putting out some studies in the

coming months and years.

So if I can't directly answer the motivating question, I'm going to take a step back and try to answer some different questions. OK. What are the big picture trends that ACOs are feeding into? I think there are two mega trends that ACOs feed into. One is there has been a colossal slowdown in Medicare spending growth, on the order of \$100 billion spending below what was projected in 2014. And there's a Kaiser Family Foundation brief on that if you're interested. So something is happening in the Medicare program to radically alter the spending trajectory. And per beneficiary spending has actually been dropping in nominal dollars since about 2010, which boggles the mind if you follow health care spending trends. So that's one trend. I'm going to put that to one side.

The other mega trend is that the prices that private health plans pay to hospitals have been rising rapidly. They've been rising faster than hospital wages. They've been rising faster than the prices that Medicare pays. And those hospital price increases are a significant contributor to the growth in private premiums. At the same time, as the introductory speaker mentioned, that employment by hospitals is on the rise, that's a very significant trend. Hospitals are consolidating with each other. Measures of hospital market concentration are on the rise. And there are these clinically integrated networks that are emerging and becoming more enmeshed with the health care system. So I would say there's a huge slowdown in Medicare spending growth, and there is a ratcheting up of provider consolidation and the prices that private health plans pay. Those are divergent trends in our health care system. ACOs, my sense is, are fairly thin layer on top of those big trends.

So what do I mean by that? If Medicare spending has slowed down by \$100 billion in 2014, the savings numbers that we just heard, they're significant. They're worth investigating. But they're a couple of tenths of a percent of that savings. The savings that are going on in Medicare I would say are mostly not about ACOs. They're about rate cuts. They're about sequestration. They're about hospital readmission penalties and program integrity. Those are the big things that are saving money. ACOs are really tinkering on the edges of the big picture Medicare spending. At the same time, the trend in hospital employment of physicians and hospitals consolidating with each other, the formation of clinically integrated networks, that was all rampaging forward well before ACOs came into existence. Those trends pre-existed. ACOs are layering on top of that preexisting, important major trend.

So let me take another step back and say I think I see this session as asking, how does Medicare payment policy interact with private plans ability to negotiate prices? And we're supposed to be talking about ACOs, but I'm going to say maybe that's not even the right place to focus. I think Medicare payment policy is incredibly important to the way the health care system works. And I think ACOs are a piece of that, but I think there are other pieces that we need to pay attention to as well.

What are the important factors in Medicare payment policy that are affecting private plans? Number one, I would say the fact that Medicare pays higher prices for a physician office visit if that physician is owned by a hospital. If the physician's owned by the hospital, the claim gets funneled through the hospital outpatient facility fee schedule. And the physician and hospital, together, get a higher fee. That is driving physicians into the arms of hospitals. It's driving up

Medicare spending. It's driving up private prices. And it's making private plans face an increasingly consolidated market. If you're worried about provider consolidation and Medicare payment policy, and I assume that's why you're here, look at the hospital outpatient pricing policy in Medicare.

I would also say that physicians are being rewarded for meaningful use. And they're being subject to performance incentives under Medicare's payment formula. Those payment incentives, I think, are tending to also drive physicians into larger groups and to affiliate themselves with hospitals. They can get their medical record system from the hospital. If they're part of a big group, the group can hire an IT person. They don't have to try to figure it out on their own. So meaningful use in PQRS are driving physicians together and driving them into the arms of hospitals. ACOs are in the mix. It's not clear to me yet how big of a factor that is. And I would say Medicare is also helping private plans by cutting hospital rates and penalizing hospitals for re-admissions. That's driving down hospital bed days. It's driving down hospital occupancy. The lower hospital occupancy gets, the more leverage private plans have to negotiate with hospitals. So Medicare payment policy cuts both ways. I don't want to say it's all cause for concern.

So with that said, let me wrap up and say that I have a couple big concerns if I'm following private price trends and provider consolidation closely. That's part of my portfolio. One of my concerns is that we have very murky data on clinically integrated networks. Clinically integrated networks are, I think, the backdrop for ACOs. We have great data on Medicare, beneficiary affiliation with ACOs. It's much harder to get a sense of what's going on with clinically integrated networks. I think they're very significant.

We also don't have a good sense of what's going on with private prices. It's hard to get a sense of whether private plans are paying higher prices if it's hard to measure private prices. And then the other thing that concerns me is I think we haven't quite worked out our vision for where our health care system is going. I think in the ACA we've kind of doubled down on two different trajectories. One trajectory is having competing private plans. If that's the trajectory you want to go, then you're going to want atomized providers. You're going to want small physician practices. You're going to want focused factories. That's the vision that's embodied in the health insurance exchanges. If you want to have integrated delivery systems with the hospital, and the SNF, and the physician, and the labs, and everything all part of one big system, that's great. But that may only work if you have everybody enrolled in a monopsonist buyer like Medicare.

So the ACA has kind of doubled down on integrated delivery systems in Medicare. It's also doubled down on competing private plans and the exchanges. And those, I'm not sure, are compatible visions. I'm not sure which vision is correct, but I'm interested to hear what the other speakers have to say. Thank you.

ELLEN CONNELLY: Thank you very much. Next we have Dr. Muhlestein.

DR. DAVID MUHLESTEIN: Thank you. And I thank you for inviting me and having this conference. I think it's a great opportunity to learn and to kind of raise some of the issues that we're seeing in health care.

So I'm going to give a general overview of the ACO landscape. And I'm going to start by defining what an ACO is. Now we've been talking about them for this whole panel, but in a nutshell, I define an Accountable Care Organization as a health care provider that is bearing risk for the cost and quality of a defined population. So this is a way of distinguishing this from other payment reform models. For example, bundled payments are focused around episodes of care. They're not focused around populations. What we're really interested in is what's happening to health care providers when they start to bear risk for a defined population. And when I talk about ACOs during this presentation I'm broadly going to focus on all Accountable Care Organizations. So these are those that are participating in the federal government programs, the MSSP and the Pioneer Program, those working with state Medicaid agencies, and also those in the commercial sector.

So to start off here is just a graph of showing how many ACOs there are across the country. Now this is going through the end of January of this year. So we have quite a few. We've seen regular growth. We see big jumps in growth at the beginning of each year, and this corresponds with the announcement of the Medicare programs. So there are a lot of these organizations. And there's a question that generally arises is why are they doing this?

So fee-for-service has been a pretty good environment for a lot of providers for a lot of years. So why are they starting to make this transition where they're no longer being paid based on the volume of care, but on the quality of care that they're providing? So there's five real buckets that I would put this into. The first is an altruism category. This is where providers believe that they really can provide better care for their patients. This is a mission-driven organization. Most of these are the not-for-profit systems that are saying, we really want to improve that quality of care, and we think that by changing how we're being paid, it will enable us to better manage these populations.

Second is a preparation mindset. These are organizations that believe that eventually these alternative payment models, they're going to be mandated. Obviously, the Secretary's announcement of the desire to move Medicare payments toward alternative payment models is a strong indication of this, but a lot of organizations, while it's still an option, they're starting to experiment. They'll put a portion of their covered lives under these risk bearing contracts and try to figure out how to manage them before they're required to do it for all their patients.

The third is an expansion mindset. And this is another opportunity where they're saying we can really increase the volume of patients that we have. Sometimes it's trying to increase the volume of services that they provide. Other times it's just trying to increase the broader market share by taking responsibility for an increased percent of the population that are within their service area.

Another area is defense. So this is where they have competitors within their market that have started to move down this pathway. And we're starting to see a lot of organizations that, for very defensive reasons, are saying that we need to become an ACO because our competitors are. And later on I'll show some visualizations of that.

And the last one, it's a smaller subset of providers, but this is something that we shouldn't overlook, is those that are not doing well in the fee-for-service environment. I think of them as almost a lost cause. They say we're going to fail under the fee-for-service system, and so we're

going to try something else, and this is an alternative payment arrangement.

So broadly speaking, with those five different categories, you get a lot of different types of organizations that are starting to participate. And so it leads to a wide variety of different provider types that are managing these populations and also different approaches that they're having to manage these populations.

When we talk about ACOs, there's also the issue of how many people are being covered by them. And they usually do this by contract. So if you have a contract with Medicare through the Shared Savings Program that may be 20 percent of your patient population. You might experiment with that and over time you want to increase the number of contracts, and you'll start making contracts with commercial payers. In this chart, it's showing the difference between government, and that's including Medicaid and Medicare ACOs, versus the commercial sector. There's a pretty consistent growth of the commercial side. And on the government side, it's usually based around the calendar year. But overall, there's now over 1,000 different accountable care contracts that we're tracking across the country.

Over here it's just a direct comparison between the number of ACOs and the number of payment contracts. It's basically a summary of the past two slides combined. The one thing that I will point out is that, at the end of 2013, you'll see that there's a very close relationship between the contracts and the lives. This is because the announcement of when ACOs technically form often comes before those contracts go into place. And so that's really driven by the late December announcements of the Shared Saving Program participants, but their contract doesn't go live until the beginning of January the subsequent year.

So now here's the maps of where we're seeing this growth happening. On the left it's at the state level. On the right it's at the hospital referral region level, which is an indication of where people are referred to for tertiary care. What you're seeing is that there is not consistent growth across the country where these are happening. There are areas of the country where there really are no ACOs, and there are other areas where there are a large number of these organizations. The reason for this is, as I mentioned, oftentimes it's competitive dynamic – where there's other competitors in your market, you start to see a lot of growth. It's also highly correlated to the population where ACOs tend to form where there are a large number of provider groups, and there are large number of provider groups where there's a large number of the population. A more interesting way to look at this is looking at the percent of the total population that is currently being covered under an ACO contract. Here, we're seeing even more variation where there are certain areas where there's a lot of activity, and a lot of areas where there's basically no activity going on.

If you look at some of the states where there's a lot of activity – look at Oregon and Iowa – that is driven by the state Medicaid program. State Medicaid programs have the ability to mandate that care is being provided under these contracts. And so that's the one way that providers are being forced into it right now. In other regions, you really see little tiny hot spots where there's a lot of ACO activity, but even where we saw large numbers of ACOs, it's not necessarily also indicative of a large percentage of ACO lives. And the reason is because right now most of these providers are still in that experimentation level where they're just trying to figure out how to manage a small

percentage of their lives before they expand to a larger number.

Here is an indication of how competitive markets are in terms of the options for providers. And so this is looking at the service area of each of the ACOs and saying, on average, how many ACOs do you have access to within your state? We're really looking at this at the zip code level. And so we're seeing any person within a zip code within a specific state, on average, based on the population, how many ACOs do you have access to? And this ranges from zero in many cases to a maximum of eight. So there is some competition, but a lot of this ACO activity is really diffused around more areas within the state. They're not necessarily directly competing.

I also just want to give a basic idea of the size of this market. So this is the growth in the terms of the Medicare ACO lives over time. I should've also included the commercial side. The commercial side saw a similar growth. Total lives right now are about 23.5 million. So that's about seven percent to seven and a half percent of the total population is being included under an ACO contract.

Now I'm going to show you just kind of the growth. And this is a time map about how many people there were in ACOs over time. And so we're just going to click through and we're going to see how there starts to be increased growth within specific regions of the country – where it really all happens at once. What we've found is that when one provider within a market says, I'm going to become an ACO, very quickly in that same year their competitors also decide that they're going to become an ACO also. And so we're seeing very market specific growth, sometimes driven by Medicaid plans, sometimes driven by other factors.

Another metric that's useful to evaluate the competition when it comes between ACOs is to look at the hospitals that are participating in these organizations. If we go back to 2010, right when the first organizations started professing that they were ACOs, we started seeing these hospital systems that would form these groups. What we see is that there starts to be jumps. Focus, for example, between 2011 and 2012, on Illinois. So, in 2011, no hospitals were part of an ACO. And you jump to 2012, all of a sudden, there's 20 or 30 hospitals that are part of an ACO. And so the Chicago market basically started its transition in 2012. We also see this happening in other markets across the country. And you see that right now there are quite a few hospitals – over 1,000 – that are participating in accountable care arrangements.

But, to put this in perspective, this is all of the non-hospital ACOs across the country. So there's still a lot of room for that growth and improvement. There's also a wide variety of providers that are participating in ACOs. There are small physician groups. There are large hospital systems. There are rural providers. These are just some examples to show the wide range of different types of providers that are trying to become an Accountable Care Organization. And if you're a small 40 physician primary care clinic, you're going to manage patient populations very differently than if you're a multi-state, multi-system hospital, integrated system.

Here's a few differences between the program – between the Medicare programs and the commercial programs. Briefly, the Medicare program is set. It's established. Everybody follows the same rules basically. On the commercial side, it's negotiated and there's a wide variety of models.

In conclusion, I just want to say that becoming an ACO takes a lot of time. We talk a lot about the payment models, but the payment models are secondary to the transformation of how care is delivered. Accountable care is not about changing the payments. It's about changing the practice of medicine. There are a lot of different challenges with becoming an ACO, and establishing a payment model is not at the top of the list. Managing that risk is important. Integrating HIT is important. And really engaging your physician population is important. But the time frame for this is long. It's not something that you do over the course of one year or two years. This is an ongoing learning experience. And it just takes a lot of time and effort as organizations start to really transform the practice of care.

MATTHEW MANDELBERG: Great. Thank you very much. We're now going to hear from Alison Fleury, who's on the phone with us from San Diego. Alison, are you there? ALISON

FLEURY: I am, Matthew, and can you hear me?

MATTHEW MANDELBERG: I can. If one of the panelists could pass me the remote, Alison, just let us know, and I will advance the slides.

ALISON FLEURY: Great. Well, thank you for having me virtually today. I'm going to now kind of take us a little bit more to kind of like a case study approach. And specifically talk about the experiences of Sharp HealthCare ACO and the Pioneer ACO model.

So first let me talk about Sharp HealthCare, to the next slide, please. We are a nonprofit regional health care delivery system that operates in San Diego, California. San Diego has about 3.2 million residents. Sharp HealthCare's been around for a very long time. We grew from one hospital in 1955 to the integrated health care delivery system that we are today.

We are the largest health care system in San Diego. And to put that in perspective, that's about 29 percent of the market that we're responsible for. So, it's a very highly competitive market. Part of Sharp HealthCare are two affiliated medical groups. We have seven hospitals, four acute care hospitals, and three specialty hospitals, skilled nursing facilities. We do have a commercial health plan that's active on the California exchange, Covered California. And in the commercial both individual and small business and large business market.

A number of outpatient clinics, urgent care centers, home health, hospice, home infusion. So really the full array of health care programs here in San Diego. We are actually the largest private employer, so about 17,000 employees, 2,600 affiliated physicians. And in California we cannot hire or employ physicians. So we have other arrangements to work with our physicians, and about 3,000 volunteers. So really that's more providing a backdrop regarding scale.

Moving to the next slide, Sharp HealthCare was probably different in the way that we walked into the Pioneer model in that we already had over three decades of experience managing care under full population based payment structures. And I'm talking capitation, as well as our ACO arrangements. So we have about 44,000 senior enrollees in Medicare Advantage, 277,000 commercial enrollees in various contracts.

We have 39,000 commercial ACO members. So these are fee for service members aligned with Sharp HealthCare. And these are through Aetna and Anthem, and then we have a United commercial ACO that's beginning this year in 2015. And then finally we have 29,000 Pioneer ACO beneficiaries in that Pioneer program. That's the number as of January 1 of 2014. And as you know we withdrew from the Pioneer Program in June of last year.

So when we walked into the ACO, we weren't walking in from a standpoint of wanting to get more risk experience. We already had a great deal of experience in risk models very much already focused on payment, for value versus payment for volume. So really kind of a different reason to walk in. And then you'd probably ask, well, then why were we interested in being part of the Pioneer Model?

So moving to the next slide, let me tell you a little bit about Sharp HealthCare ACO. It was a limited liability company. It began January 1 of 2012 with the start of the Pioneer model. And what it was a collaboration between Sharp HealthCare, the parent organization, and our two affiliated medical groups, Sharp Community Medical Group, which is the largest IPA in San Diego County, and then Sharp Rees-Stealy Medical Group, which was the first and oldest multi-specialty medical group.

This is considered to be a foundation model. So it's similar to an employment model in that the physicians within Sharp Rees-Stealy Medical Group are salaried. But, again, it is a separate organization from Sharp HealthCare. It's a separate professional corporation.

So in total we had 29,000 aligned beneficiaries, and we attributed, when we looked at the actual activity of the beneficiaries aligned to our ACO, 70 percent of them were aligned with Sharp Community Medical Group and 30 percent were aligned with Sharp Rees-Stealy Medical Group. And, as Dr. Pham mentioned, Pioneers required 10,000 beneficiaries to be a Pioneer ACO. So when you looked at the number of beneficiaries aligned with Sharp Rees-Stealy, they didn't have 10,000 beneficiaries. They had about 7,000 that aligned to them. So, they could not do the Pioneer model on their own.

When you looked at Sharp Community Medical Group, they had a sufficient number of aligned beneficiaries. However, one of the requirements of the Pioneer Model was a minimum of 50 percent of your primary care physicians needed to be on an electronic health record.

In the case of Rees-Stealy, 100 percent of their physicians are on a common EHR. In the case of Sharp Community Medical Group they were rolling out the same EHR, but they didn't have 50 percent. So it was important for them to participate in the Pioneer Model to come together. So for us to participate, the real benefit was it really allowed a collaboration between our two medical groups that could really start looking at how they coordinate care under a common model, share best practices, and really kind of move forward in that collaboration.

They are, what I call, friendly competitors within our market. They've done hospitalist programs and SNFs programs and the like. So they had some collaboration before, but this is really the first time for us to do care coordination across two medical groups, sharing information across all

three of the parties. So that was the real reason that we were very interested in the Pioneer Model.

Again, it's an LLC, so it was a third owned by Sharp HealthCare, a third owned by Sharp Community Medical Group, and a third owned by Sharp Rees-Stealy. So that's how the alignment worked.

Moving to the next slide, the goal of Sharp ACO was to provide the best help, the best care, and the best experience to our 29,000 beneficiaries. So how did we do that? We really worked very hard on our care delivery models, looking through care coordination determined where is the care being provided. It's the right time. It's the right place. It's done in the correct manner, whether we're using home health, hospice, skilled nursing and the like.

I already mentioned care coordination. A lot of our work moving down was in the IT and analytics space. So we had monthly dashboard reports that were programmed by our IT area to really show what is the top ten percent of our beneficiaries that we would consider to be high risk and need further care coordination. We had seven care management programs that we offered to our ACO beneficiaries. They were the same programs that we've developed through those 30 years of capitation, the same programs that we offer to our Medicare Advantage population.

So really when we brought on the Pioneer ACO it was a matter of increasing scale for those seven programs and really using the infrastructure that we have developed. A lot of work in patient engagement, which is very difficult, and really providing that best experience is the best way that we had to engage those patients. And then I already mentioned the alignment of incentives and that we were a third owned by each of the parties, so all of us were very much aligned in the results of the ACO.

So moving to the next slide, let's talk about those results. So I'm talking about 2013. This was our second performance year. So when we looked at that full year we felt that we had great success in inpatient bed days per 1,000 beneficiaries. We had a decrease of 17 percent for January 2013 to December 2013. Our readmission rate decreased from 14.8 percent down to 13.1 percent. Our goal is 13 percent, so we just about hit goal in that area.

And also as Dr. Pham mentioned, when you looked at the quality rating, the quality was very high. We had 84 percent on the 33 quality measures. So we looked at our utilization, our quality, and our service metrics. We felt we had fabulous success, but when you turn to the financial performance under the Pioneer Model it would show for 2013 we had a shared loss of 1.3 percent. That was considered break even under our payment track.

We had a minimum savings rate, or loss rate of 1.9 percent. So anything plus or minus 1.9 percent was considered break even. So we didn't have a shared loss payment, but as you can see the utilization and the performance that we saw really didn't align with what's happening under the financial model. So you'd probably ask why is that the case.

So turning to the next slide. So specifically talking about the Pioneer Financial model, the benchmarks are developed, and I'm talking from 2012 to 2014, the first three years of the Pioneer

model based on cost of aligned, the actual aligned beneficiaries from 2009 to 2011, so it's the actual cost of the beneficiaries that are aligned. And then they're trended forward to 2012, '13, and '14 using national inflation factors.

And the key that we had, which was negatively impacting us, is those national inflation factors, those national trend factors were not reflective of the actual rate that we were paying our providers in the San Diego area. And the two that were the most significant for us were the area wage index and Medicare disproportionate share.

So first let me talk about the area wage index on the next slide. For those of you that aren't as familiar with inpatient reimbursement under Medicare, it is DRG [Diagnosis-Related Groups], or discharge based. There is a national wage rate that is the same rate across the nation that's applied to each discharge at a hospital. And then that national wage rate is multiplied by an area wage index.

And that index is to bring that national rate to the actual salaries and wages that are paid in a geographic area. So if you looked at the area wage index for San Diego County in 2011, so that'd be the last year of the baseline cost for aligned beneficiaries, you can see it was 1.187. And as we get through 2015 that area wage index increased to 1.2881.

What does that mean? What that means is as we got to 2015 we had a cumulative trend in our area wage index of 8.5 percent. So the cost, the actual rates that we paid our providers were 8.5 percent higher in 2015 than that base line of 2011. The problem is on a national basis the area wage index is budget neutral, meaning if San Diego county rates went up by 8.5 percent there are other places in the nation whose rates went down, who had a negative trend, which then brings the area wage index to one percent, budget neutral on a national basis.

So as we look to our actually benchmark for our Pioneer ACO population it was understated by 8.5 percent on the inpatient side, just related to this DRG based reimbursement. And that was a significant component of total Medicare costs that we were responsible for.

Turning to the next slide, the other issue that we had is disproportionate share. In the Pioneer model Medicare disproportionate share is included in the model. That's different than the Shared Savings Program and really different than value based purchasing in the other programs coming forward from CMS. What does that mean? Part of that DRG based reimbursement that I just spoke about includes a disproportionate share add on.

That disproportionate share add on is based on Medicaid utilization at the provider. So not Medicare utilization, but Medicaid utilization. So the disproportionate share is a payment mechanism to help pay a provider, a hospital provider that sees a disproportionate share of undercompensated patients, so I'm talking Medicaid or Medi-Cal in the state of California.

Beginning January 1 of 2014, with the expansion of Medicaid under the Affordable Care Act, what you'll see is I'm showing you '15 here, but as of January of this year only 28 states and the District of Columbia had agreed to expand that Medicaid coverage. So that expansion is not consistent across the nation. So again, when you're getting paid, or getting compared to a national

benchmark, if you're in an expansion state like California the benchmark is understated because it's not reflecting.

It's reflecting only a partial expansion of Medicaid, which means just a partial increase in those disproportionate share payments, whereas in California we saw a significant increase in those disproportionate shared payments compared to the benchmark.

MATTHEW MANDELBERG: Alison?

ALISON FLEURY: Yes?

MATTHEW MANDELBERG: If you could take just want one last minute to wrap up, we need to get to the next panelist, as well.

ALISON FLEURY: You've got it. So going to the next page, and this is the summary, really we do absolutely support the shift from volume based business model to a value based business model. We've had 30 years of experience in that value based model and absolutely support the Triple Aim. We pulled out of the program really because we had a payment model that really wasn't supporting the underlying utilization.

MATTHEW MANDELBERG: Thank you.

ALISON FLEURY: Thank you.

ELLEN CONNELLY: Thank you very much. We're now going to hear from Dr. Schwartz. And, I know you don't have slides, but I'm going to pass that down so that our next panelist has it.

SIMEON SCHWARTZ: Thank you. I'm honored to be here and I appreciate being invited today. I do not have slides. I'm going to follow along Chapin's method. And I'm also going to follow a little bit because I'll add additional comments on our competitive landscape and our market.

So to begin with, WESTMED Medical Group is a physician owned and government organization. We have 300 physicians in our practice for southern and central Westchester County in New York. We have approximately 30 to 40 specialties within the practice. The practice has a management company called WESTMED Practice Partners that was sold this past year to the Optum division of United Healthcare.

The main business model within the practice is to operate these very large integrated sites that we call poly clinics. They typically are 80,000 to 90,000 square feet. They include primary care services, specialty services, lab, imaging, urgent care, and surgical specialties. And these urgent care is what we call advanced urgent care. They can provide approximately 80 percent of the patient care that a typical emergency room would provide. They include available CAT scans and other services at all hours that they're open, IV fluids, antibiotics. And it really allows for shifting a significant amount of care from the hospital setting to the office setting.

So we are really an advanced ambulatory care provider. Currently our local hospitals provide no

ambulatory services that we do not provide. So essentially, we only use the hospital for true emergencies and for inpatient services. The group has been committed to the Triple Aim since its inception in 1996. We were formed largely in response to the thread of the Clinton Health Plan.

We were gearing up for capitation. We got dressed for the ball and we've still been stood up for this year's waiting for this to happen. My dress needs to be pressed every few months. And as part of the Triple Aim we've been involved in all the NCQA quality programs from its initiation. All of our primary care physicians are level three medical home. And we've gone through each step of the quality process.

In our ACOs, which are both commercial as well as Medicare, we've achieved significant levels of quality, and some of the commercial carriers have described the group as one of the finest quality providers that they've seen across the country. The group is also operationally and clinically efficient. It's operationally efficient in the sense that we only have four employees per physician compared to the national average from multi-specialty group that's almost six.

We have a lower overhead than most of the multi-specialty practices in the country, despite being in one of the most expensive markets in the country for labor, rent, and malpractice. That also translates into clinical efficiency. Going into the ACO world we already had a low utilization. We had no incentive economically to put heads in beds. And as result of that our only incentive really was the patient care that we were providing, and we thought we were well positioned for the ACOs, and we thought finally we'd be moving towards capitation.

The group has really emphasized patient service for a long time. We've typically, on a Press Ganey basis been at the 80 to 90 percentile ranking. And for those of you from Northeast, you'll know that New Yorkers are not particularly friendly to provider organizations in evaluating us. And actually, in the month of November the group hit the 99th percentile in patient satisfaction. Let me just give you one quick example of what patient friendly practice looks like. I look around the room and there are a larger number of women. So many of you will understand that if you arrive at WESTMED in the morning for your routine mammogram, and it's abnormal, we'll offer you a breast surgeon appointment that day. We will biopsy you by five o'clock that evening. And we'll have a preliminary path report out by noon the next day.

We think this is where medicine really needs to go and the transformation that is meaningful at the patient level. So I'm here, in part, because we're an ACO without a hospital partner. And one of the things the FTC wanted to know is why we didn't have a hospital partner. So we're an advanced integrated provider. That was one reason that we didn't need a hospital provider, but we're a physician centric organization. And we have no one else who we're responsible for other than our patients.

And as the hospitals have acquired, and I'm going to follow Chapin's comments in this, as the hospitals have acquired more and more physicians for whatever reason, physicians have given up control and governance over how they manage patients and how they manage their own practices. And we think that that's an important part to be maintained as part of both the competitive and the quality landscape that's available.

Our local hospitals are very happy with us in the sense that we're bringing them a large number of admissions. And we're a significant percentage for both of them, of their total inpatient admissions. On the other hand, they view us as a competitor. We're not using them for ambulatory services. And, as we heard earlier, the site of service differential is really driving a fundamental change in medicine. The fact that the hospital is paid two to three times what we are paid for the identical ambulatory service of Medicare says clearly that they're using that money to essentially buy physician practices and to be a competitive force in our marketplace.

So if we were to ask what the most important anti-competitive behavior right now in the United States, it is really that Medicare has established a national trend of paying hospitals more for the identical service, a trend that you will recognize MEDPAC has recommended that be revised at this point in time.

Hospitals have no incentive for shared savings. If you'd save money you get back half the money on the Shared Savings Program, which means it's all coming out of hospital beds. So let's see for second. You give up \$1.00 to get back \$0.50. It's a very good deal. I can really recommend that highly for hospitals who have to balance their budgets.

And WESTMED did not need a hospital, either for its capital investment in the ACO or for its expertise. The only outside expertise that WESTMED uses besides its own resources is using Optum's analytics for management of our care.

So, a little bit about WESTMED's ACO, so we have contracts now with virtually all the large commercial payers, as well as we're part of the Medicare Shared Savings Program. We have 12,000 lives in the Medicare Shared Savings Program. We had a big disadvantage coming into the program, not so different than Sharp in the sense that we had a history of being relatively inexpensive for Medicare. Going into the program in Westchester County, the average Medicare recipient was costing about \$11,500, and the baseline for WESTMED within the ACO was between \$9,300 and \$9,400.

So we came into the program 20 percent more efficient. And we were concerned that we would not be able to continue to improve on that, and we were also a little bit disappointed that despite saving the federal government 20 percent of the cost of Medicare we had not received a thank you note from Mr. Obama.

So moving forward we already had probably 30 or 40 programs in place directed at quality and efficiency involving our Medicare patients. Today we have over 100 programs in place across the organization. What's happened is that we've actually in the last two years decreased our Medicare spend down to \$8,400. So we've had a further ten percent improvement.

We are 30 percent below our region in the national average in inpatient hospitalizations. We are 30 percent below in the number of ER visits. And we are more than 30 percent below in S&F days. We employ our own hospitalists and SNFs. We've also seen significant improvement in quality throughout the organization and from many of our patients. And since we treat all patients the same, those improvements in quality have gone across all payers and all individuals we take care of, which is currently about 250,000 primary care lives.

So let me end with the competitive opportunities begun by Chapin. First of all, the ACO is a valuable competitive tool. But it'll be far more valuable if we move forward with true capitation that would make the providers really accountable. The last time around we didn't have the tools to measure quality with capitation. This is a new world now. We know what quality is. We know how to measure it. And we really do need a more competitive landscape by way of capitation. We also would like to see an expansion of the Medicare Advantage Program as well as some better financial incentives for that program that are being compromised by some of the policies within Washington.

But one of the other factors which has been mentioned also by Chapin is that we take care of every specialty, and therefore we're able to move money from specialty services and other profits to primary care physicians. If we did not do that it is impossible to survive independently in this country today as a primary care physician and independent practice. And perhaps the rebalancing of the Medicare fee schedule, for which many of the private carriers use as a basis of their fee schedule, would be extremely helpful in moving true competition back into the health care system.

So, I would say that if WESTMED has three comments, we would encourage the development of ACOs in capitation. We would encourage rebalancing the Medicare fee schedule, which has also been recommended by MEDPAC, but most importantly the site of service differential has to go. Thank you.

MATTHEW MANDELBERG: And finally, I would love to hear from Kristen Miranda.

KRISTEN MIRANDA: OK. Great. Good morning. Very happy to be here this morning. And I'm going to just start with a very quick disclosure. So in California, under the header of competition, Blue Shield and Blue Cross, unlike many states in the country we actually compete pretty fiercely. Blue Shield of California is the not-for-profit Blue, and also under the header of the current health care climate is creating some very interesting strategic alliances.

Anthem, Blue Cross, and Blue Shield, about eight months ago announced that we were coming together to create Cal INDEX, which is a not-for-profit statewide health information exchange that we are kind of envisioning to be sort of a public utility. We're hoping other health plans in California will sort of join the fold. And that this will be a little bit of an enabler to help drive some of the transformation that all of the organizations up here today are talking about. So these are very wild and exciting times.

I'm going to talk to you about the journey that Blue Shield of California has been on now for actually about the last eight years. We started the work that I'm going to describe before the passage of the Affordable Care Act. So we were not calling this an ACO. We were calling this virtual integration, or as I described it, our bold experiment to see what we could do to bring costs down and quality up in a way that was very different from how health plans had traditionally looked at bringing cost down.

And just to kind of ground everybody, the ways that health plans usually had looked at addressing rising health care costs were typically through two means. One is we would battle it out at the

negotiating table over rates with providers, and those battles continue to this day. And the other is we would introduce various narrow networks to the marketplace. We would essentially segment providers according to different kinds of algorithms. What neither of those approaches does is to really get underneath the hood of what's driving health care costs, what's driving inefficiencies, what's driving duplication, and to figure out if we can actually get together with the different stakeholders in the system and start looking at a population in a very different kind of way.

So we sat down about eight years ago and looked at the premium increases that we were passing on to our customers, which at the time were running at about ten percent to 12 percent a year. They've certainly come down. That's the good news. The bad news is they're still too high. And thought we've got to find a fundamentally different way of aligning incentives and really interacting with the folks who are essentially representing about 85 percent of the premium dollar.

So we got together with a couple of our largest partners at the time: Hill Physicians, which is the single largest IPA in California, and Dignity Health, which at the time was Catholic Health Care West. They are, I think, the eighth largest hospital system in the nation. And we got together with senior leaders and to make a very long, wild, and woolly story as brief as I can, we spent about a year and a half trying to design a different kind of paradigm.

And as these things typically go, we hired a very high-priced consultant, and we had some crazy sessions, and finally decided that we really needed to create this new system on our own. And it started with a financial model. And by the way, I completely agree with David's premise that the financial models really are the easy part. They really don't re-engineer care on the ground, which is what all of this is about. And it's the only thing that makes all of this sustainable. But the one thing I will tell you is that in order to re-engineer care on the ground, you really do need to start with aligned incentives. We've seen that over and over and over again.

So I called the financial model the necessary, but not sufficient foundation. So we started with a financial model. And we actually put together, I won't go into it in detail here because we don't have enough time, but it is essentially is a global budget that has a three way risk share that varies the risk depending on the service line. But what it really essentially did was compel the three different stakeholders, the hospital organization, the physician organization, and the health plan, to really begin sharing data and sharing sort of processes in ways that we had simply never done before.

And I'll describe our results in a minute. We started this work, we went live with our first ACO in 2010. And we now have 24 of these across the state with very, very different kinds of organizations, very different kinds of populations that we're managing. And, again, I'll describe some of the results in a bit, but what we are finding is that we've had some real fits and starts. And there have been some extraordinary lessons learned, and I'll talk about those too in just a minute.

But something does seem to be working overall. There is something about bringing in different stakeholders that had been working together in many markets for many, many years. These are in some cases some sophisticated organizations that had been doing managed care and risk arrangements, and all sorts of types of integrated work together, in some cases for quite some time. But what we are doing is really coming together in much deeper ways, and it's definitely

delivering some results.

So we started, again, back in 2009, and this is just a very high level schematic showing what the risk share framework looks like. This has been written about, by the way, in Health Affairs, and, in fact, Health Affairs, there was an article in 2011 that went into some detail about the model. And I have to laugh. There was an updated article last year, I think in April or August of 2014 in Health Affairs where they described this first ACO as one of the oldest and most successful in the country.

And the reason I say I have to laugh is because we certainly didn't start this as an ACO. It was very much about the Triple Aim, and I think what I would also say to Chapin, or maybe it was to David's earlier comment, all of this work is a bit different, but I think what they all sort of share is a basic adherence to kind of the Triple Aim and an underlying fundamental sort of adherence to some sort of a value-based payment mechanism, right? This clearly can no longer be about fee for service where providers do better by doing more.

So that was sort of the basic premise that we started with. And we started with about 40,000 members who were part of CalPERS, which is the third largest purchaser of health care services in the United States. And we thought, we're going to try to develop a system where we hold health care costs flat in the first year of this work. And what that represented for this particular 40,000 members was savings in the neighborhood of about \$30 per member per month, or about \$15.5 million that we needed to somehow find to take out of the system.

And because we wanted to design a new system that was going to be sustainable we knew that we could not find those savings through rate reductions because clearly if we approached it in that way, we knew that our partners would simply come back in year two and say, well, gee, we now need an eight percent increase, or a nine percent increase. And so on. Right?

And so we passed on those savings prospectively to CalPERS through a premium reduction and then set about trying to find out where we were going to find those savings. And not sure quite what happened to the slide. We've got some missing pieces there. But, in a nutshell it's really not rocket science how this works. What we essentially do is we take a look at the data that we have got on the health plan side.

So it's administrative data. It's claims data. It's data that's coming from our claims, both pharmacy and medical claims. We take a look at the clinical data that our provider partners have. And we sit down together with clinical leaders from all three organizations. And then start looking at where we think there are the greatest areas of opportunity.

And one of the things actually that I want to mention, because I think it's a really important point, there are very different kinds of ACO organizations across the country, some of which are led by hospitals, some of which are led by physician organizations. The way that we started our work, we made the decision that we were going to sort of develop a three way partnership between a hospital organization, a physician organization, and the health plan. And we did that for a very strategic reason.

Clearly most of the savings, and I'm actually going to jump to our results, most of the savings that are coming out in the early years are coming through the hospital, right? They're coming through reduced re-admissions or reduced lengths of stay, through reduced admissions and bed days. And we really hypothesized that if we could bring- hospitals have probably got the toughest challenge right now. There's no constituency, I don't think, in the country that's got a greater challenge than hospitals do making that transition, which they are going to have to make if they're going to survive, right, from the old fee for service beds and heads mentality into pay for value.

And I know I'm out of time. I didn't pace myself so well on this, but at any rate, we hypothesized that if we could bring like-minded organizations to the table to say, we would like you to be part of the solution. And we think you can be, right, you've got a choice. The bus has left the station, right? The country's moving in this direction because we absolutely have to. If not, we're heading off a cost cliff. That if we could bring them to the table they might actually help accelerate the results which we have absolutely found, but secondly to the extent that they continued to feel more and more threatened, what would happen at the negotiating table is they continue to just hammer us over the head with continued rate increases.

So unfortunately I know I'm out of time now, but it is, I think, a fascinating and very strategic question about what role can hospitals play being part of the solution and should they play some kind of a role in that?

ELLEN CONNELLY: Thank you all for your very interesting presentations and comments. We're now going to start the question and answer portion of our panel. And in this portion we'll hopefully explore some of the issues that have come up during the presentations. My co-moderator and I have some questions for the panelists, but we will also be taking questions from the audience, and I believe from Twitter, I hear.

If anybody has a question in the audience, please flag down one of our conference staff. They're circulating through the room with some comment cards on which you can write your questions, and they'll bring the questions to us.

For the panelists, if you have something that you would like to say in response to a question, please just turn your card up, and that way we can sort of keep track of who has something to say. To start us off, I thought that I would ask if any of the panelists, having heard all the presentations, have any questions or issues that they'd like to raise to sort of start us off? Maybe questions for each other, or something that you'd like one of your co-panelists to elaborate on a little bit further. Anything?

DR. TERRI POSTMA: It just occurs to me, hearing some of the other presenters, some of the anecdotal information that ACOs have shared with me that aligns with a lot of what you're saying. It sort of seems to me, in talking with a lot of those organizations that they fall into kind of two camps. Sort of touching off your comments about how financials are necessary but not sufficient. The general split that I've sort of seen is that organizations that enter, at least the Shared Savings Program, tend to be either provider-based, so, for example, small practices that get together that have joined to form the ACO – they don't have facilities – or organizations that already had connections, from health system, or an IPA, or other organized system that often has facilities

involved.

And the challenges and the potential pluses of each of them tend to be mirror image. So the provider-based organizations tend to lack capital in infrastructure, especially these newly formed organizations that have come into the program. But they often had the advantage of having very highly motivated and engaged practitioners, which, in turn, leads to engaged beneficiaries. Whereas the other side of the coin are some of these health systems that are already in place, that for whatever reasons decided to join the program. And they often have a lot of the infrastructure and capital available to start the program, but oftentimes their concern is in the area of provider engagement, beneficiary engagement. So I think that's kind of interesting.

KRISTEN MIRANDA: I think that's exactly right. And one thing I didn't get a chance to note, but I think it's critical, and we're going to have to figure out as organizations, and it's something that we have been grappling with, is how do we help some of those organizations that don't have the capital to make those infrastructure investments, and how do we help support them, because it takes enormous resources to build that infrastructure. So one of the things that we have been doing at Blue Shield is actually helping to make some of those infrastructure investments, because, without them, some of these organizations are simply not going to get there. And what you don't want to see is that the only ones that are out there are continuing to do this work and that are continuing to stay viable are the ones that are a part of these large systems. And so, not that there's not a role for the large systems, but so it's critical that somehow we help them make those investments.

ELLEN CONNELLY: Dr. Pham, did you have something to add?

DR. HOANGMAI PHAM: Yeah. So it's nice to be able to follow on that because we certainly believe that it's worth investing in those types of organizations. And that's why we're pouring resources into the ACO investment model and hoping that other investors, like commercial payers, but maybe venture capitalists, other private actors, will look at the outcomes and decide this is an investment worth making more broadly. That would be lovely to be able to take that load of investment responsibility off of just CMS.

I wanted to follow up and actually ask David and Chapin, because you're probably the most disinterested parties on the panel, if you had an impression. All of the charts that we've seen so far have shown upward trajectories in terms of participation and engagement among providers. And we would really like to believe that that's going to be a relatively straight upward curve for the foreseeable future. I would love your honest assessment of where the momentum actually is, because we also experience on an every other day basis how tired providers are, and how real risk is once they experience it, once they have to write a check for shared losses, or contemplate that possibility. So where exactly is the market momentum?

DR. CHAPIN WHITE: I mean, if you go back to the early '90s global capitation arrangements were zooming up. It looked like they were heading to the sky and then poof, they collapsed, which, that's just to say that trending up doesn't mean it will continue up. My sense is that rebasing is really critical. And there are a lot of technical details that could sway it one way or the other, but it may also just be like global capitation where there's kind of a boom and then a bust,

but then it modulates to where it's hanging on in California, Massachusetts, but it's kind of less prevalent in other parts of the country. But I don't know. What do you think?

DR. DAVID MUHLESTEIN: I think one of the most important factors is what people believe is going to happen going forward. And I think there is a growing belief that we are moving away from fee-for-service. Right now ACOs are kind of the acronym of the day. And so people are moving toward that, but most people recognize that shared savings is not something you can do forever. So shared savings is a bridge to something. And there's definitely not consensus in what we're bridging toward.

So there's a lot of agreement that we're not going to stay in fee-for-service. We're going to be in shared savings for a time, but where are we going to go beyond that? Are we going to move toward capitation? In some cases we may. Or are we going to move towards something else? My personal belief is that it's going to be inconsistent across the country. There will be markets where providers are fully capitated, and in other markets they'll develop other models. But there is consensus belief that we're moving away from just the strict fee-for-service environment.

MATTHEW MANDELBERG: Great. Thank you. One question that we've had is wondering in forming these various types of ACOs and thinking about the trends that they've had, some ACOs seem to have had more success generating quality improvements than savings. And Dr.

Muhlestein, maybe you can speak to this. I know you've done some research on it. What accounts for this and are there certain characteristics shared by ACOs that did generate savings? Then if anyone else would like to comment as well.

DR. DAVID MUHLESTEIN: Sure. So starting on the quality side, I think a big part of quality is that it takes a lot of time to figure out how you're first tracking the quality, and then how you're going to improve that. So the organizations that were in a good position to improve quality in the first year probably already had the infrastructure in place to be able to track it before that.

So just as an anecdotal story, there are ACOs that we're aware of, that – they're a group of physician groups – that have come together, and they have over two dozen different EMR platforms. If you're trying to do any sort of a population level metric, and you have over 20 different systems that are not talking to each other, you have no idea what the health or quality of your population is. So in the first year at the ACO, you're just figuring out that crosswalk between those EMR platforms. If you are already an integrated system, and you have Epic inpatient and outpatient that's recording things, you're at a different place. And so you know what the problems are and where you can improve those. So I think it's a lot of where people started to begin with.

On the cost side it's also an issue of time, and how long it takes to implement the programs that different providers are doing. I think those that were able to succeed in the short term were already in a position to quickly implement specific programs. And so those could be readmission focus. This could be limiting unnecessary tests. But they were already well prepared to start to do that. A lot of organizations, I think, the first year they're almost in the planning stage. They're saying, what could we do and what would we like to do? But they're not necessarily at the implementation phase.

MATTHEW MANDELBERG: All right. Terri?

DR. TERRI POSTMA: Yeah. I just wanted to add to what you were saying about the quality. I think that the EHRs and sharing information and being able to identify where those opportunities exist, is important, but I think equally important is, and one of the things that's a requirement at Shared Savings Programs, that the ACO develop a process for promoting evidence-based medicine. And that takes a lot of time and energy to educate practitioners on the evidence that supports performing a certain test, or not performing certain test in certain situations. But the data often feeds into that, because as a practitioner within your four walls, you may believe that you are actually providing that flu shot to every single patient that comes through your doors, when, in fact, the data might show otherwise. And so, again, that transparency in data that I talked about is really helping to drive change.

DR. HOANGMAI PHAM: I would just add to that that I want to go back to something that David himself mentioned earlier in his remarks, which is, I think, that the global umbrella on why organizations do well, methodologies aside, it comes back to culture. And I don't mean that as a frou-frou feel good thing, but that it plays out in very concrete ways. Having the systems, having invested in the systems to track that data, and to feedback that performance data to your providers is very much driven by culture. Having the ability to speak truth within your own organization and to question standing assumptions is highly critical. So, for example, a number of organizations came into the Medicare ACO context with lots of experience with risk management in the commercial arena. It's a different population. Even if you had a lot of Medicare Advantage experience, fee-for-service Medicare is a different creature. And if you weren't willing to actually question your assumptions by looking at the data on the actual population, talking to the actual patients, figuring out what they actually think, then translating all your experience is going to be very difficult. So I really think it does come back to the cultural aspects that were mentioned before.

ELLEN CONNELLY: Dr. Schwartz?

SIMEON SCHWARTZ: Yeah, I think it's important to emphasize the importance of leadership and governance. These really require fundamental changes in the way you practice medicine. Providers are very tired of all this nonsense already. They have not seen anywhere near the financial gains they anticipated early on in the process, and you run the risk of having a significant bust. The programs, whether they be commercial, but particularly the MSSP has a variety of rules and structures that has negatively affected the financial gains for providers. And those are causing organizations to reevaluate their position. So you can have the best data in the world, and we have very good data, and you can have the best leadership in the world, but if you lose the heart and soul of your physician community, you will not be successful in running an ACO.

ELLEN CONNELLY: We've gotten a number of questions from the audience. So I wanted to get to some of those. This one is probably to start off for Dr. Schwartz or for Alison. I'm assuming she's still on the line. How important to your success, this sort of follows up off what you were just saying, in reducing costs and improving quality with ACOs is due to physician culture? That is, do you tend to hire doctors who are already strongly supportive of these measures, and if so do you think that you could have the same level of successes with doctors who aren't already on

board?

SIMEON SCHWARTZ: The good news for us is that not everybody's a WESTMED doctor. And I think that the hiring process is extremely important. The building a culture is important. You have to be clear upfront what the culture is and what the changes are, but more importantly the physicians have to be in a collaborative process. You need to build a consensus. You need to deal with your problems. Unrelated to the ACO, we had a problem with a fairly high number of C-sections this past year. And collectively we brought that rate down by about 25 percent in one year as a result of a collective physician process working together to do that. So you can't accomplish anything with the analytics unless you really have a physician culture, which requires really two things. One is it requires a culture of transparency, so we share everyone's data transparently, of course – the entire organization. And the second component is you have leadership who needs to reinforce and to guide that structure. It's not just the president or the single leader, but it is really a culture of leadership and enough individuals in the organization to sustain the transformation.

ELLEN CONNELLY: Alison, did you have anything to add?

ALISON FLEURY: Yeah, I would just agree wholeheartedly. I think that one of the greatest successes we had was a collaboration between our two medical groups. And just bringing them to the table to manage a combined cohort of beneficiaries was very enlightening in the amount of best practices shared back and forth. And also best practices from our other Pioneers. As Dr. Pham mentioned, we very much appreciated being able to look to others and to what was working well with them. So that collaboration was key.

MATTHEW MANDELBERG: Thank you, Alison. And just a follow up question. In your presentation, you noted that the different delivery models, care coordination, patient engagement, IT were all part of your health plan's approach to making ACOs work. And one of the questions that we had is that. When forming a government ACO, does that make it easier to form a commercial ACO or vice versa?

ALISON FLEURY: We started in the commercial ACO business well before the government business. And it really wasn't the ACO that made it easier, but rather the infrastructure and systems and processes that we had in place for our Medicare Advantage and our capitated book of business. So really, what made it easier, is we were leveraging existing systems and structures to provide care management programs to our beneficiaries. So I think it's more that we were coming from a different place.

MATTHEW MANDELBERG: And maybe just to throw it out to the group as well. Just in general is it that once a medical group forms one type of ACO, is it fairly easy to form the other type of ACO?

SIMEON SCHWARTZ: So, for us, we were first in the commercial space even before the Medicare ACO. We were actually United Healthcare's first ACO in the country, which is a very good contract because in our first year we've made one million dollars, but what happens is that once you make a commitment to provide a certain infrastructure and a certain level of care, you

have to do that across all your patients. You don't stop and say, oh, this person's in the ACO. I'm going to treat them differently. So it's not just an ACO – commercial, Medicare – it's really a whole process of transforming care delivery.

KRISTEN MIRANDA: Yeah. There we go. One of the other things I think that, absolutely true, you can't expect providers to, once they're reengineering care, it has to apply to their entire book of business. The infrastructure certainly does. The care processes do. One of the things that we've been finding as we've been out working with some of these organizations is part of the benefit, if you will, of the program is we've been working with hospitals, for example. We're in there working with them and bringing down, for example, length of stay, or readmission rates. They're out there taking those processes and applying them to their entire book of business. Well, for under their Medicare book, for example, even where it's fee-for-service, those have a benefit to them, right? They've got a financial benefit to them. So that's part of sort of the uptake of the entire program. So yeah, it absolutely has to apply to the entire book of business.

MATTHEW MANDELBERG: Terri?

DR. TERRI POSTMA: I was just going to mention that anecdotally some of the organizations that are coming to the program are newly formed. They've never had collaborations before. And some of those organizations have told me that they are getting approached now for commercial contracts as well. So for what that's worth.

MATTHEW MANDELBERG: And it sounds like there is some evidence not only in that you have to change your model, but that there are these spillover effects.

DR. HOANGMAI PHAM: Yes. I mean, we have multiple examples of Pioneer ACOs who almost regardless of how they have performed to date, but especially the ones that have managed to earn shared savings have become a magnet for their peers in contiguous markets, or in far flung markets. They come not just to ask for advice, but sometimes for a direct partnership, as kind of siblings, to learn how to work in this system before they set off on their own. So I do think that we're seeing some very concrete spillover effects.

MATTHEW MANDELBERG: Great.

ELLEN CONNELLY: Take another question from the audience. We've heard a little bit today about how ACOs are sort of a layer on top of a trend that's already marching ahead towards consolidation and also that the data on, particularly the clinically integrated organizations, I think you were talking about Dr. White, is pretty murky. With that as sort of a backdrop, we were wondering how do we evaluate ACOs and other clinically integrated organizations from a competitive standpoint to really determine what it is that they're doing? Are they trying to get more provider pricing power? Or are they actually trying to deliver integrated care? So I thought maybe you might have some thoughts and then I'll take thoughts from everybody else.

DR. CHAPIN WHITE: Well, start with a lot of data. And we're actually going to be approaching people who really know about ACO penetration and we're going to start sorting through all the various data sources. I mean, obviously the people on this panel have a really good sense of

what's going on in the real world, but I think we're going to want to mix that with some concrete empirical evidence. And, I mean, the challenge is these organizations are relatively new. It's a challenge just to get a hold of what happened in the last couple of months, which would be important to know to get a sense of the impacts. I think that there are private claims data, all-payer claims databases, that you can use to get a sense of what's going on the pricing side. But it's going to be a challenge. It would be much easier to wait 8 or 10 years, and then do a really nice longitudinal study, but by the point the horse will not just be out of barn but over the fence.

DR. DAVID MUHLESTEIN: So this is, again, we don't have comprehensive data to do a full analysis, but we've got some anecdotal things that start to represent what people are thinking about in the ACO space as it comes to consolidation. So, first, we've been closely tracking how many organizations that are consolidating, either purchasing physician groups, or hospitals coming together, how many of those at the onset have explicitly said that they're doing it for the purpose of becoming an ACO? And we have counted fewer than five so far that have said that

this was their explicit reason for the consolidation. Instead, what we've seen a very high number of is non-ownership partnerships or arrangements where people are coming together. And so they're recognizing they can't do things by themselves, but they're also realizing they don't need common ownership to do that. Now, whether common ownership is necessary to drive up the prices or if you can do this through non-ownership affiliations is still to be determined, but we're seeing a lot of these non-ownership partnership arrangements that are developing.

MATTHEW MANDELBERG: And just building off on that, what can we say generally about how providers and ACOs compete with other ACOs as well as providers who are not part of an ACO? Does that change how they compete with one another?

DR. DAVID MUHLESTEIN: Sure. I'll take a stab at that as well. So on the first side, on the commercial end, we're really looking at lives being determined based on insurance status. And so it's the same sort of what's the advantage of a narrower network? Well, we're going to promise you lives in exchange for a lower price in terms of delivering the service. And it's a similar process on the commercial ACOs where they're negotiating with payers to get those lives.

On the Medicare side it's different because it's free choice of where you're going to see your patient. And so it's a different aspect there and I won't go into that. In terms of whether this will change the dynamics between the provider organizations, I think that in some cases it does. In some markets we've seen providers start to change their marketing and also change how they're trying to engage patients. They're saying if we want to make money under this ACO contract we really need to engage our patients, manage them, and that's a process in and of itself.

In other markets, and I won't name them, there have been no changes at all. Where we've interviewed them, and they say this is business as usual. We're just accepting this risk-bearing contract and we're still trying to maximize our volume. And so it doesn't necessarily lead to increased competition, but in some cases we really are seeing a different type of competition between providers.

ELLEN CONNELLY: Dr. Pham?

DR. HOANGMAI PHAM: Without making generalizations, can I just give you three examples of how this sometimes plays out? We have one Pioneer market where there were multiple applicants, finalists identified. And one pulled out in terms of committing to signing the agreement until they realized that everyone else in the market was going to sign. And that was the last push that the CEO and CFO needed.

We have an ACO market where, of multiple Pioneer organizations, one was considering dropping out – actually notified us informally that they wanted to withdraw. And a competitor CEO called that CEO, the one who was withdrawing was relatively new to the organization, and said to him what are you doing? Here's what's going to happen. You're new to this market. And they changed their minds. So some very different idiosyncratic ways that it plays out. There really does seem to be this push and pull of the market momentum we've talked about versus their old competitive instincts. I think people are, they're not confused, but they're figuring it out. It's a set of new dynamics.

ELLEN CONNELLY: Dr. Postma?

DR. TERRI POSTMA: Yeah. And again, just from an anecdotal perspective, I know of several ACOs that have told me that when they've put together the data that we've given them, the data that they have, looking at it for opportunities for improving quality and cost, they noticed, in some instances, that certain specialists that they referred to, or certain home health agencies that were being used in the area were driving a lot of the costs. And so they approached those folks and said, look, we're participating in the Shared Savings Program. It's our goal to improve quality and reduce costs. We'd like to collaborate with you. We say, our fee-for-service patients are choosing your practice or your organization, and so it's been driving conversations not only within the ACO and among its providers, but also external to the ACO with some of these care partners.

And in some instances when, for example, home health agency was not willing to work with the providers in the ACO to really help coordinate the care of patients, the provider stopped referring to those organizations and put pressure on them. In another instance, an ACO told me that initially they had approached a local hospital that they knew a lot of their patients would go to, and said, hey, we want to set up a process so that when your patients are discharged back to their primary care providers, us, that we have a good coordination of that transition of care. And initially the hospital wasn't at all interested in these local practices and working with them. But over the course of time they've actually come around and seen the benefits of working collaboratively in that way. Part of that is some of the additional CMS incentives, I think, that are looking at, for example, reducing avoidable readmissions to hospitals and the penalties that apply for high avoidable readmissions. But whatever the case, those collaborations are taking place.

MATTHEW MANDELBERG: Well, thank you very much. And unfortunately we're out of time, but just wanted to thank again all our panelists for sharing so much insights about ACOs and the early developments. I want to thank everyone who's in the audience. We're going to take a 15 minute break. And then we'll be back here about alternatives to fee for service. Thank you.

[APPLAUSE]

ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODELS

Moderators:

- **Karen A. Goldman, PhD, Attorney Advisor, FTC, Office of Policy Planning**
- **John P. Wiegand, Attorney, FTC, Western Regional Office, San Francisco**

Panelists:

- **Michael E. Chernew, PhD, Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School**
- **Suzanne Delbanco, PhD, MPH, Executive Director, Catalyst for Payment Reform**
- **R. Adams Dudley, MD, MBA, Director, Center for Healthcare Value, Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco**
- **Mark W. Friedberg, MD, MPP, Senior Natural Scientist, RAND Corporation**
- **Bruce E. Landon, MD, MBA, MSc, Professor of Health Care Policy and Medicine, Harvard Medical School**
- **Lisa McDonnel, Senior Vice President, Network Strategy and Innovation, UnitedHealthcare Networks**
- **Dana Gelb Safran, ScD, Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts**

KAREN GOLDMAN: OK. We're going to get started now. Good morning, everybody. I'm Karen Goldman. I'm an attorney from the Office of Policy Planning at the FTC. And this is my co-moderator for this panel, John Wiegand. He's an attorney in the San Francisco regional office of the FTC.

In this panel, we're going to build on what we learned in the last panel about ACOs, about alternative payment models. And we will explore a variety of alternatives to fee-for-service in both the public and private sectors. There are now a wide variety of options for enhancing quality, improving population health, and reducing unnecessary costs. Some involve payments for quality and care coordination, while others create incentives to reduce volume, especially in connection with shared savings or shared loss.

Fortunately, we have a very distinguished panel here, with expertise across the entire range of payment models to explain the latest developments to us. My co-moderator will introduce the panelists.

JOHN WIEGAND: Thank you. I'm going to introduce them in the order in which they will be speaking, and very briefly. You'll have a bio sheet which has a much more detailed description of the work they've been doing and tell you about everything you'd want to know about them except their favorite baseball teams. We have Suzanne Delbanco, the executive director of the Catalyst for Payment Reform. And then Adams Dudley, who is the director of the Center for Health Care Value and Health Policy Studies at the University of California at San Francisco.

Then Lisa McDonnell, Senior Vice President for Network Strategy and Innovation at the UnitedHealthcare Networks. Mark Friedman, a senior natural scientist at the Rand Corporation. Bruce Landon, Professor of Health Care Policy and Medicine at Harvard Medical School. Michael Chernew, who is the Leonard Schaeffer Professor of Health Care Policy at Harvard Medical School. And finally, appearing remotely over the screen, will be Dana Safran. She is the Senior Vice President for Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts.

Karen?

KAREN GOLDMAN: Suzanne will begin. She'll provide a framework for the panel with an overview of alternative payment models and Catalyst for Payment Reform's perspective.

SUZANNE DELBANCO: Thank you, Karen. Thank you, John. It's a lot of fun to be here, and to get to talk with all the people on the panel here and all of you about this topic, which I think about every day. If we can pull the slides up.

I wanted to start just by introducing myself, for those of you who are not familiar with my organization, Catalyst for Payment Reform. It's an independent national nonprofit organization that is working to provide thought leadership to, and coordination among, very large health care purchasers, including private employers and Medicaid, employee, retiree, and Medicaid agencies.

Actually, if you go to the next slide - who has the clicker? Because I'm happy to do it myself, if there is a clicker. Thank you. Realized I was missing an essential tool.

And we basically spend about 2/3 of our energy helping big purchasers figure out how to be smarter purchasers of health care to get better value for their health care spending. And obviously, if you take a look at our name, payment reform is a big focus of ours. But we also get into other issues that we think either impede or could improve value, like price transparency, or looking at the impacts of provider consolidation on market power. And then we spend about the other third of our time trying to research, analyze, report, score things that are happening in the health care system that we want to bring attention to. And I'll refer to some of that work as we talk this morning.

To start, just to state the obvious to this probably very well-informed crowd, when you wonder about why it is that payment reform is the hot topic du jour, it's partly because we've learned over the last 15 years or so that quality isn't the same everywhere you go. And, in fact, there are big failures, and continue to be big failures, and a lot of unevenness, both across and within institutions, and across and between different types of procedures and care, and care for people with chronic conditions.

But also, over the last five years, we've become much more educated about the fact that we also pay wildly different amounts for the same thing. And I think there are some people on this panel - not to pick on you, Lisa - who have probably known that for a long time. But it really has become news for some of the purchasers of health care that I work with, and perhaps some of you who analyze the health care system, to realize that we pay such wildly different amounts for

care, the same care, whether or not the quality varies. And that there's really no correlation right now between the prices we pay and the quality of that care.

When you think about the fact that we have unreliable quality and we pay amounts that have nothing to do with that quality, you can imagine how some of the employers and other purchasers I work with feel like they're not getting a good deal a lot of the time. And so what is it that we can do about that?

And the way we pay for care today in many cases allows for that poor value to continue. But while we go for the gold, and try to come up with alternative payment models that will save the day in terms of improving quality and making care more affordable, there are tweaks that we can make to our current payment system. And the truth is, it's going to be around for a while. And so we shouldn't ignore it. And, in fact, fee-for-service, we all like to talk about how we're moving away from it, but it's really the underlying basis for all the alternative payment models that we're trying today, with very few exceptions.

Now, the health reform law, as you know from the last panel and the discussion about accountable care, created several game-changers. The whole ACO movement was really given a huge amount of momentum because of the reform law and patient-centered medical homes, et cetera. But the truth is, the evidence is still pretty mixed. And we don't know what the impact's going to be long term. And we still know very little about what works in terms of different payment methods. And the only thing we do know is that there's no one-size-fits-all solution. Context matters. Details matter. The providers you're working with matter. The dynamics of the market that you're working in matter.

And fee-for-service, which we all like to rag on, has problems because sometimes we pay for care regardless of whether it's necessary. But sometimes we also don't pay for care that we should be paying for. And so there are fundamental flaws that we want to change. But do we really need to start from scratch, or can we build on what we already have?

When CPR got started, we created a payment reform framework, because we realized, in having discussions with people about payment methods, that we were all over the map in how we thought about them, defined them, what we meant by them. So we created this framework that basically increases in complexity when you move from left to right. Increases in potential provider resistance when you move from left to right, because you're moving from what they're used to things that they're not as used to, with some exceptions. But also potentially greater accountability on the part of provider. Greater risk. And maybe greater reward. But all of these methods could be improved. There's still a lot to learn.

The other way that I would provide a basis for understanding the rest of this panel discussion is to say that most of the payment reform methods that are being tried today are really falling into three buckets. And they have to do with the offerings of carrots and sticks. There are many methods in place today - and you heard this in the last panel - that offer an upside to providers, where you could potentially earn more. You could earn part of the savings. You could earn a bonus. You could earn something that is a positive increase in income. Or, in some cases, it's a trade for lower fee payments, but you make it up by achieving certain quality scores. And that's

the vast majority of what we're seeing in the market right now.

There are some methods also that have been entering into market which offer a downside only to providers. One example would be in South Carolina, where they stopped paying for early elective deliveries, both the Medicaid agency and the Blues plan, which together cover about 85 percent of births. Of course, other examples you've heard a lot more about have to do with hospital-acquired infections or readmissions.

And then there's the two-sided risk model, where providers have potential both to have an upside financial potential, as well as potential losses. And those are shared risk arrangements, that on the last panel people were saying one day we probably need to move to.

If it helps in understanding the array of what's in the market, we like these three buckets, because we haven't really found much of anything that doesn't fall into one of them. And I think there's a lot of interest in talking about which ones make sense when, which types.

So, how much progress have we made on payment reform? Well, we know that there is a flurry of activity. Since we first measured how much payment reform was happening in 2012, looking at commercial data, commercial health plan data, we've had a 29 percent jump from 11 percent in our 2013 national scorecard on payment reform to 40 percent in our 2014 national scorecard on payment reform. And what I will say is that hospitals have a bit more experience with payment reform than physicians. But that's changing, as more and more programs are targeting physicians.

And while we don't have insight yet, really, into what's happening in Medicaid, we will soon be producing a New York scorecard on payment reform that will look at both commercial and Medicaid data. And so that will start to give us some insight about how different Medicaid is from the commercial plans.

The other thing I'll mention that we found in our scorecard is that in terms of the balance of payment between primary and specialty care, we are starting slowly to see a shift of more spending in primary care and less in specialty. We're also seeing a growing number of plan members being attributed to some kind of provider with a payment reform contract. That correlates with the growth in ACOs that we just heard about.

We used to be alone at CPR in setting goals for payment reform. And, in fact, our goal is that by the year 2020, at least 20 percent of payments will flow through methods that have been proven to improve value. And by value, we mean improving the affordability of care as well as its quality. And the proof part is the hard part. HHS just came out with a set of goals, also, as did an independent task force of providers and plans and employers. And everybody's setting different goals.

HHS has said that they want to increase alternative payment models, both in Medicare fee-for-service as well as in some of the alternative payment categories, significantly over the next year or two, and the next few years. And when the announcement came out, I got a lot of calls from the media saying, how come their goals are bigger than yours? And we said, well, we are pretty certain that we're going to see rapid growth in the use of new methods.

The big question is, are we going to wake up and suddenly realize we have 100 percent of payments no longer in what I would call traditional fee-for-service, or legacy capitation approaches, or things like that? And it'll actually be our biggest nightmare, because we won't have seen any improvement in the quality of care, and we won't have seen care get more affordable. And yet we've spent a huge amount of energy changing how we pay for care.

So, at the end of the day, where I'm really curious about to hear from all the panelists, is what have they experienced? What kind of implementation are they seeing with these different methods of payment? But also, what are the results so far? And how scalable are they? How replicable are they? Because at the end of the day, the whole point of this exercise of moving from traditional payment methods to alternative payment method is to do better by the patient and by all of us. Thanks.

JOHN WIEGAND: Thank you very much, Suzanne, for setting that framework for us. Adams is up next. He's going to be talking about pay-for-performance.

ADAMS DUDLEY: Hi. And just one quick process suggestion. This is the first time ever I've contemplated giving a talk with a giant Dana Safran behind me. And while we all want to feel like Dana is blessing us, I just wonder, can the audience see the slides?

AUDIENCE: No.

ADAMS DUDLEY: OK. I'm wondering if maybe you want to put the slides up on the big screen? It's fun to watch Dana get water, and so forth.

SUZANNE DELBANCO: I think my slides will be available after the fact, if you couldn't see them. Sorry. I didn't realize that.

ADAMS DUDLEY: Yeah.

KAREN GOLDMAN: I think your slides have probably been visible on the monitors? Or no? Well.

ADAMS DUDLEY: On these small monitors. But they're hard to read, especially if you have lots of words on your slides. Picture slides were probably OK.

So, now I'm a little behind. I'll go a little bit fast.

Pay-for-performance. I'm supposed to talk about pay-for-performance. But actually, I want to talk about the general observation that what really matters is how people feel about the reimbursement system - it's not totally true. At some point they're going to sit down and do calculations. But it's crucial how people feel about where the payment system is pushing them. I really wish Alison Fleury from the last panel could have been here in person, because I want to call her now and talk more.

It's not common for a business organization that's been in one field - in this case, something ACO-like - for a really long time, as Sharp has, to try out a new experiment that's not very far off from what they've been doing, break even, and then quit. And I think the reason that they quit wasn't that they broke even. I think that a huge part of the reason they quit was the reasons they broke even. The reasons they broke even they felt weren't fair.

And that's crucial to how people respond to incentives. If you feel like the system isn't fair, then the math matters too, but that feeling is sometimes even more important. And so if you remember from the last panel, they felt like the only reason they didn't actually make money when they were lowering admissions and readmissions was because Medicaid expansion didn't happen in every state. And they got penalized for that. And the wage index calculation, which was a national phenomenon, penalized them. And so they won but lost at the same time. Even though they broke even on that, they felt the loss more than they felt the winning. And so they quit.

And so now what I'm going to do here is say overall, pay-for-performance hasn't really hit people a lot. Fundamentally, that's because it hasn't ever felt like a really big thing to people. But on the whole, it has nudged people slightly in the right direction. So, small pay-for-performance causes small effect. And then I'm going to jump mainly to next generation ideas that get at that kernel of how can we set up a payment system that makes people feel like they're supposed to do the things they want to do anyway because of their professional training and so forth?

And therefore, I'll skip this slide. Well, no. Actually, I'll talk about a couple things. So, mainly positive results in the pay-for-performance literature. Some mistakes we've made in design get to this issue. If you set up a tournament, say I'm going to pay the top ten percent, people can improve a lot. But if other people also improve a lot, then they don't win. And they don't know what other people are going to do. Again, that combines the feeling of unfairness with uncertainty. Those two things kill people's willingness to respond to incentives.

Another mistake that we've made in the past is to pay on percent performance. That means every patient counts if I pay on your percent performance. And so we have seen reports of people, as an unintended consequence, wanting to avoid patients that are more difficult, because they're afraid that they will affect their percent performance, their percent of quality.

And then, we have in past pay-for-performance programs chosen to measure unimportant aspects of care, so people don't feel like that's a really important clinical goal.

Now I'm going to tell you about a payment program that didn't do those things, or that reversed all those things. This was a program, a randomized controlled trial that we undertook in New York City, focused on small practices that had a lot of Medicaid patients. The reason for focusing on those is if we want to be sure that people respond to incentives, and it's just a question of how much, then we have to go to the toughest place for people to be able to respond to incentives. Small practices without a corporate structure that will help them respond, have a lot of Medicaid patients, so they, among practices, are somewhat less resourced than other practices. If these folks can respond to incentives, then anyone can respond to incentives.

And so we did this randomized controlled trial in New York. We randomized at the practice level. And crucially, when we developed the incentives, we tried to think ahead of time, or work ahead of time, to deal with the issue of how people are going to feel about that. And an important way to do that is to actually get their feedback about what they want the incentive to look like before you get started.

One of the things that we asked them about is, tell us what unintended consequences we might have if we do this wrong. And then tell us how to avoid it. And a crucial thing that they told us - these are all small practices in New York - I'm going to jump onto the next thing - a crucial thing they told us was that under pay for performance, we get nervous sometimes with certain kinds of patients. Or we just give up. And in particular, we get nervous if those patients, if it's going to be harder to reach the goals.

We picked goals that they thought were clinically important, like blood pressure control, that feels to them like a really important thing for a clinician to be focused on. Actual control, not write down, make sure you check the box that we measured the blood pressure, but rather, is the blood pressure actually in control. But they also said, well, yeah. While that feels clinically important to me, I'm worried. There are people with certain conditions that make it harder to achieve blood pressure control, particularly diabetes. There are people with certain social factors that make it more difficult to control, like my Medicaid patients. It's harder for them to get transportation to the office, et cetera.

What we did was we set up the incentive system not to be we'll pay you for achieving the goal regardless, but rather, we'll pay you X for achieving the goal. And if it's hard, if you're going to have to do more work to achieve that goal, then we'll pay you more than X. And we asked them, what does it have to be? And they said, well, if they're one of these clinically difficult patients, it has to be 2X. And if they're one of these socially difficult patients, it also has to be 2X. And if they've got both, it has to be 4X.

If you look at our incentive system for blood pressure, which now has replaced Dana, you got \$20 for an insured person with no comorbidities. If you had an uninsured person or Medicaid patient, you got \$40 for blood pressure control. If they had vascular disease or diabetes, you got \$40. And if they had both, you got \$80.

For the sake of time, I'm going to jump on. Here are the other measures in it, all things that the providers felt were important: giving aspirin to people who were at risk for having strokes, trying to get people to stop smoking, in addition to blood pressure control. And I'm going to skip the technical aspects of it.

I show you this slide only to say these really are people who are taking care of a lot of lower-income patients. This is a hard population. They've got a little over 1/3 patients Medicaid. And almost 40 percent of Medicaid are uninsured. I give you this slide to show you that even when you think about it, you can get it wrong. One of our measures was cholesterol control. And they were topped out at the beginning. But look at the blood pressure control among diabetics - really, really low. This is what they were talking about. This is baseline. It's really hard to get these people under control. So, ten percent in one group, 16 percent in the other group.

Because of differences at baseline, we did a difference in differences analysis. We're looking at how much did they change over the year. And what you can see is that there were several positive changes that were statistically significant. And if you look at the central number there, the blood pressure control in diabetics, you say, oh, well. It only went up by an extra 7.8 percent. That may not sound like a lot, but if you remember, it was ten percent to begin with, or 16 percent. That's actually all of human history gets us to somewhere between ten percent and 16 percent, and a year under P for P gets us up into the 20s.

I just want to quickly, then, show you what the providers thought of this program. We surveyed them afterwards. Now these are providers who have had their performance measured and their payments based on that performance. Usually at this point, they're really ticked off, right? Sharp's leaving the program. And we've seen an awful lot of instances where providers are feeling like if you measure my quality and I don't do well, it just means your measurement system was wrong.

But what these folks are saying - and we had a 75 percent response rate to our survey, which is an indication in itself - but they're saying they received and reviewed the reports. The reports accurately reflected their progress. There's no arguing about the measures here. And, in fact, if you look there in the middle - do we have a pointer here? Nope. Oh, boy. They agreed that the program was clinically meaningful.

This is a program we've built where the providers are actually having their performance measured, they're being paid for it, and they actually like the program. Improving care in the hardest possible situation - small practice, with lots of low- or no-insurance patients. And they end up liking the program, believing it's measuring stuff that's meaningful. They're using the quality reports. And the reports reflect their progress.

So I think, as my mother would have told me before I ever started out in this field, she didn't think we needed to study incentives. She's like, of course people respond to incentives. It comes down to how you do it. And that isn't characteristic just of pay-for-performance, but of any of these programs we're going to talk about. And I will stop there.

MARK FRIEDBERG: Thank you very much.

KAREN GOLDMAN: Yes. Thank you very much. Mark Friedberg will now discuss the evaluation of medical home interventions.

MARK FRIEDBERG: Thank you very much for inviting me to speak. Building on what Adams just talked about, and, I think, in reference back to Alison's presentation in the last session, I think a lot of what I'm going to be talking about resonates with the general theme that the details of payment programs matter at least as much as the form of payment. And it's possible for a well-intentioned payment program not to achieve the intended goals.

First, just a note on defining the medical home. I'm just going to say, there is no such thing as the medical home, singular. Instead, there are multiple definitions of medical homes. And in general,

if you hear someone talking about the medical home, it's worth asking them what exactly they mean by that. You can never assume that two people talking about the medical home are talking about the same thing.

The first question I think is good to ask when discussing the medical home is, do you mean the medical home as a model of primary care practice or as an intervention applied to primary care practices? And I'm going to say a little more about that on the next slide. Some studies evaluate models. Others evaluate interventions. And they don't always come with big flags that tell you in the title, or anywhere in the article itself, or the report, or whatever it is, what they exactly evaluated.

And you really have to get into the weeds to figure it out. The reason it's relevant to today's panel in particular is that changing how a primary care practice is paid is a kind of intervention. The only kinds of studies so far that are really going to tell you much about how to pay a medical home are those that evaluate medical homes as interventions, not as models of primary care practice.

Here are the ingredients of a medical home intervention. You might have new resources for primary care practices. These commonly include technical assistance or coaching for the practices. There might be some in-kind contributions as well. They might, for example, give practices EHRs, or electronic registries. They may pay for a nurse educator to be in the practice.

And there's also enhanced payment. There's multiple possible forms of this in medical home interventions. The most common one is probably a per-member per-month supplemental fee that's paid to the practice. There might also be some shared savings, similar to ACOs, but on a much smaller scale. And you might stay in fee-for-service, but instead change the rate, depending on whether the practice is meeting certain goals of becoming a medical home. They might still be paid fee-for-service, but maybe a 15 percent bonus on all of their primary care billings.

In exchange for these new resources, practices typically have some kind of requirements. The most common one is practice transformation. This means adopting new structural capabilities, like electronic records, new kinds of staff, maybe some enhanced access. And generally speaking, the folks who are writing the checks don't just take the practices' word for it. They want to see some kind of proof that this has actually happened; they need to demonstrate medical homeness. This can come through NCQA recognition. There's lots of other kinds of medical home recognition out there as well. Sometimes a payer will come up with its own kind of medical home recognition.

Here's the relationship between a medical intervention, medical home model, and patient care. Let's say you have the pilot practices. They receive the intervention. Some practices will adopt the medical home model, however that is defined by the intervention, to varying extents. You never assume that all these practices are going to get to 100 percent of the possible score on whatever scale they're using. And there may or may not be some changes in patient care as a consequence of adopting that model.

Ideally, you also have some kind of comparison group, some kind of counterfactual to which the

intervention would not apply. Now, it's certainly possible that practices not exposed to this intervention could still adopt a medical home model. You can't assume they won't. And they might also have some changes in patient care.

Here's an example of a medical home intervention that we evaluated. This was the southeast region of the Pennsylvania Chronic Care Initiative. And it had a lot of features that were similar to other medical home interventions that were conducted over the past few years. First, in terms of inputs, there was technical assistance. And there were per-member per-month bonus payments tied to NCQA recognition levels.

In return for those bonus payments and the technical assistance, the practices were required to obtain NCQA medical home record recognition at Level 1 or higher within the first 12 months. There are three levels, so they had a low bar to get over, over the first 12 months. And they also had to participate in learning collaborative activities, and to report registry-based performance data.

We surveyed the practices about their capabilities before and after this intervention was applied. And we saw that they really did transform as intended in a lot of ways. The frequency of meetings about quality of care more than doubled. Only ten percent at baseline had a registry of high-risk patients. That went up to over 90 percent. Outreach for hemoglobin A1c testing, an important service for patients with diabetes, approximately tripled. And e-prescribing more than doubled. So there was a lot of structural transformation.

Now, did this result in changes in patient care relative to the comparison group? Unfortunately, not many. There was statistically significant improvement on one process measure of diabetes care, which was nephropathy monitoring. We did not see other measures of quality achieve statistically significant separation from the comparison group. However, there were trends, broadly speaking, for diabetes.

Taking away from this, I would say, yeah, they improved quality on diabetes processes. That seems fairly clear. There weren't any spillover effects to other quality measures. And there were no effects on utilization or cost of care that we could detect. These findings were robust to numerous sensitivity analyses, including alternative functional forms, attribution rules, and patient sub-populations. So we looked really hard.

What can we take away from this evaluation? It is possible for a medical home intervention to have limited effects on patient care over a three-year period. It's certainly possible that something happened in years four through six. We weren't able to evaluate that. We can't comment on it. Findings, however, are similar to evaluation of other early medical home interventions. At the bare minimum, it's not a sure thing. If someone does a medical intervention with these ingredients, there's no data, at least from our study and the body of literature to date, to suggest that they would achieve different results than these.

However, not all medical home pilots are alike. And implementers are refining their approaches as they go. There's lots of ongoing medical home interventions - more than 100. They have different components, including different payment models than were applied here. And all

these ongoing pilots may produce different results.

I think all this heterogeneity is a good thing, because we can use the evidence to refine medical interventions as we go, including the payment component. So, within another couple years, we should see results of another 20 to 30 pilots published, including three giant CMS pilots. They released their first-year results about a month ago. We're still waiting for the remaining results on those.

Heterogeneity creates opportunity. There are different intervention recipes in all of these. And it can lead to different outcomes. And as long as evaluations are similar in their design, and we can make sure that any differences in results we see aren't due to the differences in evaluation design, but are instead due to differences in the implementation itself - the setting, the practices they were involved in, the payment models - we can, hopefully, define which payment models seem to work best. Right now, we do not have an evidence base that identifies the best ways to improve, to reform payment in medical home interventions.

I'll point out one key thing here. Bruce did a nice study not long ago he may talk about where shared savings seems to be a more common component of medical home pilots right now. There have been no published evaluations of interventions to date that feature that payment model. So, stay tuned.

JOHN WIEGAND: Thank you. Thank you very much, Mark. Next up is Bruce Landon. He's going to be speaking to us about payment models for medical homes and ACOs.

BRUCE LANDON: OK. Good morning. And thank you for inviting me to participate in this panel. I think across the speakers today, you'll hear a lot of common themes, and maybe getting at things from different ways. One of the things I'd like to do is really spend most of my time talking about what some of this heterogeneity of medical home models looks like that Mark was speaking about. But also to start linking this to ACO models that we'll be hearing about later in the panel that are becoming more prevalent, and also was the topic of your last panel.

So, it's clear that the primary care system in the US is broken. And that's really the foundational principle of our trying to move toward a patient-centered medical home model. The current system is completely dysfunctional. But at the same time, I think there's pretty much uniform agreement that primary care in some form is good for patients and for the health care system overall.

And the goal of - as Mark described them - these PCMH initiatives is to put in place policies and incentives that are designed to achieve a high-functioning primary care system. So in other words, primary care practices are going to respond to their incentives. And, in fact, that's how we got into this mess in the first place. If we change those incentives, hopefully that will lead to behavior changes that result in delivery of better primary care.

So PCMH initiatives - these are the interventions that Mark was talking about - are generally organized by health plans, states, purchasers, or other groups. And they seek to use alternative primary care payment models to create an environment that supports the transformation of

primary care practices to a more enhanced version of primary care, as envisioned by the patient-centered medical home.

And often, these are aided by learning collaboratives, practice coaches, and data and feedback, all of which are really designed to accelerate any kind of change processes that's going to happen. The current primary care system that evolved under fee-for-service payment has evolved over decades of those types of payments. And we really can't expect it to turn on a dime if we change the payment system. So any way that we can, any method we can use to help accelerate change is probably going to be helpful towards achieving those goals.

My colleagues and I actually went and tried to understand what the diversity of some of these initiatives are. These are results from a survey that we conducted in 2013 that tried to characterize all the extant primary care or patient-centered medical home initiatives that were present throughout the country. An important caveat being, here, that these were initiatives that included some form of payment reform. Because it's our belief that you really couldn't change primary care fundamentally unless you changed how it was paid for.

And this demonstrates some of that heterogeneity that Mark was talking about. Out of 114 demonstrations that we surveyed throughout the country, a very small proportion of them were relying on the uplift of fee-for-service that Mark was talking about, which can either be additional fee-for-service codes that they could bill under for things like care coordination, or just a percentage increase in the payments for places that demonstrated some sort of medical home capability.

Also, and relatively infrequently used, was getting rid of fee-for-service altogether, and going to, really, more of a primary care capitation model, where there was really a per-member per-month payment, usually with some pay-for-performance as well. And that was only seen in a very small number of the demonstrations.

Much more commonly, we saw models where there was a traditional fee-for-service payment. And then added on top of that was a per-member per-month payment, or a per-member per-month payment plus some pay-for-performance payments, the so-called three-part model. And, of course, the question that remains - as Mark was alluding to - is, is one of these methods going to be better than the others? So not only do we need evaluations that will compare these two, sort of a null where primary care payment is unchanged, but, potentially, we want to compare them to each other.

One of the interesting things that we also found, that Mark alluded to and I'll talk about in a little more detail later, is shown here below the line, which is that almost 40 percent of the initiatives that we identified in this survey were actually starting to incorporate some sort of shared savings payment bonus plan into their payment model.

Focusing on the per-member per-month payments for a second here, we found there's a lot of heterogeneity across the different types of demonstrations. There's a mean across all the demonstration programs of about \$5 per member per month, with a range of \$3 to \$8, or interquartile range. But there was a lot of variability.

So we look down a few rows to the multi-payer initiatives. There's a higher mean level of \$7.25, but the range is also much larger, ranging from \$5 to \$24. And that really reflects a range of the different types of patients. Most of those multi-payer initiatives included Medicare as one of their payers. Patients are older, have many comorbidities and illnesses, so they're going to be getting much higher monthly payments. In contrast, when you have commercial demonstration programs that have younger, healthy, working people, many of whom have no chronic medical conditions, you'd expect it to be a lower per-member per-month to take care of them.

We also took our results and compared them to a prior study that we did back in 2009. And I just want to highlight a couple of the enormous differences over that time. First, the number of initiatives back in 2009 was just 26, and that's increased by almost fivefold to 114. And the number of patients covered under these initiatives has increased from about 5 million to over 20 million, which is getting to be a reasonably substantial proportion of our population. We can also see that many fewer of the initiatives are time-limited, meaning that these are really not seen as demonstration programs, but changes in the way of business. Finally, we see that there's more of them that are multi-payer, and that mean size of the initiatives is much larger.

And again, here, focusing on that issue of shared savings, back in 2009, none of the programs were using any shared savings incentives, whereas in 2013, we had 44 percent of them. And I think this really highlights an important issue when you're studying interventions like medical homes. So this is really something that's common to all forms of implementation science, which is that the interventions change and evolve over time.

I think what we're seeing here is that payers and those that have been designing these programs, whether from high-quality research that really evaluated programs such as the study that Mark described to you, or just their own anecdotal experiences from the programs that they've implemented, they're finding that they needed to do more.

So it's very clear that they needed to go more down the payment reform path, having higher per-member per-month payments. But they also realized that there was no way that patient-centered medical homes were going to be paying attention to overall costs of care unless they built in some explicit incentives there. And that's the direction we see going there.

Now, as you start to think about that, we can think about what the operational tools available to a PCMH are to improve care. They use multi-disciplinary teams, enhanced use of HIT and chronic disease registries for population health management. They use data to inform care management. They use online patient portals for proactive care management of acute and chronic conditions. And they focus on care transitions and care coordination.

Now, as you think about these tools, you really think about what the medical home is evolving to. It's starting to sound a lot like other organizations we've been talking about today. It's really thinking about all the places that the medical home has to interface with - your hospitals, your specialists, the insurers, the data centers, the labs, the prescription drug forms. We're seeing an evolution, really, in patient-centered medical home payment policies that really are starting to align with what we've been talking about related to accountable care organizations.

This makes us think of the ACOs and the PCMH. We should start thinking about them together, maybe. I think most people agree that in order to succeed, most ACOs will need to build upon a solid primary care foundation. Someone is going to have to manage those patients. We also can understand that attributes of enhanced primary care are fully aligned with the goals of ACOs.

Yet we also know the current ACO programs have not specifically changed payment for primary care. In fact, ACO contracts explicitly say, if you're an ACO and want to change your payment for primary care, that's fine, you can go ahead and do that. But that's not something we as a payer are going to get involved in.

This leads us to think, are there ways we can think about really integrating the PCMH into ACOs. And these are things that I would say anecdotally we're not seeing out there. But I think it's worthy of thought. It's these two distinct types of interventions have been evolving to become more and more like each other.

First of all, ACO contracts could include explicit support for enhanced primary care. These could be written into the payment contracts. They could be per-member per-month fees, or enhanced fee-for-service, or something else. ACOs themselves can invest in developing PCMH capabilities internally, whether directly through primary care or through primary care and other aspects of the ACO. And ACOs that are really more employed physician models can actually change how physician performance is measured and compensated, particularly within the primary care space.

So in conclusion, clearly PCMH payment models are evolving over time. Payments are larger. They're more divorced from typical fee-for-service payments, and including incentives based on spending utilization. More integration of risk-sharing and accountability suggests that PCMHs are becoming much more similar to ACOs, and the two models are actually starting to converge a little bit. It's clear that PCMHs will likely serve as a foundation of ACOs. But ACOs likely will need to incorporate some reformed payments to support enhanced primary care. Thank you.

KAREN GOLDMAN: Thanks, Bruce. Lisa McDonnell will now present UnitedHealthcare's perspective and presence with regard to value-based contracting, primary care, and medical homes.

LISA MCDONNELL: Thank you. Thanks very much for having me this morning.

I'm going to start with a little bit of context setting, first of all. The panelists have done a fantastic job of setting up my presentation, so I will spend less time talking about the fundamentals of patient-centered medical home and more time talking about what UnitedHealthcare is doing in this space. And I'm sure that will lead to some interesting discussion later.

First of all, we have a broad array of value-based programs that we have deployed. We have about 30 years of experience, dating back to, whether it's PacifiCare in California, Oxford in New York, MAMSI [Mid-Atlantic Medical Services] in the mid-Atlantic, legacy plans that we have acquired. And those plans, many of which had different types of payment reform in

place, and have for many years. So building off that foundation and really understanding what works well about those programs, what doesn't work so well, as we build new programs going forward is where we're largely focused.

We have three categories of programs. And folks have used different terminology here, but I think we're talking about basically the same thing. The first is that pay-for-performance area, where we're talking about rewards for our providers associated with performance against specific metrics, preferably outcome measures, and less on the process side, in terms of what we're looking for. And looking at quality and efficiency improvements in those programs.

The center category, which is condition- or service line-specific, this is where we are working with providers around taking risk on certain patient conditions or certain services such as bundled payment around a knee replacement or hip.

And then, lastly, the orange category is the population health. This is more where providers are in the patient-centered medical home or ACO or other types of arrangements. Again, many, many different terms out there over the years. But what we're talking about is providers that are looking at and taking accountability for the population of patients across the full continuum of care that those patients require.

We have programs in all of these categories right now. About \$36.8 billion in spend. I should've mentioned that we have managed Medicaid plans, managed Medicare plans, as well as commercial. That \$36.8 billion is over a foundation of about \$100 billion in medical spend. I think it's about \$105 billion in medical spend.

So just overall, 520 accountable care programs. Now, that includes medical homes. That includes ACOs. It includes some of our legacy population global capitation models in certain areas and certain products. We have about 100,000 physicians and 850 hospitals in these programs. And we estimate that that is impacting about 11 million members.

Some results from these programs you can see here on the slide. I'm sure we'll be talking about those a bit more. And those range. And not all providers are successful. Maybe that's a little bit Captain Obvious, but not all providers are successful in these programs. And we are looking at what makes providers successful? And how do we engage in more of that activity in supporting their progress? And what needs do they have to increase their opportunity for success? Because when they win, the payers win. The consumers win. And so the goal here is to actually make the change and get the transformation that we're looking for.

Value incentives - if you are paying for the right outcomes, you are more likely to get those outcomes. If you're paying for each service on a fee-for-service basis, you're going to get what you pay for. So again, a little bit of Captain Obvious. The areas that we have focused on in incentive programs have largely centered around primary care as the core of those programs. Not exclusively, but largely. And we will continue to do that, as we do think primary care and enhancing primary care services is critical to the care delivery and transformation.

The structure of our PCMH models - Bruce did a nice job talking about it a moment ago. You

have fee-for-service as the foundational element. It certainly exists here. You have a care management fee; sometimes goes by different terms. You have some sort of performance bonus or gainshare that rewards the provider on the back end for producing better outcomes. And that is the total net of what the provider might receive - or not receive, depending on their performance. I think these models are fairly self-explanatory, but certainly if there are questions, we can address those later.

Medical homes. The goal here is to really transform care delivery. And in looking at that, we took our early launches of medical homes. Some of these medical homes were just UnitedHealthcare, the one in Arizona, as an example, was partnering initially with IBM, one of our customers. And it was just UnitedHealthcare. And then, some of these others on the list were actually payer collaboratives. So more than one payer, not just United.

What we did was do a study, a propensity match study, which looked at the population that was in the medical home in those same markets, compared to the population in those same markets that was not managed by a medical home practice. And we looked at making those populations like populations. And then looked at the results over the three years of those programs. And you'll see them here.

We did see improvement in medical costs. That improvement got better over time, and got even better for the same population that was in the medical home program from beginning to end, right? Versus those that add to the program over time. We were able to reduce avoidable hospital stays, improve diabetes management, improve patient satisfaction, and increase care coordination. So I do have some results on that that are positive. But not all medical home practices in these pilots were successful. Looking at what makes a medical home successful, funding and resource support to enable the transformation is critical. We really do need to help these practices, especially the smaller practices, invest in the kinds of care management tools that they need in order to achieve success. We also need to support them with actionable data. Some of that data is retrospective, just helping them understand how they're performing on certain metrics.

But we need to provide more real-time data - patients that were admitted to a hospital, or patients that were in the emergency room - so that we can really help facilitate closing the gap - the knowledge gap, the information gap - with those practices, and allow them to take action on those patients, make sure they have visits within seven days of a discharge. They're taking their medications to the hospital before their admissions. Things along those lines. So we really do need to be proactive and support those practices.

And then the proactive patient engagement and retention that really does maximize value. As we saw over time, that cohort of patients that was in the medical home practice over the three-year period had much better results than those that ebbed and flowed out of the practice.

I was also asked to talk a bit about our oncology episode program. This has received some press recently. And \$33 million in savings. We have five practices that we worked with in multiple states across the country. And our goal here was really to help the practices improve the care rendered to cancer patients, and see what outcomes we could produce.

Instead of - many people know that there's a high margin paid on oncology drugs to oncology practices. And they rely on that revenue, for good or for bad. Rather than paying that fee - that margin, if you will - in a fee-for-service structure, it was converted to an episode payment. And in order for the practices to receive that episode payment, they had to agree to abide by certain protocols. They also had to agree to provide us with data. And in working with them, and sitting down and reviewing 64 quality metrics, how they're doing relative to the peer groups over time, and really supporting those practices.

And in our study what we were able to see what was the improvements that - I apologize - the improvements that you see here. We did see \$33 million lower cost for the patients that went through that program. And we can talk about how we measured that. We did look at the practices we chose initially. We did choose better-performing practices initially. But we neutralized for that in the study results. And we also looked at these patients relative to patients that were paid in a more traditional fee-for-service model that are like patients with similar diagnoses and similar stages of cancer. And we were also able to neutralize for the fee-for-service differences by looking at the relativity based on a Medicare reimbursement schedule.

So we were able to do some unique things in that study. We were able to drive the improvement. And that largely came in looking at the details underneath, from reduced hospital admissions, as well as reduced radiation oncology for those patients. So, just a brief overview of that program.

And I think that concludes my comments. Just, we are also doing a cancer pilot with MD Anderson that we don't have any results from at this point. We've just entered in this arrangement. Again, another innovative payment model in the cancer space. All right. I think with that -

JOHN WIEGAND: Thank you, Lisa.

LISA MCDONNELL: Sure.

JOHN WIEGAND: Next up, Michael Chernew is going to be speaking on bundled payment.

MICHAEL CHERNEW: Wonderful. Thank you. That was incredibly comprehensive what everybody's done.

I'm going to talk about bundled payment going forward. First let me start by defining it. There's a lot of words that get used a lot. Sometimes it's called episode payments, at least what I'm going to talk about. The key point is that it spans the site of care and spans time. So, for example, I typically don't consider DRGs that strong of a bundle, because they tend to be just the admission, and just in one site of care. But we could debate that. The innovation moving forward is, often, these bundles or episode payments span the site of care and span time. Some of that's just semantics.

There's an enormous number of initiatives. Every time I come to a panel like this, there's a whole slew- I'm always on the end - there's a whole slew of people that have some different version.

And then I end up listening to someone who's at a large company. And they have a slide that shows they're meeting everybody where they are, and people are a lot of places. So there's a lot going on.

These are just a few initiatives. They are not meant to be exhaustive. But there's a lot going on in Medicare. And I'll say something about that. There's a lot going on in Arkansas. I'll talk even more about that. And there's just an enormous number of private initiatives and a whole range of ways to do this. And I just listed a bunch that you can see. It doesn't really matter. All I think you need to understand is the number of organizations that are trying some version of this is just tremendous. You can look at Suzanne's scorecard to see.

In Medicare, there's the bundle payment for care improvement initiative that links payments for multiple services during one care episode. And again, even within a model, within a program, there's different models that you can choose. So in this model, there's four versions. One of the big things, particularly in Medicare, is what you do with post-acute. Post-acute gets a lot of attention. They vary in the extent to which they include the hospital, they include the post-acute, who's in one way or another.

One other thing that's important is to understand in these models what entity is keeping the residual payments when there are savings. Who's getting the money if there's savings? And, again, that varies by model and varies by the program.

I'll talk now about Arkansas, that'll give you one variant of that. But I don't think it's uncommon. Arkansas's model is a multi-payer model. It includes Blue Cross Blue Shield and Medicaid, which is the vast majority of a lot of admissions in Arkansas. Medicare's not in, although some of the Medicare models could be used in Arkansas, but they're not coordinated. There's a number of different episodes as they've defined for things like upper respiratory infections, hip and knee, congestive heart failure, pregnancy, a bunch of things.

So this is the point that I was making earlier. The way the Arkansas model works, and the way many of these models work, they define something called the principal accountable provider. That's the entity that is responsible for managing the episode of care across time and across sites. In the Arkansas model, I should say, that the principal accountable provider is the entity that keeps the savings if they have any savings and has to pay the cost if they have any extra cost. It's a two-sided risk model, so you get to keep some of the savings, and you get - I'll say more about that in a minute. You have to pay some of the costs if you go too high. And again, as everybody said, it's built on a fee-for-service chassis.

A question that is often asked is, why will all of this succeed when it hasn't in the past? And how will all of this succeed when you have fee-for-service underneath it? So two things. Thing number one. The fee-for-service system you can move to if you don't like any of these models is a lot worse than the fee-for-service system that you used to get before Medicare as the SGR [Sustainable Growth Rate]. We'll see what happens there. Medicare's new payment rates that are set up under the Affordable Care Act. And so the alternative looks worse. That's going to push people.

And then the way they might be able to succeed when they're built on a fee-for-service chassis all has to do with the organizational stuff that lays on top of the world. So even though there still might be fee-for-service being paid, in almost all these organizations - which was clear from the previous presentations - there's a managerial layer.

At Michigan, we used to train that managerial layer. People would go out, and they would go work for these organizations that are responsible for understanding that even though money might be coming in fee-for-service as a sort of an accounting exercise, or, as Bruce would say, a way to keep score, part of that organization understands if they use too much care, if they respond straight to those fee-for-service incentives, they're going to have to give a lot back.

It's that managerial level that has to manage it. And in Arkansas, that managerial level would reside with the principal accountable provider. Because they're the ones who are at risk if things don't work well.

The basic way it works is patients seek care the way they always would. Often, we don't talk enough on panels like this about patient engagement, and how that fits in. And so I won't. But the patients don't often know what's going on here. They just go about seeking care because their knee hurts, or whatever happens to happen. Because it turns out you have a lot of body parts, and all of them can go bad. The providers then submit their claims the way they always would. The payers then reimburse the providers on a fee-for-service basis. Again, the way they always would.

But the issue is then there's a review process that goes in, essentially after the fact, and sees when there's a triggering event. Puts people into an episode. They get assigned to principal accountable provider. And then you compute savings or losses. And the principal accountable provider, or the organization they work with - because often it's not just Doctor Zhivago. It's a big organization - they have to square up at the end of the day.

The way it works in Arkansas is they set the thresholds. If you're in the red - the red is always bad, which this is illustrative - you have to pay some money back. If you're in the green, you get some money. If you're in the middle, no harm no foul. They cap the risk-sharing. There's all kinds of issues about how much risk to push down to the providers and done in a bunch of different ways. This is loosely the way Arkansas does it.

To give you some idea of how this would work for colonoscopy, there's a triggering event, which is actually the colonoscopy. I should have picked something more pleasant. Anyway, sorry. People don't want to come to a conference and think about colonoscopies.

Anyhow, once that event happens, they go back seven days for the beginning of the episode. They go forward 30 days for the end. They add everything up. They adjust for risk. In the end, they look at where you are for that, compared to a bunch of other principal accountable providers. And at the end of the day, they will then square up what people have to pay.

There's an enormous number of private initiatives. Not all of them are bundled payments. There's a trivial amount of money flowing through them. And I think this actually a number from

Suzanne. If it's not, I'm sorry for attributing it to you. But in any case, there's a number of reasons why these bundled payments have had a hard time getting off the ground, although there are a number of successful ones. I'll say something about that in a minute. But to name a few, there's a Prometheus model. There's an IHA bundled model, which was in California. There's just a lot of these.

And there's been some analysis. Actually, I'm thrilled to be here, because I like coming to DC. I like seeing you all. The person, if you actually have a question about bundled payments, I would talk to Peter Hussey, who is at RAND. Mark can give you - He really is what I would consider the national expert on this. But that said, I'm still going to keep talking.

In the Prometheus model, they had a really hard time keeping it moving. Three years into the initiative, none of the sites had made bundled payments or executed a new payment contract. I might not have that right now. This is coming from some of Peter's work. IHA, they had a number of places. Three of six dropped out. I was on a panel with Peter earlier this month. And he was talking about how they, I think, 35 cases made it through the model in various ways. That's not necessarily saying that all of them will have a problem. But there's a number of challenges in getting these things moving, I'll talk more about them in a minute.

But let me say, if you do a literature review of them, in fact, when they do get off the ground, they do tend to work. Spending's in decline. I gave a number of ten percent as an upper bound to savings. I think that's consistent with what Lisa presented. Oops. There's a reduction in utilization in a variety of ways.

People have been very worried about quality. Even the other work - I think Dana's going to present some work on global payment - you don't see big quality detriments. You see basically no effect on quality. You can find some where you think they improve. Oftentimes, these are coupled with pay-for-performance, which I brushed through very quickly. Arkansas, almost all of these have some pay-for-performance component. And you tend to see quality, at least on the things they're paying for, do a bit better or stay the same.

Let me spend the last time talking a little bit about challenges. One of the big challenges is when you try to do this beyond a particular very targeted area - so I think oncology is a great place to do this. It's something that you know when the person has cancer. You know how to measure out the episode of care.

But if you wanted to do this to be the foundation of your payment reform, then you have to deal with a whole bunch of issues of multiple episodes going on, particularly when a lot of people have chronic illness. So someone has diabetes, someone has heart disease. Some of the things, like a heart attack, might be a relation to the way you cared for diabetes. How they all coordinate together is a nontrivial issue.

And how you manage different principal accountable providers challenges. The number of episodes may increase. Unlike global models, you worry. You give an episode for, say, some hips. People get a lot more hips. Or not. There's a lot of work to be done there. Because they're spanning providers, like all of these models, you have to worry about coordination across

providers.

Another thing, which I just don't have enough time to emphasize as much as I would like, is the way you update or the way you set these payment rates. It's going to matter an enormous amount. And if you look at rates of spending increase across providers, they're incredibly variable. Ten percent of episodes account for 82 percent of spending growth. If we were really to move away from fee-for-service, almost all of these rely on some fee-for-service comparison to set what the rates are. But if you don't have fee-for-service, how you set the rates, how you do the updating, becomes a little bit of a challenge. And you can do it, because these are built on a fee-for-service chassis. But it is a challenge to see how the rates are set - that's going to matter enormously - and how they're updated over time.

So I had 30 seconds. Now I'm done two seconds early. And I talked very quickly. That's my lead-in to Dana.

KAREN GOLDMAN: I agree with that. Thank you very much, Mike. Now, Dana Safran will make the last presentation. And maybe we can get her up on the screen. Great. Her presentation will be improving health care quality while slowing spending growth, the alternative quality contract.

MICHAEL CHERNEW: I'll bet Dana would rather have people see her slides.

DANA SAFRAN: I was just about to say I think it's better if you can see my slides than if you can see me. Maybe you can see me during the discussion, perhaps. But yeah, that's great.

KAREN GOLDMAN: OK.

DANA SAFRAN: Good. Thank you. And I so appreciate the opportunity to be here, and be participating remotely. So thank you for that.

What I'll cover in the next 10 minutes or so are really three topics related to the alternative quality contract. First is to provide some context for why it was, in 2007, that Blue Cross Blue Shield of Massachusetts set out to develop this payment model. Then, I'll talk a bit about what the model looks like, and what the results have been. And then, finally, close with some views of what I believe to be some of the remaining challenges. Many of those have been mentioned over the course of the morning, including in that ACO panel as well in this one.

In 2007, February of 2007, Blue Cross Blue Shield really began to think about the development of an alternative payment model. And the reason for that really was that we were in the early months of implementing our now very well-known state health care coverage reform law. And we knew that cost would be next.

And what you see on that slide there is that medical cost growth had been, for years, looking back from 2007 in the middle to high double digits. And contrast that with the green line there, which is rate of growth in the economy overall, and the red line, which is the rate of growth in workers' earnings. And we understood that with large numbers of individuals for the first time about to be

out there buying insurance for themselves, not receiving it through an employer or public program, they would come face-to-face with these very hard to explain and justify rates of rise in health care spending. And they would, appropriately, ask some very hard questions about why is health care so expensive? And why does it increase so much more than everything else I buy?

And so the Alternative Quality Contract model, or AQC, was our effort to develop a new model of payment that could achieve what we called our twin goals. And that was to significantly improve quality and outcomes at the same time that we would significantly slow the rate of medical spending growth.

On the next slide, you can see a summary of how the model works. And what I'll highlight for you are the five ways that it's distinctive from our traditional fee-for-service contract. The first is that a provider organization that comes into an AQC contract agrees to be accountable for a patient population - their total cost of care, the quality and outcomes of care for that population, regardless of where the care is provided, or whether that provider organization is providing it.

Just to underscore how different that task is from the task of a provider in a fee-for-service contract with us, in a fee-for-service contract, the provider is accountable for the patient in front of them for as long as that encounter lasts, whether it's an office visit or a hospital stay. And then the accountability is done until the patient returns. So accountability for a population across time and space really is quite a different proposition, and leads to some of the quite remarkable transformation that we see happening in care.

Second important feature of the model that's distinctive is it's a long contract. It's five years. Our typical provider contracts are one to three years. But we understood that to take seriously and really invest in the kind of system changes needed to succeed in a model where the incentives are so dramatically different would take time. And so a five-year time horizon, both providers and Blue Cross agreed, would be a good one - enough time to really have both parties feel like there was a reason to begin to do the hard work of changing care processes.

The third distinctive feature about the contract model is that payment is based on a global budget. That is what is reflected by the dotted line going across the middle of the diagram. Very importantly, the global budget is built based on each individual provider's historic rate of spending for its patient population. So it's not based on the network average, and what spending is on average. It's not based on what we wish spending could be if some of the waste were taken out. It's based on, for you as a provider, what has your spending for your very specific patient population been.

And now there's the incentive to try to find where there has been waste in that spending, and take that waste out and share in the savings. This is a two-sided risk model; there are symmetrical upside and downside risks. A provider who overspends their budget pays Blue Cross back a share of the deficit. A provider who finds savings is paid a share of those savings.

Fourth thing about the model that's distinctive is that the way inflation is handled is that it's negotiated upfront before the contract starts for each of the five years, and designed to grow at a much lower rate than those double digits that you saw on the previous slide. And that in fact, by

the end of the five years, it's designed so that inflation looks approximately like general inflation, or general economic growth.

And then finally, the fifth feature that's very different is that there is a significant earning potential based on a broad set of quality and outcome measures. That's what's indicated by the green here. And it's been interesting the way the pay-for-performance literature and discussions like today's have evolved. In many ways, you might think of this as paying for performance, because, in fact, there are performance measures, and we are paying on them. However, they bear no resemblance to the small types of programs that we had before we started this one, both with a small number of measures and very small dollars at play.

In fact, in this model, there are a total of 64 measures, roughly evenly split between hospital and the ambulatory setting. It includes measures of clinical process, clinical outcomes, and patient care experience. And the total earning potential in the original cohorts of AQC providers starting 2009, and then the 2010 cohort, was an opportunity to earn up to an additional ten percent on the global budget, which was very significant earning potential.

Let me now turn to some of the results. The next slide shows the kind of take up that we have seen by providers in our market of our AQC model. And notably, what we have now in the market is close to 90 percent of our providers contracted under the AQC.

On the next slide is summarized some of the quality results. And specifically, these are ambulatory quality measures. On the left side, a composite comprised of measures that address process of care for patients with chronic illness. In the middle, a set of measures that comprise acute and preventive care for children. And on the right side, the results of health outcome, clinical outcome measures, for adult patients with chronic illness.

The blue line, in every case, is the trend of improvement over time for the original 2009 AQC cohort. That's the group for whom we have the longest track record of data to look how they're changing over time. And it includes some data points before the AQC. You'll see 2007 and 2008 there.

The orange line is national data. So how is national performance changing on these metrics over time? And you can see the story, the comparison anyway, between what was happening in the AQC and what was happening nationally is somewhat different in the three areas, but that in all three, you see significant improvements year by year by year in the AQC.

The piece that I would highlight as really most important is the part on the right-hand side. In 2007 and 2008, as we started to begin talking to providers about this contract, I was still relatively fresh out of a decade and a half as an academic doing quality measure development, and thought it was pretty audacious that we would ask providers to take accountability for not just process and patient experience, but outcomes.

I thought that they would say, sure, these are clinically important measures, but you must be kidding if you think that I'll accept accountability for what happens when my patient is out living their life. You know I can't. I can prescribe the medicines. I can't be there to make sure they take

them. I can instruct them about the best way to manage their diet and exercise. But I'm not there overseeing that.

Instead, actually, the early adopters of the AQC asked us to make those measures count more. They said that getting to our highest levels of performance on these outcome measures would really represent a very important achievement for population health. And didn't we agree? Which we did.

And so the improvement that you see there, I think, I would just underscore as one of the remarkable achievements of this contract model. And that you see that number in 2012 of 74 percent. What that represents is for the whole 2009 cohort of AQC groups, which is about 25 percent of our network, and all of the adults with chronic illness for which we have outcome measures that we are studying, 74 percent of the population is under good control.

KAREN GOLDMAN: Dana?

DANA SAFRAN: So this is on one measure. This is net one group. This isn't for one disease. And it's really, truly, a remarkable achievement, and, in particular, contrasted with the national data, where we see nothing's really moving. And I think Adams showed us some data about the struggles to move these kinds of outcome measures in a significant way.

The next slide, really, Michael should be presenting, because it represents results from a study that he's led over a number of years to evaluate in a very formal way the AQC using a control group that's rigorously defined. The most recent results published in the New England Journal in October of last year, showed that savings over time by the AQC groups have gained momentum. In year one, AQC groups demonstrated savings relative to the control group of about two percent. Then, in year two, about three percent. Then, in year three, about eight percent, and then about ten percent.

And this, really, is very consistent with what we see on the ground as we work closely with provider organizations that have come into this model. In the early years, there were some quick, easy wins for how to achieve savings off the budget, mostly having to do with moving care to lower-cost settings for things that patients would not be upset about, wouldn't disrupt clinical relationships, such as moving labs and imaging and basic procedures to a lower-cost setting.

But we've seen over time that once you take it upon yourself as an organization that part of your job is to be a careful steward of health care resources, you start to find that there are quite a lot of ways to identify waste in the system, and to start to get at some of that waste. So the fact is that this formal study finding the momentum gaining over time of finding and being able to extract that waste is consistent with what we see as we work with the groups.

On the next slide -

KAREN GOLDMAN: Dana? Dana?

DANA SAFRAN: if you -

KAREN GOLDMAN: Dana?

DANA SAFRAN: then put together - Sorry?

KAREN GOLDMAN: I just wanted to let you know, we do want you to finish going through the slides, but you are already a few minutes over time.

DANA SAFRAN: Oh, sorry. I'll take just one minute on this slide.

KAREN GOLDMAN: I think this is an important slide, so go ahead.

DANA SAFRAN: OK. I apologize for going over.

One of the important questions raised by the formal evaluation has been, great to see the medical trends coming down. But what about those bonus payments that Blue Cross pays? What about the all-in total cost of care? What does that look like under the AQC? That question is answered by the slide. And you can see the total cost trend, including the shared savings and bonus payments for quality included. And you can see that over time, that came down quite dramatically. In year three, cutting in half where trends had been before the AQC. And by year four, 2012, well below our state benchmark, which represents state economic growth of 3.6 percent, actually hitting growth of 1.2 percent.

Two final quick things. The next slide, really, I won't speak to. I hope you'll have copies of the slides afterwards. This is just to point out that one of the reasons we think for the AQC success is an AQC support model, where we work very closely with every single organization that comes into the contract from the minute the contract is signed until the time the next one is due in a whole variety of ways to support their success. It has changed the relationship between the plan and our provider network, but also contributed to the significant improvements in quality outcomes and cost.

On the final slide, which I won't take time to go through, I was trying to tee up on the right side there what I think some of the remaining challenges are. And maybe we'll come to some of these in the discussion. But they do include some of the issues that got covered this morning, including around how do we address the hospital part of the delivery system, and helping hospitals to transform, given a revenue model that's really built on, as I think one of the speakers this morning called it, heads in beds? How do we really make the kinds of remaining changes in the delivery system that have begun, but that have to continue. So let me stop there. Thanks very much.

KAREN GOLDMAN: Well, thank you, Dana, and to all the panelists for their excellent presentations. And so we'll now begin the discussion period. And we'll have questions from various sources. John, do you want to ask . . .

JOHN WIEGAND: Sure, sure. We'd like to see whether any of our panelists would like to follow up on any points that have already been made, either with comments or questions. If you want to speak, remember, turn your card long way high. And we will work through as many of these as possible. Sure.

MICHAEL CHERNEW: I have a question for Lisa, actually.

LISA MCDONNELL: Yeah.

MICHAEL CHERNEW: To what extent are the groups moving down or up or along the continuum of the things that you did? To what extent are the programs that they have joined remain static? And how does that change as the organizations and the delivery system changes? One practice gets bought by another practice - do they move to a different point on your continuum of programs? Do they drop out of what they were in?

LISA MCDONNELL: Yeah. No, it's a great question. I would say we have two buckets of programs. One is the legacy programs that have been in place for many, many years. Let's just use as an example capitation in California, with a lot of the groups. And then some of the programs are newer. A lot of the programs that are newer, providers first are coming largely into the pay-for-performance category. And our goal is to work with them in that area, and then move them up the continuum.

For example, we have a hospital pay-for-performance program, and it focuses on all-cause readmission, for example. It's one of the measures. If a hospital system approaches us and says, we really want to do total cost of care shared savings, and they have not even accepted yet the accountable reimbursement model for hospitals that puts them at risk for performance on readmission, they're not going to be successful in an ACO, so we won't pursue that with them. We do actually require that they demonstrate some results in some of our programs in that performance-based model before they can earn to go to the next level.

But within the accountable care programs, we are seeing providers move up the continuum, I think, in a couple of ways. One is our expectation that we set with them at the outset is that those models move to upside downside within three to four years of that contract going into effect. That's actually something we write into our contracts. That's something that we expect from them. And we are seeing, definitely, in the Medicare Advantage space moving to upside downside. And then we have moved some commercial ACO contracts into upside downside already. Those were some of our earliest ACO arrangements.

So our goal is to move them to more of that upside downside. And in some cases, full global risk is also included in those programs.

JOHN WIEGAND: Suzanne?

SUZANNE DELBANCO: I have a question for the people who spoke about medical homes, and then also, Dana, for you. One of the questions is over time, are the savings going to continue? And so in the medical home study, there weren't any savings. And so the question is, why not? What do you think the reasons were why not?

And Dana, in your case, it's really impressive to see the amount of savings increase over time. And you pointed out over time there's a chance to figure out more opportunities, and so that

might help explain it. But also, I've heard people argue that the early years of ACO, that's relatively easy, because there's a lot of low-hanging fruit. It's much harder later when you stop dealing with the high utilizers and you start dealing with the rest of the population. How are you going to make sure that you're beating the trend, or beating the cost target? I'd just love to hear some more forward-thinking analysis about what kinds of things we think we might see, and why.

MARK FRIEDBERG: I can take a first shot at that. Our study on its own can't answer the question of why didn't the savings materialize. We'd need a comparison group where some savings did materialize. And then we could compare those two, and figure it out that way. But we did talk with conveners throughout the study. And they changed the formula as they implemented in different regions in Pennsylvania.

And based on their initial observations about the southeast region, even before our results were known, first thing they did was they didn't emphasize strongly the achievement of medical home recognition upfront. So they didn't tie the payments as tightly to that in later regions. They thought that activity may have distracted the practices from doing other things that they thought would be more meaningful for patient care, like engaging in learning sessions.

And there's one other big difference, which was there were no utilization data fed back to the practices by the participating health plans in that region, which is actually very common in medical home pilots. That was addressed in later regions. And I think that's a key point that Dana just made, was the AQC support component, one of the large ones, is that feedback of the data to the practices to help them understand who is in the hospital now, or recently? And where should they be focusing their energies?

JOHN WIEGAND: Bruce, did you want to speak to that, also?

BRUCE LANDON: I would also add that the initial payment models really have nothing to do with total cost of care. We saw in our study that's changing over time. And I think part of that is a recognition that you need to put that issue front and center for medical homes, to actually pay attention to it. And also, back to an issue Mark brought up, which is getting away from paying for transformation.

My own belief is I think a lot of the reasons we have certification and recognition of medical homes is really to make the payers feel better. But I actually don't think, if you're not changing the underlying incentives, there's not really much difference in the care delivery in those practices versus others. It's really fundamentally changing the incentives that they're facing to get them to do different things.

LISA MCDONNELL: Yeah. This is Lisa. I would agree with the statements that have preceded. I think the other piece is we should not isolate this to what we get out of the providers from improving the care for the patient population. I think the next iteration is - so absolutely maximizing that is critical. I don't want to minimize that. But we also have to align incentives for consumers.

We have to figure out a way to have providers competing on the basis of quality and cost with one another - not just rewarding them for the same population that they're seeing today, but also looking at ways of steering patients to providers that have demonstrated better value. And that's through consumer incentives, benefit plan designs, that actually create that alignment. And until we get there, I don't know that we're going to see as much of the movement as we expect from what we're doing today. So it's the combination, in my mind.

KAREN GOLDMAN: Maybe, Adams, if you want to go next? And then we want to have one audience question that follows up on what -

SUZANNE DELBANCO: Can we have Dana answer the question, too?

DANA SAFRAN: Did you want me to answer Suzanne's question for me?

KAREN GOLDMAN: Sure.

DANA SAFRAN: OK. So, Suzanne, I too have heard the concern that, gee, after the first couple of years that we've plucked the low-hanging fruit, how will we find additional savings? And in our experience, if you think about some of the evidence, for example, in Institute of Medicine reports that say up to 30 percent of what we do in health care isn't providing value, you start to get the picture that we can go more than three, four, five years before we have to worry about where we're going to find the shared savings next year.

In fact, the early years of moving care to lower-cost settings is a piece of it, as I've said. The next piece is really rationalizing utilization, both in ways of preventing avoidable uses of expensive care, like keeping patients out of the hospital by better caring for chronic conditions, by preventing those conditions from worsening, preventing readmissions. But also by rationalizing the enormous variability that we see within conditions for the way those conditions get treated.

We have a line of analysis called practice pattern variation analysis that shows, really, for any condition we look at, for any specialty that we look at care of that condition, there's dramatic differences, from 0 to 100, of physicians' tendency to use various expense interventions compared to the alternative. And so by sharing that data, we've started organizations using it to try to understand why the variation occurs, and drive more best practice. But if you think about that kind of analysis across every condition, every specialty, we've got a long way to go. The waste is so marbled throughout the system. We have a long way to go before we're scraping the bottom of the barrel to find things for shared savings, I would say.

KAREN GOLDMAN: Thank you.

ADAMS DUDLEY: I started by saying it's about how people feel. And I think I want to come back to that, because I think you actually heard examples about that. Dana's goals, her actual goals, were suggested by her clinical partners. And then the support system that she described at the end - I think you're right, Mark - was very important in making them feel like Blue Cross Blue Shield of Massachusetts is a partner.

And so we've got these shared goals and we're working together. And that's analogous to things that were happening in New York, and, I think, also to the programs that Lisa was talking about, where you sat down with the oncologists and talked to them in a very clinically sophisticated way about what is cancer care? What are the elements of cost? And gave them the information that they needed to try and deal with that.

I say that as a prologue to we're now all sitting here in an FTC building. And so I think that part of the reason we all came here was to say, what is the role of government in nudging all of this to happen? And we've got really smart people on the panel. So I'd love to hear them say that, or respond to that. And Lisa and Dana are examples of private organizations doing it on their own. Is there any way that government could help you?

The fine line that the FTC and government as a whole has to walk is, hey, this costs so much that we can't just let the market do whatever the heck it wants, because it's killing us. And we need people to talk to each other about very important details of things. But at the same time, we can't let the providers totally set the agenda. And we can't let monopolistic behavior and that sort of thing happen. And we're not traditionally allowed to let them talk prices and a lot of other things they're not allowed to talk about. What is the right place for government? And all of this is probably a pretty complex thing. I'd love to hear what other people think.

DANA SAFRAN: I'd like to offer something as a response to that, Adams. It's an issue I hoped would come up in this particular meeting. Massachusetts as a state passed a law in 2012. And I referenced it in that total cost of care slide. That created accountability for every payer and every provider in the state that we not be allowed to have cost growth that exceeded the growth in the state's economy. And that number is pegged at 3.6 percent last year and this year. And a provider or payer who goes beyond that is called on the carpet to explain, why did you exceed that number? And what are you going to do about it to get it back under control?

I can't overstate how much that has changed the environment. So in an environment where we do see, not just because of the AQC, but lots of factors that are driving organizations to get larger and to consolidate, that law and that expectation by the government, I think, is one of the best policy levers that we could hope for, because it really helps to set the stage at a negotiating table for what kind of rate increases can you ultimately expect? That's one really important thing, I think, that we can do.

MICHAEL CHERNEW: I was also going to take a stab at answering that question, if I may, briefly. So a few things. The first thing is, make sure when you do various things that fee-for-service doesn't become overly generous and look like a more attractive thing. And so the most relevant thing in that regard right now has to do with replacement, hopefully, of the Sustainable Growth Rate. It's very important how they replace the Sustainable Growth Rate. The same can loosely be true in Medicaid programs.

The second thing I would say is putting in models for organizations that want to be all-in. We've done some work on spillovers. That came out in the last panel. You want to make sure that an organization's going to try and transform to become more efficient, that that organization can do that even for its federal payers. And I think you heard there's a lot of options for that now. I think

they've done a reasonably good job.

The coordination could be better. In Arkansas, for example, Medicare's not in. The reason is they have their own bundled payment model they don't match with the Arkansas bundles. I think the world would be better if they were a little more flexible at helping some of those things match.

The third, I would say, is standard setting type activities, quality measures, things of that nature. I think that would be useful.

The fourth, and last, and, maybe, the most relevant, is less about how government can nudge this along, and more about how government can make sure if we nudge it along, things don't go horribly wrong. And that does have to do with thinking about ways they're going to regulate prices or deal with monopoly power or other things that might happen.

So the concern would be we push everybody along into big organizations that can accept risk in a variety of ways. But now, at least in the private sector, we don't have a good way to manage the prices that are negotiated. So Lisa might be able to speak to what happens, how they deal with consolidation in the provider networks in the markets where they are, but that, I think, is a big issue, and something that government can do to at least help moderate a potential downside of movement along this trajectory.

ADAMS DUDLEY: Lisa, would you like to respond, and maybe bring in how competition could be useful in this respect?

LISA MCDONNELL: Sure. And thank you for introducing competition. So I agree. I particularly want to emphasize the standardized measures. I think the industry getting to some standardized, meaningful outcome measures, in particular, would really help, I think, both on the payer side - whether public or private - as well as providers. Because right now, I think we probably drive providers crazy with the multitude of metrics that are out there. And that's a challenge, because it's causing them to perhaps perform well via one set of measures and not well on another because a payer differentiates those metrics. So that's something.

And then on the issue of provider aggregation, certainly this is something that all private payers experience - and public, for that matter. I liked Dana's comments. I also think that competition is where we need to get to. We need to create a competitive foundation on the basis of quality and cost outcomes and patient satisfaction, and let providers compete on that basis, not on the basis of their brand alone, or how big they are from a market share perspective. And in large part, it's the latter that we have today.

And we need to really improve and step up our ability to measure in transparency - which I'm sure Suzanne will support - transparency around that for purchasers of care so that they understand how those providers compare, and can use that information to design benefits and incentives for consumers to make better choices in their purchasing that, I think, will drive accountability within the system that has not existed, historically.

KAREN GOLDMAN: Two related questions to that. One in regard to transparency is, should the

payment models themselves be transparent to patients? And what are the pros and cons of that? And I will just mention one other question that has come up, and that is, what size and scale is necessary for providers to accept greater risk? So maybe, Lisa, if you want to respond to transparency, and others jump in. And then we can move on to the risk question.

LISA MCDONNELL: Sure. I certainly am not opposed to that being transparent to consumers or purchasers. I think what's interesting is I get in a lot of discussions about pay for value, and how we need more information about that shared, and what have you. Well, there are certain payment models in place today that are not transparent to consumers and to payers. So it's really trying to figure out, I think, which are the payment models that should be transparent.

I don't have an issue with all of them being transparent in terms of which ones providers are under or contracted it as part of, as long as we can come up with a way of explaining that to a consumer or purchaser that they can understand. And that will probably be the biggest challenge in that space. But, not opposed to it. I don't know. Dana may have some comments on that.

JOHN WIEGAND: Dana?

DANA SAFRAN: Not a lot to add on that. I think it's quite complex. Because, I think, if we consider the idea of transparency for members about what the payment model looks like to the organization, it's actually not telling the individual patient what we're hoping to tell them. Because what I think we're hoping for them to understand is for any individual clinician they see, what are the incentives that clinician has? And one of the challenges that we really haven't gotten to address is that these models that we're talking about, for the most part, change the incentives for the organization, set up to the organization to structure incentives in a way that it feels will motivate clinicians down on the front lines.

And so it's not entirely clear to me that giving patients information about what the models look like and how the system is paid really helps the consumer understand what their clinicians' incentives are. For example, most organizations today are still struggling to find their way out of an RBRVS [Resource-Based Relative Value Scale] productivity-based compensation model for physicians. So the patient might actually be quite misled by thinking that the organization has one set of incentives, where the doctor they're seeing actually has quite a difference set.

KAREN GOLDMAN: Mark?

MARK FRIEDBERG: Just on that point about transparency. These payment models can be exceedingly complex. And however it gets explained - I'm not saying we shouldn't be sharing this information with patients and other parties who might have an interest here - but, a lot of attention needs to be paid to exactly how it gets explained in a way that's understandable.

Just to illustrate the point, on my clinical side, I work at Partners Healthcare in Massachusetts at Brigham Women's Hospital. I have no idea how the Brigham gets paid. In fact, I don't even understand my own compensation. Every monthly paycheck is a little bit of a surprise to me.

BRUCE LANDON: Very high.

MARK FRIEDBERG: Yes. Evidently, very well. But otherwise it's all a random amount.

KAREN GOLDMAN: One more follow-up to the transparency issue. One program that is going to be offered by CMS this year is payment for Chronic Care Management services. And patients are going to know about this, because they're going to be asked whether a particular doctor will be their primary care provider. And so they will know that there is a particular payment program going on.

BRUCE LANDON: What's the question, though?

KAREN GOLDMAN: So really, what are the pros and cons of that kind of a program, the Chronic Care Management?

BRUCE LANDON: And so I've written some about this. I think from a larger-picture perspective, as I mentioned before, the primary care system is in disarray. And this is really the first substantive national-based program that really has the potential to redirect significant resources into the primary care system that's really broadly applicable. It's not part of a small demonstration program, and the like.

And my own view is, actually, that I wish we could go farther down the road of actually having patients identify a point of accountability, i.e., a primary care physician, within the Medicare program. And agreeing to this model actually doesn't stipulate that, because, in fact, specialists can receive that payment, and others can ask for it. But I actually think it's maybe taking a step in that direction, which will be useful as we think about the evolution of the ACO program. Certainly would be a lot easier to do that program if we didn't have all these issues related to accountability, for instance.

And no one's been willing to say, for Medicare patients, you have to select a PCP, even if there's no ramifications to it. And this is at least an enhanced way of identifying one. I think the big challenge and problem with that program is that it's a Part B program, so there is the 20 percent copayment that goes along with the \$40 per-member per-month potential payment. That equals about \$100 per year. And patients have to consent to paying that extra fee when they probably felt like they were getting the same thing beforehand. And I think how that evolves in the market is going to be interesting to see.

KAREN GOLDMAN: Thank you. Lisa.

LISA MCDONNELL: I was just going to add - and Dana referred to it a little bit earlier - but there's a risk, in that if you make that information transparent, that it will be misunderstood. For example, just because a provider is in a medical home program or in an ACO program does not mean they've actually achieved performance that is better. And so you don't want to have the knowers in the industry misconstrue that because they're in that type of model, they're actually going to receive better care in those programs. They may or may not.

And so really where I think we need to focus is the transparency around the outcomes. What has

the provider produced in terms of patient care that differentiates them relative to others in the community? And that's the kind of information that consumers need, in my view. And that we need to focus on that, not so much how they're paid, as the differentiator.

KAREN GOLDMAN: So good quality reporting.

ADAMS DUDLEY: Yeah, and in terms of the impact of transparency on consumer choices in general, not specifically on payment issues, we really haven't seen much effect. Consumers just don't take up that information. That's even when you're providing them with information that, I suspect, they'll care about more, like do you live or die after the surgery? Or other clinical outcomes. They don't use that information. I think it's very unlikely that they're going to be willing to dig very deeply into has my provider achieved medical homeness? Or some of the other things that we're measuring.

So as a target of transparency about payment, I don't think we should expect much from consumers. Is there general agreement on that in the panel?

JOHN WIEGAND: Yeah. And we don't -

DANA SAFRAN: The other thing I would - sorry. May I? I would add into that conversation is that we have to recognize that we have, still, fundamentally a culture that believes that more is better when it comes to health care, and at the same time really is frustrated by a delivery system that feels fragmented.

And so finding a way to help patients understand what all of this trying to accomplish, and why that's helpful, and not something to be afraid of is actually a very, very challenging task, because it gets at some very core cultural expectations around what health care is, but also some of the deep frustrations and fears of people have about a system that hasn't been working in the way that they wish it would. So I think it's an opportunity, but it's a very complicated one.

BRUCE LANDON: And also just to add - I think Lisa touched on this a little bit. But I agree with Adams pretty much wholeheartedly that simple transparency alone doesn't actually achieve anything. In fact, if you're trying to do transparency for changing behavior, the effect of someone seeing a price might be actually to go to the higher-priced person, not the lower-priced person if, in fact, they don't face any consequences. And I think this really speaks to a need, as we move forward, for better alignment for patients consumers with the health care system. And this might be through benefit design changes.

This might also be the way that we can tackle some of the price differentials that provider systems with market power have been able to extract from payers if, in fact, patients feel some of the consequences of some of those prices, but don't see the benefits. So I think there's a lot of work that we need to do in aligning incentives for patients.

We've done a little bit with tiered networks and narrow networks, and that can be expanded via variable co-payments and whatnot to fit into an ACO model or a PCMH model, or whatnot.

KAREN GOLDMAN: Right. Thank you for all those interesting points.

Another question that's come up, as I mentioned, is what is the size or scale that's necessary for providers to accept greater risk in the models with two-sided risk?

MARK FRIEDBERG: Can I say a little bit about that?

KAREN GOLDMAN: We have a lot of cards.

DANA SAFRAN: I can say that we've modeled out that actuarially, to compute actuarially sound budgets that are stable and have as little noise as possible and as little chance for results that aren't real in terms of savings or deficits, a provider needs about 10,000 of our members. I don't know how generalizable that kind of sample size expectation is for a Medicare population. It's probably a safe number in most commercial populations.

MICHAEL CHERNEW: I think the word provider is a lot more complicated in this context. So even though Dana mentioned a certain size, they have many smaller providers that are part of the group. The group taking the risk isn't necessarily the underlying individual provider in a variety of ways. And there's a bunch of ways to mitigate what that risk is, and how much of it gets transferred down.

And so, for example, in Arkansas's bundled payment, I can't remember their exact patient size constraints, but they can manage it a little bit better because they have an episode, as opposed to global. So childbirth, you know exactly where that was.

But there's other ways to manage that by having a larger group being responsible, partnering with individual groups underneath. So I think that you can move risk and management down to a lower level in a variety of ways by using tools other than the way we talk about it now, which is you're a three-person provider group, so you can't ever take risk. I don't think that's true. You can be part of a bigger organization. I think Dana would talk about groups they have where they've done that. And that's how they'd manage it.

KAREN GOLDMAN: How does that risk get divided up between the various practices?

MICHAEL CHERNEW: Well, again, I would defer to Dana on this. But if the AQC is a bunch of different groups. And the groups are bigger. The groups are bigger. But there's underlying providers that feed into that group. And the ACO has the discretion about how much risk to push down or not push down to the various groups. A lot of it has to do with this organization within the firm of how - again, I'll refer to Bruce's keeping score notion - how you keep score of those incentives underneath.

But they do not all have to get pushed down to - I said Dr. Zhivago, no one understood, so Dr. Hibbert. That might be more relevant to folks. In any case, you don't have to push all that risk down to Dr. Hibbert. You can instead have that risk reside at higher levels of the organizations, depending on what you want to do.

KAREN GOLDMAN: Thank you.

DANA SAFRAN: Just as the part where Michael's saying, I think that's exactly right, and what we've seen in our provider organizations. Just to paint a picture, most AQC groups are comprised largely of individual practices that have five or so physicians aggregated up to an entity that is taking on the risk and working with their clinicians throughout their organization to manage that overall risk and to manage producing good quality and good outcomes.

In fact, since the launch of the AQC in 2009, just to put some numbers on this, our primary care physician network, which is about 6,000 or 6,500, there used to be about 2,000 primary care physicians who were both small practice - five doctors or fewer, or even a solo practice - and unaffiliated with anything larger. There are now 600 primary care physicians who are solo or small practice and unaffiliated. The rest, they haven't changed in a bricks and mortar sense where or how they practice, but they're part of an organization that is helping them to be accountable for cost and quality.

KAREN GOLDMAN: I do think we're starting to run out of time. I just want to mention that. But I do want to - no, no. Please put your card back up. I would like to go through the answers, the audience willing, of the three. And then at that point we'll probably break for lunch.

BRUCE LANDON: Sure. The question was what size is needed. And I think the answer came from the perspective of the payer. But I actually think we need to think about the provider systems and sizes that may be the right construct. It's really alignment across your different payer sources. So I think back in the '90s, maybe, one among many other problems with capitation 1.0 at that time was a lot of organizations dipped their little pinkie toe in and had, maybe, one small contract that was capitation, against an ocean of fee-for-service and traditional contracts. And it's really hard to succeed in that setting.

But even places like Massachusetts, where we have the AQC, we have five pioneer ACOs. We have our other major payers that are adopting similar ACO-like contracts. And an organization like where I work, which is Beth Israel Deaconess, even though we have risk contracts with all those payers, if you look at, actually, the business coming in the door seeing our physicians every day and going in our hospital every day, maybe 25 percent of them are under our risk contracts, if that.

That means that 75 percent of them are still traditional fee-for-service. And the hospital's not getting paid unless they admit those patients. The doctors aren't getting paid unless they see them. So even in a place where we have more alignment than we've really, practically, ever seen, the alignment is still terrible to really see organizations be willing to undertake wholesale organizational and care delivery system change.

MARK FRIEDBERG: And one other point on this idea of the minimum population. The thresholds commonly used - 5,000 or 10,000 patients, depending on which payer you're dealing with in a shared savings or global capitation contract. We got very interested in this at RAND in the context of patient-centered medical homes that have nowhere near that many patients and a

lot of small practices, yet are still participating in shared savings contracts. And we simulated this out.

We had a paper in AJMC - that's the American Journal of Managed Care - about 18 months ago, where we looked at how much in an asymmetric contract, let's say, where you share savings but no penalties with a primary care practice, what's the payer going to lose, on average, just due to statistical noise? That's a calculable number. You can use financial instruments like call options, where you can do the same thing with a stock price, where you have no control over random fluctuations from day to day, but if you don't want to expose yourself to loss, you can buy something called a call option. You can do the same exact thing in shared savings contracts. It's a funny thing to wrap your head around.

But two things came out of these simulations. The first was the contract design has a huge impact on what the minimum sample size is for patients. If you're in this naked one-sided shared savings contract with no minimum thresholds, no maximum savings payouts, yeah, you need to pay a pretty high option price to make that a fair bargain for the health plan. But if you start to put these provisions in place, and start to introduce just a little bit of downside risk, that option price falls a lot.

But the other thing, which we didn't anticipate, which I think is really important here, is if you believe that the shared savings model will work, so you think that it's actually going to produce some true savings of modest amounts, like one percent or two percent, those option prices no longer need to be charged. You can go right into these models without a lot of provisions in there with relatively modest sample sizes, and everybody gets a fair bargain.

KAREN GOLDMAN: Adams?

ADAMS DUDLEY: And I would just add - so Mark's absolutely right that the structure of the contract, what you put at risk, so total cost of care in the AQC, cost of an orthopedic bundle or an oncology bundle, which are much more constrained, in some of the bundled contracts. But separate from the clinical issues and the financial issues are really important enabling characteristics of the system around it.

There was no system large enough, or no sample size of patients large enough, under some 1990s capitation contracts that would have worked, because the information about how your patients was doing just wasn't getting back to you. You had no chance. It wouldn't have mattered if you'd had all 7 billion of us on the planet. If you can't get the information and the other support systems that you have offered in various programs now, you couldn't do better.

Our program in New York City dealt with teeny little practices. if you went to them before the whole thing started, they were a little door down a dark hallway where you felt like you were going into a closet. And all the main practice was taken up with crammed paper files. And yet they still, with the right support, those folks actually managed to change their care and improve care in important and significant ways. But that was because we gave them a lot of help along the way.

And so quite possibly the most important slide to answer the question that you asked is the one Dana jumped over about what's the support that we offer those people? And again, it came back to making it feel like it was fair. In the '90s, a lot of people felt like the capitation contracts were unfair, not because of the amount, but because of the lack of information. You put me responsible for drug costs. Even when it was just drug caps. You made me responsible for drug caps, and then you tell me six months after the measurement period is over what our utilization was. How on Earth can I possibly succeed in that?

So I think for any risk contract - and not all health plans do this - if you want to ask people to take on responsibility, you've got to have a bunch of tools there. Or you can improve their willingness to accept that risk, if you have a bunch of tools there that will help them manage it. Learning collaboratives, data coming quickly, et cetera.

KAREN GOLDMAN: Well, thank you very much. As I said, we're out of time now. And I'm sure everybody wants to get on schedule, because we have really only a pretty short lunch break. Thanks again to our excellent panelists, the presentations, and discussion. And we will reconvene at 2:00 PM for the Trends in Provider Consolidation panel.

[APPLAUSE]

TRENDS IN PROVIDER CONSOLIDATION

Moderators:

- **Patrick M. Kuhlmann, Attorney, DOJ, Antitrust Division, Legal Policy Section**
- **Danica Noble, Attorney, FTC, Northwest Regional Office, Seattle**

Panelists:

- **Lawton Robert Burns, PhD, MBA, Director, Wharton Center for Health Management and Economics, University of Pennsylvania**
- **Leemore Dafny, PhD, Director of Health Enterprise Management, Kellogg School of Management, Northwestern University**
- **Martin Gaynor, PhD, E.J. Barone Professor of Economics and Health Policy, Carnegie Mellon University**
- **Kenneth Kizer, MD, MPH, Director, Institute for Population Health Improvement, University of California Davis Health System**
- **James Landman, JD, PhD, Director, Healthcare Finance Policy, Perspectives and Analysis, Healthcare Financial Management Association**
- **Joe Miller, General Counsel, America's Health Insurance Plans**

DANICA NOBLE: Over the past 10 years, federal and state enforcers have brought a number of horizontal hospital merger challenges. The competitive effects in those cases have been widely noted and remarked upon, and are not the subject of this panel.

In *Saint Luke's*, a hospital system acquired a physician group, but the FTC's theory was still conventional and horizontal. Namely, the loss of competition between the acquired physician group and the physicians already employed by the hospital. Theories of this nature are also not the topics of this panel.

But, recent scholarship suggests that when hospitals acquire physician groups there may be anticompetitive effects that are in addition to, or exist even in the absence of, horizontal overlap. There's also new research on the effects of hospital mergers in different geographies. And there has also been discussion and scholarship about alternative health consolidation, namely that between physicians and insurers, or hospitals and insurers. And so it is hospital / physician group, geographically disparate hospital mergers, and provider / payer [consolidations] that are the subject of this panel.

My name is Danica Noble and I'm from the FTC's office in Seattle. Thank you for coming.

PAT KUHLMANN: And I'm Pat Kuhlmann. I'm going to be co-moderating the program today. I'm an attorney with the Antitrust Division of Department of Justice. And I have the great pleasure of introducing our stellar cast this afternoon. Parenthetically, I'll remind everyone that we have complete bios for all of our panelists in the materials that are available at the table just outside.

So starting to my immediate left, we have Lawton Robert Burns who's the Director at the Wharton Center for Health Management and Economics at the University of Pennsylvania.

Then we have Kenneth Kizer who's the Director for the Institute of Population Health Improvement at the University of California-Davis Health System.

Joining us from Chicago via video conference, we have Leemore Dafny who is the Director of the Health Enterprise Management at the Kellogg School of Management at Northwestern University.

Then we have James Landman who is the Director for Health Care Finance Policy, Perspectives, and Analysis at the Health Care Financial Management Association.

Next to him, we have Joe Miller who's the General Counsel for America's Health Insurance Plans. And finally, we have Martin Gaynor who is the E.J. Barone Professor of Economics and Health Policy at Carnegie Mellon University.

So our first topic is going to be physician and hospital consolidation, and Rob Burns is going to start us off by giving an overview of this topic.

LAWTON BURNS: Wonderful. Great to be here. It's a topic I've been looking at since 1985 and just beginning to understand it. And it's humbling to try to summarize your life's work in 15 minutes, but I'm going to try and do all that.

Looking at physician hospital consolidation, just a slide to illustrate what we're talking about here. Hospitals have input markets, output markets, and they're integrating in both directions. Physicians being one set of input markets for them. So this is an issue of vertical linkages in the health care value chain.

The topics I'm going to cover are the types of consolidations that are out there: the extent to which they've taken place; what's driving them; and my take on what the impact of all these consolidations have been on quality, cost, price, profitability, and the ever-elusive alignment between hospitals and doctors. And then we'll look at some alternative forms of collaboration. And all this is just meant to tee up the subsequent discussions and presentations. So, I'm doing a sort of base overview of what's going on.

So one take on the types of consolidations out there. Three types of integration are often identified. Hospitals and doctors can integrate using non-economic vehicles. They can also integrate using economic vehicles. And then thirdly, we have clinical integration vehicles that link them all up.

I'm just going to briefly illustrate what these are. The important thing here is that these are not mutually exclusive. These are typically overlapping. And so you basically have to add all of these things up, and they basically summarize what position hospital consolidation or physician hospital integration really is. And this is basically a multi-factorial engagement that's taking

place between the hospitals and the doctors.

So on the non-economic side, these are all the different things that hospitals do to try to partner with their physicians, make their physicians lives easier, things on the administrative side, acquisition of technology that physicians want, setting up physician liaisons and things like this. Lots of behavioral science stuff here.

Then when you get to the economic integration slide, it's this bewildering array, as you go from left to right, of low inclusion to high exclusion activities. And these are all the activities where money's changing hands, typically from the hospitals to the physicians. And I'm not even going to go through all of these things. But some of the things we were talking about this morning about bundled payment, pay for performance, they're on this slide. As well as the employment, relationships are more on the right side of this chart.

But, all these things are taking place all at the same time. And then most recently, after the 1990s when those provider consolidations were challenged on the lack of clinical integration they had developed, we have a whole new set of activities where hospitals and doctors can consolidate or integrate their activities. We call them clinical integration.

Here again [on the slide], is a nice laundry list of the new entrant or the new kid on the block is in the top of the right-hand column, the clinically integrated networks. You heard some discussion about those earlier.

So that's one take on what physician-hospital consolidation means. Non-economic integration, economic integration going all the way to employment, and then trying to integrate their clinical activities.

A second type of consolidation, and this slide got a little messed up, are how do you deal with physicians as an entity. I typically call this make, buy, or a lie.

If you want to buy physician services on the market, you basically have a medical staff where physicians have privileges. They're not employed by the hospital. They don't have any economic relationship with the hospital, and it's just an arm's length transaction. At the other extreme is where the hospital acquires and/or salaries the physician. That's what I call the "make." You're basically making physician services in a hospital, and that's using the hierarchy to coordinate those relationships. And then in between are all the alliances like the PHOs and the MSOs, and the IPAs of the 1990s. So that's just a totally different way to think about how hospitals and doctors are integrated.

As far as the extent of consolidation goes, let me deal first with the alliance models. The alliance models were quite popular in the 1990s. The PHOs, the MSOs, the IPAs. They topped out in 1996. They've been on the decline ever since. They were basically dismal failures in the 1990s for many of the reasons that were talked about in the prior panel. Didn't have any risk contracting infrastructure, no way to manage lives. Plus, they had few lives to manage anyway.

Some people think they're going to make a comeback under the Affordable Care Act because

they could serve as a chassis for the accountable care organizations. The most recent data from 2013 suggests they're still on the wane, so we'll have to wait and see.

As far as the hierarchy models or the employment models, there's a lot of speculation here. We know that more hospitals now employ physicians. And we know that more physicians are now employed, but we just don't know how many. And so there are lots of WAGs out there- that's what I call wild ass guess. So lots of WAGs out there on how many physicians are employed. In fact, I had an investment banker in my office yesterday telling me what he thought it was. There's a lot of groupthink out there. A lot of people just repeating what they heard or what everybody else has said. And what I tell people is when you encounter statistics like this you have to get out your BS detector. I actually brought one with me if you want to see it after the panel. It comes in very handy at Wharton with MBAs who on the first day of class use words like synergy, platform, and scale. This thing just goes off automatically.

Anyway, what does the data actually show? Well, if you're looking for the percentage of physicians who are actually employed by hospitals, one of the WAGs out there is from Credit Suisse. They say it's 2/3 of all physicians. The Wall Street Journal just published an article in October of last year. They also said that 2/3 of physicians were employed. But then when you actually do the data analysis, which I have, you get much lower bound estimates. The lowest bound is from the American Hospital Association, which after all, surveys hospitals and asked them how many of their doctors employed. You find out it's about 1/7 of all physicians are employed. SK&A is a data house from Cegedim Dendrite, a pharmaceutical marketing firm. At most, it's a quarter of doctors. So there's a real disconnect between what everybody thinks is going on and what I think is actually going on.

And then when you look at the percentage of medical groups who are employed by hospitals, we have two estimates out there. They're both pretty close. It's less than 20 percent. And of course, these percentages vary a lot by specialty. But this whole thing about employment has been overblown. I think it's just scaring the heck out of people thinking everybody's sold their practice; I better sell my practice too.

Now, what's driving all this? Hopefully you can see this [slide]. I have on the left column the goals that hospitals espouse when they consolidate with physicians. And on the right the goals that the physicians espouse when they consolidate with hospitals. I've tried to line them up. And so the green ones are where there's general alignment between the two sides, at least they're roughly comparable. And everything else is they're disparate reasons.

And so what I take away from this is several conclusions. First, there are a lot of reasons for why doctors and hospitals are consolidating with one another, and there's no one set of things. Secondly, the reasons don't overlap that much, not as much as you might think, which suggests to me there's going to be a lot of disappointments out there when hospitals employ physicians just because they're not on the same page. The third thing is, and this is even more troubling, and I'll let Leemore and Marty weigh in on this, very few of these rationales actually line up with economic thinking on why you do vertical integration in the first place. So it's not clear to me that's what's driving this is what's theoretically grounded.

As far as the evidence base for physician-hospital consolidation, the evidence base is pretty much on the economic integration side. And I've just summarized it here in one slide, in terms of various outcomes.

The most recent evidence suggests that physician-hospital integration increases hospital costs. It's more expensive. And it's not surprising to me- I've been studying these things for a long time - hospitals lose money on every primary care physician they acquire. It used to be \$100,000 a year per doctor, now it's over \$200,000 a year per doctor.

Quality, mixed impact: there [are] some studies that say it rises, some say it falls.

Prices. The most recent evidence suggests that when hospitals acquire physicians they raise prices. I think the Idaho case [*St. Luke's*] sort of lends some confirmation of that. Hospital profitability: hospitals lose money when they integrate with physicians because they're losing so much money on their primary care physicians.

Little impact so far on the IT linkages. Little impact on clinical integration. And little or no impact on alignment between these two parties.

And the reason I know this, we've actually gone out and surveyed the physicians in multiple systems over time just basically to find out from the doctors what- do you feel more closely aligned in terms of what you're doing and what the hospital's trying to do? And the doctors basically shrug their shoulders. I mean they don't really know.

One finding that seems to be favorable, and that was fortunately confirmed in the prior panels, that there seems to be some positive evidence for the effects of bundled payment. I look at bundled payment differently than the prior panel, however. What I'm looking at is where hospitals and doctors are getting bundled payment. So the CABG [Geisinger's coronary artery bypass graft program] demonstration of the 1990s, the ACE demonstration [CMS' Bundled Payment ACE Demonstration] that was launched in the late 2009. Those things seem to have some positive effect on costs and quality.

Overall, however, there are few consistent effects of integration. And if I had to say there were any consistent effects, they'd be in the wrong direction. So alternative models of collaboration.

Other firms can integrate with and employ physicians beyond hospitals. First off, physicians can do it themselves. In fact, physicians are the number one employer of physicians. It's not hospitals. It's doctors in group practice.

Secondly, insurance companies are getting into the business of employing physicians and partnering with them. We're going to cover that at the end of today's panel. And then there are equity-backed firms. The old physician practice management or PPM firms of the 1990s are making a comeback, led by firms like MEDNAX, which is in the anesthesia space. So a lot of those things that came around the '90s are coming back around again today.

And there are also lots of other types of vertical integration that we could talk about: hospitals and ambulatory surgery centers; hospitals and long term care; hospitals and retail clinics; pharmacies and retail clinics; [and] PBMs and pharmacies. The list goes on. There's very little research on any of these things.

So I'll stop here and pass the baton.

KENNETH KIZER: Thank you. I was asked to make comments along be the same lines, as well as to provide, perhaps, some reflections on the *St. Luke's* case, particularly with regard to efficiencies.

I would note that I've been at least thinking about these issues for about as long as Dr. Burns has, although I've been looking more through the lens of a health system manager, beginning in the early 1980s when we tried to implement managed care in the largest Medicaid program in the country. And later trying to reform the VA health care system and sitting on the boards of a number of hospital and managed care plans, and a variety of other things.

So I think we actually come to pretty much the same place, although from somewhat different perspectives. How to make these work?

So, I would concur with essentially everything that's been said. Certainly, the drive to consolidate providers is largely driven by this need to achieve clinical integration because of the new value-based payment models, the need to improve quality, the need for population health management, and a variety of other things. But certainly, those are the three that I would put at the top of the list. And I would echo what has been said, also, that while there are many claims that the independent physician is an endangered species, I'm not sure that the facts actually support that. Indeed, I would posit that independent physicians are going to be around for quite a while to come. The nature of those practices and how they're organized, it's going to vary in different areas for a variety of reasons.

Certainly, there's been lots of rhetoric about the efficiencies and improvements and other benefits that accrue from consolidation. But, overall, the evidence is pretty underwhelming, that supports these various assertions. Perhaps there's some, as was said, mixed evidence about the quality of care, but from a service satisfaction, or health outcomes, or cost of care, the data are not at all convincing.

And I think perhaps part of the problem and the nuance that may not have been given, as much attention is that clinical integration is about integrating clinical care and patient care. It's not about organizations. And that distinction is not trivial.

Just saying a little bit about this further, there's a religious belief almost that integrated delivery systems produce integrated patient care. But, unfortunately, the evidence does not necessarily support that. And the two terms, integrated patient care and integrated delivery systems certainly are not synonymous, nor is financial integration and clinical integration synonymous either.

Indeed, if we push back and say what exactly is an integrated delivery system, things get a little

murky. There simply is not a standard definition of what that means, and it's generally taken to mean some sort of organizational structure in which there are varying degrees of administrative or non-economic, economic, or financial, and/or clinical integration. But, they come in different sizes, shapes, and forms.

And I think there is significant evidence that integrated delivery systems do not necessarily produce integrated care, with perhaps the two best examples being the VA health care system in the early 1990s, before the reforms later in that decade, in which they were totally administratively and financially integrated, but were absolutely not clinically integrated. And much the same applies today in the Department of Defense, or at least in the Department of Defense centering around two health systems, the TRICARE and then the military treatment facilities. But, you couldn't find a system in which there is more command and control hierarchy, administrative and financial integration than in the military treatment facilities. But they are notable, and the DOD is trying to address the fact, that they also are not clinically integrated.

And I think what comes out of this, and there's actually a modest literature that supports this, that what's important for achieving clinical integration are a number of core functionalities, and not the structure or the form in which the pieces are put together. And indeed, if we were to distill down that literature, there are seven to nine, to perhaps a few more of these core functionalities- I think that seven, perhaps, captures it- this notion of having a common vision for how health care delivery should be provided. And that that vision is widely shared and understood and has very clear clinical objectives and goals. And that there's both a patient-centric focus and the population health focus, which historically neither have been strengths of American health care. Things have gotten a bit better from a patient-centric perspective in the last ten years, but most systems are still trying to find their way into population health management.

Second is just having some critical information management tools, such as electronic health, records health information exchanges, data analytics to support population health. Health care is one of the most information intense industries ever conceived. Yet historically, it has done a pretty poor job of what it does with either analyzing that information, or once it's analyzed then applying it in some sort of systematic way.

Policies and procedures for coordinating care across time and then space, and all the other players that are involved. Team-based care, methods of accountability, including especially a clinical performance management system that actually both monitors, tracks, feeds back, and again, something is done with the findings of that performance management system. Strong clinical leadership is absolutely imperative, and engagement of front providers is part of that. And then having some way of shared financial risks and rewards. Shared governance is perhaps the last thing. If those characteristics or functionalities are present, it's much less clear that the organizational structure or form matters.

So perhaps the last point in this regard is just that health care systems by and large have done a pretty lousy job of engaging front line clinicians and what they do, notwithstanding that the basic business of health care is taking care of patients. And these are just a couple things that underscore this point. The notion, some of this has led many people to conclude that well, if we employ the doctors, they will a priori become more engaged. However, the evidence shows

that employed docs are not necessarily engaged, and conversely, independent docs are not necessarily not engaged. And if one actually focuses on those six or seven things that really engage front line practitioners- autonomy, mastery, purpose, simplifying their lives- and this isn't the forum to go into those. But, there are several things that are pretty well known that if you actually focus on those things you will get a pretty engaged physician workforce.

So let me to turn to, in the last few minutes, to part of what I was asked to comment on, which was the *St. Luke's* case. The facts of the case and the issues there, I'm assuming have been discussed, and they've certainly been discussed in the media and other forms, so I'm not going to go into it to them.

There are a lot of takeaways from this case, a lot of takeaways that don't necessarily go to efficiencies. And just to highlight a few of these, mundane things like one should be careful about what they put in writing, because it may come back and be part of the evidence. Things like use of the Herfindahl-Hirschman Index is valued, and used, and those calculations are going to continue to be given weight. The thing and this may not directly derive from the court's decisions, but as an observer of what happened here, one of the things that I found particularly striking, at least based on reviewing much of the information, was the apparent paucity of board involvement in the deliberations about this.

So let me- I'm getting the time slides. Let me move forward. There are four or five lessons, I think, that particularly derive from this case regarding efficiencies.

The first, and the one I would put at the top of the list, is that claims or assertions that improved efficiencies, improved quality are going to drive from the merger have to be more than aspirational or speculative. First, again, one of the notable things that was missing in this case, there was no baseline data. So any postulation of what, actually, the improvements were, were based against an unknown baseline.

The evidence of improvements has to be able to withstand scrutiny. A number of claims were made in this case that, on closer inspection, quickly fell apart. And indeed, the organization backed away from those when it became apparent how little evidence they were based upon, or how poor that was. Those efficiencies or the improved functioning also has to be clearly linked to the consolidation or the acquisition. And perhaps the fourth point that probably should have been there, listed as well, is that those efficiencies have to be part of a strategic plan that actually is aimed at achieving those. They have to be linked to some sort of deliberative process as to how they accrued. You can't- it didn't just happen. They have to be part of the consolidation strategy.

A second lesson here is simply that employment's not required for providers or practitioners to gain access to electronic health records or population health management tools. Again, one of the claims in the case was that they had to be employed to gain access to these tools. And this kind of flies in the face of the fact that most physician practices already use these tools to some degree and have access to them in other ways as well.

Perhaps a third lesson with regard to efficiencies that was made in this case, and candidly, I was

somewhat surprised, was the assertion that a core number of primary care physicians is necessary to provide integrated care. The problem with this assertion was simply it's not supported by any facts or evidence, and the court concurred with that.

And lastly, the notion that- well, the court opined, indeed, I think one of the lessons is the employment of physicians is simply not necessary to align incentives, to transition to the value-based payment methods. Indeed, this has been discussed already. The evidence doesn't support that. There are alternative methods that can achieve these means to achieve clinical integration as well.

With that, I stop. Thank you.

PAT KUHLMANN: Great. Thank you. Those presentations nicely set the table for some discussion, and we'll invite all our panelists to jump in on any topics.

But I thought maybe one way to start off would be Rob, in his presentation, surveyed some of the factors that are driving hospital and physician consolidation. I thought it would be interesting to get some industry perspectives on what's driving this type of consolidation. So, I want to see if maybe Joe or Jim has anything they'd like to add on that topic.

JOE MILLER: Sure. Get one of the mics to work. Can you hear me? Good. So, on the idea of the vertical integration hospitals and doctors, a couple of thoughts. I think the FCC and DOJ are sponsoring this conference because at some points it's going to inform some enforcement decisions, on top of being just generally interesting. And one thing I'd encourage is the importance to pay attention to the Medicare payment rules for a couple reasons. One, I think there's an opportunity for competition advocacy. I think those who set the rules in CMS don't always have competition sorts of concerns top of mind. It's actually gaining a little traction.

There's a bill- it's not in legislative language. It's being discussed now in the Energy and Commerce Committee, 21st Century Cures, that this is a concept that CMS HHS Secretary should consult with the Federal Trade Commission when thinking about these sorts of things. I think that's very useful.

A lot of what you hear about the reasons for some of these transactions have to do with revenue maximization and not efficiency. And so there might be a lot of good reasons to do it, but they're not the typical reasons that you hear in other sorts of transactions, in other industries about cost savings efficiencies or the ability to maximize output- something of that sort. There's a lot of complicated reasons having to do with the regulatory backdrop that are important. But, I think that's very important.

There's a couple of examples that are popular. We heard one on the last panel from the person from United about how they pay for oncology as an episode of care because of the incentives provided by reimbursement over the drugs used to treat cancer. Some of that is driven by, if you're employed by a hospital- I don't understand how this works – but I take it to be true that if you're an oncologist employed by a hospital, the reimbursement for the oncology drugs is higher than if you're an independent practitioner. So you can understand why that's driving an

acquisition from hospitals to oncology practices, not to do with the fact that a hospital or if a hospital's a better site of care for oncology treatment. But now the fact that under current payment rules, driven by Medicare and picked up by private payers in a lot of instances, are really influenced to a significant degree by things other than efficiency.

JAMES LANDMAN: HMFA has been working for about the past five on something we call the Value Project. And we recently released report on physician and engagement alignment strategies as part of that project. And opened with a quote we heard from a medical group management executive, which is "What's wrong with medicine today? You can't make money seeing patients."

Now, is that true? It's a great attention-grabbing quote, right? Is that true? Well, there are- it actually really varies by specialty. So following on Joe's comments. Some of the Medicare payment policies have created some incentives that actually are pushing for certain specialties' employment.

A great example is cardiologists. In 2009, the Medicare payment rules for cardiologists in private practice changed. So their payments were reduced on a certain number of tests that made up about 30 percent the typical cardiologist revenue. Over the course of 2007 to 2012, so this payment thing came in early in this span, the American College of Cardiologists estimates that the number of employed cardiologists tripled, and the percentage of private practices fell from 59 percent to 36 percent. So probably a cause of relation there.

But as I said, there are big differences by specialties. So if you look at some data from the American Medical Association- this is a 2012 report for the American Medical Association- looking at single specialty groups, they found that 45 percent of internal medicine had some form of hospital ownership. But less than eight percent of radiology or anesthesiology groups had some form of hospital ownership. So really wide divergence across specialties.

Now, flipping over on the hospital side, what do some of these changes mean? So let's say we've had an independent cardiology practice that we've been very involved with over this and been important stream of referrals for us. They come under financial pressure. They essentially indicate their intention to be acquired or to seek employment. You can let them go out on the market or you can try to preserve that market share by defensively acquiring or employing that hospital practice.

Another interesting thing that came up on the provider network panel yesterday, this is a recent example on a site visit we were doing on the Value Project. A hospital had contracted for emergency physicians with a national provider of emergency care services. That group decided to go out-of-network with the dominant payer in that market. And so the health system very quickly responded by terminating the relationship with the contracted emergency physician group, and employing emergency physicians that could offer the community in-network access to emergency care. So if the health system was in-network for most of the patients, they wouldn't come in network to the emergency room, and then gets a surprise of an out-of-network bill for the actual emergency physician care. So, there's a variety of reasons and incentives that are in our current markets that are driving some of these employment decisions from both the physician and the hospital side.

And then big picture, getting into Dr. Emanuel's comments from yesterday morning, the framing comments, where we're seeing some profound shifts in the market. One of the big questions is what are we going to? Are we going to some sort of population health management system? And what will that look like? Well, there's general agreement that population health management will really depend on the management of primary care. And if you look at the data, a survey of our members in hospital and health system settings, there's a huge interest in expansion of primary care services. Now, that does not have to be done by employment. But a huge interest in expansion of primary care services, especially among the larger hospitals and systems that are probably a little better positioned to start thinking about that transition.

So there's a whole lot of stuff going on, both in terms of current market conditions, and in terms of what is being anticipated as future movements that are driving these decisions.

PAT KUHLMANN: Thanks. This might be a good opportunity to bring in a couple more of our economists on the panel. Maybe Marty or Leemore might want to weigh in on what economic theory can teach us about the potential competitive harms and benefits of hospital physician consolidation.

MARTIN GAYNOR: Yeah. Sure, and I apologize for jumping ahead of Leemore. I'll let her go in a sec.

So let me say a little something about the benefits of integration, or what antitrust folks call efficiencies. There are a number of ways these can be achieved. But, one of the main ways in a situation like this is if integration facilitates investment or actions by the firms- in this case, a physician practices and hospitals- in things that are mutually beneficial, and they're really sort of specific to the relationship. So that being a part might have weaker incentives for those kinds of things. And for example, some of the things that were discussed, like IT, coordinated care, things like that are examples of that. So one could imagine potentials for this, but it's also important to point out that economics as that you don't necessarily need integration via acquisition or merger to do that. You can do as via contracting.

Francine Lafontaine who's the director of BE at the FTC, and is here in the audience, has done an awful lot of work on these sorts of things in general. So it's possible to do these both via integration and via contracting- an arm's length relationship which maintains the independence of the firm.

The other thing to point out is that, I think, as Rob and Ken have made abundantly clear, the evidence for these efficiencies just isn't there. It seems like there's some potential. And a lot of the industry and policy analysts have sort of drunk what I'd call the integration Kool-Aid, as if you're a hospital and you're a physician practice and you shall integrate as the 614th commandment and everything else is just commentary on that. But the fact is that not only is the evidence for that weak, a lot of the evidence seems to run the other way. And there are a few anecdotes here and there, like Intermountain Health Care does really well. That may or may not be the case. But one example does not constitute an evidence base.

So I think this is something where what seems to be the common wisdom just really is not supported by the facts. It doesn't mean it won't happen at some point in time. But again, what we've heard I think drives home the fact that this is something that takes a lot of work. You don't simply buy up a bunch of physician practices and overnight you've achieved population health coordinated care, what have you.

So on the competitive harms side, like always, these things don't have to be harmful, but they can. And there are a couple different ways this can happen. One is simply a horizontal effect of vertical integration. So if there are, say, two large hospital systems in town, and, say, a bunch of physician practices- 20, 50, 100- and they're all acquired by the two hospital systems, now you have two large physician practices, instead of, say, 20 that you had previously. And so that integration can reduce competition solely in the market for physician services.

In addition, of course there can be a vertical aspect of these things. They don't have to harm competition, but they can. You could imagine that if one hospital, say, acquires the only oncology practice in town, or the really well-known, high-quality oncology practice, and it's hard for other oncology practices to get in and start in a place like that, it gives them a real competitive advantage. It reduces competition between them and the other system and enhances their bargaining power. And can result in higher prices. So there are ways in which these things can also have vertical impact as well.

The evidence base here, as Rob said, it is not large. But the recent evidence, and it's really only two papers that I know of, point in the direction of positive associations between hospital ownership of physician practices, and spending per patient, and price per patient. So that's not the full evidence base we'd like, but it certainly does give one pause.

LEEMORE DAFNY: OK. This is Leemore here. Marty, could you give me a thumb up if you can hear me? All right. OK.

So I was just going to elaborate a tiny bit on some of the things that Marty said, and then just make one additional point.

And the elaboration pertains to the two economic arguments for vertical integration, which would be relationship-specific investments that are facilitated by integration assets, be it financially, or through some other vehicle. And the ability to what an economist would call internalized externalities and what a layperson would call realize spillover effect within an organization.

And I would just give an example here - a hospital that is doing joint replacement may build a relationship with a particular chain of rehab facilities or skilled nursing facilities. And they might invest together in a relationship, in common protocols, in electronic health record in order to ensure that a patient is cared for appropriately and doesn't bounce back to the hospital and doesn't require costly post-acute care that could be avoidable. And it would be a motive, as Patrick and Danica asked, a motive for integration, which is not the same thing as financial integration. We're talking about clinical integration, which could be achieved in a variety of ways. And the argument for spillover effect where there's a vehicle for compensating different

providers that are part of an organization caring for a patient is pretty similar.

The additional point I wanted to make had to do with the strategic elements that I believe is driving some of these acquisitions. There are a number of hospital systems out there who may not wish to acquire physicians. They've listened to Rob Burns and they know this is not likely to be good business, at least narrowly construed. But, they're concerned about the option. And if rivals are acquiring these physician practices, then when they decide they might need to acquire some in order to ensure referrals, what they'll be left with are the lemons. And so you could see how there would be this effect where in a marketplace, more and more physicians will be acquired so that you don't get left at the dance without a partner.

DANICA NOBLE: OK, thank you. And if there may be some more issues, we will address them after we go through our next two topics. And so we're actually going to come back to Leemore and listen to her talk about cross-market consolidation. And this topic overlaps with the first topic, and so there are going to be some crossover in themes and comments, but I'm looking forward to hearing your presentation.

LEEMORE DAFNY: OK, terrific. Thanks. I've got the slides in front of me, and I'll indicate when they should be advanced. Hopefully you have them as well.

And I apologize. I'm likely to slip into lecture mode. That's the reason I'm coming at you from Chicago. I'm doing a lot of lecturing all week.

And so the subject right now is going to be the effects of cross-market combinations, theory and evidence. Next slide, please.

As Danica said at the beginning of this panel, there's been a lot of research on standard horizontal mergers, of combinations in the same market where rivals are competing for patients consuming the same end service.

And the theory and empirics on that are pretty well-established, and enforcement is really focused on that. But my subject is not that. And part of the reason we're talking about it is that there have been an increasing number of cross-market mergers in recent years. And I have some examples up here.

Cross-geographic market combinations. There's a 43 hospital system in Texas that was formed in 2013. A community health and health management associates, 206 hospitals in 29 states recently closed.

There's Tenet and Vanguard, a lot of other combinations like that. I've also put up cross-provider combinations. In the cases that I listed, these are also spanning multiple markets, but they needn't.

And an example would be DaVita, the large for-profit dialysis chain, and Health Care Partners, the largest health care practice chains. Next slide, please.

But I'm an economist, of course, and anecdotal examples won't do if I can possibly get some data. And I did hire quite a large number of research assistants this summer to clean up some data from the American Hospital Association.

The system ID, which some of you are aware, has some issues. And to merge that along with information on affiliations from the market intelligence firm, Irving Levin Associates. And when I talk about some recent research, I'm going to be referring to these data later.

What this chart shows you is the number of hospitals and along with that, the system size to which the hospital belongs. What you can see from that is first of all, it's most common still in the US to be an independent hospital.

But between '98 and 2012, there was a big reduction in that. And of course, a concomitant increase in system size, with the biggest increase occurring in systems of 21 or more. So these are larger systems that span multiple markets, hence the cross-market merger theme. Next slide, please.

And that doesn't quite tell you about the horizontal overlap. So this slide, I believe, does. What it does is it takes the 528 unique transactions among general acute care hospitals that we've identified from the Irving Levin data, and it counts each of them once. And in the bar that is marked same CBSA, so just under 50 percent of the transactions.

What that means is that the target firm and the acquiring firm each have a hospital that is located in the same core-based statistical area, which is metropolitan statistical areas- we're familiar with that I think- as well as micropolitan statistical areas as defined by the Census Bureau. So populations of 10,000 to 50,000.

And most hospital markets, certainly for antitrust purposes, are defined more narrowly than that. So you should think of this really as an upper bound of the share of transactions that are horizontal.

The next bar gives you the share of transactions where the target and the acquiring system both have hospitals in the same state, but none in the same CBSA. And you can see that's more than 1/3 of transactions. And out of state is as low as that 15 percent.

So really quite a lot of consolidations in the hospital sector that are not traditionally horizontal. Next slide, please.

So what? That's an interesting phenomenon. Why are the FTC and DOJ interested in this? Well, there's evidence that has come out, anecdotal and systematic, suggesting that these mergers are followed by price increases.

And I think anecdotal is perhaps not a fair way to characterize what I've listed under the leading example here, which is a community tracking study. Because that study was funded by the Robert Wood Johnson Foundation- many of you are familiar with it- involves seven site visits to 12 metro areas with extensive interviews of various individuals and organizations involved in

delivering health care in all the community.

So it's a longitudinal study, and as systematic as such evidence can possibly be. And the most recent installment of a study, the last one, is a theme that we will pick up on in just a couple of slides when I talk to you about some work that I'm doing.

And let me read that for you. That numerous participants in contract negotiations between health plans and hospitals noted that provider leverage depends on how big the hospital or hospital system is. And how much of an insurer's patient volume it generates.

So you can see that is not about the end user market. This is really about the purchaser of hospital services that bundle these services- the insurer market. And that's going to be a big player in the research that I'll describe.

As for systematic evidence, I'll just mention the most recent study. A set of studies by some researchers at Clemson, and another- Kevin Pflum- I can't remember his affiliation now.

And what they find is that when an independent hospital is acquired by a system that has no presence within 45 miles of that independent hospital, that prices increase on average 14 percent to 18 percent. Next slide, please.

All right. So price is increased. But there are many possible explanations for why prices increase, and that's what I'm going to get to next.

First of all, there's the possibility of measurement error. Maybe you're not measuring exactly the mix of services and the types of patients correctly. Certain services were closed down. Let's set that aside.

Suppose prices really did increase once you've dealt with that. What could be explaining it? Well, it's possible that quality improved. And that's very significant because if quality improved, then price increases. So long as the price increase isn't too great, consumer welfare may have improved. So the fact that there's a systematic and anecdotal evidence showing price increase is not alone indicative of harms to consumer.

The next reason is the changes in bargaining skills and risk aversion. A series of small hospitals gets aggregated out by a large chain. That chain has bargaining expertise. Is more risk-neutral. Less concerned about walking away from a bad deal than a stand-alone hospital might be. And as a result can walk away with a better deal.

Anybody who teaches the MBAs knows all about your BATNAs- Best Alternative to Negotiated Agreement- - and how that can enable you to capture more of the economic profits from a transaction.

That, I should note, is not what many would consider an antitrust actionable effect, if you will. And then the last, and what I want to talk about today, really, are the common customer and common insurer effects. And throughout I'm going to try to allude to what seems to be a natural application of Section Seven, such that a cross-market combination could be

construed as a lessening of competition, and that that is the source of the price increase.

And what are these explanations might not fall into that category, and therefore, are not likely to see antitrust action. Next slide, please.

All right. Big picture, then I will dive deep. So big picture, the common customer effect. Here's the idea: if the same customers, even in different geographic or product markets, value two providers, then their combination can reduce competition to be included in the bundle of services that the insurer is offering that customer.

So let's think an example that has arisen at DOJ and at FTC for some time, has to do with employers.

Suppose that an employer is looking in the city center and draws employees from the North and employees from the South. If hospitals in the South raise price such that health care in this area becomes quite expensive, they might lean more heavily and recruit employees from the North.

If these two hospitals merge, even if they're not serving the same patients because they're in distinct geographic areas, then that leaves the insurer that is bundling hospital services to sell to the employer with fewer options to turn to in order to compete for that employer's business. That's the rationale.

And the same thing- actually, let me mention briefly the common insurers, and then we'll advance to the next slide.

So common insurers. The big idea here is that now imagine providers in completely separate markets where there is no common customer for these providers, but there's a common insurer.

And if these providers combine, there is a greater range of contracts they can strike that can have effects on prices. And I've put the up and down arrows because in some markets prices could increase, and in other markets prices could decrease. Next slide, please.

So in the standard model that is currently being used in enforcement actions, and has dominated the academic literature as well, unless providers compete for patients in the same end service market, then their combination doesn't have an impact on the bargaining position of those providers. Or in the vernacular that we use in this business, a willingness to pay.

But as I've mentioned, customers actually buy a bundle of services, such that if the same customer values both providers, it would then follow the combination of those two providers could affect the attractiveness of the product being offered, and therefore, the bargaining position of the insurer.

So another way to see this is imagine that I'm a mother- don't imagine, I am, I'm a mother- - and I value pediatric hospitals and high quality adult hospitals. It's conceivable that I might buy a health insurance plan that had the best adult hospital but not pediatric, or the best pediatric and not adult. But the two of them gone together could make the product not viable.

And that's how you can see how even if they're not substitutes at the point of service, they could be substitutes into my demand for insurance, and insurance competition can affect the demand for these products.

The last point is kind of key for the empirical results I want to show you, although I realize I am running out of time rapidly. But it is that this effect should really matter more for consolidations that are in close geographic proximity, if they're a cross product market. But also, across geographic markets, as the example I gave you with the employers of the North and the South.

So the results I'm going to show you are going to distinguish between mergers where the markets are closed- I'll call them adjacent- - and mergers where the markets are farther apart. Next slide, please.

The common insurer effect. For those of you who miss your days in the classroom, then this slide is for you. But I'm still going to try to make a high-level takeaway that I hope is accessible to everyone.

I've made for you two towns. A town A and town B. Town A is more industrial town, and where consumers are priced premium elastics. They are going to be more responsive to changes in premiums for health insurance in terms of their purchasing of that.

And town B is a beautiful resort town, hiring some more affluent. Consumers are less premium elastic.

There's a single hospital in town A and town B, and the same customers do not use these hospitals. There's no employer that's employing people in both town A and town B. They set their prices with the common single insurer independently.

And then the insurer then marks that up and sets premiums. And what should be going off potentially in some people's head is that sounds like double marginalization. There could be some inefficiency there.

Suppose that the hospitals merged. They might say, you know what, because customers are so price elastic in town A, I'll take a hit in town A, and I'll lower my price there and have a higher price in town B and take my profits that way.

So the ability to cross subsidize for these markets enables changes in price that can increase the payments to hospitals. But the effect on consumers is ultimately going to be ambiguous.

A similar mechanism, and this one has come up with some recent mergers, would be the political constraints that might be in place. Suppose in town B, the hospital wants to charge its monopoly price, but there's a mayor who keeps making speeches, or an attorney general who keeps issuing reports saying that the prices are really much too high and you've got to do something about it.

Well, one thing you could do is acquire the hospital in A, or maybe C, and take your monopoly

rents in those markets. Next slide, please.

All right. So can we empirically try to tease out these effects? Because what you'd really like to do is separate those effects which could potentially be due to a lessening of competition, ideally, from those that could be due to bargaining power or changes in services.

And we make an attempt to do that at the moment we really got the customer and insurer effects pulled. And I would argue the customer effect is the more natural one that goes with Section 7. And we're working on teasing those out.

Let me tell you a little bit about this project, as I was specifically asked to do so. So I should preface the next couple of slides by that request.

This is the working paper with Robin Lee of NYU, and Kate Ho of Columbia. And it began when I was serving as a deputy at the FTC. These ideas arose, and there was very little empirical evidence at the time: almost none on cross-market mergers, or on the theories for how these might occur.

And one of the challenges in assessing the effect of any integration is the fact that integration isn't randomly assigned. Hospitals that are acquired or physician groups that are acquired are different from those that are left behind. And how can you be sure what the but-for world is.

So we have an approach to dealing with this, and that approach is to focus not on the hospitals that are probably the drivers of transactions, but to focus on what I'll call bystanders of those transactions and see what happens to them.

And especially to contrast what happens to bystanders that gain a system member in an adjacent market, versus bystanders that gain system members, but in nonadjacent geographic markets.

That would enable us to kind of control for the common effects of acquisition that might have to do with bargaining skill or risk tolerance, and to try to isolate those effects that have to do with proximity.

Not so proximate that you're competing for the same patients, but possibly that you're competing for the same employers or that the insurer's geographic territory is what is affecting the bargaining position of providers. OK, so next slide, please.

All right. I've got another picture. And this illustrates the methodology that we're using. We've got two samples for this project.

The first sample consists of mergers that were investigated by the Federal Trade Commission between 2008 and 2012, but were consummated. Consider the two systems, systems A and B, so we only have system mergers here. And each rectangle represents a state.

The wavy lines within the rectangle signify geographic hospital markets in the state. Suppose that there is, since the FTC investigated these specific mergers, there was a horizontal overlap

of concern. And those are the red hospitals, A and B.

So for our analysis we top out those hospitals. We're not setting horizontal effects. Danica said not this panel. So what we're interested in is the effects of gaining a system member in an adjacent market. And I'm using that term loosely. We don't quite have enough data to really be formal about adjacency. But you can see I've got green lines extending from some lettered hospitals, and it goes to that label adjacent treatments, and those nonadjacent.

Those that are called adjacent treatments have gained a system member not in their own geographic market, but in their own state, where the common customer, common insurer effect is likely to be at play.

And the nonadjacent treatments have also been acquired or have gained system members, but not in the same state. And they're going to serve as sort of an interim treatment group where the effects that don't have to do with these common customers and insurers can be captured. Next slide, please.

Actually, I'm going to switch, and given the time, go to the last slide. And say the results are fairly similar. We have that FTC sample, and then we do something analogous where we take the entire sample of system mergers. We toss out any that are located within hospitals where the merging parties are located within 30 minutes of one another, and also we toss out all of the crown jewels of the transaction. That is hospitals that are the largest in the transaction, so that we're really focusing on bystanders and not the drivers of the transaction where there may be some other confounding factors at play.

And let me walk you through what this graph is. It's the result of a regression analysis, but you should think of it as the percentage change in price for hospitals that acquired an adjacent system member, relative to hospitals that did not. And then the red is- so the blue is adjacent and the red is acquiring a nonadjacent system member.

And what we find in the years prior to the merger, there's not much going on, that is the treatment was plausibly randomly assigned. These hospitals have similar price trends to the hospitals that weren't acquired or weren't parts of the acquiring system.

But following the mergers, we find that those that gained a system member in the same state experienced some nontrivial price increases. And the average, if you start from period one, the average between one and three is a ten percent increase.

Next slide, please. Last slide. And I have one minute to go.

So to summarize, what we find is that cross-market mergers where the markets- and we were focusing here on geographic markets, but the theory pertains to cross product markets, too- are associated with price increases of five percent to ten percent.

The five percent, the conservative, being from the smaller FTC sample, and the ten percent from the much larger sample. And we don't see that from the addition of a system member outside of

state.

And what we're going to try to do next is really separate out how much of this is common customer, how much common insurer. We suspect it's the former, but we've got some challenges in trying to figure out how you would gauge the dominance or the strength employers that might span across multiple geographic areas in a marketplace.

And I'll just conclude with the provocative statement that says, look, there really may be reason for enforcers to look more closely at these cross-market mergers. And I'll be the first to say that there, of course, has to be limiting principle.

What our theories suggest is that a limiting principle has to do with the degree of overlap of a common demand for the merging providers, and common negotiating parties for the merging providers. So there is a limiting principle. I haven't meant to put a stake in the ground at all and claim that all providers in independent markets can exercise market power or anything like that.

And I will close.

DANICA NOBLE: OK, thank you, Leemore, for sharing. I wondered if the panel had any reactions. Flip your card up if you'd like to- Joe.

JOE MILLER: Thanks. So a couple of thoughts. From the insurer perspective I get a lot of the incoming from the membership saying why isn't the FTC doing something about this. And sort of explain to them how hard it is to win a case in litigation.

But it sounds like maybe the math and the theory are starting to catch up with AHIP members intuition that adjacent market transactions can have anti-competitive effects. Listening to Leemore's talk, this is new to me.

But it struck me as maybe this is theories and the next step and the recognition that the significant economic factors that you should look at is the bargaining between those who buy the services- in this case, insurers, among others- - and the hospitals.

And so as the geographic market theory advanced from Elzinga-Hogarty to looking as *St. Luke's*, among others, has recognized look at the effect on prices to insurers, that this is maybe the next step in that.

The other thought I had as I was listening is that if you're really thinking about that bargain one on one, it might imply a price discrimination product market theory, or geographic market theory. That is, if you can tease out the same bundle of services being sold to different customers at different prices. Because of the inelasticity of their demands, there may be something there to think about, as opposed to aggregating all of it, the way we typically do in market definition.

PAT KUHLMANN: I think then Jim, Marty, then Rob.

JAMES LANDMAN: Just very intrigued by the common customer example and the adjacent

market. And looking specifically at the employer example you gave, where you have an employer in the central city, but employees living really across a metropolitan region.

When we were doing our acquisition affiliation strategies report, we were seeing the emergence of kind of an interesting model. So say you're in a metropolitan area that has a dominant provider that's perhaps growing organically, but has actually coverage, fairly good coverage across that geographic area. And is in a very good position to contract with the employer for the service of employees across the metropolitan area.

We're seeing the interesting emergence of collaboratives of independent but adjacent geography systems that are forming nonexclusive networks, but that can be assembled to compete against that dominant provider in the market. In other words, linking together, again, in a nonexclusive arrangement, adjacent markets to compete effectively for a large regional employer, perhaps an employer coalition.

So it's going to be fascinating to see what the impacts of that are, as opposed to a control of ownership merger.

LEEMORE DAFNY: Nonexclusive is what antitrust enforcers love to hear.

JAMES LANDMAN: That's the key word. [LAUGH]

MARTIN GAYNOR: Yeah. So let me emphasize that this is important. I think, as Leemore made clear, this is a big chunk of what's going on. And for the most part it's been dealt with, as particularly the examples had to do with the hospital sector, but it's much more general.

That these cross-market mergers are not an issue for competition. And if, indeed, they are, then that is obviously very important because there is a lot of this happening.

As Leemore also made clear, it's not just, say, about say hospitals in different geographies. It can be within the same geography, but different kinds of services.

I think that actually those phenomena, while they have something in common, they are fairly different. So a large employer who wants to put together a bundle for a national base- and that is increasingly common because we do have many industries now dominated by national or regional firms, whereas before they were mostly local or regional. So that is something that has very much happened.

That's, I think, rather different than thinking about individuals who ex ante want the right to purchase a bundle of services that are not in themselves direct substitutes. So, for example, obstetrics and orthopedics are not direct substitutes. If you have a bad knee, going to an obstetrician is not likely to do much for it, and vice versa.

But, beforehand, you want the ability to go to either one of those if you need that kind of care. And that's one of the phenomena that Leemore and her co-authors are focusing on. She did point out- and she didn't have a lot of time- briefly at the end that they are working on teasing that out. I think that is actually something that is quite important to do. And the basic insight here is one,

that in a sense already exists in the kinds of frameworks we have. And the question is really about the negotiating power of these providers, and if it's enhanced by the merger or not.

And what's being done here is to extend this in a sense to a broader base, and really try and tease out what's happening. So I think these are very laudatory efforts. Again, you hear lots of things, like Joe and Jim were saying. The talk about this, and really trying to sort of work this out and see what we can do to build the evidence base, is very important.

The last thing I'll say, we're focusing on health care 24/7 here. These sorts of issues come up in all kinds of markets, not just in health care markets. And so any findings from these kinds of studies potentially could be very important because they could be very broadly applicable to grocery stores, to funeral homes, what have you.

Not to suggest that orthopedics, obstetrics, funeral homes, and peanut butter, and toilet paper are all the same thing to us. But that there are some common factors.

LAWTON BURNS: Yes. I just wanted to say, Leemore, enjoyed your talk. We've actually been looking at some of the same issues, but with different outcomes in mind. We've been looking at the operating costs of these hospitals and systems that's combined.

And what we're finding is that there's basically a gradient in operating system efficiency or inefficiency. And the farther out you start to integrate hospitals into these, within a market, adjacent markets, nonadjacent markets, the farther out you go, the less efficient those operations are.

And so you're seeing not only price increases, but there can also be cost degradation in the hospitals that put these far flung systems together.

LEEMORE DAFNY: Very interesting.

PAT KUHLMANN: So maybe one quick question. I think Rob just touched on it, but if the antitrust agencies were to challenge this type of transaction, what sort of efficiency claims do you think might be made in defense of the transaction?

JAMES LANDMAN: Yep. So that's a big question, right? So certainly with some of the very large systems, and including nonadjacent market systems, some of the things you might be looking at are the extent to which you're able to consolidate back office functions, for example, the revenue cycle functions, their IT functions, perhaps some of their governance and administration.

You get harder in some of the, especially the non-geographics, in looking at what they're doing in terms of clinical integration on the ground because they might not have that same level of concentration in a regional or a local market that an integration claim often depends on. So there's differences there.

There's also kind of an interesting- just one of the examples you pointed to, Leemore, was the Baylor Scott & White merger. And there's this new- maybe not new- but it's part of, I think, our

whole conversation today about these different forms of consolidation. We're having, perhaps, as much of a focus on economies of scale, but of economies of skill.

So Baylor and Scott and White, part of what Baylor was getting from Scott and White was significant health plan experience, actuarial expertise, care management, total cost of care. Some similar ones were with SSM Health and Dean Clinic up in Wisconsin, where you had a merger of one of SSMs, a horizontal, but it embedded that into a much broader geographic system.

HealthPartners and Park Nicollet in the Twin Cities area where Park Nicollet had a lot of risk-based contracts who brought in HealthPartners total cost of care skills.

So do we start seeing economies of skill, especially as we're getting these systems that are moving into risk-based contracting, and bringing in these skills, the complementary skill of an acquisition partner. What's happening in those?

So maybe moving from an economies of scale even to an economies of skill analysis and see how those skill implants, if you will, are affecting total cost of care within the merged entity.

LEEMORE DAFNY: Do I get to say something?

DANICA NOBLE: Please do.

LEEMORE DAFNY: Thank you, Jim, for bringing up those examples because it reminds me of something I wanted to say, which is an advantage when you've got a large sample, then you can make a generalization.

But in reality, particularly as you're making an efficiency argument, for something to be cognizable it has to be merger-specific, which reminds us that the circumstances do need to be evaluated one case at a time.

And I know from experience that that's- what DOJ and FTC do is they look at it and are there skills that are not just being transferred, but otherwise would not be accessible on the open market as a result of the transaction. That could be counted as a merger-specific efficiency.

One of the reasons that I didn't address efficiencies in the talk beyond time was that a lot of this is not particular to cross-market mergers, but just in general efficiencies for merger defenses. And there may be some unique efficiencies for cross-market mergers having to do with common negotiating partners.

I think lobbying, there could be some efficiency there if all the rural critical access hospitals get together. They could pool their dollars or some such. Maybe that's a cynical observation.

MARTIN GAYNOR: If I could say-

PAT KUHLMANN: Just very quickly, yeah.

MARTIN GAYNOR: Yeah, I know. You need to move on.

I think in terms of cross-market efficiencies, it's not clear to me that cross geography gets much of anything. But when you're thinking about cross types of care, you might do better, actually, with coordination of care, for example. So that's something to think about.

On the competitive harm side, I think one thing to be careful about here is to really distinguish market power from other kinds of things that could lead to price increases.

And I think this has been alluded to but I did want to mention it specifically, and that has to do with one-stop shopping. That can be something that increases value to consumers and can lead to a higher price, but is not necessarily in and of itself enhanced market power. It could be associated with it, but not necessarily.

So again, I think this is terrific. I do think it's very important. But there are some further challenges associated with teasing this out.

PAT KUHLMANN: Great. Sorry, Jim, but we want to make sure and move on to capture our third and final topic, which is payer-provider integration.

LAWTON BURNS: OK. I sort of alluded to this at the end of my last slide, but this is just another type of vertical integration that's been out there for about 20 years, and now it looks like it's beginning to make a comeback. And that's where the insurers are getting into the provider business, and conversely, the providers are getting into the insurance business.

This has quite an interesting history, which I've tried to outline here. I always knew those history courses came in handy. You have the group staff model HMOs of the West Coast in the '30s and '40s. And then you have as competitors with those you have the more IPA model HMOs, basically in California to compete with the group staff model HMOs.

Then we had the role-based integrated delivery networks, like Scott & White, and Geisinger, Carle Clinic in the '70s and the '80s. In the '80s, that's when the insurance companies got into the primary care business. And we also had one investor on hospital, Humana, try to get into the insurance business.

The 1990s, the insurers tellingly sold off all their primary care groups to the physician practice management companies, which virtually all went bankrupt by the end of the decade. I think the insurance companies knew what they were doing back then.

And then the 1990s, the hospitals, nonprofit hospitals beginning to get into the insurer business in anticipation of capitated care, and also partly stimulated by the Balanced Budget Act, which included a proviso for provider-sponsored organizations, or PSOs. We're not sure where those went, but they're not here anymore.

And so what's happened is that since 1996, 1997, the percentage of U.S. hospitals that had a health plan of any kind dropped and continued to drop until 2012 and 2013 when they start to

make a comeback. Very slight, but as of right now, 14 percent of U.S. hospitals have an HMO, 14 percent of U.S. hospitals have a PPO. I don't know about the overlap between those two.

But just recently, I think it was this past week, Ascension Health has a clinically integrated network in Michigan, and they announced a \$50 million acquisition of an insurance plan to basically tie into their hospital physician network in Michigan. So we're seeing some of this stuff play out before our eyes.

When we look at the hospital-sponsored health plans, that's where the providers get into the health plan business. As I said, this wave peaked in the mid '90s. The products here rarely achieved any substantial scale. The literature back then suggested health plans had to have a scale of about 100,000 lives. The hospital plans never came even close to that.

We did a review of whatever evidence there was in 2000, and all these provider-sponsored plans suffered from about 50 problems. I've only listed six or seven here, but any one of those 50 problems would have done them in, and they all did.

And then we had some evidence from the tracking study, and that's what the bottom things are there. And the provider plans basically died off in the late '90s, early 2000s. Hospitals divested themselves of their health plans, as the market transitioned to more of an open access rather than a closed access model. But that may be starting to change around.

If you ask providers why they're getting into the insurance business, here again, we have a list of things that they'll say. Position themselves for alternative payment methods, risk-based contracts, position themselves to become ACOs, position themselves for population health management, maybe gain some leverage over payers by having their own in-house health plan.

And I'm going to let Marty talk a little bit about the experience of Pittsburgh because that's where you see this thing play out on a major scale.

There's been a never-ending effort on the part of providers to try to disintermediate payers, and a never-ending effort to try to manage the care continuum, and now it's called the triple aim.

As far as the research evidence, it's really scanty. I can only find two studies. It basically shows that when hospitals or IDNs invest in not only hospitals, health plans, and physicians, they have lower operating margins, often negative operating margins. And what we found is that the more hospitals invest in these diversified businesses, the more they lose money. So it's the quick way to lose a fortune.

Also, the more recent article two years ago by Frakt, Pizer, and Feldman showed that when health plans invest to link with providers to serve the Medicare Advantage population, it's typically associated with higher premiums. So not whopping evidence, but not really positive evidence either.

Now, it's funny I'm here today because the National Academy of Social Insurance sponsored a study that Jeff Goldsmith and I and two other people did. It's being actually released today, and

this is shameless self-promotion on my part. But copies are sitting out in the lobby, along with another paper we did. So today's the official release date.

MARTIN GAYNOR: Rob will be signing those afterwards, \$5 a pop.

LAWTON BURNS: But I thought I'd just give you a quick run through of just a couple of the findings.

What we did is we looked at 15 of the largest IDNs around the country. And what we were trying to do is get information on all their lines of business- their physician business, their hospital business, their health plan business.

It turns out that seven of the 15 of these large IDNs have their own health plans. Two more have significant capitated or risk-based revenues. And so that's nine out of the 15. And in six out of those nine, at least a quarter of their revenues are at risk.

And so what we did here is we tried to see well, so what? What happens when these large hospital systems now are operating health plans?

And so what we found here, we find that there's no relationship between how much revenue you have at risk and your cost of care, which is rather surprising because you'd think there'd be lower cost of care in places that were bearing more risk. We also found that they weren't more profitable either.

A second set of findings- don't bother reading the stuff on the left. I tried to simplify it on the right. What we found out is we compared the flagship hospital of these 15 IDNs with their largest in-market competitor. And we looked at Medicare spending in the last two years of life comparing these matched payers.

And it turns out that when the IDN flagship hospital had no revenue at risk, they were less expensive with their competitor. But when the IDN flagship hospital had significant revenue at risk, they were more expensive than their competitor.

And so we're really wondering what does this mean for care coordination advantages of hospitals that have their own health plans and they have all these alternate payment methods. It doesn't seem to show up, at least in their operating results.

The one thing I would say, and it's what this slide's about, is that these things are really difficult to study. Let me just skip ahead to this slide. They're big revenue generators, but they're also really inscrutable institutions.

Public information on their performance is not aggregated to the IDN level. It's hard to tell what each of their business lines is contributing to operating revenues. You can't tell whether they've used their market power to grow their earnings, and you can't tell how the insurance vehicle is used by the IDN.

We're really trying to develop a bigger scale study to understand how these three-headed beasts of hospitals, physicians, and health plans operate. Everybody thinks Kaiser-like organizations have an advantage, but we're not seeing it here, at least in the sample of 15.

One other thing I'm supposed to talk about are other types of integration. That's where the payers lead the integration with the providers. And so what this slide just shows that insurers who have been buying physician group since 2010, you can see the illustrations there, including what UnitedHealthcare has done in the bottom part of the panel.

The reasons why they're doing that, well, they're positioning themselves for increased Medicare Advantage enrollment, which has been skyrocketing. They're positioning themselves for increasing Medicaid enrollment, which has been skyrocketing. They're developing networks to try to manage their really chronically ill patients. That's a lot of what United Healthcare's Optum division is doing.

There's a belief among many of these organizations that in order to manage risk contracts and satisfy value-based health care, they have to own the front end of the ambulatory care system. That's the physician.

And then the last bullet point is, perhaps, the one that's most relevant for this panel. And that may be just a way to deal with the threat of hospitals getting in the insurance business, here's for insurers to get into the hospital business, and perhaps to have some countervailing power.

But I think the real interesting thing is what's played out in Pittsburgh, and I'll let Marty comment on that.

MARTIN GAYNOR: Oi vey. I don't have a lot of good things to say about what's happened in Pittsburgh.

But let me just briefly recap what Leemore and I said about efficiencies with hospital position because theoretically, they apply here as well.

In principle, you could imagine that integration could work to mutual benefit and to society's benefit, because they're important spillovers between health care providers, say, hospitals and doctors, and insurance companies. And you don't have to think too hard about that, how they might do better that way.

Again, by being together they might have proper incentives to make good investments on things that are mutually beneficial. It also may help with incentives. So all that are the kinds of things that one could imagine.

It's not clear, however, if the integration Kool-Aid, from what Rob said, tastes nice, like a pleasant lemon flavor, or perhaps more like used automobile oil flavor Kool-Aid, and I suspect it's more like the latter than the former.

So, in Pittsburgh what's happened? Going back a ways, University of Pittsburgh Medical

Center created its own health insurance plan. That plan was initially relatively small.

On my view, that was simply a strategic move by UPMC to increase its bargaining leverage with insurers, particularly the dominant insurer in town, Highmark, because they had an alternative.

If you don't make us a good deal, well, we have our own health insurance plan. And guess what, they'll pay us whatever we want. So that, I don't think actually improved the state of affairs in Pittsburgh.

What transpired much more recently is fairly complicated, and I think integration actually is an artifact, rather than a leader there, and I don't think it reflects positively on the situation. Again, very dominant health system, University of Pittsburgh Medical Center, UPMC dominant. Health insurer Highmark.

UPMC simply refused to deal with Highmark, would not contract with them, would not accept their enrollees. And Highmark was left an insurer without providers. So they acquired Allegheny General Hospital and West Penn hospitals- basically the two largest entities that were left- - And created Allegheny Health Network.

Again, I don't think really inspired so much by efficiency considerations, as an act of desperation. And the only possible good thing I can think of to say about this is if that allows there to be an alternative to UPMC, then it will preserve some degree of competition in a market that is very severely compromised and is not serving the interests of the community.

Outside of that, things are great in Pittsburgh.

DANICA NOBLE: We're going to invite the panelists to address any of the topics that we've talked about here today. Just raise your hand, Leemore, or flip your tags up. And of course, if the audience has any questions, now's the time to write them on your cards.

LAWTON BURNS: Can I say one thing?

PAT KUHLMANN: Sure.

LAWTON BURNS: What we're talking about here today, vertical integration, is a subset of what we normally call diversification. We have 40 or 50 years of research on diversification. And the question is does this improve performance for the company?

And for a long time people thought well, related diversification will outperform unrelated conglomerate diversification. Turns out that's not really true. Then we thought well, maybe related diversification will outperform focus. And that's not really true.

But now we're thinking maybe focus outperforms related diversification, and there may be some evidence for that, but we're not really sure about that either.

And so at the end of the day does diversification help to improve performance? The answer is definitely no-yeah. But as Marty says, but that's not final.

PAT KUHLMANN: Maybe we'll do Leemore then Jim.

LEEMORE DAFNY: OK. I want to echo something and elaborate on something that Marty was saying, which is that on the one hand, there can be some advantages to the integration of payers and providers, or rather when providers start to introduce plans, and that can inject more competition into the insurance industry.

In many settings, the insurance market is highly concentrated. Research shows that that leads to higher premiums. So to the extent that the providers get into the market, and compete against the payers, that to add increased value in order to maintain market share, that could be a good thing.

On the other hand, devolving all of the risk down to the providers strikes me as potentially inefficient because they're quite numerous, and the insurers perform a lot of functions, and those functions still need to be performed.

So breaking that up into small insurance functions across a large number of provider organizations can have some efficiencies. And I think that there really is a tension between those two things.

JAMES LANDMAN: Yeah. I just want to say I'm not sure if UPMC Highmark is our best example of what's going on in the marketplace right now. It's really kind of a Clash of the Titan situation that isn't necessarily indicative of what's going on around the country as a whole.

HFMA, our organizational focus is very much, right now, on the way in which these somewhat separate and sometimes formerly antagonistic circles of physician, hospital, and payer are coming closer and closer together in very interesting combinations.

And I think what we're seeing more and more are very collaborative relationships emerging between the hospital, the payer, and the physician groups. And we've heard over the course of the conference today some really fine examples of that.

For example, the Dignity Health, Hill Physician Partners, Blue Shield of California, example in California. Or we're seeing in Arizona Aetna, Banner Health, and the Banner Health Network, which has three separate physician groups, only one of which is employed. And it's had huge successes both in the pioneer ACO model and in a private ACO with Aetna.

So I do think that these combinations- and right now we're trying to figure out, too, they each contribute something. The payer brings actuarial expertise, analytical expertise. The physician and hospital size bring care coordination and care management skills. And really, what is the best

combination of aligning the interests of these entities in something that's really going to move the system forward.

So what we're seeing- and really the topic of this panel is what we're seeing in terms of this flux and really trying to work out what these best combinations are. And we can get to this later, but

we don't really know yet. So we're really trying to see which of these experiments is going to work the best.

MARTIN GAYNOR: If I may, let me just reinforce what Jim said. I think what's happened in Pittsburgh is an ugly, bare knuckles brawl and it's all about market power and strategic motives. And it's really not, in my opinion, about efficiencies.

So we shouldn't necessarily regard that as representative. It certainly doesn't tell us about what the upside is for these kinds of arrangements.

PAT KUHLMANN: Looked like Joe had his-

JOE MILLER: Yeah. I wanted to go back to the discussion about *Saint Luke's* for a minute, because there's an important point here I don't want to get lost.

The opinion is so hostile to even the concept of efficiency is that there's a point relevant to this discussion I don't want to miss.

The level of hostility I think took a lot of people by surprise. You can imagine as sort of a thought experiment, imagine if the FTC's brief to the Ninth Circuit led with the arguments that they accept it. *Procter & Gamble's* the last time the Supreme Court's talked about this. No such thing as efficiencies. Doesn't exist.

Sister circuits have talked about in dicta, but nobody has really accepted it as controlling in any sort of sense. To the extent it might control it's got to reverse the anti-competitive effect. It can't just be a nice thing that happens as a result of transaction that might be positive for consumers.

Academics, conservatives such as Posner, Easterbrook and Bork, are also hostile to the concept. So imagine if the FTC brief had said that, it would have been quite controversial. Because, of course, starting in '97, the merger guidelines specifically accepted efficiencies. And I think in the course of normal practice for folks coming in before the agency, efficiencies is a big part of what they are trying to discuss/improve.

So there's so much hostility to it I'm wondering if a lot of the discussion's going to miss the point that the court blew past quickly on merger specificity. So AHIP put in an amicus brief to really draw out this point on merger specificity.

Health plans, among other entities, are available to do the sorts of things that Saint Luke's said that they wanted to do, the District Court took as very positive, and I think most people would agree are very positive. Asserts a population health management sorts of functions that the court credited them with, both in terms of their motivation and their ability to do it after the transaction.

I think that point in terms of health care transactions going forward shouldn't be lost. District Court found not merger-specific. The Court of Appeals agreed, but only in a paragraph, and didn't really draw out the discussions they might have.

So I didn't- for this conference, this purpose- want to let that pass.

PAT KUHLMANN: Great. So we had one question that maybe if you- I won't try to paraphrase it if you have the question on hand.

DANICA NOBLE: Yes. We, actually, before our panel started, received this question from two different people. And maybe for those of you who were here yesterday, I know it kind of crossed my mind when I heard the opening remarks of Dr. Emanuel.

So the question is "Does the shift from fee for service to pay for performance and risk sharing models mean that provider and payer interests are so closely aligned that the consolidation, and maybe even increased market power, should not be a concern for antitrust regulators, as long as the providers are committed to pay for performance or similar models?"

Marty.

MARTIN GAYNOR: No.

[LAUGHTER]

No. That's very, very wrong. That's a very wrongheaded way to think about things.

Now, let me get blunt from here on in. Here's the reason why. There are two reasons, and it's not at all complicated. So think about the following.

Think about the incentives of firms to accept innovative new payment methods, say, bundled payments, or reference pricing, or what have you. If you have a dominant firm, why should they do this? If fee for service, which is the most common method, is profitable for them, why should they accept something else? And if they have market power, they're going to be in a position where they don't have to. That's one.

Two, regardless what the form of payment is, whether it's a fee for service, a bundled payment, a reference price, if a firm has market power, they're going to get a higher payment.

So one, that means a higher price, whatever the form of that price. Two, to the extent that innovative payment methods work because they put some pressure on providers, the incentives to be better in whatever way they do, the higher payment reduces that pressure and can actually undermine the good design.

So my point is actually that any of these things- let's just assume, for example, bundled payments in principle are a good idea. They will provide better incentives for providers.

If these things are not going to work, no matter how well designed or beautiful they are, if the markets that they have to operate in don't work well- - firms have market power. Either they simply don't have to accept these forms of payment, or they'll get higher forms and the incentives

just won't work.

PAT KUHLMANN: Jim?

JAMES LANDMAN: I'd agree competition's going to remain important. I think the metric we're looking at is going to be different. So it's going to be who can compete best on a per member, per month basis. But it's still going to be which health management company or whatever we want to describe, the entity of the future, which is most able to compete effectively on quality and price.

And again, looking at price now as more of a per member, per month, assuming some sort of population health risk bearing arrangement. The competition among systems that are trying to provide those services will still remain vitally important.

PAT KUHLMANN: Leemore?

LEEMORE DAFNY: Marty said no resoundingly, and I was go with a more light-hearted, are you kidding me?

[LAUGHTER]

And say well, not unless you want to substitute regulation for competition, just as Jim just said now. It is competition among clinically integrated entities that is going to lead us, hopefully, to the triple aim. Or we will see more of what we're seeing in Massachusetts, where regulators will come in and will say we've got a global cap. Our target is this, and increasingly more stringent stick because the competition isn't there, isn't working.

So I think that our system is predicated on competition. We want to protect it and defend it. And it's difficult to see how we'll achieve our aims without multiple competing sources of care.

MARTIN GAYNOR: The only thing I'd add real quickly is, yeah, you could imagine substituting regulation for competition. And without commenting on the relative merits of those, we don't have regulatory systems in place at present. And the prospect of those coming about, in all but a few states, I would guess would be rather slim.

So I'm agreeing with Leemore, but I just did want to mention that. It's not at all clear that even if optimal regulation could deal with the problem, that that would be forthcoming.

LEEMORE DAFNY: And I'll just say we have to figure it out a little bit, because in some areas there aren't going to be that many rivals. So ability to measure and hold providers accountable for performance when the market doesn't, but payers need to, is an important area to work on.

PAT KUHLMANN: Great. What I think is probably another softball question, but one truism that we hear quite a bit is, is the Affordable Care Act forcing providers to consolidate?

We can work our way down toward me. It looks like we got- if you want to start Marty, it's-

MARTIN GAYNOR: No. So let me give a slightly more nuanced response.

One hears all the time the ACA made me do it.

[LAUGHTER]

As a parent, I'm used to those kinds of responses. And sometimes there's an element of truth in them. There is a little bit of an element truth, but there's nothing in the ACA. And I think the White House has made this very clear, that it requires consolidation.

The ACA encourages- I want to encourage coordination, right, the triple aim. But it's agnostic about exactly how that should be achieved with the exception of ACOs, which are explicitly encouraged. But also, bear in mind that ACOs are subject to antitrust scrutiny, and that was built into the ACA.

Now, having said that, one certainly hears from providers that there's a widespread perception that this is the case. And I'll defer to Joe and Jim on this because they're in the front lines on this particular matter.

JOE MILLER: Yeah. So I put my card down because Marty captured it. So this is, at least at conferences, a common reframe, and the place to start in discussing it is the law still applies.

If the transaction is anti-competitive, it's still illegal with the ACA or without it. And does not give the Secretary of Health and Human Services any ability to waive anything regarded to competition laws.

We're very explicit in the ACO program to make it a part of what they were doing, to make sure that there was guidance such that providers could, in some quick way, understand whether they were going to get caught in an antitrust net, and whether they'd prefer not to go forward with the transaction.

But you characterize it as a softball, and I think that's right. This is an easy one.

JAMES LANDMAN: And I would agree that it's no. I do think, however, that there is a perception out there that it does. So certainly our members are hearing a lot from consultants, from legal advisors, et cetera, that there is a, at least an implicit encouragement of consolidation, in the Affordable Care Act.

But if you look at- and frankly, I was surprised actually just reading up for this panel in some of the academic literature. I can't say I actually came across references to the Affordable Care Act encouraging consolidation. So it's out there. That perception is out there.

But if you look at, let's take two of the signature care delivery initiatives of the Affordable Care Act- The Medicare Shared Savings Program and the Bundled Payment initiative.

You can look at the ACOs that are out there. You can look at the bundled payment initiatives that are out there, and it's obvious that a lot of the participants in those programs, and a lot of the most successful participants in those programs, have not consolidated.

They have formed these organizations. They are working- a hospital's working with the independent physician group to do a bundled payment, they don't see a need to consolidate to do it.

So it's certainly encouraging greater care coordination. It's certainly encouraging better integration of efforts, but it's not requiring consolidation.

PAT KUHLMANN: Great. And maybe for our final question- I know you have your card up, but we've got a question for you from the audience. You can either answer this question or the previous question.

So this is for Rob and Ken who argued that hospitals buying up physician practices doesn't lead to benefits better than those achievable via other ways of improving health care delivery. But is it better than nothing? How does it compare to the status quo?

LAWTON BURNS: Well, I'll tackle the second question if I come back to the first.

There's evidence that suggests that hospitals that acquire physicians don't perform any better than hospitals that ally with those physicians using the MSOs and the PHOs. And they really don't do that much better than your traditional medical staff, independent practitioner arrangements. So it's not clear to me that hospitals are getting anything no matter which way they go.

I think the important thing that I've always seen this is it's not the structure that you try to deal with physicians, it's the processes by which you deal with them, and that's what's important.

KENNETH KIZER: Yeah. I think one of the flaws in the line of thinking, perhaps, around the question is that nothing is happening. There's a lot happening. There's all kinds of things going on that are, by and large, good.

But it's not, perhaps, being as studied, and it may not lend itself to a closer study as one might like, just because of the rapidity of change and not having good data and other sorts of things.

JAMES LANDMAN: Certainly, when we were doing our physician engagement research, one of the messages we heard over and over again was that employment does not equal alignment.

And there's so much work that has to be done beyond that in terms of creating a culture in which the physicians feel that they have leadership, meaningful input, where your compensation structures are aligned appropriately so everybody's chasing the same rabbit.

I mean there's so much stuff that really has to be done in addition to that, that it's really not- it's not a panacea and you cannot substitute in employment for true alignment.

LAWTON BURNS: One thing I'd point the audience to is in the last few years, the AMA and the AHA have pulled together a joint task force, and the issue to document and get it all online each year. And it's basically looking at what are the necessary ingredients for doctors and hospitals to work together.

And it's not necessarily based on an employment relationship, but what goes on between them. It gets back to some of the issues we heard earlier this morning.

PAT KUHLMANN: Great. And then if you want- I'm not sure if you wanted to get back and finish this off by addressing the Affordable Care Act question.

LAWTON BURNS: Oh, sure. The answer is definitely no. I think the ACA isn't forcing anybody to do anything. But I think what's driving hospitals and doctors to do the things they're doing this day is the incredible uncertainty that any great federal reform has.

I tell my students, the only thing disruptive in health care is CMS and the federal government, because they just get everybody in motion and nobody really knows what to do.

And unfortunately, I was trained as a hospital administrator, so I'm one of "them" initially. And so I don't mean to be rude to them. But there's a lemming instinct that goes on when these big reforms come out, and that lemming instinct happens to coincide with the herding instinct when they form these systems. The lemming-herding instinct.

Anyway, so I think that's what's going on. And we actually learned this back in 1993 when the Clinton health care plan was proposed, because hospitals and doctors did the exact same thing for the exact same reasons, except Clinton health plan died a year later, and hospitals continued doing it. I guess they missed the funeral, but they kept doing all these things.

And so what I tell my students is the Clinton health plan was the single-most influential piece of legislation that never passed.

DANICA NOBLE: Well, a big thank you to our panel. It was really tremendous. Thanks for sharing your work, Leemore. Thank you to each of you. It's been terrific.

For those of you here and those of you watching online, the slide presentations will be available on the FTC and DOJ's workshop website, so you can find them there. We'll be back in about 10 minutes for the final wrap-up and closing remarks, and there will be some light refreshments during this break. So enjoy.

[APPLAUSE]

SUMMATION ROUNDTABLE: ANTITRUST PERSPECTIVES ON EVOLVING PROVIDER AND PAYMENT MODELS

Moderators:

- **Tara Isa Koslov, Deputy Director, FTC, Office of Policy Planning**
- **Leslie C. Overton, Deputy Assistant Attorney General for Civil Enforcement, DOJ, Antitrust Division**

Panelists:

- **Mark J. Botti, JD, Partner, Squire Patton Boggs LLP**
- **Martin Gaynor, PhD, E.J. Barone Professor of Economics and Public Policy, Carnegie Mellon University**
- **Thomas L. Greaney, JD, Chester A. Myers Professor of Law and Co-Director of the Center for Health Law Studies, Saint Louis University School of Law**
- **Dionne Lomax, JD, Partner, Mintz Levin Cohn Ferris Glovsky and Popeo, PC**
- **Mark B. McClellan, MD, PhD, Senior Fellow in Economic Studies & Director of The Health Care Innovation and Value Initiative, The Brookings Institution**
- **Monica Noether, PhD, MBA, Vice President, Charles River Associates**

TARA KOSLOV: Welcome back everybody, we're going to go ahead and get started. We have a lot to cram in an hour and half of what we think will be a very interesting summation panel. So we're going to try and keep this moving along. So my name is Tara Koslov, I'm the Deputy Director of the FTC's Office of Policy Planning. I am joined by my friend and colleague and co-moderator, Leslie Overton, who is the Deputy Assistant Attorney General for Civil Enforcement at the DOJ Antitrust Division. And I'm going to very, very briefly introduce our panelists, but because you have all of their bio-information in your materials - basically, we have everybody lined up here in alphabetical order and you have the list in front of you.

What I wanted to highlight is that in addition to everybody's current positions that you have listed here in front of you, almost, I think, everybody who's part of this panel has a very interesting prior that you can see in their bio. I think everybody here has had prior government experience. And so, I think part of why we selected these people, and we're very delighted that they joined us for this panel is that they are all bringing that additional interesting perspective from the positions they've held before in addition to their current positions.

And I'm going to turn things over to Leslie to explain the format that we're going to use for our panel today.

LESLIE OVERTON: Thank you very much Tara. You all have heard a number of wonderful informative presentations throughout the two days here, and so we are not going to have presentations per se, this format is all Q&A. And hopefully that will keep things moving and keep everybody awake at this time in the late afternoon. I would ask that when our folks are walking around with index cards for you to write any questions - that you try to get us your questions on the earlier side, because we want to integrate them into our Q&A.

If there's some pressing question you have that gets prompted by the discussion, then you'll have a chance later to submit it. But we'd like to get the Q&A going early so that we can integrate them nicely. And now I'll turn it back to Tara.

TARA KOSLOV: Great. So, let's see. For our warm-up round here, we're going to start with the topic of ACOs, going back to one of the panel topics from earlier today. So I'd like to start with just kind of a big picture question, but one that will really help us hone in on the competition issues. I know we've been hearing a lot over the course of the two days really drilling down on the specifics of what's going on in these various marketplaces that we're learning about. But if a couple of our panelists could help us really tease out what are the competitive implications that we can draw from the early returns that we're seeing on ACOs thus far?

And we've heard that there is some anecdotal and more qualitative information that we're getting about ACOs, there is some quantitative information that's starting to come out that we heard, in particular, from the folks at CMS/CMMI. So what is that telling us about what we should be thinking about from a competition perspective? And why don't we start with, let's see, I think both Mark and Marty were particularly interested in this question. So Mark McClellan, why don't we start with you, and then Marty and then if others want to chime in. Thanks.

MARK MCCLELLAN: Thanks, it's odd I guess with a panel mostly of lawyers to turn to the two non-lawyers on the panel for the start of the discussion, but- you've all heard a lot already from some of the people who've been doing the leading work on assessing ACOs so far. My sense is- I think you heard earlier, too- is that we're still in the early stage of implementation of ACOs. And so policies that support ACO formation, because of the importance of the goals of the ACOs, remains very important.

I would just like to highlight the diversity of ACO activity taking place now, and the limited amount of evidence on which forms of ACOs are more effective. I know- and this came up earlier too- when a lot of people think of ACOs, they think of big, integrated organizations. But actually most of the growth in terms of numbers of ACOs recently has been in smaller organizations that are not at the level I think of raising any kinds of anticompetitive concerns. So think about physician groups, maybe even just primary care groups who are starting to take on some accountability for overall cost.

And some of the early results from the CMS experiences, as we reported in a *Health Affairs* online article, some of the more impressive savings in the first stages of ACOs have come from these small organizations. That said, there are successful ACOs in every size range, and a diversity of contracting arrangements. And I think the guidance that DOJ and FTC have already put out, which has suggested a path forward for ACOs- even some that may raise anticompetitive concerns - is a good place to start.

Given the diversity of responses, and the fact that there probably isn't going to be any time soon a specific set of rules or criteria that you can just check off to say this is going to be a successful ACO or not, I think it heightens the importance of antitrust and competitive policies that focus on working at the actual performance of the ACOs in the markets. We had some earlier discussions

at this conference as well about getting better measures of both quality impacts and cost impacts of accountable care organizations. And if these organizations are there to do anything, it's to actually be able to focus explicitly on getting quality up and getting cost down.

And I think if there is an area where competitive policy and CMS policy could make a bigger difference in promoting ACO formation that really does lead to the desired goals of better quality, and lower cost, which is the point of competition policy, as well, having more evidence, more measures that could support that is very important. And maybe we can talk a little bit more about how to do that.

MARTIN GAYNOR: So, I'll try to be relatively brief, and maybe focus a bit more on the competition side. So with ACOs, the competition issue is fairly simple, and it really is not particularly specific to ACOs. If there's something about an ACO- the way it's formed- that leads to harm to competition, then it's a problem. And I do want to emphasize that if that's the case, then that's actually working completely contrary to the purpose and the intent of the ACO movement, which, of course, is to deliver better care at lower costs to U.S. citizens.

So that's not what anyone wants, and this is actually a good example of interagency coordination, and cooperation. CMS, DOJ, and FTC have really worked very closely on this and are keeping a close eye on things. I think also Mark made a couple of points that are important here - that ACO - I joked for a number of years, the big question with ACOs is whether ACO stands for Anti-Competitive Organization. And thus far the answer seems to be, well, not really. It doesn't look like, up to this point, we're experiencing major problems. And a lot of that is because a lot of these are not particularly large, they don't necessarily involve merger or acquisition.

There are lots of ways to skin this cat, and I think that was really the intent of the ACA, to try and encourage innovation in organizations to achieve better quality care at lower costs for Americans.

TARA KOSLOV: So one thing that we've heard come up a couple of times over the course of the few days is the mention of the policy statement that the FTC and DOJ had put out regarding accountable care organizations. So at least from the two speakers we just heard from, you seem to be indicating that the guidance is adequate. I want to make sure I throw out there if anyone on this panel wants to take a contrary view- do you disagree? Do you think that more guidance is needed from the antitrust agencies about ways to form ACOs consistent with competition law and policy?

MONICA NOETHER: I'm not going to disagree, I just want to point out that because ACOs come many flavors and forms and are certainly still evolving, there may be a point in the future when it's worth revisiting the guidance. But I think locking in anything more firm now as the whole market's evolving might actually have a deleterious effect. But it's something I think that needs to continuously be revisited.

THOMAS GREANEY: I'm not sure we have very good data yet as to the degree of concentration reflected in the ACO structures, but I will mention a couple things. As with all of health care, you really have two levels of competition- you have the provider level, so to the extent that

markets are not competitive- especially hospital markets are not competitive- there's a real question of, as Marty was suggesting just a moment ago, there is a real question of how much they're going to devote to the cost-saving effort.

And secondly, I think the premise is that we're going to have inter-ACO or inter-network competition at the other level. And it's not clear to me that that will occur in all markets. And we have what I think we'll return to later- I'll certainly bring it up- is what Clark Havighurst called a little while ago- the provider monopoly problem. We've got a lot of dominant hospitals, dominant physician groups, and the ACO model is not an answer for that. And when we talk about regulation, we'll talk about some of the avenues to pursue in that direction.

MARK MCCLELLAN: I'm looking forward that discussion. I think, as Tim emphasizes, this is a hospital market problem- or it's a general anticompetitive problem- not an ACO-specific problem. And this would highlight the point about revising the guidance in the future, as everybody on the panel that has spoken has emphasized, we need more evidence on what's working and what's not. The thing that I worry most about in the short term is that it's hard to get that evidence.

You heard earlier about some really earnest efforts by a large number of people, including CMS themselves, to assess the early impact of the program, and it's still early. But the fact is the data are pretty limited, and that's a concern to me for a program that is supposed to be about producing measurable improvements in quality of care, outcomes, and health care cost. So I think a bit more is not a DOJ and FTC issue, it's probably more of a CMS issue and more of an issue for the private payers, but a bit more effort around getting comparable, meaningful measures of quality, and cost impacts from the ACOs- it's right, square in the center of the intent of ACOs, and we're still only seeing limited and not very comparable evidence, especially outside of Medicare.

MARTIN GAYNOR: Actually just let me touch on a couple things that Tom [Tim] and Mark just said. I think Tom's [Tim's] comment about the functioning of health care markets has broader implications for any kind of health reform. ACOs are one realization of that, but of course, there are lots of other things. We talked about this a little bit on the panel- whether we like it or not, we have a market- based health care system, certainly with regard to provision, and for the most part, even with regard to financing. And no matter what the reform is, those reforms are layered on top of that system.

And so, I think Tom's [Tim's] comment about ACOs touches on that in a very important way, but it manifests itself throughout the system. The other point I'd like to touch on that Mark raised is CMS and Medicare. Often in the health care arena, and particularly in antitrust enforcement, there's a great deal of emphasis on the private sector. And that's, of course very, very important. But competition and the function of markets affects Medicare beneficiaries and Medicaid beneficiaries as well, in very important and profound ways.

LESLIE OVERTON: All right so we are going to move on to our next topic- Consolidation and Concentration. And I'm going to start with a subtopic that generated some interesting discussion at the last panel, and that is cross-market consolidation. And we heard a number of things,

including some interesting work that Professor Leemore Dafny is doing along with Robin Lee and Kate Ho. And I'm interested in reactions from this panel on the theories of harm with respect to consolidation across geographic markets or across our product markets, and what evidence we have about competitive effects in these situations. And the extent to which this should be an area of focus for the agencies. Dionne, you want to start?

DIONNE LOMAX: That's my cue. First of all, again I thought that the other panel did a great job addressing this issue, so in a nutshell my perspective- and again focusing on the cross-market consolidation of hospitals- I actually think that cross-market hospital mergers are more likely to raise competitive concerns when it involves a hospital or a health system with market power that also engages in bundled or full-system system contracting. I certainly think that the concern- again as Leemore Dafny raised- is that these transactions may result in higher prices. And again the other panel pointed to some studies of these higher prices, but I think that occurs, again, because these hospitals may be able to increase their bargaining leverage vis-a-vis the health plans by threatening one or more holes in that particular plan's network.

I also think that there are some instances where these hospitals or health systems are seeking significant rate increases, and in some cases they are seeking significant rate increases for the hospital or facility that's perhaps geographically distant. And so I think it puts the health plan between a rock and a hard place, because the plan has to weigh, OK, do I pay these increased rates and have to pass off these rates in the form of higher premiums to my enrollees, or do I risk being dropped by this, perhaps a very large health system, and having network disruption, having employers not be able to offer my plan to employees? And essentially not being able to offer an economically viable plan in a particular area?

Do I think the agency needs to be going after these transactions? I do think that it is important that they take a close look at scrutinizing some of these transactions, because I do believe that there are certain factual circumstances under which they can be anticompetitive and in terms of the evidence, I guess I'll just point to some of the factors that the agency may want to look at if they're going to analyze this. Obviously, as I've already mentioned, does the health system, or are there facilities within that health system that have market power? Is the system engaging in full-system contracting or bundled contracting?

If they are, what's the rationale for that? Is there a procompetitive justification, or are there certain efficiencies associated with it? Or is there an anticompetitive intent there? You have to also look at the extent to which health plans have mechanisms that they can use in order to escape or defeat an attempt to increase prices anticompetitively. Can they use tiering mechanisms? Can they use steering mechanisms to steer patients to lower cost facilities?

Finally, I think that, obviously, you want to look to see if the system is seeking a price increase for the system or for particular facilities within the system. Are those proposed price increases anticompetitive? Or, do you have a situation that I think Leemore Dafny articulated well- do you have a situation where the overall bundled system price is actually competitive? Maybe they've actually reduced the rate, say, for the must-have academic medical center, but they've increased the rate for the other outlying community hospital. So I think ultimately, if the agencies really want to look closely and critically at the impact these transactions are having, dare I say they may want to consider a hospital cross-market merger retrospective.

LESLIE OVERTON: All right, thank you Dionne. Monica, can we get an economist's perspective here?

MONICA NOETHER: Yeah, I'll add just a little bit. I think, certainly some of the questions that Dionne raised are relevant questions, but I think a lot of those questions are relevant within what we would normally consider a single geographic market, when you've got a system, and- is there a bundled or tying kind of issue. And it can also happen between hospitals and physicians for example as well. So there can be a product aspect of it. We were chatting a little bit in the break with a couple other folks about when you get to the cross-market stuff, is some of it a definitional thing? Like how are we defining market?

So we think of hospitals in distinct geographies that we would consider different markets, because the patients who are using those hospitals don't overlap, and they're not going to travel from one market to another. On the other hand, if they're both employed- and Leemore Dafny mentioned this- by the same employer, and that employer is looking for a single payer to cover all of its employees, then maybe the customer in this case is the employer or the plan who is contracting with the employer. And you need to kind of think about the whole market definition a little bit differently.

So I think it's kind of in the early stages. And in terms of the competitive effects, I think we've got a little bit of empirical work going on now, but I don't even know that we quite know exactly what we're trying to measure at this point. So I really do think it's much too early to say whether there in fact is evidence to support what obviously seems to be a concern that's expressed in different places.

LESLIE OVERTON: And Marty wants to jump in.

MARTIN GAYNOR: I'll try to be brief. I think that great points have been brought out. I think that one thing- in a sense, thinking about things in this way is not really any different from what we're calling conventional kinds of analyses, in that what we've really focused on is competitive effects. And focusing on antitrust of course. I think we've been moving towards competitive effects and away from somewhat mechanical attempts at market delineation for quite some time. The 2010 horizontal merger guidelines reflect that, and I think that's a good thing. So I think that's really what we're focusing on here, but I also agree it's relatively new, we're still wrestling with it.

The paper that Leemore mentioned- she has with Kate and Robin has some early evidence- the Lewis and [INAUDIBLE] paper has some early evidence. And again, there's a lot of anecdotal- I don't if I should call anecdotes evidence- but there are a lot of anecdotes from payers in particular, and some employers that are consistent with this. But I do agree that we're not quite there. It's important, but not quite ready for prime time in my opinion.

MARK BOTTI: Can I jump in on this? I think about cross-market in terms of the hospital-physician transactions that were talked about as well. I'm going to tie this to Marty's comment on anticompetitive effects. And the reason I pick on hospital-physician markets is the interaction

between hospitals and physicians in the marketplace and how either plans as customers, employers, or patients choose hospitals has long been viewed as influenced by the physicians who admit to those hospitals and the medical staff in a unique way.

So anyone who's done a hospital merger knows that you look closely at the physicians associated with those hospitals in deciding what you think about competition between the hospitals. That's a very unique cross-market relationship, and is somewhat different, I think, than many of the examples that Dafny put up on her slide. Even cross-market hospital things. The explanation, if you will, as to why whatever change you see in the marketplace following the consolidation is anticompetitive may be missing so far in these other matters.

In the hospital-physician matter, I think there's been a lot of work done that could explain it in terms of how there's a loss of competition. And it takes me to this notion of anticompetitive effects which should not be confused with merger effects. Mergers can have changes in the marketplace, prices can go up, down, products can change. Not all those changes are anticompetitive simply because they result from the merger. And some people like them, some people don't like them. And I think you need to be able to connect up this early empirical work to some type of theory so that we don't go off on a tangent in health care enforcement that's divorced from antitrust enforcement in all sorts of other industries.

LESLIE OVERTON: Alright, I'm going to move to regulation, because I know that's an interest for Tim and Mark McClellan among others. And so from a competition perspective, what does the panel think of the use or attempted use of regulatory consent agreements, statutory caps like we've heard about, certificates of public convenience or similar approaches to addressing dominant providers? And I'll start with Tim.

THOMAS GREANEY: The answer is not much. These so-called conduct decrees, as Dr. Emanuel mentioned yesterday are really settlements of anticompetitive mergers in which the Attorney General of the state allows the merger to go forward subject to judicially supervised- and I'm going to use a dirty word here- regulations. And it's really a regulatory decree in the sense that it dictates rates and other matters. Typically caps on price increases, limits on future affiliations, and limited bundling of bargaining, so that a system may only bargain its academic medical center separately from its community hospitals.

A lot of doubts were raised in the Massachusetts Partners case, which was just decided by the Superior Court judge. And people raised objections about the ability of regulations to really set prices, ex ante, would require predictions. And the institutional capabilities of judges and understaffed state attorney's generals to really police these things. In fact, the judge herself, in rejecting the consent decree said, you know, I just don't want to do this for 10 years, and I'm not capable of doing it. And I think she had a picture of Judge Harold Green on her wall who was the judge who supervised the AT&T decree for 10 years. So there are real problems with these decrees. Now I'm going to say a kind word, out of character, but I'm going to say it, which is- for the state Attorney General, there's the question of, what's an Attorney General to do faced with a dominant hospital, extant monopolies, there's a bundle of proof now coming out of studies by Massachusetts, Dr. Sheffler's talk yesterday that they charge premiums, and those premiums are un-correlated with quality and anything else you can think of.

So the answer, at least in these cases was to put some kind of cap on the dominant provider. And I think there's a lot of sympathy for that. And we may come back to that later, and there's some interesting writing being done. I'll just mention now Catalyst for Payment Reform put out a very interesting piece a couple of years ago with sort of a menu of things to do to deal with the dominant provider. And most of those used that dirty word of regulation, but I think most economists would agree that at some point regulation has to be an answer.

MARTIN GAYNOR: So I think this is a really, really important topic. But I guess I would like to frame it a little bit differently and ask the following question- what can government do to facilitate competition? And think of this as a helping hand to the invisible hand. And I think of this as a relatively light helping hand. So obviously antitrust is designed with that goal in mind- facilitating competition. But I think there is a number of other things, some of which the agencies do. So trying to do things to advocate or work with various levels of government to minimize restraints on competition, on entry of new forms or entry of existing firms into new areas, of innovation, and unfortunately state legislatures and regular departments are quite innovative but usually those go in the opposite direction.

So that's an area of great, great importance. I do want to mention a policy innovation that I think has actually been quite productive based on what I've seen at this point. And that's, in Massachusetts, the creation of the Health Policy Commission, which is a monitoring agency. It has the authority to collect quite extensive and good data about the health care sector in Massachusetts and write reports, issue guidelines- but it has no enforcement authority whatsoever. Nonetheless, it seems to me up to this point, it's been quite influential and successful. And coming back to Partners, which was a problem with a very, very large dominant system, the HPC issued reports that were quite influential.

They were cited over and over again in the court's opinions, as well as by the Attorney General. So I think that sort of thing, which is a fairly light hand, is a model to be thinking about. I do want to say something- I'm not going to say anything about conduct remedies because I have nothing nice to say, and my mother taught me if you don't have anything nice to say, don't say anything. With regard to regulation, in particular all-payer regulation, this is something that's been talked about a lot recently in the past few years.

And it's so natural that that would come up because we do have quite a few markets that are dominated by either one or a very small number of health systems. Can you say Pittsburgh? But I would hesitate somewhat before going that route. It does suggest itself, but I think the evidence on all-payer rate regulation, health care is mixed. Maryland is often held up as an example, but there's some recent evidence showing that it actually doesn't seem to work as well as advertised. You can do lots and lots of comparisons. It's hard, generally, to get good scientific evidence on this, but I would suggest even casual or sort of tougher research doesn't lead to a firm conclusion one way or another on this.

And if we look at lots of other industries, it's not to say that regulation can never work, but there have been real serious difficulties with, say, price cap regulation, for example, and in other industries. So I think it's something that if we're considering, it should be approached with care.

LESLIE OVERTON: Thank you very much Marty, and thanks for highlighting competition advocacy, which is certainly an important tool for both agencies. So I'm about to shift over back to Tara for our efficiencies discussion, but I wanted to just make sure- Mark, did you want to jump or do you- oh, Monica?

MONICA NOETHER: I can jump in for a little bit, I just wanted to augment a little bit about what Marty was saying. Certainly as an economist, I'm not going to condone the use of regulation as a replacement for competition, but I do think- particularly after listening to the last couple days- that, at least in some markets- however we define those markets- we are going to struggle, whatever the form of clinical integration takes, even if it is short of ownership, unless everybody is totally nonexclusive.

That there isn't just going to be areas that just don't support a lot of competition across the kinds of entities that we're envisioning for value-based payments, and population health, and whatever other jargon you want to use. And so I think we are going to have to start thinking about what some of those trade-offs are, and what may be some reasonable alternative ways of handling it are.

MARTIN GAYNOR: I'll agree with that, I just will say that that to me emphasizes the importance of all levels of government doing what they can to try and enable competition. So even if we have incumbents in a certain place, as we know, there's a long history of incumbents being toppled. And we want to have conditions under which that can happen.

MARK MCCLELLAN: And this is a very dynamic industry, where the ways of delivering care hopefully five years from now are going to be different than they are today. And a lot of these regulatory structures may have a hard time adapting to that, and new kinds of contracting models, telemedicine, new team approaches to care- the kinds of things that I think Marty was emphasizing that the legislature seemed to be getting in the way of sometimes rather than promoting. I think what has helped in Massachusetts is getting more information out about just what kind of impacts these health care organizations are having.

And I stole- we saw this experience when we implemented Medicare Part D, you can get a lot more competition if you have reasonable transparency. And I know we're going to talk about- or I think we're going to talk about exchanges and things like that soon too. But in addition to trying to foster approaches to competition, promoting ways of giving individuals, payers, public policy makers better information on how these systems are actually doing in the areas that we really care about- health outcome impacts, cost impacts.

These are hard things to measure historically in health care, they haven't typically been part of a public normal routine, public reporting. The report that was released yesterday here that NASI was involved with, they couldn't really find any reliable information on things like quality and cost impacts of even large systems. I mean that's not a good place to be at a time when a lot of what we're doing in health care reform is directly about improving outcomes and lowering costs. So I think that's where some of the Massachusetts effects have come in and just shining a light on what is really going on with quality and cost impacts. And I think it's a really underutilized area of a policy for promoting competition.

TARA KOSLOV: So somewhat following up on that, but also taking off a little bit from our discussion of concentration and those sorts of consolidations- as we know as antitrust lawyers and economists, you can't have a discussion about the competitive effects of consolidation without seriously considering what the efficiencies arguments would be. And so we did want to spend at least a few minutes drilling down specifically about what we may know at this point about efficiencies. And we do have the benefit of the recent *St. Luke's* decision, which we heard about during one of the earlier panels. But we did want to get some thoughts from this panel about what sorts of lessons we can draw from what we've seen in *Saint Luke's* regarding how efficiencies are being treated or should be treated in health care transactions.

And kind of as a corollary to that, I'll throw out this second question as well and then people can discuss- what we are hearing from the *St. Luke's* court is basically a lot of skepticism about whether efficiencies are sufficient to justify a merger that is increasing concentration and potentially leading to higher prices. So what alternatives does that leave? What are the other ways that you can align economic incentives short of merger? And what do we know about those sorts of trade-offs? So let's see. Dionne, why don't you start and then Monica and then we can go from there.

DIONNE LOMAX: Sure, I'll talk a little bit about what I think some of the lessons that we can learn are from the *St. Luke's* decision. I think the first lesson obviously is that, unfortunately, provider mergers I think are going to continue to be subject to very stringent efficiency defense standards. I think, as Tara just noted, the Ninth Circuit expressed great skepticism regarding whether or not an efficiencies defense is even appropriate in a merger context, noting that the Supreme Court has not really expressly recognizing an efficiencies defense to a Clayton Act Section 7 claim.

I think, as we all know, and it's been greatly discussed- the court agreed with the district court's view that *St. Luke's* efficiency claims were not merger-specific, but also noted that even if they had been deemed merger-specific that they would fail because there was no showing that the efficiencies increased competition. I actually think that this standard places a significant burden on defendants. I think it's, quite frankly, probably very difficult to meet. And I have a little bit of a concern that there are certain providers that actually may have a reduced incentive to actually pursue certain transactions, particularly if they view antitrust as an insurmountable barrier.

And so I think, broadly speaking, I think the case highlights the difficulties that providers may face going forward persuading courts as well as the agencies that their claimed efficiencies are merger-specific. In particular, I think this case leaves a number of questions about the type of efficiency claims that were being asserted. It's focusing for a moment on the fact that the claims being asserted in part were quality improvement claims. I think right now it's unclear precisely what type of evidence the FTC and the courts for that matter would find persuasive on that particular issue. And I think that there's also a bit of confusion about how quality in merger specificity should really factor into a merger analysis.

And so one thing that I'd like to throw out for consideration is- let's consider where in the merger analysis these types of quality improvement claims really should be considered. Should they be

part of the efficiencies analysis? Or should we try to persuade courts that they're best analyzed as part of the competitive effects analysis? Again, query- we don't know - but query whether these types of claims might have an ability to fare better if they're analyzed as a procompetitive justification under a competitive effects analysis. And I'll also throw out for food for thought that also query whether if they are viewed under that competitive effects rubric, would that alleviate defendants of this whole merger specificity issue?

And I say that because whether or not the analysis of competitive effects under Section 7 mandates that quality improvement claims be merger-specific, I think that's been debated, particularly in the *Evanston* case. And so I think when you take a few steps back and you look at the *St. Luke's* decision, I think overall it's fairly clear that when you have a transaction that's deemed likely to substantially reduce competition and increase prices, evidence of improved quality or reduced cost is really not going to carry or save the day. Under the Ninth Circuit's specific analysis, I think that efficiency claims that demonstrate an ability to enhance competition may have a chance of succeeding, but I think that's probably only going to be in the context of a transaction, perhaps in a moderately concentrated market, with a insubstantial impact on competition.

TARA KOSLOV: Monica?

MONICA NOETHER: I'll take up the piece about what can be done in terms of achieving efficiency short of merger. And we've actually had a lot of discussion about that over the last couple days, but frankly the main takeaway I've gotten is that the evidence is kind of mixed in its early days. And yes, you can certainly do some things short of merger, but the question is can you really do as much? And so I guess I share Dionne's concern that the bar is too high right now just because the evidence isn't out there and it's very hard to generate that kind of evidence right now. And I think, going back to basic principles of the theory of the firm, you tend to get into these decisions of making, or buying, or contracting, versus owning.

And you think about what the alternatives are, and they tend to involve what are the costs of entering into a complete contract? Translate that into the context here, what's the cost of aligning the incentives sufficiently that you can really move towards the clinically integrated network? And then what are the costs of- if you do get that contract - of monitoring and enforcing? And again, it's all about aligning incentives and making sure that that works. And I think health care markets are ones where you've got a lot of complexity. And that may suggest, at least from a theoretical piece, that you are going to need mergers in situations like this.

Certainly providers are behaving like they do, and I realize they may have mixed motives, but I think there is a lot of sense right now that they're not really going to be able to deliver on population health. And some of it's a scale issue and a scope issue, but some of it I think is this incentive alignment. And that's, I think a very hard thing to demonstrate. And then you think about what some of the poster children for integrated networks are. And there are places like Geisinger or Intermountain or Kaiser, or Group Health at Puget Sound- they all tend to be very clinically integrated networks that are integrated through ownership.

So I think that while it's certainly not the only form out there - and I don't want to dispute the

counter-evidence that others have put up - I do think that it's certainly a way that a lot of providers are seeing as the most likely to be successful in the environment.

TARA KOSLOV: Just to play devil's advocate on that a little bit - one of the themes that I've picked up over the last couple of days is that we've heard a lot that the form of organization may not be as important as the qualitative nature of the integration and the way that a culture is changed, and the provider behavior is changing. And I'm not sure that we've necessarily seen evidence that just because you are fully integrated via merger that you are necessarily going to reap those efficiencies—that that's any more likely - that it may just be a question of how well you do the integration, no matter what the form of integration is.

MONICA NOETHER: I absolutely agree with you and I think- Zeke Emanuel actually framed it that way by distinguishing between consolidation and integration. And I guess the way I would put it is that consolidation is certainly not sufficient. And the question I'm trying to throw out is, is it a way that is more likely to succeed in getting to the true clinical integration than other ownership forms? And I don't necessarily have the answer to that, but I guess I'm expressing some skepticism about a definitive conclusion that it's not.

THOMAS GREANEY: Just a quick comment, I believe I'm correct - and Andy Gavil can confirm this, because I think I got it from his case book, which I use- there's never been a Section 7 case in which efficiencies was the determinative factor in approving a merger, certainly not in the hospital area. Typically judges cite efficiencies when they're ruling in favor of the merger on other grounds, and vice versa. And there's a reason for that, because the whole task is really unmanageable. The idea of weighing efficiencies and somehow calculating them against the market power is really quite a Herculean task. So I think I'd agree with Dionne that perhaps- not so we don't put economists out of work altogether- that perhaps the question could be put into the effects issue.

And I think there is room for talking about quality-adjusted prices. Which, again, is one of those things which antitrust law so far has not done very well with.

MARTIN GAYNOR: So let me agree with Tom, we don't want to put economists out of work,

[LAUGHTER]

I second that definitely. But let me touch on a few things that have been brought up, and one is the treatment of efficiencies. And I'm free from constraints of the law or lawyer's opinions or precedent because I'm an economist, and there are fantastic lawyers here, so they can -

TARA KOSLOV: That was not true while he was here at the FTC, by the way. Now that he's not here anymore, he -

MARTIN GAYNOR: That's all I'm saying at this point. But from an economic perspective, there's really no sharp divide between efficiencies and competitive effects. The question is whether consumers are better off or not. And efficiency is a part of that as well as competitive effects. And for that matter, efficiencies, if they're there, do affect competitive effects, and so

that's not novel, it's not innovation from the point of view of economics. How courts think about that and how to - the right language, I understand, is important - but from the point of view of economic analysis, I really don't think there's any dichotomy here. It's really, in a sense, a false dichotomy.

With regard to efficiencies in this sector. Look, I'm going to differ at least slightly, maybe to a larger extent, with Monica. The evidence says they aren't there. And we heard extensively from Rob Burns, who is the leading scholar on this and Ken Kizer, and it's not like this is new. We have 20-plus years of evidence on all kinds of different organizations, not just hospital-hospital, physician-hospital organizations, and so on. And for the most part, it hasn't worked. In previous waves, these things fell apart because they were not effectual, they actually ended up costing money instead of making money.

So I think we start from the presumption that the efficiencies are not there, and of course, in a specific instance, if evidence can be brought forward that actually there's good reasons to think those efficiencies will be realized, and again that's merger-specific, you need the merger to do that- fine. But I think there's a very strong presumption in the opposite direction, and we don't have to agree on that. Another point that I think is very important here is that if a merger or some other arrangement occurs and competition is harmed, once competition is gone, it's gone and it ain't coming back. It's very, very hard to undo these things. So I think that caution is appropriate. I'm not saying that efficiencies shouldn't count- just the opposite. But I do think that harms do have to be given a great deal of weight.

MARK BOTTI: Just one quick comment. For many years, horizontal mergers between direct competitors are presumptively lawful. They eliminate competition and I think infused in that presumption is that they are efficient. And when you're doing merger enforcement, I think it's important for the agencies and people thinking about this not to get caught up in the stylized court analysis of how we weigh burdens of proof, and where they come into effect, and keep in mind on the front end of a merger walking through the door, motivation- why are they doing this strategic merger- is clearly an important question. If it's not, stop looking for the anti-competitive intent documents.

And the whole area of health care reform- there was a discussion earlier today about is the ACA requiring mergers? OK, no. But is the Affordable Care Act and health care reform causing mergers? Sure it is. And I think agencies should not lose sight of that when mergers come through the door, in understanding that this transaction is coming here because of all these changes in the marketplace. And not say, oh, well, that's an efficiency defense, I don't want to hear about that. The efficiencies, the justifications for the merger- the reasons for it- are very important to understanding what you're reviewing.

MONICA NOETHER: Well, I think it's in that health reform context that we don't yet have the definitive evidence on, as the whole system evolves, what's it going to take to be efficient?

MARTIN GAYNOR: I'm going to emphasize again, in the absence of evidence, I don't know that that simply implies that we let these things go through, even if we can say that the fact that health reform is going on is a major motivation. That still doesn't mean that it's good for the

country if these things happen. And once they happen - we've seen this, right - due to the courts failing to enforce the antitrust laws in the health care sector we had massive consolidation over the past 20 years. And now we're faced with Partners, were faced with UPMC. And they are mirrored all over the country, and I think they're causing a great deal of harm to the United States. And as a matter of fact, I think that they make health care reform far less effective.

LESLIE OVERTON: OK, I'm going to jump in. So we can keep moving. So we're going-

TARA KOSLOV: I'm just going to throw out, if anyone does have questions- as you can see, we have plenty of our own. But if anybody has any, I just want to make sure that we know the comment cards are available.

LESLIE OVERTON: Absolutely. So I'm going to move us to concentration and competition on the payer sides. We're going to talk about insurance exchanges. And we had a good session on that previously. We heard some early returns about what's going on, very preliminary but we heard that- where exchanges were bringing in new entrants. Premiums were rising at a significantly lower rate than in markets without new entrants. And so I want to know to start with Mark Botti and get a take on- what are you seeing so far in terms of how competition's playing out on the exchanges?

MARK BOTTI: Well, I can't add much to what we're seeing beyond what was reported in the earlier panel. Those folks looked closely and reported as to what we're seeing. I will offer a little interpretation of it. In past merger matters, antitrust agencies looked to certain things to suggest you could have anticompetitive effects in a health plan market. These are barriers to entry, right? That's been the focus on these cases. Brand is a thing that's pointed to as a barrier to entry. Lack of information is another barrier to entry. Sometimes distribution is referred to as another impediment to competition. And lastly, I think, access to an economically competitive provider network. I think those are the main factors that have been sighted in markets that are viewed as contributing to that anticompetitive market.

And one thing I took from the panel is that many of these factors are important in consumer's choice. In the individual market, these factors have been reduced in terms of their ability to impede competition in the marketplace. So that suggests exchanges are designed pretty well to accomplish their purpose. I will say I don't know that historically there's been much real concern that individual markets are behaving anticompetitively- I know people don't like their rates, I know that they're dominated by certain plans, but whether that's an anticompetitive situation- I'm not sure that's correct. I think you have to search long and hard, you'd probably end up in Montana to find a matter in which the individual insurance market was mentioned as a place where anticompetitive effects were being found.

LESLIE OVERTON: All right, well- let me ask, first of all, does anybody else want to jump in on that question before I move to another? OK. So what, if anything, should the agencies be doing to promote the exchange's ability to promote competition?

MARK BOTTI: Let me keep it going and then I'll turn it over, because I liked Marty's theme earlier, which is don't create barriers to entry. And one of the things I think that is a potential danger here- you've now intervened in the market. The states, the federal government have

dramatically intervened in the health plan markets and said, we're going to become the main distribution source of health insurance if we can. That sounds good, tears down barriers to entry, and you get more competition.

There was a great quote from Bill Baer earlier this year about how competitors and others eventually go to regulators to seek protection from competition. And I think people have to recognize that health exchange regulators are not natural referees of competitive markets the way the FTC is, the way to DOJ is. And if you want to find an area for competition advocacy and for vigilance, it is to watch the exchanges in these areas of potential regulation, which could become worse than what they were intended to cure. That could become the real barrier to entry and, there are some signs of that already occurring in the marketplace.

And I thought some of the discussion that we heard tended to go that way. There was a lot of talk about how- I'm sorry, I know you guys want more data- if we had a lot more information, we could make a lot more choices about what should be offered on these exchanges and really intervene more in the marketplace, all towards a well-intended end. But again, oftentimes, regulatory intervention- this is why I liked your comments, Marty- ends up in the wrong place.

LESLIE OVERTON: Go ahead Marty.

MARTIN GAYNOR: Again, let me echo what Mark said. For just a simple example of regulatory response as it happened at the state level that I think could harm competition- are any willing provider regulations which can really, really hamper the ability of health plans. And network adequacy, either regulations or actual hands-on interventions usually by state departments of insurance. Not to say that there might not be some concerns about those, but they're not usually things that are either passed into legislation or enforced with competition in mind.

So there's a broader theme- health care is a complex industry with government involvement at many, many different levels. And ideally, communication and coordination is the way to go. There may not be good incentives often at the state level. But if these entities had the opportunity to consult with DOJ/FTC on these matters, if they're deeply interested, then I think sometimes a little can go an awfully long way here.

THOMAS GREANEY: Let's not forget that one of the big issues when the ACA was being adopted was whether to have a public option, and the reason was because there was so little competition in individual insurance markets. And although there's been some improvement, there are still a number of states- Iowa, Mississippi, with one competitor. And several others with two.

And the idea of a public option was there'd be someone to get in there and shake up the market a little bit. And the Justice Department a couple years ago did a study, and they found that the main barrier to entry was the difficulty of network formation. So to the extent that we're talking about procompetitive regulation, to the extent that there are things that, as Marty suggests, get rid of laws that impair network formation or impair entry.

But perhaps there are others that would encourage or facilitate entry. The co-ops were an attempt to do that, and I don't know if there's a better way of doing it. But, obviously there is a need for more competition in some markets. And the difference between those states and a state like California- which has an abundance of entrants- shows what competition can do. And in that case, I think the state has had great success acting as an active purchaser.

And, remember, being an active purchaser is really what an employer does when it sorts through its bids for contract. So the negotiation at that stage can produce some more price sensitivity, especially when you have a large number of applicants. But if you're Iowa, you cannot be a selective purchaser.

LESLIE OVERTON: So just to keep us moving, I'm going to shift back to Tara in moving to something actually related- network and benefit design.

TARA KOSLOV: Yeah, Tim, I would actually like to stick with you and pick up on this theme of regulation and maybe expand that discussion a little bit to talk about some other things that are going on in the regulatory environment. And I know Mark McClellan, you have some particular thoughts on this as well. So maybe you could talk a little bit about what we're seeing in payment reform, especially in some of the alternative payment methodologies that we heard about in one of the earlier panels. And also, if you have any additional thoughts relating to network structure and operation.

THOMAS GREANEY: Yeah, I suggested this topic. Back before most people were born in this audience, 1988, I wrote an article called "Competition in Health Care: the Vulnerable Revolution." And the point I was making was that there are regulations that impair competition, and maybe there could be some procompetitive regulations. And I think we've seen that played out, and I've just collected a laundry list. And we've heard a lot about different regulations throughout the course of the last two days.

So certainly there's the good, the bad, and the ugly. We have the bad ones that have been pointed to- any willing provider, overly-stringent network adequacy rules- nobody's mentioned the medical loss ratio regulation. But that's an interesting one, because at some level, it may encourage insurers to put more money back into the provider side to improve their medical loss ratio. So it does seem to act counter to the idea that they should be more vigilant in controlling costs.

We talked about state laws that may inhibit entry of providers, nurse practitioners, et cetera. The old favorite- certificate of need. And remember the ACA really put the clamps on specialty hospitals, and for good reason. Specialty hospitals were a problem. But specialty hospitals were one source of competition in concentrated markets. So perhaps there could be a look at finding ways to allow specialty hospitals back in the game, and curb their cherry-picking and other things they did. There are good regulations too, though. We've talked a little about transparency laws, disclosures of quality information, all-payer databases, and we heard about regulations that facilitate tiering and are working, apparently, in Massachusetts.

And then finally, I'll just mention what Joe Miller said in the last session - how important looking hard at CMS's payment regulations are, because they determine an awful lot about how

private commercial payers pay and the rejiggering of resource-based relative value scale physician fee schedule is a very important step. And the rules that are really being debated now about benchmarks for ACOs will encourage or discourage entry by ACOs in certain markets.

There's a lot being written now by the ACO community about that, just how to set benchmarks in order to encourage entry. So there are a lot of things that can be done. And I'll just say a word that on the ACO side- there was a lot of talk about the risks of ACOs and you may recall that the Justice Department and FTC tried to put in- I think they had five no-nos that they were going to discourage dominant hospitals from undertaking. So that was an attempt to sort of persuade by just dictate that you shouldn't do this.

I don't know how effective those things are. But maybe that kind of advocacy is important. The FTC's done a very good job of what I called avuncular advice to states, and I think they ought to continue that. And perhaps at the federal level intervening or at least encouraging CMS in areas which would promote entry in competition.

MARK MCCLELLAN: I think it does highlight just how much factors that influence competition and market performance are determined by things other than DOJ and FTC policies. And I think doing this kind of advocacy is helpful, but it just highlights the importance of emphasizing these other factors that are ultimately going to be the biggest determinants of how markets perform. In terms of the alternative payment models, I want to particularly emphasize that these generally have the flavor- at least the ones that CMS and private payers are trying to encourage- they generally have the flavor of moving away from paying for specific services and paying more at the level of a person.

So switch from supply-focused payment systems to more person-focused, the level of an episode of care in the case of bundled payments or the level of overall costs and outcomes in the case of ACOs and more capitated arrangements. And one can imagine a future where there is less of a distinction between what the plans do in terms of taking on overall capitated risk and what provider networks do as well. In addition to some of things that Marty emphasized, like being careful about any willing provider restrictions, network adequacy restrictions, I think some of the same things may apply to active purchasing. Active purchasing is a good idea if you know for sure what you ought to be purchasing. I'm not sure that we do. I'm not sure it came up earlier, but some of the evidence on whether the active purchasing states are doing better than some of the other states in the exchanges is at least not clear to me from what I've seen.

We took a different tack with what I think was a very important set of policies for promoting competition when we implemented Medicare Part D. So that's the closest thing we've had to something like exchanges, where you all may remember there were big concerns about, not only might there not be very many competitors, there weren't even Part D insurance plans. That might not work.

One of the things that we emphasize there that I haven't seen so much in the ACA exchange implementation is the availability of meaningful information on quality and access. So as a condition for participation in Medicare Part D, every plan had to make a pretty serious effort at providing transparent information on the price of every formulation of every drug at every pharmacy in the United States. And that was a direct reflection of what we heard when we asked

beneficiaries what they wanted to know. What do my drugs cost at my pharmacy in the different plan options that were available to me?

The nice thing about- there's a lot of consternation among the plans in producing this information that our contracts change, our pharmacy networks change, it's hard to keep up to date. Something similar in terms of making information on the provider networks, the hospital networks, the physician networks, maybe some information on price I think would make it easier at least for people to compare, and maybe give more of a boost to entrants who otherwise might feel like it's going to be hard to break into a market that's dominated by a single, large, well-known insurance company.

And I really haven't seen much of that. And I'd put more effort into that direction than into trying to figure out which exact kind of provider, network arrangements, and which exact kind of forms of insurance we want to support.

MARTIN GAYNOR: If I could respond to that. I think that's an extraordinarily important point in terms of sort of a helping hand to help competition. I think we're seeing this movement, both through the exchanges, but also through employer-sponsored insurance, towards selective contract - well, we've had selective contracting for a long time but what are called narrow networks, which are not really a new thing - high-deductible health plans, putting more on the shoulders of consumers. That's happening inside the exchanges and outside.

And I think that we need to think hard about what needs to be done to best enable effective choice. Information's part, but probably not quite enough. The other thing that comes up in this context that's also important has to do with consumer protection. Particularly as consumers are expected to play a more active role, there's a potential for things that are either deceptive or unfair to consumers. And those are a direct concern in and of themselves. But in particular, also, if those are problematic in health insurance or health care markets, then they can undermine the working of the market.

So if people choose high deductible health plans, and they get hit with unexpected out-of-network bills - these have received a lot of publicity recently - then the viability of those plans may be undermined. The viability of the entire market may be undermined. And so there's a really important role for monitoring and enforcement in consumer protection as well.

TARA KOSLOV: So Marty you had mentioned narrow networks- limited provider networks. And there was one particular question that came up - I believe it was at the first panel yesterday - that I wanted to run by our panelists, and see if anyone had any thoughts on this. So it was in the context of talking about whether the effectiveness of limited provider networks might differ depending on how concentrated the provider market is. And I think it was Paul Ginsburg who hypothesized- or at least threw out- that you might have a situation where, in a relatively concentrated provider market - where you've got maybe two hospital systems - that the use of limited provider networks might actually enhance competition in a market that might not otherwise have as much competition, because it would increase the incentives for them to be playing hard against each other. Curious if anyone else either heard that or would like to react to it now, and what your thoughts might be.

MONICA NOETHER: As Paul Ginsburg explained, I think that narrow networks can be a tool for payers to cause competition in areas where there aren't that many providers to be enhanced. Of course, you need to have something that controls the providers from saying, you have to take me, or I'm not going to be in at all. And that's, I guess, even more true on the tiering side, where they demand to be in the bottom, the most favorable tier, which was also mentioned yesterday. But I think like in any kind of exclusive contract situation, if you've got competition to be part of that exclusive or narrow network, then that can certainly work.

I would echo Marty's point though that I think narrow networks can be effective, particularly for price-sensitive customers where they're willing to forgo complete freedom of choice in return for having lower premiums. But you need to have adequate information so that consumers, whether they be employers, or their ultimate, the employees, can accurately evaluate what it is that they're giving up in terms of choice to get that lower premium.

TARA KOSLOV: Mark Botti, I wanted to- along these lines- one other thought that we heard is the idea that the insurance exchanges, the existence of them may be the ideal- I think it was also Ginsburg who said - the ideal marketplace for narrow networks. And so I know this is something you've thought about a lot- to what extent the exchanges are facilitating or encouraging the use of narrow networks, and how that plays out, how that affects competition.

MARK BOTTI: And so I think you can observe that narrow networks, either offered by insurers or actually provider-sponsored narrow networks have some opportunity in exchanges because you've disaggregated the purchasing of insurance down to the individuals. And so some individuals who otherwise might not have been allowed to choose a narrow network because they were part of a group within an exchange can drive volume to those narrow networks. And so there's an opportunity, and I think we see the emergence of these, in part, I'm guessing, because of that.

The other point to make in connection with that is that you don't want the exchanges through regulation to impair them. This is the network adequacy point coming out in the context of the active purchaser, who says, we don't want that as a purchaser. And Marty, I agree with your consumer protection point, very well taken in this area. But there's always a danger with consumer protection that it over-reaches. And what is consumer protection on the basic fraud and non-disclosure can become protecting consumers from their own choice. And there's a lot of health care that is not emergency care that you need to have within 5, 10 miles of your home. A lot of people travel great distances to Costco and other places to save money on buying their groceries.

And you can travel some pretty significant distances for scheduled health care. You may not be allowed to do that under the current regulatory regime, but if you were allowed to do it, if payers were given that tool, it may help mitigate that market power. It's not going to eliminate it, but it can help control the market power of localized dominant players.

MARTIN GAYNOR: Let me jump in quickly. I'm going to agree with Mark certainly on consumer protection. We don't want too little or too much, we want just the right amount. Easy to say. And I think there's an important point to be made about the sort of narrow networks. One,

like I said, they're just selective contracting. But two, you can't create competition where there isn't a potential for it. And in particular, narrow networks are not some kind of magical tool that will take a market in which there's really no potential competition, say, between two very large health systems, and transform it into one in which there's tough intense competition. The potential has to be there in the first place.

So I think that's very important to realize. But also that again, what that means is, say, using a tool like a narrow network or some other kind of reform is only going to be as effective as the market underlying it. And that, I think, is a critical point that sometimes gets lost, or at least elided a bit in some policy discussions. And another aspect of that- as we think about selective contracting - it can be that a buyer, for example, engages with the threat of selective contracting, ends up all the time having contracts with all the providers in the market, but is able to extract very low prices or perhaps very good quality on behalf of consumers because of the potential to exclude somebody, even if that doesn't necessarily happen at the end of the day.

MONICA NOETHER: I certainly agree. There has to be a credible threat which requires that there be somebody else to go to, and it also requires that consumers don't demand to have complete free choice.

TARA KOSLOV: So those two comments are a good segue to one of the final questions that I wanted to pose specifically to the panelists. So let's assume that we have a market where there is this potentiality for competition as we're talking about, but structurally it is possible to have it. But then we layer on anti-tiering, anti-steering, all-or-nothing contracting, these sorts of provisions that may be put into place. And one important question that I think the antitrust agencies are considering is to what extent those contracting practices are affecting competition, in particular, perhaps, influencing incentives to innovate.

I think we heard from Fiona Scott Morton yesterday, gave one specific example of the concept where a network might want to use a centers of excellence type of strategy as one innovation where they would like to direct all of the patients to one particular facility, and that if you've got some sort of anti-steering provision, it might prevent that. So that would be one example, but I think we know of many others. So I'll just throw that out as the final question and what do we think the competitive implications are of those contracting practices.

MARK MCCLELLAN: I agree with Fiona that it's hard to say in general whether these are going to be procompetitive or anticompetitive, and this would tie this back too to our discussion earlier around consolidation verses integration. A lot of the so-called narrow networks that exist in exchange plans today are not really networks in the sense of providers who are working together to deliver more efficient care, they may just be providers who, according to the health plans, have lower costs or a better track record individually.

And I think a lot of the stories and consumer protection concerns that Marty was raising about people finding out that the nearest provider in-network is far away, or is not actually part of their network, could be addressed by both encouraging - by providing clearer information, but also by recognizing that markets and provider arrangements are not static. And that if we really are encouraging competition and true narrow networks, that is going to probably require some kind

of - if not like formal new kinds of integration, at least new kinds of contractual arrangements, new kind of information sharing, other stuff short of actual mergers that could actually help lead to better quality care and lower cost. If you're going to support these steps towards narrow networks, I think you have to also encourage new ways of providers to work together to form more meaningful narrow networks than what we have today.

MARTIN GAYNOR: So I would certainly agree. I think that one comment Mark made earlier is actually that this is- contrary to some popular belief- a pretty dynamic industry. There's a tremendous amount of ferment going on in health care right now. And what's good about that is there's a lot of experimentation, trying out of new things. And we do want to see what works. I do have a concern about well-intended regulations that actually could, again, unintentionally, be counterproductive.

And I think that is the area where we really do have to be careful. There's not going to be a single right answer to these kinds of things. But again, I think there could really be some substantial benefits for greater communication and coordination between different levels of government. Particularly state government and the federal antitrust enforcement agencies, where the antitrust enforcement agencies can lend their expertise to the states without trying to tell them what they absolutely should do, but making themselves available. And I think that actually FTC and DOJ have been doing a very good job in this regard.

But things can go very badly wrong. There is evidence, for example, that- there was a very big backlash against managed care. Following the managed care revolution in the 1990s, a lot of states passed laws that were a response to this, and that greatly limited the kinds of organizations that could emerge. And actually there is some evidence suggesting that this led to a very large increase- tick up- once again in the rate of growth of health spending that set us back many, many years. And of course that eats away at the well-being of Americans. Increase in health spending over I think the 1990s to the 2000s ate up basically all of the increases in income for an average family in the United States.

MARK BOTTI: Couple quick questions and comments on anti-steering and anti-tiering. You think about them in two different contexts. One is single firm- a single hospital- signs a contract with a plan, and it says, you won't steer the patients away from me, you won't put me in the lower tier. So that's a one-on-one negotiation. That hospital could have refused to deal. And I think in terms of - whatever you say in terms of why might anti-tiering or anti-steering be unlawful in that context, you have to think about it carefully in terms of what's the principle of law you're announcing, here antitrust, in terms of the unilateral right to sign a contract on the terms and conditions you want.

It's a little different when we think about anti-steering and anti-tiering and we get to multi-hospital systems, which now takes us a little bit into the world of bundling and tying I think. And now you get into questions of when is bundling and tying potentially unlawful or not. Anti-tiering and anti-steering can be complements, I would think, to a tying approach. Last comment on this. In the world of population health management, anti-tiering and anti-steering for hospital systems might actually have a significant justification. I think CMS has this exclusivity rule for primary care physicians, because they recognized some difficulties in attribution.

I think in the private markets when systems are looking to take on risk, there is a lot of challenge around attribution of population- how do we figure that out? And anti-tiering and anti-steering could be elements of those contractual negotiations and allow them to solve the negotiation and enter into these risk-shifting contracts. I don't know what the answer to that is. It's simpler- it's more complicated than saying, ah, it gets in the way of narrow networks- it must be bad. I think there's a lot that needs to be thought through on those clauses.

THOMAS GREANEY: One quick question. I'm going to be catching a plane, so this will be my farewell address. That circles me back, at least, to the monopoly provider problem. And I'll mention a couple of articles, neither of which I wrote, but Bob Berenson has a very good one coming out in the next issue of the *Journal of Health Politics, Policy and Law*, as does Bob Leibenluft, a former FTC official. And both are questioning where antitrust is and where it's going. And I recommend you take a look at it, especially Bob Berenson's piece, which does say what I said earlier, which is the dominant hospital that's imposing the anti-tiering is almost certainly doing it for an anticompetitive reason, I think.

And it certainly does have an effect. And I know that Blue Shield and another insurers have made that point, and they face it with some regularity. So I still think the elephant in the room is what to do with those dominant providers who the evidence shows are the cause of the cost issues. So I'll part with that and recommend both of those articles.

LESLIE OVERTON: All right. We have now reached our lightning round. We have all of six minutes left, and I think we have six panelists. I'm not an economist, but I think that's a minute a person. And so I would like each panelist to quickly react to one of the following questions- either where should the antitrust agencies focus their health care related enforcement or advocacy efforts? Or, alternatively, looking ahead, when it comes to the promise of increased health care competition, what are you most optimistic about? So, starting with Monica.

MONICA NOETHER: I guess I'll try to end on a positive note, and I think that clearly, as we get through the transition and move on to the next transition, and however it ends up, it will involve clinical integration if the forces that everybody seems to be feeling are there are there. I think it is going to change the dynamics of competition and the whole way we think about competitive effects. So I think if we can muddle our way through this transition period that we're in now and try to look forward without- but at the same time not stop everything that's going on now. I think there's enough momentum and enough incentive to get to a future place that I think we will make progress.

LESLIE OVERTON: OK, all right. Mark?

MARK MCCLELLAN: Maybe a combination of both. I think the *St. Luke's* action did have an effect. It was a challenging case to pursue, and in some ways it's easier than dealing with a lot large, horizontal or vertical mergers or combination mergers that may not have such a clear email trail and so forth associated with them. But that kind of enforcement action is just absolutely critical. It gets to Marty's point about- maybe if there are some markets that are not yet fully consolidated, and there's not a good reason for that to happen, some more enforcement

deterrence could really help there. On the positive side, though, I would really highlight- I think Monica was making this point too- that we are in very much a transition state in terms of the way health care is delivered.

And the more we encourage some of these transitions, the better. So I would be very careful about general approaches that restrict things like new formations of networks- I wish everybody in health care has as good legal advice and expertise as people like Monica on alternatives to full integration for doing coordinated care, but there's still a lot of questions out there among health care organizations about what can we really do- despite the guidance that's there- without running afoul of stark and anti-kickback rules, short of fully integrating.

So I think encouraging these kinds of alternative arrangements and making sure we don't adopt policies that get in the way at the same time as we're trying to get more information available to people who are making decisions on exchanges or making decisions about which hospital to go to about quality and cost. That seems very feasible in the next few years. Putting those things together, I'm pretty optimistic about the future for health care innovation and value.

LESLIE OVERTON: All right, thank you. Dionne?

DIONNE LOMAX: I guess I'm a fan of ensuring that the agencies are somewhat measured in their vigorous antitrust enforcement. I do agree that we are kind of in a nascent state- well maybe not nascent, but we're certainly at a stage where things are continuing to change. And I really don't want to see the agencies take steps that will chill what I view as innovation. I really do see a number of clients who are trying, really, in significant ways to enter into risk-based contracting.

You see certain provider groups who have done a better job of learning how to control cost, wanting to consolidate and partner with other groups who may not be so good at it and enter into these risk-based contracts to really lower costs. And so, because I certainly deal with providers who are really trying to make a good faith effort to make it work and to really achieve an increase in quality, I would have a concern if the agencies were just being overly aggressive, particularly as they look at provider consolidation.

LESLIE OVERTON: Alright and next I think we've got Tim, and Tim has to leave right after his-

THOMAS GREANEY: I really will be one minute.

LESLIE OVERTON: Exactly.

THOMAS GREANEY: What I said earlier, I believe I'd recommend close coordination and cooperation with CMS in talking about their payment policies, looking at the early and late returns from ACOs, seeing how things are going, and participating fully in that. Continuing the avuncular advice to states- perhaps even putting out some kind of roadmap of procompetitive legislation and things that can be done. And on the optimistic side, I'll say the FTC is doing a great job. And nobody's mentioned it yet- they won a case in the U.S. Supreme Court today.

They won the *North Carolina Dental* case six to three.

TARA KOSLOV: I tried to figure out a way it was relevant to this panel, and I couldn't really figure one out. So I'm glad you said it.

THOMAS GREANEY: Congratulations to them. And they're on a winning streak, and I think they're doing a good job. And with that brown-nosing, I've got to leave.

LESLIE OVERTON: OK, thank you very much, Tim. And I will note for my last two panelists- we are already at 5:30. Go ahead, Marty.

MARTIN GAYNOR: This is very hard for a professor, but I will try to be brief. So I'm 100 percent with Tim on advocacy and outreach- don't take the feet off the gas on enforcement. But I think really in terms of having a big impact on markets going forward, I actually think advocacy and outreach can have bigger impacts on the fundamental competitive environment because antitrust enforcement, while important, is to some extent be a rear guard action. And that includes communication and coordination with the important parts the federal government as well as state governments.

Consumer protection- like I said, I think is an important part. But as Mark cautioned, the trick is getting it just right. And we don't want, for example, the consumer protection role of the FTC to overstep what's appropriate and overdo it and unintentionally harm competition and consumers. The last bit, and this is also critical- is research. It's part of the FTC's mission- I guess it's past the 100th anniversary, but pretty close. Part of the enabling legislation for the Federal Trade Commission has research as part of its mission. And obviously, all of these things- advocacy, outreach, and enforcement have to be informed by research and the knowledge generated by research can help these markets function better.

MARK BOTTI: So I'll tie the Dentist case into this. The dentist case showed the important role that you play in policing government agencies. And Chairman Ramirez said at the beginning of this conference that competition is entirely consistent with health care reform. I think she meant that in terms of- we need to police the private markets- but I think you should think about it in terms of policing the regulators who might be trying to influence health care reform. Make sure that they implement health care reform consistent with competition in order to nurture it. I think that's what Tim and Marty said, and I think it's where you should be putting a lot of effort and resources.

LESLIE OVERTON: All right, go ahead-

TARA KOSLOV: Please all join me in thanking our wonderful panelists. This was really fun for all of us.

[APPLAUSE]

And if my panelists will just sit tight for a moment, I'm going to invite up to do our quick closing remarks, Bob Potter, who's the Chief of the Legal Policy Section at the DOJ Antitrust Division.

And Marina Lao, who's the Director of the Office of Policy Planning at the FTC. While they're coming up, I will also note by the way, we still have some refreshments left over from our event last night and so we've set them out again. And if people would like to continue the dialogue and mingle, it was actually really fun last night for those of you stuck around and so you are welcome to do that again today.

CLOSING REMARKS

- **Marina Lao, Director, Office of Policy Planning, Federal Trade Commission**
- **Robert Potter, Chief, Legal Policy Section, U.S. Department of Justice, Antitrust Division**

MARINA LAO: Thank you, Tara, and thank you all for coming. I won't keep you long, because I know many of you have flights or trains to catch. And in any event, it's been a long day of very, very good talks. And, I don't have anything more of substance to add. But I do want to close by thanking our speakers who took time to come here and share their expertise with us.

I would also like to take this opportunity to acknowledge the enthusiasm, dedication, and hard work of every one at the agency who helped make this workshop a success. As you know, it usually takes a lot of people to put together a quality workshop such as the one that we've just had. And I can't begin to thank everyone by name who has contributed to this effort. But I'd like to just perhaps recognize those whose support and help were the most important, starting with Chairwoman Ramirez, who has been supportive throughout this process. I also want to thank Andy Gavil, Former Director of the Office of Policy Planning, and Marty Gaynor, who, in addition to having been a speaker on two of our panels, was also former director of the Bureau of Economics. They provided the leadership during their tenures to this particular workshop. So thank you both for helping produce such a wonderful workshop.

Additionally, deserving special recognition is the core team who worked tirelessly to develop and implement and put together this entire workshop. They include Stephanie Wilkinson – don't know where she is now – Tara Koslov, Patricia Schultheiss, who unfortunately cannot be here today because of a family emergency, but I want to especially note that she had worked long and hard for months for this. And, we're sorry that she cannot be with us and our thoughts are with her.

Additionally deserving special recognition within the core team are Karen Goldman and Tina Papagiannopoulos from the Office of Policy Planning – I hope I didn't butcher your name, Tina – Ellen Connelly from the Bureau of Competition, Tom Iosso and Dave Balan from the Bureau of Economics, Andrea Kelly from the Office of General Counsel, and Erika Wodinsky, John Wiegand and Danica Noble from the regional offices.

Also deserving thanks for providing really helpful and substantial feedback to the team during the planning stages are Debbie Feinstein, the Director of the Bureau of Competition, Markus Meier, Rob Canterman, Gary Schorr, and Michelle Yost, also from the Bureau of Competition, and Stuart Hirschfeld from our Seattle office.

Now we at the agency have this very good practice of thanking all of our support staff, and, as you know, it is as it should be, because critical to the success of any project is the work of the support staff behind the scenes. So, those who made significant contributions include: Chris Bryan from our own Office of Policy Planning – who was here earlier today, but he's not here now; Lara Kittleson and Fawn Bouchard, our event coordinators; Carrie Gulula and Wayne Abramovich from the Division of Consumer and Business Education, who designed the beautiful posters that you see, the web page, the agenda, and all the workshop materials; Bruce Jennings, James Murray, and Glen Savoy, the ones that you've seen walking around, who ensure that the technology and everything else ran properly today; and Betsy Lordan, Gail Kingsland, and Cheryl Warner from the Office of Public Affairs. And a wonderful group of volunteer paralegals – Jacqueline Lightle, Chip Taylor, Jennifer Wang, Haydn Forrest, Samantha Serafica, Andrew Anderson, and Katia Barron. They volunteered for two whole days to help us with all sorts of things.

Now, before I turn it over to Bob for his closing remarks, please note that the comment period will remain open until April 30th and we welcome your comments. Also, the webcast, the transcripts, and the speaker presentations, will all go up shortly – at least, as soon as they become available. So feel free to check them out. So, thanks again and have a safe trip back. Bob?

BOB POTTER: With health care such an important part of our economy, I think the numbers that have been bandied about- \$3 trillion dollar spending this year- 17 percent of GDP- it's incumbent upon the Federal Trade Commission and Department of Justice to understand the health care markets. This is especially the case in the changing transition nature of this industry that we heard of today: advent of exchanges, ACOs, telemedicine, EMR, movement from fee for service to risk-based or value-based payment systems; increased vertical consolidation, cross-market mergers. All of these are important developments that the agencies really have to have an understanding of how they're going to impact the competitive analysis and dynamics of the industry.

As our framing presenter, Doctor Emanuel said, predicting the future is very hard. But, workshops like this one helps us gather the information we need to engage in that endeavor. One thing I was struck with, however, after listening to all presentations, is that I realized the more we learn, the more we have to learn. There's a lot of things that people said, 'not really sure what the analysis of that is yet.' 'Don't have the empirics on that.' 'We haven't reached any conclusions.'

I think we have to continue going on and continue using these panelists and others to educate ourselves on this. Now let me turn to the thank yous. Almost done now. I want to personally thank on behalf of the Department of Justice the approximately 40 panelists who took their time and their expertise and shared it with us today. We are eternally grateful for that, as- I don't know that everybody knows, but- we don't give payments for this. These people have volunteered their time, their expertise, and their travel, and it is just wonderful that they do it on our behalf.

Second, I want to thank very much my colleagues at the Federal Trade Commission. It is

extraordinarily important on these policy issues that we work together. This is just the latest in a series of numerous workshops that we put on together, and we have to stand together on these important issues.

With that, I would like to thank by name some of my colleagues at the Department of Justice who worked on this. I'll start at the top. I want to thank Bill Baer for his support and efforts in this, I thank Leslie Overton, Caroline Holland. Next, I'll thank some of the people who spent the most time on this from the Department of Justice- Patrick Kuhlmann, Matthew Mandelberg, Helen Knudsen, Natalie Rosenfelt. I'd also like to thank Peter Mucchetti, Barry Joyce, Mike Murphy, Beth Gundermann, Kevin Wallentine, Kristen Mickel, and Njere Mugure. Finally, I would like to thank the audience- both those who attended in person, and those who attended via webcast. I was struck when we found out that about 1,300 people had tuned into some part of the webcast yesterday. I may be dating myself, but I can remember when we put these workshops on, and if we had 100 people in the room, we thought we were doing great. So that is a tremendous benefit from the technology that we have, and with that, thank you very much and the workshop is over.

[APPLAUSE]

[END OF WORKSHOP, DAY 2]