Administration for Community Living
Affordable Care Act Webinar
Integrating Care: Partnerships between Community-Based Organizations and Accountable Care Organizations
September 28, 2012
2:00-3:30 pm Eastern

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. After today's presentation, we will conduct a question and answer session. At that time, to ask a question, you may press star then 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time. I will now turn the conference over to Ms. Marisa Scala-Foley. Ma'am, you may begin.

Marisa Scala-Foley: Thank you so much, Don. Good afternoon everyone. Good morning to those of you who are on the West Coast, Alaska or Hawaii. My name is Marisa Scala-Foley. I work in the Office of Policy Analysis and Development in the Center for Disability and Aging Policy at the Administration for Community Living.

Thank you so much for joining us for our September Webinar. Our latest in a series of Webinars that are focused on the Patient Protection and Affordable Care Act, also known as the Affordable Care Act or the ACA. And its impact on older adults, persons with disabilities and aging and disability networks.

Our Webinar series is designed to provide aging and disability organizations with the tools that you need to participate in ACA related efforts in your area

such as Accountable Care Organizations, as we'll talk about today, but also the Community-Based Care Transition Program, state integration for dual elligibles, and health homes and more.

So part of the delivery system reforms being implemented under the Affordable Care Act, specifically Section 3022 of the ACA includes the development of what are called Accountable Care Organizations or ACOs, which are organizations formed by groups of doctors, hospitals and other providers that have agreed to work together too coordinate care for people with Medicare across settings.

So they take responsibility for the quality of care that they provide to people with Medicare in return for the opportunity to share in savings, realize through high quality, well coordinated care. Community-based organizations can play an important role in the care coordination that is provided by Accountable Care Organizations.

And in this Webinar, we will provide both an overview of ACO efforts to date and spotlight a partnership that has developed between a Pioneer ACO and community-based providers in Massachusetts. So before I introduce our terrific panel for today we do have a couple of housekeeping announcements.

First of all, if you have not yet done so, please use the link included in your email confirmation to get on to WebEx so you can not only follow along with the slides as we go through them, but also ask questions when you have them through the chat function in WebEx. If you don't have access to the link that we emailed you, you can also go to www.webex.com. Again, that's www.webex.com, click on the Attend A Meeting button in the upper right hand corner of the page and then enter the meeting number which is

669692973. Again, that meeting number is 669692973. And our pass code is AOA WEBINAR in all capital letters.

If you have any technical problem getting in to WebEx contact WebEx's technical support at 1-866-569-3239. Again, that's 1-866-569-3239. As Don mentioned, all participants are in listen-only at this point. We do welcome your questions, though, throughout the course of the Webinar. There are two ways that you can ask your questions.

First, as I mentioned before, is through the Web using the chat function in WebEx. Just enter your questions and we will sort through them and answer them as best we can when we take breaks for questions after presentations. In addition, after the presenters wrap up we will offer you a chance to ask your questions through the audio line. When that time comes, Don will give you instructions as to how to queue up and ask your questions.

And as always, if you've joined us before you've heard me say this before, if you think of any questions after the Webinar or have any questions you'd like us to follow up on, please do feel free to email them to us at affordablecareact@aoa.hhs.gov. Again, that's affordablecareact@aoa.hhs.gov.

As Don also mentioned, we are recording this Webinar. We will post the slides, a transcript and the recording of this Webinar on our Web site as soon as possible. Hopefully within a week or so. And I will post on WebEx a direct link to where you can find - where you will be able to access those slides later on, as well as those slides recording in transcript of all the Webinars we've done thus far.

Okay, so enough with the housekeeping. Today we are thrilled to be joined by our wonderful panelist presenters. And I'm going to introduce them in the order in which they will be presenting.

So our first presenter will be Dan Farmer. Dan Farmer is a member of the Stakeholder Engagement Group at the CMS Innovation Center. He joined the Innovation Center at the Centers for Medicare and Medicaid Services in 2011.

Our second speaker, and actual the team of speakers who will go after Dan, first is Emily Brower. Emily is the Executive Director of Accountable Care Programs for Atrius Health, a non-profit independent alliance of community-based physician groups. And she is joined by Amy MacNulty. Amy is President of MacNulty Consulting, a healthcare management consulting firm that provides strategy and planning services to healthcare organizations.

Okay, so with that I will turn things over to Dan to start things off.

Dan Farmer: Well, thank you very much. I'm going to be pretty quick today because I think Emily and Amy are really the stars of the show today. But again, my name is Dan Farmer and I work at the CMS Innovation Center in the Stakeholder Engagement Group.

And I'm here today to talk to you a little bit about some of our initiatives around the Accountable Care Organizations, or what we're going to refer to as ACOs. Just a quick note about the CMS Innovation Center. We're a new part of CMS that was created to develop new models of payment in care to test and evaluate to see if they're successful in improving the care provided to beneficiaries served by CMS through Medicare, Medicaid and (SHIP), improve the health of those beneficiaries and also lower cost of those programs.

So first question that I'm going to try and address today is what is an ACO, which is a really good question. First, you know, there's a legal definition. It's a legal entity that's recognized and authorized under state law. But more broadly speaking we think of an ACO as groups of healthcare providers and suppliers who are working together to give coordinated high quality care of their Medicare patients.

What does this mean? So if you think about patients, not just Medicare beneficiaries, but any patient who might have multiple chronic conditions or multiple care needs. That patient might have to see multiple doctors, follow multiple care plans and really have a lot of things that they have to worry about and stay on top of.

Our hope is that by coming together these providers and suppliers can give that beneficiary a better care experience by working together more closely. In terms of our ACO vision, there are a number of things that we're trying to accomplish here, but really I think the most important ones to think about are creating patient centered care and putting the beneficiary and family at the center of their care.

And making sure that we're giving those beneficiaries involved - or whose providers are participating in ACO high quality care. Next slide.

So I wanted to take a second just to talk about some of the ways that we're supporting ACOs at CMS because sometimes we get the question, you know, can you tell me about the Medicare ACO program. I mean, there's actually not one Medicare ACO initiative at CMS. We've a couple of different things. The first is the Medicare Shared Savings Program. And that's administered through the Center for Medicare, a different part of CMS.

And that is a standing program that every year takes applications for more participants. Then there's the Pioneer ACO model which is an initiative with the Innovation Center and the Advanced Payment model which is another initiative at the Innovation Center. And finally, we have a physician group practice transition demonstration, which is the continuation of a physician group practice demonstration that started a number of years ago.

So why do we have all these programs and initiatives? Well, when we started talking about ACOs, we found that there are a lot of providers who are very interested in working with us as ACOs. But some of those providers were starting from different places in terms of readiness to work with us.

So we tried to create a couple different sets of initiatives that would give ACOs an opportunity - excuse me, healthcare providers and organizations of healthcare providers an opportunity to participate with us, regardless as to their level of readiness to do so. So for example, the Pioneer ACO model, which I'm going to talk about a little bit more in-depth in a little - in a couple minutes, is designed for organizations that have already worked in ACO, like arrangements in the past, and really offered this kind of coordinated care to beneficiaries in the past.

While the advanced payment model is designed for ACOs that are in the Medicare Shared Savings Program. But we give them a little bit of a boost in the form of some upfront capital, along with monthly payments that are repaid throughout the life of the program through earned shared savings. And those payments are meant to help those ACOs get off the ground and get started and make investments in care coordination.

So the takeaway message here is we're really trying to work with a wide variety of groups in moving them toward this vision of more coordinated care through Accountable Care Organizations. Next slide.

So this is just a little bit of a visual for you to see how these different programs are interacting. MSSP is the Medicare Shared Savings Program. That's that main initiative that I was talking about that continues to accept new applicants every year. And you'll see the advanced payment model is really just a way that we're working with some of those ACOs in the shared savings program.

However, the Pioneer model is a completely different separate - or completely separate initiative. Next slide.

So as you can see, we have a number of partners here already at CMS. We've got 150 Medicare Shared Savings Program ACOs, 32 Pioneer ACOs, and there are 6 physician group practices participating in the transition demonstration I mentioned a moment ago. In total, those ACOs are already serving over 2.4 million beneficiaries. Next slide.

So before I talk about the details of the Pioneer ACO model, I wanted to really show you that we have a pretty geographically diverse set of Pioneer ACOs. Again, I mentioned there are 32. You can see they're in a wide variety of spots all over the country which is really exciting. Next slide.

So the Pioneer ACO model, like I mentioned, designed for organizations with experience, operating coordinated patient centered care, so that care coordination I talked about at the beginning. And also operating in ACO-like arrangements. In the first few years of the Pioneer model we're going to be testing what's called a shared savings and shared losses payment arrangement.

So that means we hope that ACOs are going to be successful in keeping patients healthier and improving their care.

And if they're successful in doing that we think that that can lower the cost to Medicare. And if they are successful in offering that kind of coordinated, high quality care that lowers costs. We're going to give them an opportunity to share in some of the savings.

Now, in the third year those ACOs that are successful over the first few years in achieving those savings through high quality care are going to be eligible to move to a population based payment model. This is a little bit different. And as I mentioned, we have 32 Pioneer ACOs.

I also wanted to take a second to clarify a couple important things for beneficiaries related to ACOs. The first is that a beneficiary who's in fee for service Medicare is not going to be impacted if their physician decides to participate in ACO in the sense that they're going to continue to have the same benefits they did under original or fee for service Medicare.

And there's no lock in of any kind to specific providers. So this is very different than managed care. Beneficiaries can continue to see any healthcare provider, doctor, hospital that accepts Medicare the same way they did before. Next slide. So I guess as part of my transition here, I'm going to introduce one of our 32 Pioneer ACOs that we're very excited to work with, Emily Brower with Atrius Health. Emily?

Emily Brower: Thanks, Dan.

Dan Farmer: Actually, hang on. Marisa, did you want to take questions?

Marisa Scala-Foley: No, I think we're okay at this point. All the questions we've had have mainly been administrative in nature. So why don't you go ahead and take it away, Emily.

Dan Farmer: Great, thanks.

Marisa Scala-Foley: And thank you, Dan.

Emily Brower: Sure. Thanks so much. I'm very excited to be speaking with you all today because locally our Pioneer ACO, Atrius Health, has been doing quite a bit of work with our local AAAs. And we think that it's a great alignment of strategies and a potential model for how ACOs and community-based organizations can work together to achieve that AAAs that Dan mentioned of great patient experience, improved outcomes and affordability.

So what I'm going to cover today is a little bit about Atrius Health, who we are, why we decided to move into the ACO work and what we are doing with our AAAs which in Massachusetts are called ASAPs, or aging service access points. And then how we're spreading that work. And then we'll have a little time for questions.

So Atrius Health is a non-profit composed of six independent non-profit multi-specialty medical groups. So physician, provider lead organizations delivering primary and specialty care across eastern and central Massachusetts. And you can see there the six groups. The largest and the one that may be most familiar to folks is Harvard Vangaurd Medical Associates, which used to be Harvard Community Health Plan, one of the first staff model HMOs and - on the East Coast.

So together these groups that form Atrius Health take care of 1 million patients, mix of adult and pediatric and a mix of primary care and specialty care. So one of - a couple of sort of foundational features of all of the Atrius Health groups that we believe made us ready to take on the Pioneer ACO program and in general to take on accountability for those AAAs and goals are listed here.

We are together on one medical record called Epic. We, all of us in the individual medical groups, and together as Atrius Health, have a long and rich history of working under global payment where we are taking full accountability for both the cost and the quality and the patient experience of care.

We use a lot of some of the more advanced population management tools that a very rich electronic health record and the data that comes from your health plans will enable you to do to both reach out to your patients, understand their experience of care, and also to track the quality and measure and report on that. And the foundation of all the Atrius Health practices is the patient centered medical home. Next slide. Thanks.

So when we were first talking about it the end of last year, middle to end of last year, about why we felt that Pioneer ACO was a good fit for us we believed that it really was very highly aligned with what we think of as our core values and our core services. And for all of new work that we do, we get together and we develop what we call our reason for actions. Why are we considering doing this work.

So back when we were considering it we put - we came out together with these four points. One is that to the extent that we can have one model of care for all of our Medicare beneficiaries as opposed to right before we entered

Pioneer where we had one model for our Medicare advantage patients and one model for our traditional Medicare fee for service patients.

We can have one model of care and deliver the same good services to all our Medicare patients. That's very important to us that we always be moving towards that. And when we do that, because we think the Medicare beneficiaries are often the sort of canaries in the coal mine, the population that really helps you to determine what your successful programs will be, that success in the Medicare population spills over to success with our commercial patients or younger patients.

And as I mentioned, being able to be accountable for the care of all of our Medicare beneficiaries and working in partnership with the Innovation Center to be able to have the full dataset and to have the full picture of care for Medicare patients was highly important. So because we provide only primary and specialty care, and we don't own a hospital, own many sub-specialty services, when we see a patient we really don't have a complete picture of their care.

So having the data, the full data set means that we can have the full picture of care for our patients. And then we have a continuing goal in Atrius Health of moving towards 100% global payment. We think that that payment model is much more highly aligned with the AAAs of reaching quality outcomes and high patient experience than the fee for service paid only for a visit kind of model that is in traditional payment. Next slide.

We also often look back to our roots and think about how many of the Atrius Health medical groups first formed. And that their goal was to be able to better organize care to achieve high quality and outstanding patient satisfaction. And that reorganizing that care is very much in line with the

ACO model that looks to develop relationships across the healthcare continuum to be able to be accountable for the total delivery of care.

Especially important for Medicare patients who receive many more services outside of the multi-specialty practice than other populations. Sorry, I just lost my slides for a sec.

So, when we thought about the different pieces of work that we would need to put into place to be successful in this endeavor with the innovation center, we developed a number of different workgroups. And one was focused on home based care. And so I pulled this slide from - the sort of reason for action around why we felt we needed to put resources and effort and focus into home based care.

And this is really where our work with the - with our ASAPs or AAAs so I just wanted people to have some of that context. It's really that last point being that even though the services provided by community-based organizations when they're not services that are billed to Medicare we are not technically responsible for managing.

We know that those services can be just as important in delivering effective care for the elderly and disabled population. So for us it's very integral in our home based strategy to be partnering with our community-based organizations. Next slide.

So what I pulled out here is a visual that one of the groups within Atrius Health developed so you could see where this sort of fits in the design and delivery of the ACO model. So right in the middle there we have our patient center medical homes or the foundation, as I said, for all of our ACOs. If you think about the ACO is the medical neighborhood, the medical home is what

delivers primary and some specialty care, and the medical neighborhood or the ACO is where you're coordinating the care across the continuum.

And you have different pieces that you need to be effective in delivering on those goals. And if you look on the lower right hand corner you can see the care for Socioeconomically disadvantaged populations and high risk populations, populations with behavioral health issues, those are sort of the three areas where we're most actively working with community-based organizations, which for us right now are the AAAs. Next slide.

So the other - also, if you look at - also, if you were to splice up the dollars, the claims data, where the resources are going and the Medicare benefits, those would also drive you towards working - partnering with your community-based organizations. And as I said, if you think about - you're looking at this. This is actually our Medicare advantage budget - buckets, but it's not that much different.

When we started we didn't have the Medicare - the traditional Medicare claims so we looked to our Medicare advantage experience. And what we see is that many, many services are provided outside. In fact, the bulk of services are provided outside of the walls of our medical homes, of our primary and specialty care.

And so we needed to be able to organize the care and all of those other slivers of the pie. And care provided at home, care provided in skilled nursing facilities, connections with the acute hospitals, and other services are very important into planning that strategy. And that's how we sort of drove down the decision tree around we need to be partnering with hour AAAs. Next slide.

So I'm going to turn the conversation over to Amy MacNulty who is - has a very unique role in organizing the Massachusetts AAAs or ASAPs, and with whom I started doing this work. Together we started doing this work to link up the work that we are doing at Atrius Health to deliver on our ACO goals and the work that the Massachusetts AAAs were doing in delivering - in working closer with delivery systems to improve the care for the elderly and disabled. Amy?

Amy MacNulty: Great. Thank you, Emily. This is Amy MacNulty and I very much appreciate the time today to explain some of the work that we've been doing together with Atrius Health. And I would start with understanding the - sort of the evolution of community care linkages which is now going into its third year of existence.

It is a strategic initiative by the Mass homecare which is the overarching association of all the AAAs in Massachusetts. So there are 27 ASAPs, these aging service access points AAAs that have been in place in Massachusetts for 30-plus years. And as you can see from the numbers, managing significant individuals, many low income frail elders, as many of you know this population.

I would say that Mass homecare and its members, the ASAPs, about three, four years ago recognized the opportunity that health reform really presents to the whole long term services and supports network. And in that the ASAPs understand that in many ways they have been working towards the AAAs. And they could not only continue that work, but also help whether it's ACOs or patients that are in medical homes, or the organizations that are really trying to be accountable for population health, that they could help achieve those goals.

And the opportunity around health reform is not only just the care delivery part, but also the payment system, changing towards this flexible system that is not tied to the traditional third-party payor billing codes. That we now have an opportunity to look at the value that services actually can provide to support health outcomes, better experiences and lower cost.

And as I think many of you know who work in AAAs know that the - understand the chronic care model and the concept of wrapping around services and support, around medical services and the value that that can really achieve for people to be healthier and at a lower cost. And to be happier because they're in their home in their desired locations to live.

So we really saw the alignment and this strategic initiative as a consultant I am retained as a project director to really work with all the ASAPs across the state to help them translate these - this opportunity into a continuum of services and partnering initiatives to really achieve this. So we can go to the next slide.

I think you all have this for each of your states. I use this as sort of grounding for the AAAs in Massachusetts who are responsible for $340 million. As you all know, one of the valued components of the AAA network is that you have a vetted network of providers in the community that can provide a whole range of services that would take years and lots of money to duplicate by ACOs or - and I'll talk a little bit more about what we're doing around the dual eligible population.

So the important piece of our work is to say this exists, how do we scale this up to meet the needs of the fee for service Medicare population. And so we are working together as a network to really show how we can support the

ACOs and other patient center medical homes and other entities that are going to go at risk for providing care for their patients and members. Next slide.

So overall, the strategy around community care linkages is to really link the primary care medical services to community homecare services to long term services supports. Just like the movement of, you know, the aging and disability populations coming together under the administration of community living.

We have seen that the ability for the AAAs to service all ages, to support this AAA objective to achieve what (CMMI) is trying to achieve, which is sort of the end game. Which is defined - is sort of outlined here, referred to as a community integrated healthcare system 3.0. So that's really where you move from providing high quality care, sharing risk, to really being accountable for the outcomes of a population, as well as integrating with community resources.

And so this shift and alignment I think really is sort of the value proposition for the AAAs to step up and to say here's what we can do. And so that's - in that context is how we proceeded to reach out to - we now in Massachusetts have five Pioneer ACOs, four shared savings ACOs. I think Dan could probably correct me on that, that it's a changing - I have to check the Web site frequently to know the exact numbers.

But the point being that we have a lot of ACOs in Massachusetts that are trying to work towards what Atrius Health has - what Emily so well articulated. But we also have an initiative by the state that is focused on the dual eligible population. So Massachusetts is one of 16 states that is working towards creating integrated care organizations that will have a new care model

that merges the streams of Medicaid and Medicare to support a very difficult population.

We believe we have about 120,000. I don't think all of them will fall under this new integrated care model called an ICO. And so we potentially could have, you know, five to ten ICOs across the state that, again, the AAAs will have to work with and contract with for coordination of long term services and support.

So the model is similar. Different terms, slightly. But the goals and objectives are very much aligned. Next slide.

So in addition, we think that there's sort of a - the work that we're doing around the community-based care transitions program in Massachusetts, again, reinforces the model, reinforces the capabilities of the AAAs. And as you may be aware, overlaps with the ACOs in the sense that, as you can see, in Massachusetts we have four funded (30-26) community-based transition programs. And that really includes approximately six health systems, almost 15 hospitals, and 6 ASAPs.

So we're now really sort of hardwiring some of the linkages with the hospitals and the AAAs. And at the top of that there are - Emily and I have discussed and we've worked - trying to work through with Atrius right now, what happens when an Atrius Health Pioneer ACO patient is at a hospital and is discharged home and is assigned to care transitions coordinator from one of our community base care transitions programs. How do we really coordinate that.

And the reality is the ASAPs, the AAAs in this case are billing CMS directly for that care transitions intervention which is now showing up on - in this case

on Atrius Health expense side, the total medical expense for their ACO patients. So again, you see this, you know, kind of hard wiring going on. We are - we're really working - and I'll talk a little bit about how - what we see we can do to try to make this a successful connection. And really deliver on what we think are these great opportunities. Next slide.

So Emily, I'll start on this and do you want to jump in? I'm thinking that this is really where we are coming together.

Emily Brower: Yes.

Amy MacNulty: We have worked together now for almost two years. There is a monthly community steering group that reviews a variety of activity. Emily, why don't I let you do this one and then I'll come back.

Emily Brower: Sure. So when we look at populations of patients and being accountable for their care, we often talk about the care team which for us is the primary care medical home based team. Usually physician, care manager, potentially licensed or non-licensed, sometimes a coach.

And then going out from there all of the specialty providers and hospital providers. And so what we said when we started out this work, sort of when we were coming up with a vision statement for our work together with the ASAPs, we said fundamentally it's about expanding the care team to include the patients, home and community-based networks. That's really why - that's really what's driving our work. Is that we want the AAAs to be part of our care team.

What that requires is moving from a - sort of the old world which is that those community-based providers receive referrals from many places. Sometimes

our primary care offices, family members, community - other community connections. And provide services to our patients and we may never know. And so the idea is, when we talk about closing the loop, I mean, we're talking about making direct referrals, knowing - making sure we know who are the services providers.

Connecting with them in a personal way. And being able to manage the patient together with that community-based organization as part of the care team. And then doing warm hand offs so that we know what each other are providing to that patient. Of course, with the patient's permission.

And we believe that that will result in more complete care plans because we'll have a better picture together of what the goals - patient's goals are in and what the barriers for them are. And then we will have a more realistic plan, the two of us, when we have that more complete picture. And so the work started with one practice within one of the Atrius Health groups and one AAA.

And we've been spreading that practice based model since we work with many AAAs across the Atrius Health network. And then we're also looking at particular population based intervention. That would be across Atrius Health regardless of what the practice - the local practice - how far along the local practice was in implementing the pilot.

Amy MacNulty: and I would add to that, you know, for many of you as AAAs thinking about this, the AAAs in Massachusetts had to really rethink their whole connection to their service area, the geography. What was the - how could they - the challenge was not only to link with the Atrius Healths of the world to the ACOs and the medical and hospital communities and skilled nursing facilities in many ways were out there working with them now.

The real - the challenge was as a network, as multiple AAAs, how do we work together to make sure that all of Atrius Health's population can be, you know, we can work towards this single model of cadre with them and create that together. And it challenged us to sort of move towards a more flexible view of the geography that we cover. I hope that makes sense to people as they're listening.

Because I think that it was a major set of mind shift for all of us to say, you know, we really have to - we have to be flexible as AAAs about how we're going to respond to what is needed out there. Next slide.

So these are the practices and the AAAs that are working together in the communities. This gives you an idea, this is what we were facing from Day 1 when we could look at all the Atrius Health sites and all the AAAs saying, you know, where do we really start here. How do we do this.

And by starting with one, I think we have learned a great deal and then have been able to spread that. We could go to the next slide. That's fine. I'll just sort of cover, you know, part of this, Emily. And then maybe you can pick up on the workflow, okay?

Emily Brower: Sure.

Amy MacNulty: So the first pilot - I just want to sort of distinguish this pilot was literally to - if you're thinking about a AAA care manager, case manager. The, you know, picking up after someone comes in through information and referral, goes to a care manager who then is working through a point, doing the home assessment, working through a plan.

In this case what we were doing is really identifying an individual that the practice in this - the Atrius Health practice could connect with. So sort of a dedicated person that they could call and make the referral. And that that person would follow up and visit the patient, put information together and report back to the physician practice in this case.

Now, right away, this is more than what is done under the normal information referral, which is, you know, it comes in to the AAA. The AAA does the work. There's no real loop back dedicated link. But in this, again, we were leaning forward.

The AAAs are now saying we want to figure out how to make this work. We're going to identify a dedicated person. This is a time and resources, so it's an investment. And we want to learn. And again, you'll see from the various pilots what we're trying to understand is what are the scope of services that an Atrius Health, as a Pioneer ACO, really wants from a AAA, from us.

So that with our coordination at the monthly meetings and then our pilot activity, we have the sort of continuous effort, a communication at multiple levels on the ground. You know, what's happening right in the home and with the practice. And then - but then being able to translate that at higher levels at the organization so that we can learn from this.

And eventually what we're thinking is that these pilots can inform Atrius Health about how they actually build this part with us to provide long term services and supports for those in need. Do you want to do the next one, Emily?

Emily Brower: Sure. So here's - when we were developing this pilot, both of the two pilots that we're showing today, there was a lot of - you know, we sort of started out just by getting to know each other. Because even though there might be a resource and a primary care practice who comes from a social work background, or has been with the practice for a long time, or is very aware of community resources who might be referring, it was a - you know, in Massachusetts it's 1-800-AGE-INFO.

And that will help you to get the information referral request to the right ASAP. Because of the geographic (diversity). So we had - that was happening in many practices. In some practices where we had really long time people doing that work. They had developed their networks. So we had a social worker in one of our practices who over time had gotten to know very well the care manager at the local ASAP.

And so they had sort of developed this on their own. Where they would talk to each other on kind of a regular basis. They both liked each other a lot. And what they were providing, what they had developed without even really thinking about it, was this enhanced level of service.

Where instead of that practice coordinator calling 1-800-AGE-INFO, she just started calling (Mary). Because she knew her. And then (Mary) would call back. And even though across the network we certainly - there was - it was always clear that there was no expectation that a AAA would be getting the plan of care back to the practice, that was never sort of part of the work.

In this case, they were doing much more of that. So we said, wow, there's something really valuable going on in that practice, between that practice and that AAA and let's build on that. So we sort of took what they were doing. We said can we describe that in what we call at Atrius Health standard work.

So a process by which that is not dependent on two people who have grown up together in the community and know each other, but could be replicated by anybody. So that's what we tried to map out here. Is what is the actual process when we say that a practice and an ASAP and a AAA are working together in a coordinated way and closing the loop for individual patients. And that's what this outlines.

It's the referral as sort of the decision-making around whether or not the patient is going to need and receive services from the ASAP. And then closing the loop and checking in. So it's fairly - on one level it's very basic to say, hey, what we're talking about is that we're going to talk to each other. But in many ways there was no road. There was no communication (pass).

So we had to build point to point communication. We set up secure email. We set up ways for the local practice and the local ASAP to be able to talk to each other. And of course, our goals are totally aligned. So on the individual practice, every person in the practice wants to be able to have this conversation with the AAAs.

And the AAAs want to be able to do this work. In many ways they just didn't know how to reach each other. And sort of that's the piece that Amy and I play as sort of matchmaker, trying to help the local practices and the local ASAPs work together in this more coordinated way.

Amy MacNulty: And the next slide kind of shows a similar kind of pilot. But what's different about this is we've kind of now actually developed a referral form. So you can see that the work process is evolving to be more defined about what's the data that needs to be transferred. And who needs to see what, when.

So we're learning about this and understanding what kinds of information. As you all know we have a very extensive home health assessment. The practice doesn't need to know all that. But they, you know, this is some - the referral form is our first attempt at trying to really understand what do they need to know.

Actually working through the intake process. And finally, really not just closing the loop by phone call, but also that the - we know that the practice is taking our notes and information and flagging them into the medical record. And now that we've moved to secure email, we can do that referral electronically.

Ideally, it would be to have, you know, the referral form and the follow up kind of assessment note to be somewhat standardized so that could be easily recognized in the Epic medical record, electronic health record. So that's really, again, we're learning. We now know how this can work. We tried it at a separate practice. We're sharing it back with the others.

And the third pilot is kind of a different type. The next slide is we're now moving out of sort of a pilot specific or ASAP - or AAA specific initiative. But more towards the recognition that as a Pioneer ACO one of the quality metrics is a Falls Risk Assessment. So Atrius Health came to us through our monthly coordinating meeting and said, you know, we have to make sure that this is done across the board, is there a way that the AAAs can help.

And so we sat in several meetings and with not just the AAAs, but with the VNA, with the various practices who are doing different things around falls risk. So part of it is just that even Atrius Health with the different physician practices and the multiple 20-plus sites that they're practicing, not everybody knows what's actually going on around this. So we're sharing who's doing

what when and how do we avoid the duplication and share that in a way that Atrius Health can meet its goal of making sure that everybody has - over 60 has a Falls Risk Assessment every 12 months.

That's the standard. And we want to - you know, as a valued partner with Atrius Health, we want to make sure that what we do at the AAA level can be fed into the - their system so that there are three or four questions in the home health assessment that are directly related to a Falls Risk Assessment, there are questions about that.

That there's no specific definition of what a Falls Risk Assessment has to be. Right now, according to the Pioneer ACOs, so it's up to Atrius to really define that. And that's what they're doing. So we now have, after the third meeting, they now have a work process. We understand it.

We know, for example, whether, you know, if somebody comes in to an office visit they may get the assessment there. If the VNA is involved they may get the assessment there. If the AAA is involved they'll get it there. So somewhere, you know, they'll get it.

So that's been very helpful for us and we hope to be able to do more work around those kinds of initiatives. And just in terms of just overall that we are now - we do have a contract with Atrius Health to - we do have one of our AAA social workers who's imbedded in one of the practices part time. And provides the care coordination and home assessment activity for that practice.

And we actually have in a contract with another ACO where are - the ASAP care coordinator and - community care coordinators working with their care managers to help them access the AAAs across the states. So there are different things.

You know, I really see that the ACOs are at different stages in terms of their, you know, how they're evolving and how they - how ready they are to partner with the AAAs. I know that it is a challenge. We have many ACOs and now ICOs, as I said, coming on deck. So our ability to really identify the right people and connect with them and, you know, build a relationship is critical right now.

Because I think the challenge, we've said this from Day 1 with community care linkages, we started this process, understanding that this was a buy/build decision for these health systems. And what we want to do is make sure that they don't feel - that these health systems don't feel they are obligated to build a whole new long term services support system.

And we want to be able to show that we can be valued partners so that we can partner with them to expand this and make sure that this is aligned with their objectives. And it, obviously, for the AAAs it's a different - a whole different revenue source. So it definitely presents challenges of growth, expansion, capital, you know, working capital.

And how you actually, you know, kind of get from here to there. But we're, you know, as I said, this is a - it is an opportunity to move in that direction. And clearly, what we've seen in Massachusetts at Atrius Health is really the furthest along in their thinking, in their articulation, and their implementation of this relationship and partnering effort. I think that's the end of my slides.

You - yes, Emily, you wanted to talk about these things, right?

Emily Brower: Sure. Very important. So as we - really speaking to Amy's point about the buy or build decision, right. So ACOs, if they haven't been doing it before, they

are now responsible for coordinating all of the care for their patients across the continuum. Most of them know that they need - that patients need coordination of home based supports and community services.

And so their question is, so do we hire social workers and do this? Who's out there providing care. How can, you know, do we buy or build. So for us, being able to make the case for what the, you know, return on investment is for working with or contracting with, even directly, the AAAs versus building it ourselves is a very important decision.

So we are monitoring these measures to be able to support spread. So just understanding what's happening, how many referrals are going, what are the services, are we getting that information back into our electronic health record. And then what is the - what are the costs that are coming out of the system that are supporting the investment.

And, you know, our hypothesis is, as I'm sure many of you would make the same hypothesis, is that if you provide good support in the home, in the community, you're going to prevent unnecessary hospitalizations and you're going to prevent unnecessary (ED) visits, emergency room visits.

So those are the two metrics that we're tracking. And then, of course, because we also have goals and are measured around patient experience, we want to make sure and - and the other quality measures we want to make sure that we are measuring those as well. So the one that Amy mentioned around Falls Risk Assessment we'll be tracking when those Falls Risk Assessments are happening and are being provided by the ASAP.

Are we getting that data so that we can report on it. Is the assessment - is there an intervention afterwards, that kind of thing. And then what are our patients

telling us around their experience of care when that's provided by the ASAP. We, as the ACO, are responsible and have to meet certain quality measures around patient experience.

Even though, if you remember that pie chart, we're only providing a small sliver of that. We have to guarantee really excellent patient experience across that whole pie. So all of our work that we're doing with other partners is also measuring patient experience for the services patients are receiving from those partners.

Amy MacNulty: I just want to point out one thing that I think we kind of skipped over. I mean, we just - we didn't - I didn't think to mention which is that unlike most Medicare Advantage populations the populations of Medicare recipients who are in the Pioneer and also in the MSSP, the Shared Savings program, ACOs, so the ACO Medicare patients, have a much higher percent of dual eligibles.

So they have younger Medicare patients, younger Medicare beneficiaries. And they have beneficiaries that also has Medicaid. So that's very different from the Medicare Advantage population that we still have and we still take care of. And so the higher level of importance and need for building in those community-based supports is often new work for Pioneers.

Many Pioneers didn't realize the extent to which those beneficiaries were in their populations. And they had never really been accountable for that part of the care. And so even in their Medicare Advantage work, which most Pioneers have been doing, so been accountable for Medicare services, that population in Medicare Advantage wasn't requiring them or pulling on them to develop these connections with the ASAPs in the way that the Pioneer population does.

Emily Brower: Marisa, I think that's - we're done.

Marisa Scala-Foley: Okay, great. Well, thank you both so much. And I'm going to take just a very brief time to go to through the last couple of slides because let me tell you, we have gotten a pile of fantastic questions in from our audience. So I want to leave as much time as we can for that.

So as always on our Webinars we try to provide a list of resources that pertain to the topic that we're addressing that particular day. So we do have some resources here from CMS on ACOs, both a resource on - generally on ACOs as well as on the Pioneer ACO model. As well as another resource that is specifically designed for Medicare beneficiaries that you can find on medicare.gov.

Now, I know some of you are probably going, "I'm frantically copying down these URLs." Please don't worry about that. We will have the slides posted on our Web site within the next week or so. And you'll be able to get all the URLs there. If you would like the slides sooner than that, please feel free to email us at affordablecareact@aoa.hhs.gov. Again, that's affordablecareact@aoa.hhs.gov. And I can send those to you ahead of time.

And so we also have some general resources on the Affordable Care Act, including link to the place where all our Webinar recordings, transcripts and slides are stored. And some other useful resources on the ACA.

Our next training we're going to continue to look at integrated models of care. And hopefully we'll be addressing the topic of health homes. We'll be looking at doing that later in October. Please do watch your email early to mid-October for registration information.

And as always, if you have questions, comments, stories about your own work with ACOs or suggestions for future Webinar topics. We also invite you to send those to affordableact@aoa.hhs.gov.

And with that I think, Don, if you could let people know how they can start to queue up for audio questions. I will tell you, we've probably gotten at least 15 questions in through chat. So we'll try to take a crack at those.

But if - I'm going to try to take them in the order in which they came in. So if you asked your question a little later in the Webinar you may also want to try to queue up on the audio line to ask your question. You're welcome to do that as well. But we'll try to get to as many of these chat questions as you can - as we can in the time we have left.

But, Don, you can tell people how they can queue up to ask audio questions?

Coordinator: Yes, at this time if you'd like to ask a question please press star then 1. You will be prompted to record your first and last name. To withdraw your request at any time you may press star then 2. Again, to ask a question please press star then 1 and record your first and last name when prompted.

Marisa Scala-Foley: All right, so let's start to take some of the questions via chat while we wait for the folks to queue up on the audio line. The first question came in from Jocelyn. And I think this question could either go to Dan, generally, about ACOs, but also Emily more specifically. Can you talk about the extent to which ACOs, and Atrius in particular, are covering rural areas?

Dan Farmer: Well, this is Dan. The Pioneer ACO model does include some rural ACOs. We have some in both Iowa and Maine, for example. And, you know, we're very excited to have those as a part of our ACO community here at CMS.

There are also some - the advanced payment model I mentioned during my presentation is designed, in part, to help rural based ACOs succeed in the Medicare Shared Savings Program as well. And we're really excited to have 20 ACOs participating in advanced payment model.

So we are doing work. We do have partners who are working in the rural areas of America. And we're really excited about the progress we've made there. Emily, I don't know if you want to comment about that?

Emily Brower: You know, we don't - while within Massachusetts we have communities that are more rural, we don't - we're not really a rural area. So greater Boston out to central Massachusetts is our service area. There is some pockets, but...

Amy MacNulty: And I would just add that there are not any rural - we don't have that model here in Massachusetts with the advanced payment model. But we do have one of the care transitions - community-based care transitions program that is for technically rural. It's in the western part of the state. But that's about as close as we get.

Marisa Scala-Foley: All right, thank you. Our next question comes from Susan who asks - and again, this one both I think Dan and Emily may want to comment on this question. How do ACOs differ from sort of the old managed care organizations, like health maintenance organizations and how and why will quality and savings differ?

Dan Farmer: Great, so I'll take a crack at it from the CMS perspective. I think the biggest difference for us between managed care, like you mentioned, and ACOs are the restrictions on beneficiaries.

If I'm a beneficiary and my physician (unintelligible) participate in ACO, I still have all the same benefits and all the same freedoms I did under the original fee for service Medicare. Which means that I've - first of all: I'm still getting all the same benefits, number one; but number two, I also always have the freedom to go see the doctor, hospital or healthcare provider of my choice. So I think that is probably the most important distinction in our mind.

Emily, did you want to add anything to that?

Emily Brower: That's all true. And the one distinction I would add is the very - the big difference for a provider group that is taking accountability for the traditional Medicare patients under an ACO is that we have 33 quality measures that are - that we are measured. And our performance on those determines what level of shared savings we would have to reinvest in programs.

So unlike Medicare Advantage where the quality component is sort of a separate bucket of performance dollars that you can achieve in the ACO, both the Pioneer and shared savings, the quality program is the gate through which your performance is measured. So it's quality first and quality includes patient experience. So there are measures in there around how the patient reports their experiences care.

So quality first. And then if you achieve on the quality measures, if you had achieved savings, then you get a portion of those savings to invest. So that's very different. That's different from any other program that we particulate in, in terms of that quality piece.

Marisa Scala-Foley: Okay, great. I think we'll take one more question from chat and then we'll switch over to the audio line. And then we'll come back to some of the chat questions. So don't worry if your question hasn't been asked yet.

Since we were talking about sort of other health plans, can you talk a little bit about the relationship -- and I think you alluded to this a little bit, Emily, in your presentation -- but can you talk about the relationship between ACOs and Medicare Advantage plans?

Emily Brower: So I think from our perspective, patients sign up for Medicare Advantage. Patients in traditional Medicare who have not signed - original Medicare have not signed up be - the patients that we touch in our Pioneer ACO. Because it's really - it's the provider group. It's Atrius Health that signs up for the Pioneer ACO.

The patients, as Dan has explained, still have original Medicare. So it's different in that way. It's different in those quality measure that I described. But in our care management activities, so how we organize the care for the patients, we are doing - putting all of our efforts into making that one, seamless model of care.

So for Medicare beneficiary, regardless if they are choosing a Medicare Advantage plan, or if they are receiving services from how we have organized ourselves as a Pioneer ACO, they are getting all of the same great care management, disease management, chronic care management activities that we have built as part of our Atrius Health system of care.

Dan Farmer: Yes, this is Dan. I think Emily really said everything that I would have said. I think the one thing I would just say is the Pioneer ACO model and our Medicare Shared Savings Program at CMS are really meant to zero in on those fee for service beneficiaries.

Marisa Scala-Foley: Okay. Don, do we have anybody on the audio line? And then we'll come back to the chat questions.

Coordinator: I am showing no questions in the queue.

Marisa Scala-Foley: Okay. Well, we'll keep going with the chat questions then. I think, Emily and Amy, you had talked about sort of the importance of the referral process and warm hand off. We got a question that sort of relates to that issue of the referral process. And this question comes from Mike, who asks, do the ASAPs have access to the electronic medical record? If not, how does it relate to their own data systems and how are you sharing data electronically?

Amy MacNulty: At this point we don't have direct access to the medical record. We are talking about it and thinking about that. I mean, that's part of the process, the discussions right now underway with Atrius about how that might happen. What we're trying to do is sort of influence how - what data they want to make sure is included in that medical record. Are there data elements?

For example, we've been in meetings with the folks who are sort of maintaining the Epic medical records, saying, do you want to have a data element that indicates the AAA that that individual is going to. We know from other ACOs that that's what they're doing in the medical record. They're actually having a pull down that says, yes, they're a patient that goes to this AAA. It could include other information.

Now, that's just for the contact information. Right now, we're looking at how do we incorporate our - sort of a summary notes that could be attached to the medical record. It could be - so when the patient goes in to see the physician, the physician or nurse practitioner opens it up and says, oh, okay, they had a

home visit. They can see. They can see who the care manager was at the AAA and they can call, you know, contact information, et cetera.

So right now we don't have that total connection. But I could see that evolving over time. It's - Emily, you know, I would jump - feel free to jump in about, you know, how much work you're doing now to get the medical records to support all that you're trying to do as an ACO.

Emily Brower: Yes. You know, we are actively looking at how can we make the record available to providers of care outside of Atrius Health. And we're sort of chipping away at that. So both with our VNA or home health providers and with our ASAPs we are working on how can give them access to the records that's HIPAA protected, get some of the information that we need to them. How can we move closer and closer towards integrating the exchange of information.

So we're not there yet. But it is a piece of work that we are...

Amy MacNulty: And I just - I really want to add that we're sort of coming the other way down the pike. Our Mass homecare with the 27 ASAPs are working. We have a data steering committee that's working with the state executive office of elder affairs about how do we mine the AAA database, which is in our case (sims).

You know, that we are tracking all of that home health assessment question information related to those questions and et cetera. How do we take that information, create like a template and a portal that outside - that Atrius Health or other physician groups or hospitals could actually access through a secure connection.

So we're kind of - we're working on that now. And it appears that they're making some progress. So we hope that we can kind of provide a portal for individuals at, you know, different healthcare organizations to get information. Again, all HIPPA compliant.

Marisa Scala-Foley: No small task on that front. So we got a question in from Susan who asked, Emily, on your slide with regard to sort of why Pioneer. You talked a little bit about the 100% global payment model. Can you provide a little bit more detail on that?

Emily Brower: Sure. So we have a mix of fee for service, sort of the way care has, you know, traditionally been paid for, and global payment. Where we are accountable for the total cost, quality and patient experience of care. So if you think about the ACO model, even though the cash flow is fee for service everyone is still billing Medicare, conceptually we are accountable for the total - we are accountable for the global cost, quality and patient experience.

So when we say global payments, that's what we mean as a payment model that reflects the fact that we are taking accountability across the full continuum of care. So right now we're really 50/50. About 50% of our patients are in that kind of more advanced model, and 50% are still in traditional fee for service, where there's no payment model except for the actual transaction, the visit, between the patient and the provider.

So moving toward - more towards global payment, you know, as far as 100% is our long term strategy.

Marisa Scala-Foley: Great, thank you. So we got several questions from different folks about sort of the training and experience or the qualifications of different professionals, whom you mentioned as part of your presentations. So the

medical social workers, the ASAP care managers, and transition coordinators. Amy, I don't know if you want to talk a little bit about that, as well as Emily, I think.

Amy MacNulty: Well, I mean, from the AAA point of view they are, you know, licensed social workers and the - sometimes RNs. We do not have RNs across the board as care managers. However, we are looking at the need to sort of augment the - not just with the ACOs, but with the dual eligible population it's becoming apparent that there will be a need for significant amount of RN assessment.

And we're looking at training and building up that capacity to respond to that. But the - it is the - either the - and some of our care managers are VA social workers. So we really don't, you know, we are focused on sort of the traditional, I think for most of you, that have the traditional skill set for care manager at a AAA level.

Emily Brower: And I would just add that the medical social worker, the licensed social worker, we don't have very many across the Atrius Health Network, so there are just a few. And then we have care management for the most part done by RNs.

We have some practices that have care coaches. Some of whom are RNs and some of whom have different training. But most of care management still is delivered by nurses.

Marisa Scala-Foley: Okay, great. Thank you. So we got a question - and I think this one may be more for Amy. The question is, how is the - how are the ASAPs ensuring conflict free options counseling or care management through - with this linkage with the ACO?

Amy MacNulty: Yes. And it continues to be the same role. In other words, we're still providing that long term services supports coordination. We're not direct providers of the services. So our work is around the assessment and the care coordination. So it's not around the direct provision of those services.

We continue to access the, you know, the network of home service providers. So that continues. And so it - at this point we have waivers specific to that, but I think that the - that model is going to continue, you know, with the ACOs and the ICOs.

Marisa Scala-Foley: Okay, great. Another question for you, Amy. This one came from Jane. Do the ASAPs -- and Emily, also -- do ASAPs yet, or the ACO, have a way to capture the cost, the medical cost savings, from your activities?

Amy MacNulty: I'll just respond because it's sort of linked to what Emily was saying a little bit before about the global payment. This is actually very critical. Good question. In that you can see that the work that the AAAs are doing are not currently in the total medical expense, other than what I referred to around the community-based care transitions projects that CMS has just funded.

But so all this care coordination around long term services support is an expense that is off the radar screen for the ACOs. They're not seeing it as they see their total medical expense. So that really behooves us as the AAAs to make the business case about the savings.

If you were to spend this money, you will have the savings. So we are trying to really track the individuals that we're seeing, what their experience was before, during and after. The, you know, this sort of the one issue of making that case and does, you know, does the ACO have the data to really see where those savings are.

And then, you know, because the AAAs don't have that data. We don't know what the actual reduction - we can see what's publicly published. But for Mrs. Jones, we can't see the total medical expense. We can't actually see what happens to Mrs. Jones if she's - what her readmission rate was before, during.

We are on these pilot projects but not, you know, right now on everything else. But - so the point being that we need to partner with Atrius to share this information, to work together. To understand we did do these, these were our cases, our consumers, at the AAA. What was their experience.

And the issues are really, one, of being able to tie the data together. To tell the story about Mrs. Jones. And two, to really, for the ACOs, to be able to kind of book the savings to actually say yes, we did save money there. And to move it down to a practice level. So that the practice administrator and even the ACO isn't just looking at adding more expenses, but can actually tie the two together and say, oh, we're going to have less hospitals so we can spend more here.

We really have to make - this is, you know, so this is a very key effort. And I think we are, you know, we are working - we're trying to work through that now. But it is a major challenge. And the incentive is more at - it's sort of at the global level. And it has to get translated down to the communities so that we know that, you know, AAA number one and practice number one did these things together.

And they, together, actually experienced a savings. So they get a credit so that, you know, they can buy more of the AAA service.

Emily Brower: And I would just add going back to my point about global payments, that's why we want to always be moving towards global payments. Because under traditional fee for service where a practice is only paid for the transaction, between the patient and the provider, there are no dollars to pay for this. This is not a paid covered service, right.

So the only way that you can get dollars out of the system to invest in these kinds of programs is if you're in shared savings, global payment. Some payment arrangements that reflects the fact that you're accountable for the total cost of care, so then you can say let's develop the data that shows that by partnering with the ASAPs, you can save on hospital admissions, (ED) visits.

And the expected cost of that are taken out of the system and invested in the work with the community-based organizations. So the pilots that we're doing, the reason we're tracking those metrics are so that we can make the case. And say in these programs, where we did this more coordinated care with our local AAA, we achieve these outcomes, here's the dollar value that we can assign to that. Therefore, we can spread it.

We don't want to wait until the end of the year and see if they were savings at the ACO level. We want to be able to measure it as we're going along so that we can say we've got to really quickly ramp this up. We've got to spread this. Or, we need to fix this before we invest more.

And I would just add that, you know, this is really the strategy that you're all facing in terms of how to connect with the ACOs. If you are really just knocking on the door saying we're here, we do all this great stuff, it is great. But they've got a lot of people knocking on their doors.

And the - so what we've tried to do sort of strategically is break it down into smaller pieces and try to develop free pilots. You know, to actually try something that will demonstrate the potential and opportunity and move from that to a paid pilot. And maybe to a paid contract, eventually.

But it has - it's a step wise process. They're not going to just spend more money on the hope that they're going to save money.

Marisa Scala-Foley: Thank you. Yes, that's a really complicated question. And I think it's the key question, that AAAs and others, as we're engaging in this work, are asking.

Emily Brower: I would just want to add, Marisa, to that.

Marisa Scala-Foley: Sorry.

Ebb: No, I just think this is such an important point.

Amy MacNulty: It is.

Emily Brower: Because when Amy and I sort of presented this work to the 32 Pioneers, you know, there is - because of the fact that people were not aware, really, of the level of dual eligibility of their populations, so younger Medicare patients, patients who are often eligible for these services, so both of those two groups, the poor, elderly and the disabled. Because they hadn't seen those populations in Medicare Advantage, they weren't thinking along those lines.

They're thinking around traditional care management, chronic disease management, high risk management for elderly patients, right. That's your

sort of Medicare toolbox. So for this population people really had to think different.

And many Pioneers didn't even know what kind of, you know, Medicaid eligibility they had in their practice, I mean in their population. They are only starting to discover that. So they are sort of ripe for making those connections. And also, any AAAs that are involved in 3026, the Community-Based Care Transitions Program, the Pioneers just learned about that in a recent Webinar. So that's another way to connect.

Because they're starting - the Pioneers are starting to get more educated around working with community-based organizations, particularly around care transitions.

Marisa Scala-Foley: Okay, we got just a question related to - because I know we could talk about this for probably a long period of time. But I do want to try to get to at least a couple other questions and try to get to the audio line one more time before we break in a few minutes.

We got a question actually that relates to at ACL our populations of interest, both older adults and people with disabilities of all ages. And it seems like the focus of this, the pilots, has been on older adults. Are there plans for connecting for centers for independent living or what plans do you have in terms of serving Medicare beneficiaries who may be under age 65?

Amy MacNulty: I can start, Emily, with that. The AAAs in Massachusetts are actively working with many of the independent living and recovery living centers across the state. And we are actually in collaboration for now this new demonstration project for the dual eligible. And we'll - I think it's a model that can translate to the ACOs fairly easily.

And we're seeing that of course that collaboration is coming in under the aging and disability resource consortium. So the ADRCs are the vehicle by which historically there's been communication but we're actually seeing ADRCs in our state become incorporated. And will be come a contracting vehicle for these kinds of - for the population.

And it will include the ILCs. And we're collaborating right now with them to develop the care model for this population for the dual eligible population. So it is a key piece. It is very much at the ground level. You know, in other words it has to be, you know, put together for each community.

Emily Brower: And we are - from the practice perspective, that's great news to us. The sort of no wrong door concept...

Amy MacNulty: Exactly.

Emily Brower: ...is very important to us. Because we're not going to be able to work with, contract with, partner with, you know, hundreds of Massachusetts community sort of organizations at Atrius Health when you look at that sort of geography. We need a coordinated approach from the community. So the fact that the community is organizing themselves to do this is music to our ears.

Marisa Scala-Foley: All right. I think, Don, we're going to try to visit the audio line one more time. We probably have time for one question and then we really do need to close out. And for those of you whose questions did not get answered, feel free to email us AffordableCareAct@aoa.hhs.gov with any questions that you need answered. We'll also try to take a look back at the record we have of the chat and try to get - I'll try to work with our panelist to try to get some of those questions answered.

But Don, do we have anybody on the audio line?

Coordinator: I'm still showing no questions.

Marisa Scala-Foley: Okay. I think we are at - I show it's just at 3:30 now. So I do want to thank our presenters for a wonderful, stimulating presentation. When you have more questions than you have time then you know it's a great Webinar. So we thank you for - we thank the panel for their time and for the work that they put into to their presentations. And we thank all of you who were on the phone and on the Web for joining us on a Friday afternoon to learn about this important topic.

We hope you'll join us again next month and please do email us any questions or suggestions for future Webinar topics at AffordableCareAct@aoa.hhs.gov so we can make these as relevant to you all as possible. Thank you all so much.

END