ALLIANCE FOR HEALTH REFORM

# Beyond the SGR: Alternative Models
# Alliance for Health Reform
# The Commonwealth Fund
# January 24, 2014

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ED HOWARD: Good afternoon, my name is Ed Howard; I'm with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Blunt, and our board- today's program on what may be one of the most vexing and persistent problems with how Medicare operates. And that is the method of payment of physicians. Guess what, Medicare spends a lot on payments to physicians – 70 billion dollars or so in 2012. That is fee for service payments only. So major changes, particularly if they are decreases in those payment rates – attract a lot of attention. Now the focus of our attention today is one tool for restraining the growth in those Medicare physician payments and that is the sustainable growth rate. SGR. That is the one acronym – I guess it's not an acronym if you just say the letters, but that is one contraction you are going to have to internalize to follow the conversation. It's the law of the land, its complicated formula for holding down growth and it's produced scheduled cuts in those physician payment rates, so severe that Congress has acted more than a dozen times in just the last decade to postpone them. Now these temporary actions known collectively as the "Doc Fix" have become a regular feature of Washington life around this time of year, like the lighting of the national holiday tree, I guess. And the periodic fixes don't touch the underlying flaw in the existing law. Now we are here today because there is a growing consensus in Congress that there is a need to alter or abolish the SGR and our goal is to explain a bit about why current law needs attention and lay out some of the principles and the specific plans being discussed to deal with the sustainable growth rate. Now we are pleased to have as a partner in today's program, The Commonwealth Fund. A century old philanthropy established to promote the common good, the common wheel. And we have with us the Vice President of the Fund, Stu Guterman, whom we will get to in a moment. I want to just handle a couple of logistical items up front 00.02.32 and then we can go straight into the discussion. I should note that you can see on the slide that is up now, a Twitter aid if you are in a tweeting mode, the hash tag SGR Fix is what you can use and we would be gratified if you would tweet up a storm. There is a lot of really good information in your packets including speaker biographies, more generous than we are going to be able to provide you orally. There is also a material's list that you can go to on our website, allhealth.org, and connect to an even more extensive list of background materials if you want to take those next steps. There will be a web cast available of the briefing probably on Monday at our website, and a couple of days after that a transcript, for those of you who want to relive every beautiful moment of the conversation you are about to hear. There will be also copies of the slides that the speakers will be using today. You can ask a panel member a question, at the appropriate time, by either using the green card that you find in your kits or one of the microphones that is set up. At the end of the briefing, there is a blue evaluation form in your packets that we'd appreciate if you would fill out to help us improve these briefings. So let's start with my co-moderator as the beginning of a very illustrious group of presenters today. Stu Guterman is the Vice President of Medicare and Cost Control at the Commonwealth Fund. In addition to those duties, he is also a former CMS official with experience and expertise about paying physicians under Medicare. How handy it is to have you here. And in that regard, Stu, in addition to your words of welcome, we have arranged for you to help us frame the issues and explain a little bit about why we are here. Stu.

STU GUTERMAN: Thanks Ed. So first a little bit of background on the issue with the SGR. The sustainable growth rate mechanism was intended to control Medicare spending because unlike lots of other services, the physician is in direct control of how many services his or her customers use. Many people have said that the most expensive medical device in our system is the physician's pen. So the Congress established a new way of paying for physician services and that went into effect in 1992. They were concerned about increases in volume, an intensity of physician services. So in addition to setting the fees for individual services, they established a mechanism for adjusting for the total growth in spending. That mechanism has been revised. It was revised in the beginning of 1998 to what is now called the SGR. The problem is as spending continues to exceed the target that is set under this formula; the formula produces large cuts in physician fees. There is concern about that, certainly from physicians, but also more importantly from the aspect of affecting access to care from Medicare beneficiaries. Unfortunately, the large cuts produced by this formula, since they are in law mean that it is costly. And I put quotes around the word costly, because as far as the score goes, it is costly to eliminate the SGR or it has been costly historically and still is. So Congress has deferred cuts a little bit at a time under the philosophy that it is safer to bite off a little bit of poison and eat it one bit at a time, than to take on the whole thing. So a little bit about what the SGR has done. This is the whole kind of history of physician fee updates. This is the update to the fees for each service over time. You can see here the year that the SGR started to really cut. The SGR went into effect in 1998 but that was okay, because the target was based on the growth rate of the economy as a whole. The economy was growing pretty fast at the end of the 1990s, but it slowed down in 2002. The SGR formula produced the first negative update, the first cut in physician fees. It kind of took everybody by surprise. Congress let it happen, and so physician fees actually went down across the board by 4.8% in 2002. Ever since then, you can see that the light blue bar is what the formula produced, and the dark blue bar is what the update actually was because Congress every year has stepped in to supersede the results of the SGR formula, but done so piece meal. And that has prevented Congress from taking a broader approach to really reforming the way Medicare pays physicians. A lot of people have expressed concern about eliminating SGR because they feel like for all its' flaws, it helps control physician spending. I took a look at the data over different periods of time, and you see here the first couple of years the SGR formula was in effect, there were fairly generous updates, an average of 3.8% a year between 1998 and 2001. Part B spending per beneficiary grew at a rate of 7.3%, a lot faster. The period 2002 to 2007, the SGR formula started producing annual cuts in physician fees, and the Congress generally stepped in and overrode those cuts. But for the period as a whole, physician fees were basically the same at the end as they were at the beginning of that period. During that time, annual spending per beneficiary in Medicare Part B rose at an 8.4% rate. So there's a big discrepancy here between the fees that are set under this formula, or under superseding legislation, and the amount of spending that actually goes on. And then more recently, spending has been more moderate, and the physician fee updates have actually been a little bit more generous than over the previous period. But still, there doesn't seem to be much effect of the SGR in terms of holding

spending down. So that is basically one of the major features of the SGR. One of the problems is that the formula cuts payment rates across the board, no matter how appropriate or inappropriate the service is and no matter what kind of physician is providing a service and how effective they are. It still maintains incentives for individual physicians to increase their volume and intensity. And it fails to address all of the flaws of the fee for service, physician fee schedule that is in place. So it is really not a solution to anything, and it creates an annual problem of how to deal with these formula cuts. For years, Congress has been talking about finding an alternative. The problem is that even as recently as of June 2012, the estimated cost of repealing the SGR was – and even just replacing it with a 10 year freeze on physician fees was estimated to be about $270 billion. That is just Medicare costs. There would have been additional costs to beneficiaries as well, as they pay part of what the physician fee is under Medicare. But more recently with the slower growth in health spending, the cost of repealing the SGR for the next 10 years was estimated to be about $117 billion. So in a way, the repeal of the SGR is kind of on sale right now, and it has generated renewed interest in trying to find alternative ways of paying physicians. So in July 2013, the Energy and Commerce Committee passed a bill to replace the SGR with what they called a fair and stable system of payments. They would limit the annual update for the first several years and then beginning in 2019, the annual update would be set at a moderate rate. But providers could choose to participate in and be paid under alternative payment models. And so, the question here is, what are some of the alternative payment models that one could move to? Because you can repeal the SGR but you've got to figure out some other way to pay physicians. The Energy and Commerce Committee, by the way, passed that bill unanimously. So it is really a bipartisan agreement that something needs to be done. Last October, the leadership of the Senate Finance Committee and the House on Ways & Means Committee released a discussion draft that described a similar approach to repeal the SGR. They were going to freeze the annual update. And I think since then, and deliberations in the committee, that was raised to .5% which is similar to the Energy and Commerce Committee. There would be bonus payment for high performing providers and incentives for care coordination for payments with multiple chronic conditions. In December, both of these committees passed bills along the lines, one by acclamation and one by unanimous votes. So there is pretty strong support for finding some way to get away from this SGR approach. But the question is what do we do instead? And that is what we are going to put some ideas on the table about now, and we will ask the panel to talk about how well they think alternative approaches can work. And what steps does Congress need to take to replace the SGR with a more workable payment system? We have a terrific group of people to address these issues. We are going to start with Gail Wilensky, who is a senior fellow at Project HOPE and a former administrator of the Health Care Financing Administration, now CMS. Will be followed by David Share, talking about what he has been working on as Senior VP for Value Partnerships at BlueCross BlueShield of Michigan. And then we will have bat and cleanup, Mark McClellan who is a senior fellow at the Brookings Institution and also a former administrator of CMS. So I look forward to hearing what you folks have to say and thanks.

GAIL WILENSKY: Thank you Stuart for the nice setup. I am going to phrase the conversation slightly broader, although as you will see, I'm actually not saying anything different than Stuart Guterman was describing, and talking about where we are and how we have gotten to where we are. I just find it helpful to talk about this, not as just the SGR Fix, but as the RBRVS SGR Fix. And the reason is that I don't think you can talk about getting rid of or fixing the sustainable growth rate without talking about why there was a sustainable growth rate put in place, in the first place. That was concerns that the very discreet unit fee schedule, that the relative value schedule represented in Medicare would lead to higher spending than was desirable. And what that means is that in order to fix SGR in a way that will be sustainable, you really need to go back and review the underlying fee schedule, the relative value scale. Contrary to where most of our discussion is today, either in Medicare or in the private sector, which is how to try to reward and encourage value, the relative value scale as it now exists with billings for some eight to 9000 different codes, rewards volume rather than value. The fact that there is believed to be a number of areas where the codes themselves are overvalued, that is they provide too much reimbursement for some kinds of procedures, exacerbates the problem of the relative value scale. But even if you had a perfectly arranged relative value scale, you would still be rewarding volume rather than value. For me as an economist, it has been particularly troublesome that with the relative value scale as it is now laid out, billing for some eight or 9000 different CPT codes, there is a disconnect between the behavior of any individual physician or the physician's practice, and what happens as a result of the SGR. And the reason is that the SGR is determined by the aggregate behavior of all physicians, irrespective of what any individual physician or physician's practice does. No physician or a physician's practice is big enough that it can swing what happens to aggregate spending. And what that means is that there is no reward for good behavior and no consequences to bad behavior. Not a very good arrangement for most economists who believe that institutions and clinicians, as others, respond to incentives. And oh by the way, as Stuart Guterman has shown in very clear graphics, it has not worked. So the question is, what are the alternatives? Well in the last decade, most of the alternatives were not, shall we say, very imaginative. Primarily they left the relative value scale as it is, although always some focus on the fact that there are overvalued procedures and it could be constructed better. Mainly what was raised was the possibility of having several SGR's, anything from two or three, to six to eight. But basically, that would not have changed the problem that I have raised. You would still have a world in which nothing that individual physicians or their practices did would result in either increases or decreases in their fees that they would receive, because they were not big enough to swing the whole amount. As Stuart has just indicated, we are now really in a very different world, have been for the last year, where initially last summer you saw bipartisan effort by the Energy and Commerce Committee. And then in October, you saw a bipartisan bicameral effort with this discussion draft come out of the Finance Committee and Ways & Means. And if you step back and look at these two pieces of legislation, there are very clear similarities between them. He went into more detail. I just want to remind you that again, not focusing on the very specifics, but zero to small

updates, higher adjustments for physicians who participate in alternative delivery systems that are deemed to improve value, and over time, lower payments for docs who do not improve value or at least indicate that they are taking steps in that direction. So important differences in the literal legislation, but in terms of the general issues that have been raised, very similar in terms of concept. Now there are some very important challenges, as promising, as the fact is that we have seen both bipartisan, hardly something we can assume these days, yet alone bicameral efforts that look very similar. The most obvious is while the SGR Fix is, as Stu Guterman has said, on sale at the moment, it is not a trivial amount of money. The minimum amount is 116 billion. The Energy and Commerce bill was estimated by CBO to cost about 175 billion. That was because there was some spending in addition to just replacing the SGR. Presumably, it will be somewhere in between those numbers, not a trivial amount to figure out how to finance. But there are other issues that are very important. If we are going to have an increase update for activities that we believe improve value, you've got to decide, which are those activities that actually improve value? What metrics specifically should determine these payment shifts? Or what should you assume by definition that if a physician joins a particular type of alternative delivery system, does that mean that they should get higher updates? What kind of advance payment models should be included for these higher updates? Fortunately, we have a lot of activity going on. So the question is, can they help to answer the questions about which of these alternative delivery systems actually looks like it may provide increased value? There is a lot of activity going on. The patient-centered medical home has gone on for the longest time. They are probably the most of them. Many models are being tried. It is looking at the moment like modest savings at best. To date, there have been not very many independent evaluations. Most of what we are hearing are what is being reported, either by the sponsors or by the medical homes themselves. That will improve over time, that CMS has and others have sponsored. Commonwealth Fund has sponsored some independent evaluations. So we should be able to get a sense about what is going on. Frequently they are just layering on a payment for coordination, although some of them begin to have upside and downside risk attached to them. Accountable care organizations. Again, we are going to hear more detail from both Mark and David about some of the specific ideas going on, is another type of risk sharing model that is being tried. Again still relatively early, at least for the Medicare ACO's. Private sector ACO's have been going on since about 2007 or 2008. Mark can give us more specifically with some of the work that he and others have been doing in this area what they are finding. Very mixed results at least to date, particularly for the pioneer ACO's who were the more experienced group at hand. Everybody reported, like with the group practice demonstration, an improvement in terms of quality metrics. The actual savings were more mixed. Nine left the program, the majority to go to the regular shared saving but two just left altogether. Some very interesting mixed models. Michigan is one of the most intriguing, focusing more on what happens to the community and population based health. And David will provide a lot more information about that. The Medicare/Medicaid Innovation Center is trying a number of bundled payment initiatives. They are interesting. They are different models. They have hospitals with post-acute. They have physicians, hospitals in post-acute. They cover different time periods. For me,

it is unfortunate that all of them have the hospital as the focal point of who receives the money. I am worried. I have spoken about this a number of times. That we are going to exacerbate the problem of the increased power shift that has gone on to hospitals in the last decade with all of the mergers. Interesting initiative being tried or developed by the AMA in terms of a condition based payment for specialty physicians. It would cover the cost of the specialty physicians for treating a medical condition, very much in its' development phase. I hope they hurry up and get moving with this. But what has not been tried are systematic ways of paying for physicians outside of the hospital bundle. It is not that there are not different ways being used, but not in the same kind of a systematic way that would allow us to assess what the effects might be of these different models. Episode based payments for physicians with different time frames, for example, or bundling all the different physicians into a single payment for a medical condition. Now part of this lack of focus, particularly on specialty physicians may reflect that in the past, specialty physicians, unlike primary care physicians, have been more or less happy with how life was. That could well change in the future, and might leave them to be more interested in some of these assessments. A final word before I turn it over to the colleagues. As important as some of these pilot projects will be, to answering the question about what kind of alternative delivery systems or payment models we ought to regard as sufficiently valuable to have increased payment associated with them, we are going to have to be very careful. We are very early, certainly in terms of evaluation. Frankly, we are very early in terms of the implementation of some of the models. All of them are voluntary, that raises huge questions about the effects of self-selection, of people who volunteer to be part of this leading front. And it has a lot of question about the generalized ability of any of the findings that we see. It also may be that early savings may not be sustainable, for all sorts of reasons, including the fact that some of the projects are taking advantage of early one time subsidy, like those that were available from HITECH, for example, for the electronic medical records. Having said be a little cautious, be a little careful about reading too much in the findings, for somebody who has despaired for two decades now on how we pay physicians, this has got to be the most promising time we have seen in a long time. Thank you.

DAVID SHARE: Good afternoon. So I am going to give you a brief full view of work we have been doing for over a decade in the state of Michigan. It is a very broad partnership between BlueCross BlueShield of Michigan and physician organizations, and hospitals and others all across the state. So it is not a small demonstration project. It really is a bold transformative program that is an equal partnership between the provider community and the health plan. It is a marathon, not a sprint. So it is really important to emphasize that change of this sort cannot be measured in a couple of years, and programs and policies and new reimbursement approaches that you might think to implement should not be evaluated after a couple of years. We are talking about iterative change and growth and learning that has to occur in the context of a community. I want to emphasize one really important point. If you don't take away anything else, please take this idea with you. That payment strategies by themselves are tools. They are not solutions. They will not transform the healthcare system. That you really have to think about how to apply them

in community context, how to harness intrinsic motivation of providers and in a context in which they have positive social engagement, and they actually care about the way in which they use new approaches to reimbursement, to transform systems and to yield better care for their patients. Gail made the point that the SGR fundamentally does not really have much of a hook, because the economic impact is so far afield from the direct experience of the provider. If you think of new payment systems in community, in context where communities of caregivers shoulder responsibility in common for a community of patients, I think you can get that hook in place and then you have the opportunity to make change. And I think you will see, from what I am going to describe, that we have in fact done that. Now this is my second favorite slide because at the bottom, there is a little icon which evoke evolution. We have what I would call an intentional striving towards a preferred future. It is not passive reliance on natural selection. But we are now just upright, and I want to explain where we started and then very briefly describe the mechanisms that we have used. But we started a decade ago in 2003 and '04 wiping the slate clean and first starting talking to providers about what a prefer transformed health system would look like, and how we could change reimbursement to get there. We very quickly understood that it could not be done at an individual physician level. It had to be done with a community context. You had to engage physicians in their organizations, so that they would have leadership and structure and resources to be able to effect transformative change. We chose to change from a fee for service to a fee for value reimbursement system, so that we stopped at a certain point increasing fees. And then all incremental professional reimbursement first, and now hospital reimbursement becomes dependent upon improving population performance. There is an organizing concept or construct, which didn't start out to be the patient-centered medical home model but has evolved to be that. And fundamentally, those concepts have been in place for some decades and we harnessed those at the outset. We envisioned transforming systems of care and integrating information systems, and care management systems across the continuum of care with PCP specialists and facilities, and then holding those communities of caregivers accountable for their performance. Not just holding them accountable as the ACO program tends to do, and hoping that they figure it out. We call that organized systems of care. And I think you will see, as I go through these other slides more quickly, that this vision has come to fruition in a pretty meaningful way. The root causes that we identified at the outset were a lack of systemness, which is why we decided to focus on system transformation and not just hope that people could figure that out. That there was no locus of control for owning system change, and both modernization and functioning. And so the physician organizations that I mentioned took on that leadership role. And that the focus on individual physician performance or individual payment for specific patients was really off the mark. You had to be thinking in population terms, and rewarding and incentivizing in population terms to be effective. So guided by the patient-centered medical home model, we began to shore up primary care first. As you could see in that first slide, there is a timeline and we started with primary care intentionally because it was in disarray, as it was and probably still is in many communities. We focused on population accountability, identifying the population as those patients or members

attributed to the PCP practices, the primary care practices, especially the medical home practices. And then we focused on getting those practices and their specialist counterparts in the context of physician organizations to integrate together common information systems, care management systems, and then do a performance evaluation at a population level in common. And then accept that their fees would be dependent upon optimizing performance in cost and quality terms. The physician group incentive program is the program that we use for this, and we have transformed reimbursement in that context in a number of ways. We have what we call a physician group incentive program incentive pool. And that takes about $100 million a year, a little more than that, about 5% of total professional payout. It is not a withhold. It is an additional amount that is used to pay the physician organizations to transform systems of care. The more that they do that, the more they get paid, and to pay them for optimizing population performance. In 2009, we stopped all increases to professional reimbursement. So fees have been flat since 2009. And while we still use a fee for service chassis to make payments, the payments are variable dependent upon the performance and cost in quality terms, that the practice is in concert yield for the population that they serve. The medical home based practices get additional increases in their evaluation and management fees, in order to stand up and support team-based multidisciplinary practices to proactively manage their populations. There are additional codes to pay for proactive provider delivered care management, not health plan delivered care management, by nurses, social workers, nutritionists and others in a multidisciplinary team that manages both individuals and populations. We have transformed our hospital contracts, so that the hospitals are now on the hook for the same population performance as well, and also the specialists in concert with the PCP's share the same population. Again, the population being those attributable to the PCP's. So the specialists and hospitals are not getting paid based on who stumbles in their doors. They are getting paid based on population performance for the very same patients, for whom the PCP's are responsible. And then finally, this is not in place yet, but we are developing new insurance products where the member will have aligned incentives as well. And so, if the member chooses a medical home practice voluntarily and uses that medical home, and goes on referral from the medical home to specialists and hospitals, they will have much lower out of pocket liability. But if they choose to not do that, they will have substantially greater out of pocket liability. And so now, both member and the entirety of the provider community has aligned incentives. So in 2005 when we began this adventure, we had ten physician organizations. We now have 45, but actually some of those manage several smaller physician organizations. So there are really over 100, with over 18,000 physicians, about a third primary care. We have 39 organized systems of care OSC's, which is our term for ACO's. It is a program we began before ACO's emerged and as I said earlier, somewhat similar in concept except there is a before the fact responsibility for these OSC's to actually create the systemness that I described, as well as an after the fact accountability for the performance of that system, which is what you hear about in regard to the ACO's. We have half as many ACO's in Michigan, and half of those 20 actually are really just groups of physicians who are willing to take the bet that they can outperform the performance threshold. They are not really transforming systems. They are not organized to do that. And so I would argue that the ACO program

is weakened by not having a broader construct as I am describing with the OSC's. Just to move along more quickly, we have now 1243 designated patient-centered medical home practices, and another 2000 practices that are working actively towards that designation status. So really we have covered the waterfront with these transformed practices. And the impact is shown here on this slide, I think somewhat dramatically. Since 2011 for our commercial underwritten PPO business, we have had 10 straight quarters of a commercial cost trend of less than 2%, which is about half of the market's experience. The professional use trend for that time period has been negative for 10 quarters. The overall physician group incentive program has been evaluated by independent folks at the School of Public Health in Ann Arbor, and found they have saved about a point and a half annually. But importantly, the medical home program which is growing has saved about five to 6% annually, and shown substantial improvements in various preventive and chronic illness quality measures. I would like to direct your attention to the last sub-bullet here. It is a really important bellwether of impact. Ambulatory care sensitive condition admission rate means the kinds of conditions that are acute, where if you get to care on a timely basis in your medical home or chronic if they are managed proactively, in a way that keeps people from getting sick, that you can keep them out of the hospital and the emergency room. And the medical home practices in Michigan have, even as the program has grown from just a few hundred to 1200, have had about a 20% reduction in rate of ambulatory care sensitive condition admissions, consistently for four years. So just the last slide to wrap it up, some lessons learned, and again emphasizing the importance of harnessing intrinsic motivation. When you tell people what to do, they do the least necessary. I would say PQRS is a good example of that. When you empower them and harness intrinsic motivation, they do the most possible and I would say our experience in Michigan is a really powerful example of that. In the interest of time because I have gone over my time, I am not going to go through each of these bullet points, but invite you to look at those statements about sort of the summary concepts that I see as our lessons learned, and I will look forward to the dialogue.

ED HOWARD: Thank you David. Let me reclaim the clicker and arm Mark McClellan in his cleanup role.

MARK McCLELLAN: Thanks Ed, and thanks all of you for taking time to be here this afternoon. So you have already heard from Stu and Gail about the policy context for the SGR Fix, the reasons we are here, and what should be done about it. From David, through some excellent examples of transformative payment reform that really harnesses the motivation and opportunities for our care improvement, that health professionals working with their patients in new ways can bring. I am going to take a step back from that, specific context in Michigan and talk a little bit more broadly about the need and opportunities for payment reform in Medicare to help accomplish this goal. So I am going to focus particularly on the alternative payment model piece of the SGR reform proposals that the committees have passed on a bipartisan basis. As you heard earlier, one very important reason that this is timely and urgent is the rising cost in the Medicare program, the gap in the SGR, a wedge between where we are supposed to be under the

legislation and where we actually are, that has led to continuing reduction and fee for service payment rates. And the one reason for doing this is just to get to a more sustainable system on the payment side. I do want to emphasize the same thing that David did about another very important reason to get there, and that is to align the way that Medicare pays physicians and other health professionals with what it is that they really want to do for their patients. Right now, even though SGR does provide reimbursement for some important services, there are a lot of things that health professionals think are important for their patients that just are not happening. We have been doing a lot of work in this area and the collaboration at Brookings on value and innovation in healthcare. And through the market initiative on clinician leadership in healthcare reform, it involves Dr. Kavita Patel, Dr. Farzad Mostashari, Dr. John O'Shea and Dr. Darshak Sanghavi, that have identified a lot of these opportunities around the country that physician groups and others are undertaking to fill in these gaps in care delivery, and the mismatch between what clinicians think are most important for their patients, and what they are actually paid to do. So it is not just that the payment rates are getting tighter, but things like payment for care coordination, support for care coordination services, the phone calls, the time to work efficiently with specialists as David eluded to, the use of some new technologies that have the potential for really transforming the way that care is delivered. Everything from remote sensors that patients can wear and use at home to get information to their clinician, and to help modify their treatments. Those kinds of things just are not reimbursed and just are not supported under our current financing systems. New team approaches to care, where physicians rely on approaches that involve nurses and pharmacists, and other systems of care delivery. Those just are not paid for under our fee for service payment system. So regardless of what you do with fixing the rate, you are not going to get there. You are not going to fix that fundamental misalignment. Similar ideas are happening in other areas of care, where the payment systems are also moving to help hospitals and post-acute care providers, and others do a better job of focusing on the person and supporting the care that they need. And I think even if there weren't budget pressures here, this problem would not go away and we will see a continuing interest, and hopefully momentum for physician payment reform because this is the future. Care is getting more and more personalized. The right combination of treatments for an individual patient depends on a lot of things that are specific to them, and a lot of things that just are not reimbursed, if you think about it, in traditional healthcare systems. So we are moving to something else. There are a range of reforms out there and the Michigan approach covers a lot of these. Ones that involve taking some payments that physicians get away from pure fee for service into something like clinical pathways, that are based on the physicians or other expert judgments about the best approaches to care based on the evidence. Medical home and other case-based payment approaches, again where the payments at the person level or the practice level for all of the patients that they treat, based on having characteristics in place and being able to show improvements in care delivery and quality. Movement towards bundled payments that replace individual fee for service treatment payments with more of an overall payment that gives the clinicians more flexibility in what they are doing, and in conjunction with some more accountability for showing improvements in care. And then

a lot of programs that are also relying on shared savings. Physicians are a small part of overall spending, but as Stu mentioned earlier, their decisions have a big impact on overall healthcare cost. One of the worse things about the SGR is that it tends to pit different clinician groups against each other in determining who can fight for the biggest rate for their RVUs, rather than recognizing that clinicians working together and can do an awful lot more to bring down overall healthcare cost. The slides have a few examples of thinking about these overall shifts and payments. This is from the perspective of if you are a clinician in practice, what do these reforms really mean for you, and in terms of overall spending on healthcare. So right now, the top bar here shows that fee for service payments to physicians make up the bulk of their payment in the traditional Medicare program. That is a small part, less than 20% of overall healthcare cost, a lot of which is probably not being spent as efficiently as it could be. And what many of these reforms, including medical homes or payments based on guidelines or other types of practice improvements do, is take – is add on an additional payment for the clinicians that is based on meeting the conditions of the medical home or taking some other steps to improve care. Now this is fine from an overall spending standpoint, if the improvements in care that result from these new case based payments, whether it's medical home or some other approach to case based payment, actually lead to reductions in overall costs as the LS rated here. It is a challenge from an actuarial standpoint if these additional payments don't. And what you heard from David was that in their experience in Michigan, they have been able to get something that looks more like this – overall costs go down, quality goes up, as a result of shifting some of the payments or adding some of the payments that clinicians get through a case management fee. In national experiences with implementing these reforms, there has been more of a mixed bag and David pointed out that some health care organizations that are moving to these alternative payment systems, may not be implementing the full set of changes and practice that are really needed to get overall reductions in care and that is why it's challenging to just add on payments for things like a medical home or other new supports for clinical practice – just add it on to our existing payment system. From an actuarial standpoint, there is a lot more interest in systems like this that would shift some of the existing fee for service payments into payment that is more focused on what the clinicians really want to do to support patients in their practice. And there is some examples of these kinds of programs as well. The challenge is that it takes some real effort, time, money, redirection of services, to implement reforms in clinical practices around the country. So there are often some upfront cost associated with it, plus there is a lot of uncertainty here even though clinicians know they are not getting paid for the stuff that really matters in many cases. They at least know the current system; they know the risks that they are facing for time that they are spending with patients that is not reimbursed and so forth. They don't know that with these new kinds of systems. So this approach is hard to implement. A number of other reformed have focused on shared savings, like some of the ACO programs that physician groups are participating in. So if savings materialize, if costs actually go down as a result of things that clinicians are doing differently, they get to keep some part of those savings, so that can finance this better alignment of the care that clinicians would like to provide with the care that they are actually delivering. Again, that means physicians are facing some uncertainty up front

though and not getting from here to there. So in a lot of cases around the country, what seems to be happening is something like this – I think this roughly describes David's experience too, is that there is some additional payment streams coming into clinicians that are based on what the payers and the clinicians really want to see. Some measures of better care and lower overall costs, because there is some upfront investment associated with that, these may add to costs in the short run. So in the bipartisan legislation, there is some bonuses that physicians get for switching to these new kinds of payment systems. But in order to meet the goals of both improving care and getting the Medicare program on a more sustainable path, these programs might transition over time to something that involves some shifts of physician payment. So one way to do that is what David did, just no increases in payment over time. So the real fee for service payments go down and then new payments coming into the providers are in the form of these case based or patient focused payments, plus perhaps shared savings. So expect to see more things like that. I was going to wrap up – I'm not going to go through all the rest of my slides, but I want to make three more points quickly. One is that it is very important to think about other reforms in conjunction with just changing the payment system for these approaches to work. Clinicians cannot improve care if they don't have the data that they need at hand for them to make better decisions with their patients about what matters. So very important as part of this would be new support for the Medicare program to get useful claims data on physician's patients – to those physicians in a format that they can use. These are now being combined in some of the most promising reforms around the country with other sources of data from electronic records, from health information exchanges, to registries or other decision support tools that clinicians can use that are focused on the overall quality and efficiency of care for their patients and that is to import these kinds of changes in decision making. These kinds of changes in care delivery. Going along with that as well are better measures of performance, doing this consistently is very important, as Gail said, for being able to evaluate which of these reforms are really working, as well as reducing the burden on clinicians and not having a whole bunch of different measures or measures that don't really capture what they think are important, rather than having measures that can be drawn from – these better data systems that they would have available to deliver patient care. Finally, it is very important to align these reforms with others that are taking place, involving other types of healthcare providers and I would also add to that, consumers as well. You are kind of rowing with one oar if you are only changing the way that clinicians and other providers get support and still having basically a fee for service system that pays more for more volume, more intensity, regardless of quality or value on the benefits side. So engaging consumers is really important.

There has been a lot of bipartisanship in this reform effort so far. Of course there is one more big thing on the table, which is how to pay for all of this. The cost is a lot lower, but it's still pretty significant finding $140 or $160 billion to do those additional steps that I was describing along with just changing the payment systems is really important for the success of this program. The bonuses for clinicians, the steps to make sure they have the data and measurement support that they need. That is probably more in the range of

$140-$150 billion dollars all together. There have been a number of ways discussed to try to pay for it, including other provider payment reforms that would go in the same direction and also changes in Medicare benefits potentially, which I think could be implemented while both bringing average costs that beneficiaries pay down and also getting beneficiaries more engaged in getting to these better care systems as well. That is still a big lift in the next few months. So one other possibility might be – instead of just doing a one year or two year short term patch and hoping that somehow that ten year basically permanent funding will come together in the future, would be to do something intermediate. So if it's a possibility of getting $50, $60, $70 billion in savings, well that could potentially put in a fix for more of the medium term and also start getting down the road of implementing these alternative payment systems. But it's going to be an interesting few months to see what is possible to come together here. I do think in the longer term though, we are definitely going to be moving away from fee for service payment in healthcare, not just for reasons of cost, but for reasons of people getting the best possible personalized care and hopefully Medicare can help lead in that process.

ED HOWARD: Terrific, thank you very much, Mark and the other panelists. You now get to join the conversation more directly. Someone is already holding up a green card. Excellent example setting for your colleagues. And if you do that, someone will come and bring that green card forward. There are microphones that you can use to ask the questions in your own voice, which we would encourage. If you do that, we would ask you to identify yourself and your affiliation and keep your question as brief as you possibly can. And if I can just try to frame this – Mark, you talk about intermediate length stops along the way and I wonder whether you or some of the other panelists might be interested or Stu as well, would talk a little bit about how maybe the natural progression of some of the experiments like David is putting in place in Michigan, like the rest of the pilots that you have been describing, like the growth of Medicare Advantage, which puts payment in a very different place, might over time actually alleviate or eliminate the program with the SGR by eliminating the incentives that drive it. That drive the problems that flow from it. And if so, how long might that take?

GAIL WILENSKY: I was with you until you got toward the very end. I think the – I like the notion of thinking about it as a semi-permanent fix. I think that is a very good way to do it, because it's just too much money to contemplate being likely to be raised to give a permanent fix. As it turns out, both pieces of legislation set up a point where you get stability in payment - either zero or very small increases - but known so that you don't have clinicians wondering whether or not they are going to fall off this cliff at the end of the year. Even though it has only happened once, its easy for somebody like me who is not dependent on having the fee schedule actually come through, say it's not going to happen. So you could do the first steps of what all of the – both pieces of legislation or the draft and legislation do, which is provide a known piece of stability for several years and put in place some specific activities to try to move forward with the performance metrics. The ACO's have 33 metrics that they are using. NQF and other groups have ongoing activities in this area. There is a lot of interest to minimize the

burden on physicians, of different metrics being used in that five year window. You could decide on the metrics that are appropriate going forward. I have been to allow physicians and other groups to participate in setting them up like they did with the PQRs. That would be one. It would also be to look to see whether there are any activities not currently underway. Like paying all of the physicians for bypass surgery or any high cost, high volume activity that Medicare undertakes. If those innovations are not going on either in the public or private sector, to use that five year window to start to see whether or not – even though there is a lot going on, its different if it's not done in a systematic way in assessing the evaluation. And then be able to move forward at the end of five years to be in a better position of saying, here are the alternative payment models that we can show provide both improved value for patients and seem to be more consistent with what clinicians would like to do in terms of providing better care. I think the point that Mark and David made, that this has not only been frustrating for payers, but the system has been very frustrating for the clinicians as well.

DAVID SHARE: Yeah, I would just like to add briefly that physicians are, I think, certainly in my experience, really enthusiastic about moving towards a value based reimbursement system and away from the hamster wheel that they are on, dealing with volume and discounts and so they are ready, but there has to be some stability in terms of many years of knowing that payment will be reliably reframed for them to make the investments to be able to change the systems, to be able to deliver the better value. It can't be on an "if come" basis year by year the government decides whether they are going to maintain a transformed approach to reimbursement.

ED HOWARD: Stuart do you want to say anything about that?

STUART GUTERMAN: Yeah, just one comment. Whatever fix, whether it's permanent or semi permanent, is made, needs to be made with a clear understanding that we are not going to go back to the system we have now. Otherwise, you know, people can wait it out. We do – it is going to be some time before we are sure to how alternative systems that are already in place, work, and it will be even longer before the debate subsides on what the results are, because these things tend to not be so clear cut, that people kind of generally agree that they are going to save X dollars. And so there needs to be a mechanism. Step one is – and I think this reflects the structure of all of the bills that have been passed, that step one needs to be – we are not going to do fee for service any more and step two then is, and we are going to really – and you need to help us find alternative ways that have potential for working. Because it's not – going back to or staying with the current system just can't be an option.

MARK McCLELLAN: I do think the frameworks that are in the current bills for – basically saying that. Through bonuses to shift to the new systems, the tightening payments if you stay in fee for service – that can all stay even if you don't get ten years worth of payment offsets. You do need a longer period of time in just one or two or three

years. It needs to be a longer period of stability to help clinicians and all the others – the rest of the healthcare system, move to this new kind of approach.

BOB: Thank you, Bob [name], BMJ. We all know the scenario that the US spends more than any other industrialized country and has poorer incomes in most instances. If you look at where other countries spend their money, they spend a lot more on social services. US spends a heck of a lot more in terms of a gross numbers of specialists and how much money they receive. What are some of the other reforms that we can do to try to sort of restructure our spending and our training of people in a more rationale manner? And then secondly for Dr. Sharp, the Michigan example, you seem to have a very high ratio for the US of primary care physicians to specialists and I would like to hear a feeling as to why that might be. Might part of it be the geography where it tends to be outside of major metro areas where the specialists tend to congregate?

DAVID SHARE: I will start. You ask a very broad question about whether we have a healthcare system or a medical care system and we lean a little heavily toward medical care system and thinking of social health issues, social determinants of health as being separate from public health, was kind of divided off as a poor step child quite a few decades ago, sadly. There were a lot of transformations that can occur, so my practice has been in a community health center for several decades, actually three different ones. One for the last 30 years. And so I am very used to a multi disciplinary approach to care, where we are not just talking about medical issues, but its also behavioral health and tangible needs and housing and stability and nutrition and so forth. And poverty. And so I would say that with the advent of this patient centered medical home neighborhood concept and with more responsibility for managing populations in the dual eligible world for example, that this multi disciplinary practice, which goes beyond the medical model, is coming to its own, finally. And I think it will really help to rebalance things. So that is my hope in sort of a broad brush way of stating it. With regard to your question about Michigan, yes it's very cold there, no, it's not that isolated. It's actually – the population is mostly metropolitan and I would say if you are noticing a bit of unusual distribution of PCP and specialists, it's because we started with PCPs in our program and intentionally worked to include them and shore up their practices and have them serve as the foundation for this transformed healthcare system that we envisioned. And so they joined first, the specialists have come on board later. We actually probably have a similar distribution of specialists; they are just a little bit later to the game. So there are more specialists who are not in the incentive program yet, but they are quickly coming on board and they will be. So I don't think we are actually that much different. What we have done differently and it's a really fundamental difference, is we are not engaging the specialist with incentives about their personal practice. So for example, we don't say to the cardiologist, how are you doing with your cardiology practice? We say to the combination of PCPs, cardiologists and the hospitals where they work, how are you doing collectively for patients with cardiac conditions? And you are all equally responsible regardless of where those patients are cared for. And so they all know have an incentive to keep people out of the hospital on the ED setting, keep them out of the

catheterization lab, get to them more upstream, engage them more actively in their patient centered medical homes as participants in their care. And so that is a pretty big transformation in the nature of the relationship between specialists and primary care. And that is what is unique about Michigan. Not so much the distribution.

GAIL WILENSKY: I would like to make a broader comment about why focus on these payment reforms or alternative delivery, when there is so much else that might be even more important in terms of determining the healthcare spending that goes on in the US. And the short answer is because that is where we are now. We can't just remake this 2.8 trillion dollar system, even if some people would want to, it would have more than major affects in terms of employment and innovation and other changes. Figuring out how to try to slow spending in a sustainable way. Keep it slow. Improve value. Try to change the organizational structure in the ways that Mark and David have described, which are going on in the United States. Could perform some major benefits in terms of both improving health and having some economic pay off in terms of slowdown in spending. It won't make the US look like European and other countries when we do that, but it could put us in a sustainable position. After three and a half years on the WHO commission on the social determinants of health, I feel comfortable with saying all countries struggle with this issue about how to do a better balancing between the social determinants of health, poverty, treatment of women, employment, the issues of environment and what they spend on medical care. We are more extreme than most, but if we can tame on a sustainable way healthcare spending, it will put us in a position to be able to provide more support for some of the public health measures first and then for some of the social determinants, if that is where the will of the country is. But we have to make sure we have a sustainable higher value healthcare delivery system and do it in a way that doesn't completely destroy or upset the economy. When you are talking about 17% of the economy, you want to be a little gentle how you make these changes. Massachusetts is having to deal with that in an up close and personal way where one out of five jobs is healthcare related. They are desperate to make sure they slow down their spending, having been so successful in expanding coverage. But they also have to be very careful how they do it or we will find a lot of unintended consequences in their lap.

STUART GUTERMAN: Gail's mention of Massachusetts reminds me that the efforts to develop health reforms that work are not limited to the federal public sector or the private sector. There is also a lot of activity going on at the state level. And with regard to the mix of social services and medical services, I can't tell you how many people I have heard claim that they were the ones who invented the concept of buying air conditioners for asthmatic patients. To spend $200 to save countless emergency room visits. That kind of consciousness on how we can improve the health of our populations, I think it is starting to happen already and I think a lot of people are thinking about how to do that. So it's not a discontinuous thing where we are phase one and then we jump to phase two. It's a lot of changes that are starting to happen right now.

ED HOWARD: Give us your name please.

LAURA TRUMAN: Laura Truman, The Heritage Foundation. I wanted to ask about the idea of value – moving from quantity to value. We are in a situation right now where we are getting sense of people don't really like it if you tell them this is the insurance you must have, versus – not this kind. And how do you decide what is value medicine? Obviously abusive practice of medicine is clear, but how do you do that in a way that doesn't get in-between a doctor and their patient and – so that is the question.

MARK McCLELLAN: It's a really good question and there is no perfect way – there is not a great way of measuring value, there is so many things that matter in different ways to so many different people. I would just go back to the fundamental problem I started with, which is that the fee for service payment system that we have in Medicare now, just doesn't match up with what doctors and their patients think is most important in getting to better health and doing it the lowest possible cost. That is value. Now we don't have a perfect system for measuring it, but I don't think we are gonna get there by continuing in this cycle of squeezing down the fee for service payment rates. What a lot of these reforms really end up at their core is taking more of the funds that currently are tied to the volume and intensity of specific services; they are set according to this 8,000 different fees that Medicare regulates and putting it into resources that are more available for practices to spend and direct in what they think is most important for their patients. To have accountability along with that and to help patients make choices about which doctors to go to and so forth, I think it's really important for them to have better measures of what matters. Measures that are consistent and allow them to compare different doctors and hospitals and care systems as David was describing. This fits with, I think, some of the – and you are from Heritage – some of the Heritage proposals about basically putting more resources in the hands of patients working with their clinicians to make decisions about where healthcare should go. So it's a real challenge to get from here to there, but we are not going to get there by just continuing to squeeze down the payment rates and revise the 7800 fees and the RVU schedules.

GAIL WILENSKY: As I listen to you, I think one of the important questions you are raising or how I translated it, is what role do we put to individual preferences and how they might prefer to interact into the healthcare system, versus other people's views about that? If we are to – and the answer is that people will have different views about the value or importance of acknowledging and accommodating different preferences in terms of either where people receive healthcare or how they receive healthcare. It will be hard to have it be meaningful if there is not good information about which physician or physician groups or hospitals provide good clinical outcomes, clinically appropriate care, respond to patient preferences, but it also means you have to have some agreement on who is paying for it. Whose money. The notion of not getting between the patient and the provider is – providers, clinicians or others, who may have inadequate information on which to base appropriate clinical decisions – is it using someone else's money? That makes it much more complicated. Its why if you have choices of some sort, which exists to some extent in the Affordable Care Act, but not as much as others think maybe

appropriate. You can say, well if people have some choice about what they buy and how much it costs them, that is a way to try to acknowledge that preferences will differ for different people and they will carry with them different costs. The issue about how much choice to allow and how to acknowledge that some people may be in a better position to pay up for a more expensive choice than others. It's obviously a complicated one, but its an important issue that what we mean by value is not just clinical outcomes and a clinical appropriateness, but how individuals feel about the choices that they have.

LAURA TRUMAN: I would just add, it's also about, who is the determiner? So for example in the Affordable Care Act, there is a lot that says, as determined by the Secretary of Health and Human Services and so who determines these protocols and how do we make sure that it's not bureaucrats that don't really know what - ?

DAVID SHARE: I would say in answer to that and also the earlier part of your question, I think there is lots of latitude in the Affordable Care Act and I don't see that there is a lot of micromanagement of clinical decisions where paras do prior authorization and precertification and get into the weeds on individual patient and provider decisions – that is when tension arises and I think appropriately so. But I think you just have to look at the choosing wisely campaign to see that physicians recognize that there are a lot of services that don't add value, that do add cost and are used and could be avoided in the vast majority of cases. And to me, it seems – your concern about the patient and their autonomy and being able to act from their personal preferences is really important. That resonates for me as a clinician in a medical home based practice. That is the right place for those decisions to be made, and when you have an alternative payment model that supports medical home based practice and brings the patient to that, through incentives and then in that context, the physician is asking – a physician and other team members, what matters to you? What are your goals? How can I help you? And then you can mediate decisions about what services to use through that – informed through the lens of what those preferences are. You make judicious choices and as I said earlier, in Michigan for ten quarters, we have had a negative use rate for professional services. But we are not experiencing rebellion by the patients. They are much more satisfied; they are really thrilled to have these closer relationships. So I think valued based payment can be liberating for providers and for patients.

ED HOWARD: Can you describe with some greater detail exactly what you did in Michigan to decide what the value judgments were?

DAVID SHARE: So I would like to take that question Ed, as an opportunity to draw a distinction between trying to measure and reimburse value at what I call a wholesale level or population level. Distinguish that from what I would call a retail level or individual patient level. When you get into trying to decide what adds value for an individual patient and have a payer involved in that or you are trying to pay on a bundled payment type basis and trying to decide what is in the bundle – what services are in and what are out and which provider should or shouldn't get paid through that bundled payment, it

becomes in my mind and our experience from past trial, somewhat of a sorcerer's apprentice experience. And it adds a lot of administrative complexity and it doesn't really get at the value proposition in a direct and effective way. When you leave latitude to the patient and the provider to decide what adds value in care and then measure episodes of care amongst communities of caregivers in aggregate. Look at how they stack up when evaluated in a pattern at a population level. And then you can determine, relative to other communities of care givers, how efficient the bundles of payment are and how effective they are in terms of the outcomes. You can identify variation and you can begin to see a pattern of more or less value. So what we have done in Michigan is on the proportion of payment beyond the fee, the base fee that is variable based on delivering value, is dependent on those kinds of analysis. Does that get at your question?

STUART GUTERMAN: Okay, we have a couple questions that are closely related. One was to Dr. Share about the impact of increased consolidation that might come out of requiring physicians to work together more closely and how is that effected in how your program operates and how your payments are determined? And on the flip side, how much market share does Blue Cross/Blue Shield of Michigan have in your area and what impact does that market power have? And more broadly to the panel, that general question of the tradeoff between coordination and provider consolidation, what the potential impacts would be.

DAVID SHARE: I never had those questions before. Provider consolidation is a big concern. Gail raised it and I think it's really right on, to be concerned about having the frame of reference be on health systems or hospitals because it is in their nature to consolidate resources in power and physicians then in those context become employed and to become disempowered and it really is bad for the market and it's bad for care. I think. But we haven't really actually had that problem nearly as much as it appears to be unfolding in other markets. And the reason is – remember I said we started with physician organizations as the organizing construct and frame of reference. The locus of control for bringing together practices, getting them to create systems, accountability for population performance. And there are more of those physician organizations in Michigan that are federations of private practices. Mostly small private practices – over half the practices in the state and I think that is probably true in most states, are one to three physician practices. But they become empowered by banding together without losing their identity and autonomy. And a few of them are vertically integrated systems that are part of health systems, hospital systems, that are more complex and interestingly, it's just as likely that a federation of private practices is going to be very high performing in Michigan, as it is a vertically integrated system. And so I think that by starting from that standpoint, thinking about primary care and patient first as the foundation, physician organizations built around that foundation and then bringing hospitals and specialists in as partners, not always owned, often times in virtual contractual relationships, affiliated, that is a construct that has worked. With regard to the market share that Blue Cross/Blue Shield of Michigan has, we have shy of 50% of a market, population wise, 70% of the commercial market and the people often say, well, okay, you can do it, but we could

never do it in our state. And I would say, it really is – there are other Blue plans that have that kind of market share and aren't doing what we are doing or just beginning to move in that direction. There are lots of plans that are collaborating in Michigan with providers to do what we are doing that are much smaller. I think it's mostly dependent upon vision and will, if you believe you can do it, you can. And then secondly, where there is not a payer with a large market share that is willing to take the risks that we have, that I have been describing and partner – give up control and partner with the providers to transform the systems, you can rely on regional health coalitions to bring purchasers and payers and providers together to create a sense of common purpose. So I think it's doable in other contexts.

GAIL WILENSKY: As I indicated, I am quite concerned that under the current incentive system, the consolidation that has gone on with hospitals and the purchasing by physician groups of hospitals, the offering up of many physician groups to hospitals because of uncertainty about the future, is going to exacerbate some of the problems that we have seen that larger hospital groups can and do on occasion, use their increased power to force higher rates being provided to them. This is quite different from what healthcare systems can do, because in that case you can do well financially by keeping people healthy and well and out of expensive institutions. But you need a reimbursement system where that is the case. It is possible with shared savings that you could motivate some different behavior, but it is still basically not in a financial interest for a hospital not to make use of their in-patient and institutional settings because of the fundamental incentives that are in place. Its not the point a finger of blame to them, as much as to say, if that is what your financial system rewards and you have given institutions an ability to make use of their increased size and power, don't be too surprised if it happens.

MARK McCLELLAN: There is this core problem in anti-trust enforcement. On the one hand, you can always make a good case for more consolidation – it is going to lead to better coordination of care and efficiencies of scale and scope and things like that and that is why – that is the motivation used by some of these larger systems. They need to be more integrated. On the other hand, the bigger you get, the more opportunities there are for raising prices or not providing the services that people really want and we could really use some better enforcement tools to distinguish the one from the other. As David said, you kind of know a group that is doing well when you see it up close. They have the will, they have the vision, they are doing a lot of things to change practice but it would be really helpful to have some better tools, including better measures of what is actually happening in these organizations in terms of impact on not just cost and Medicare, but impacts on private sector costs and overall quality of care to help with antitrust enforcement. I would add too that to get coordination and better delivery of care, doesn't necessarily mean and often doesn't mean that you need to have more actual integration. So David talked about a lot of physician groups in Michigan that are taking steps to deliver better care even though they are still quite small by antitrust standards and for example, if you look at the Accountable Care Organizations that have been formed in Medicare in the past year, most of those have been physician led groups that don't have

associated hospitals. Now, I think some of them are probably in the category of not really having a whole lot of systems in place or a clear plan in place or how they are going to get to lower cost or less hospitalizations and so forth. All that goes to refining the measures that we are using and the policies that we had to encourage better coordination of care and lower cost and not just consolidation. I would also add that there are a lot of other policies and Gail alluded to this too, that are driving consolidation now that are worth looking at. So more uncertainty tends to create it. So having a fix for physician payment that worked and that would give smaller groups an opportunity to see a good path forward that doesn't involve being bought out, that would be really helpful. Addressing the big and growing wedge between payments for the same or similar services in a physician practice versus in a hospital outpatient department, Medicare would really help a lot too. So some other things that could help address this challenge as well.

DAVID SHARE: Can I respond to Mark's observation about the need for metrics or data to help differentiate those systems that add value and are worth placing the bet on those that are just trying to aggregate market power. So I think by analogy, there might be an opportunity here, which is – so as part of our patient centered medical home program, we have a systematic approach to designating practices as medical homes and to tracking every six months through the physician organizations, the growth of medical home capabilities, there implementation in the practices. And we, again, in partnership with the providers have identified a set of 140 core capabilities of medical home practice and for every single PCP practice in the program, we know every six months which new capabilities have been added. In parallel to that, for the organized systems of care that do involve hospitals in the value based contracting, where the hospitals are at risk for population performance as well, we are tracking what we call organized system of care capabilities, which are the parallel capabilities on the institutional side that link up with the medical home systems and care management practices, so we know which hospitals are actually implementing those capabilities and using them and adding more value sequentially and which are not. So I think there is – and we also validate that out in the field. So I think there are ways actually to get at that challenge.

ED HOWARD: I don't know if this is the right time to read this particular question from one of our cards. We decided not to ask it up front so that it wouldn't swallow the rest of the discussion. Both Mark and Gail explicitly talked about the problem in the existing legislation or proposals in that there is no way specified to pay for these changes and as you have pointed out, not a considerable amount of money. So this questioner wants to know – this is going to give you a chance to make some enemies I guess – "how can The House and Senate packages be reconciled and what are the pay for's?" Actually this person had a Freudian slip, "who are the pay fors?"

GAIL WILENSKY: I will take a crack and then turn it over to Mark and he can add to it. I regard the reconciliation as the easier of the two issues, without meaning to offend the Energy and Congress Committee; I regard it as the gentler version of ways and

means. I mean, they are very similar, it's a question of how aggressive and how fast do you move to saying you get a period of stability by while we mean either no increase or a small increase. How long a period is that? And then at what point do you start pushing hard to say those that are in value producing alternative delivery systems, to be defined. Get an increase and it will be by definition, if you are an X, Y and Z and then other activities, you can engage in. And otherwise, you start getting a reduction. In part, it depends on how much money you want to put on the table. I regard them as directionally very close. As I have said, I characterize it, since I have characterized it to some of the staff directly, I feel like its okay for me to say it publicly as just being the gentler version of the slide. So it really is – do you want more money or do you want less money? Now, where does the money come from is the tougher one. The House did come up with a listing of some pay for's that it intended as part of entitlement reform. Not to use this – it included some of the things that Mark had mentioned in terms of income related premiums and a listing of other activities. So it's not that we haven't seen where in Medicare you might be able to take out some money. It's going to be, what do you want to do with that. Now, that doesn't mean they are easy to get, but there are such lists that have gone on for the last several years. It is going to be – is there an agreement that this transition away from the relative value scale – SGR, is so much a part of having a sustainable Medicare program, that this is an okay place to put it, as opposed to have it go directly into what is called a bucket for Medicare or entitlement reform. I don't understand – I have never understood how anyone thinks you can have healthcare reform when you have a screwed up way of paying physicians – which is what we have. You pay them for doing more and more complex procedures. Fortunately many clinicians ignore some of the strong financial incentives and do what they think is right, sometimes at their own financial peril. Not always. That is really a bad system. We've got to be able to enable and reward physicians for doing what they want to do and what the rest of us need for them to do. So I would regard this as a perfectly okay place to put some of the money that The House came up with in terms of entitlement reform. But it's easy, because I'm not running for office.

MARK McCLELLAN: Yeah, a challenging question. I do agree with Gail that relatively easy part is reconciling the reform and alternative payment model sides of the bill – I think the only urge that – or point that I would like to – that I hope is reflected in what comes out is that there needs to be enough of both a push and support for getting to these alternative ways of payment for the legislation to really have an impact. So we are not talking about the 1% little bonus if you are willing to shift into a new system, but really something that is more significant help up front and more significant expectation that care is really going to change and the Michigan models are a good example of that and it does take some significant help and some significant redirection of resources. But lets assume they can work that all out. Whether there can be as much bipartisanship on the pay for side, I think still remains to be seen. I'm hopeful. There are a number of reforms – and I had a slide on this – that I think actually could promote that spirit of bipartisanship, because they reinforce the goals of healthcare reform that the physician payment reforms are all about. So right now for example we are spending an awful lot of

money on post acute care and ways it varies a lot across locations and settings and there is some of the same principles that we have talked about here for physician payments could be applied there. We talked about differentials in payment. We talked about some of the importance of the consumer side of this, of helping people save money when they get better care and take steps to improve their health and there are a lot of opportunities for Medicare beneficiaries to save by being more of a part of this through benefit and Medigap reforms. So I think it remains to be seen. We had an event on this general topic back in November and one of the speakers was Dr. Mike Burgess, the Congressman from Texas who paraphrased a former ways and means committee leader, following quote, "You don't throw your friends under the bus until the end of the parade." So just because we are not seeing a whole lot of visibility around how is it going to be paid for right now, doesn't mean that there aren't a lot of discussions going on, but it is going to be a big challenge to maintain support for the legislation. Not just when it's about fixing the SGR and spending $150 billion plus, but finding a way to pay for it and I sure hope that same spirit of bipartisanship can continue through that difficult last step.

STUART GUTERMAN: Let me just add one point. The Commonwealth Fund had a commission on high performing cell system that Dr. Share was part of and one of the points that it made in it's last report that came out in January and this approach was echoed in a number of reports by different groups of stakeholders, including a couple that Mark was involved in, that when you talk about entitlement reform and you talk about pay for's, then you have to think about the system that you are working with and do things that help improve that system move in that direction. Because if you are moving in the other direction, then you are really going to diminish the effectiveness of the policies that you are putting in place and there are a number of ways you could think about trying to save money in a healthcare system that are consistent with each other and you want to kind of stay along those lines.

DAVID SHARE: Yeah, I just want to make this is a little bit more tangible and I have to say I don't envy the staffers of the CBO in trying to model out what the spend impact might be of different approaches to alternative payment mechanisms, but it seems to me that is the heart and soul of the opportunity here and that is where the money ought to come from, is the potential impact on use. And so I'm going to give you a couple of really quick examples. We have what we call a Michigan value collaborative. I didn't talk about a whole set of programs we have working with hospitals on optimizing value, that is a subject for another day. But one of the newest gets hospital CEO's, CFO's and lead clinicians together to look at variable use in quality outcome rates for common high cost bundles of services. An example – turns out some hospitals, after hip replacement, send people to acute rehab for a few days and then to home with PT. And others keep them an extra day in the hospital and send them right home most of the time. Saves a lot of money. Nobody really knew that except maybe some people who are interested in the ledgers at the hospitals that use the acute rehab regularly. When 20% - 30% of the reimbursement is dependent upon moderating use and cost, they all sit up and take notice and try to figure out how to harness these approaches. So that community of hospitals is

becoming very much more engaged. What is the value of that? How much is going to be saved? It's going to be substantial. One other quick example – so we had colleagues from the Louisiana Blue plan come up for a day, a couple days, to look at our medical home program and get together with the 350 physician and nurses and administrator – the leaders that come together quarterly to talk about how to optimize value in their own communities. It's a very collaborative environment. But right before that, we took them on a couple medical home site visits. One of the nurse managers in a physician organization population manager were explaining what they do and they were talking about their population use rates for ED and in patient use and the complex chronic illness management program they have and etcetera, and the chief medical officer of this Louisiana Blue plan stopped this woman mid sentence and said, I'm sorry, who do you work for? Why are you talking about your use rates per thousand? And she said, oh well, I'm the population manager for the physician organization and who do you work for? And he points to the nurse in the practice. She says, oh well, I'm just the care manager. But they were talking about use rates in the same way that health plan people talk about use rates – identifying the opportunities, sending out the team to act on them in a proactive way to reduce those rates. He said this is like an alternative universe to him. That people in practices would be coming together in this way and talking and thinking this way. But to us, it was common place, so it was really fascinating to see this other perspective. So my point being that alternative payment mechanisms harnessed in local communities can have a huge impact and it would be really worth while to try and estimate what that – the dollar value of that impact is.

ED HOWARD: And convince CVO of it. I can see the last float in the parade coming around the corner and if I can ask you to suspend for just a second. While we are waiting for this last Q&A, I will ask you to fill out that blue evaluation form and I have a special request for you. In the comments section, I would like to read what you have to say about the inclusion of a couple of background pieces in the reminder notice that we sent you yesterday so that you could get up to speed with some of the jargon and some of the concepts before you walked into the room. But please fill out the blue evaluation form in any event. Yes sir, you have been very patient. Last question.

JOSHUA: Good afternoon. First of all, thank you all for your team and your presentations and for coming out today. My name is Joshua, I'm supposed to be attending medical school later this year, so just to say, if we could get this sorted out in the next five years, before I start residency, that would fantastic. But currently I'm an intern at the Heritage Foundation. Dr. Bob Moffit wasn't able to be here, but he had a specific question for each of the panelists. One of the big statutes that was often discussed in the original 1965 Medicare legislation specifically pertained to prohibiting any federal officer or employee from exercising super vision or control over the practice of medicine or the manner in which medical services are provided. So in light of what we have discussed today, the SGR fix, the current innovations in Michigan, etcetera, do each of you agree that this statute still applies to Medicare, that no federal officer should exercise any supervision or control over medical practice.

GAIL WILENSKY: Well, technically, as far as I know, the law is still in place and so it is true in terms of direct control. That certainly doesn't mean that there are not incentives in place either because of actions of the Executive Branch or measures taken by the Congress, that encourage or discourage all kinds of behavior on the part of clinicians or institutions. One of the issues that we didn't know about in 1965 that we have become acutely aware of in the last ten or fifteen years in the impact of medical errors on patient outcomes and the importance of patient safety strategies being employed. We didn't realize that in many instances, people get about 53% of what independent groups of clinicians regard as clinically appropriate care and that it's only modestly better in many academic health centers. The notion about trying to provide better information and incentives to use that information and to encourage better behavior in the sense of more clinically appropriate outcomes by both the physicians and patients is important. That is really different from saying, should a federal individual directly control what a clinician or other person involved in healthcare does? And I don't think that occurs either in the public or in the private sector. Not have a heavy influence on behavior – that is a different matter and frankly, given much of what we know, its not clear, a lot of that wouldn't improve healthcare as well.

MARK McCLELLAN: Well, in just speaking as another former CMS administrator, I think our general counsel would have told us if there was something really running afoul of that law or any other. But I just want to reemphasize Gail's point about what clinicians want to do in practice and that leads to frustration. It leads to higher cost and it leads to worse outcomes. I think the legislation that we are talking about now is a big step in the right direction, I'm glad there is kind of bipartisan recognition of that. I'm also glad that you are going to medical school, because I think the future for doctors is actually both really challenging but also really interesting. Where that locus of control is or should be with these kinds of reforms especially, is between the doctors and the patients with some accountability there for getting to better results and avoiding unnecessary costs and I don't know that our policies are going to fix that – well, I pretty much know that they are not going to fix that problem perfectly in the next five years or probably the next 20, but hopefully through reforms like this and people like you going to medical school, we will keep moving in the right direction. There is so much at stake for the health of the country and for our nation's economy that we really gotta make some progress on this.

DAVID SHARE: So I would add that I don't either experience in my practice or hear other physicians talking about it, that the existing legislation and the current regulatory changes that have occurred or any that are anticipated in the kind of payment changes that we have been talking about today as being constraining on physicians. My experience is that it in fact, if anything, physicians and patients are becoming more empowered to better serve the needs of the patients. So I don't see that the long arm of the government is intruding on the doctor/patient relationship. I think it is strengthening and bolstering it. I would say that I expect – though I am not a lawyer or a former CMS administrator, that the law also says something about medical necessity. That benefits are

provided for medically necessary care and appropriate care. And so you could have an overly broad interpretation of that excerpt from the law and take that to mean that the doctor and patient can do anything they want and Medicare has to pay and nobody should ever say anything about it. Unsafe care, unnecessary care, inappropriate care, ought'en to be provided or paid for. So I would hope that there would be some guard rails that the government would put in place to attend to those concerns.

ED HOWARD: Great. Well, we have come to the end of our time – Stu do you have a closing comment you would like to offer?

STUART GUTERMAN: Well, I would like to thank the panel for their great presentations and this great discussion and thank you all for your great questions and for coming to attend this. It is clearly a topic of great interest and much broader than a particular provision and a particular program.

ED HOWARD: Great and let me just add thanks to The Commonwealth Fund for their active participation in shaping the program and their co-sponsorship of it and I want to thank the Alliance staff for surmounting the weather, the deadlines that arose, the dense subject matter that we were dealing with today – they did a terrific job and that is why it all went so smoothly. So let me ask you to join me in thanking them and thanking the panel for a really good discussion.