The High and Rising Costs of Health Care: What Can Be Done?
Alliance for Health Reform
June 12, 2012

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ED HOWARD: I'm Ed Howard, with the Alliance for Health Reform, and on behalf of Senator Rockefeller and our board of directors, I want to welcome you to this discussion of healthcare costs, the last in the series of three briefings that we have put together with the help of a group of our advisors, some of whom are here today. There is a list of those folks in your packets, and we're grateful to them. John Rother, who's also on the board of the Alliance, chaired the group, and helped us shape this both in substance and in the way we put it together, structurally.

Let me just say that we could not have put this together without the help of the sponsors whose names are arrayed on all three screens around you. I'm not going to read off the names, but let me just say that the responses that all of the folks you see, represented by their logos, was very positive, very swift in putting together the package that allowed us to make these meetings happen, so we're very grateful to all of those sponsors.

Just a couple of logistical items I'd like to tick off, one of them is that there's a blue evaluation form in your packets that we would appreciate it if you would fill out before you leave, and we're particularly interested in the

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question that asks you for what steps we ought to try to take next in this process.

One of the things that you ought to be aware of is that as we jumbled the agenda to try to accommodate a full scope of the folks we wanted to encompass, we lost the break that you were going to get about 2:30 or 2:45, so we would urge you to take advantage of changes in speakers or whenever, and take your break when you need to take your break.

One of the last things I want to ask is that you feel free to stick around after this discussion because the excuse we offered for putting this series together was that we've been doing the kind of educational work that the Alliance has become known for, for just over 20 years now. This was our version of a celebration. We are going to have a reception following the program, at which we would ask each of you to stick around and have a glass of Coke or whatever with us to mark the 20 years.

We're also incredibly grateful that Susan Dentzer who is, as you know, the Editor of *Health Affairs*, among many other achievements in her career, to keep this distinguished group of folks on target and on task, and we're going to ask her to take the microphone and the lead at this point.

Thank you all for coming, and let's have a great discussion.

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SUSAN DENTZER: Welcome, everybody. Those of you who were here for our first several forums know that we have worked our way through a lot of the causes of rising health spending. Today's topic is to bring us to a conclusion, to talk about what we might do about it.

As we know, and those of you who are able to read David Blumenthal's terrific *New England Journal of Medicine* perspective, we have a great deal, now, in the national performance improvement toolbox. It is now, as he wrote in his perspective, well stocked. The question that we're going to put on the table today is, is it as stocked as it could be? What might we need to add to that toolbox? And, most particularly, how do we take full advantage of the tools in the toolbox, and work as quickly as possible to bring health spending growth down to a sustainable rate that also addresses the other very important objectives that we all have, with respect to the AAA [misspelled?]?

We are going to focus as much as possible today on the perceived solutions, and as Ed said, what the next steps might be as we carry not just this conversation forward, but this performance improvement process forward as expeditiously as possible.

We're going to start with a discussion raised by Marilyn Tavenner, the Acting CMS Administrator, and I'll just

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make the point again that in the interest of time, we've decided to forego elaborate introductions, we're just going to read name, rank, and serial number, for all of our speakers and reactors today.

With that, let's turn things over to Marilyn to tell us about the efforts underway under the agents of CMS, CMMI and others, to promote good health, good care, and lower costs. Marilyn, welcome.

MARILYN B. TAVENNER: Thank you. Obviously, it would have helped if I'd attended the first two in the series, but I'm happy to be here today, and I want to talk to you a little bit about where CMS is heading.

Sorry I'm not here for the entire afternoon, but I know Nancy and others are, and as the solutions unfold, please do not be shy about sharing them with us, because part of what we are doing is actively looking for solutions.

I think I try to talk, when I go to the Hill to speak with members of Congress, one of the things that I try to lead with is how do we use money wisely? I use that as the starting point, so if I look at the studies that many of you have done, if I look at David's article, I think what we understand is that we're really dealing with at least four categories, and this list is not meant to be all-inclusive, and you all could certainly add a lot to it.

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One obviously has to do with payment reform, and by payment reform, I'm talking about those areas that exist today in traditional fee-for-service payment that need modification, either because of the time they were initiated, or because of changes in cost, we may actually be, if you will, over-paying for certain services. If you followed the work that we've done, I've now been at CMS for about two and a half years, if you follow the work that we've done, we have tried to use both the in-patient payment rules as well as the out-patient payment rules, to target those [Missing Audio –] to get the pricing more in line with costs. That's one area in where our research has shown that we've actually overpaid, if you will, or because things have changed about the cost structure, we are making those changes.

The second one, obviously, has to do with pharmaceuticals and medical supplies, and you will notice that we've done a lot of work with part D, a lot of work with Medicaid formularies, and this is all designed to try to bring some of those costs in line.

The third area, and I'll talk more in detail about this, has to do with over-utilization, and a big part of what we're doing every day is moving from payment for the number of services delivered, to payment for those outcomes that we want to see. Obviously you see that in value-based purchasing, the

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work and the Innovation Center moving to a more coordinated care approach [inaudible], putting primary care physicians more in charge of an episode of care, and again I'll come back to those.

The last area that I want to touch on today has to do with administrative costs and data sharing, which is a big part of what we're about.

I'll talk a little bit at the beginning about our priorities for payment and delivery system reform. Our priorities include the following: We are trying to elevate the experience of beneficiaries, both in the fee-for-service and the Medicare Advantage program, because we think that the more our beneficiaries buy into what we're trying to do, the more they understand about what it is we're trying to do, and the more they can explain to us what their service was like, we will be able to better control costs through their awareness and through their feedback to us.

Not only will you see that in our Medicare Advantage and fee-for-service programs, but you'll also see it in the work we're doing around fraud and abuse, whether it's the Medicare Senior Patrols or other things, it's an educational process to the beneficiaries. They know what to be alert for, and they can help us identify, if you will, a waste in the system or inefficiencies in the system.

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Second, we're trying to incentivize care that is coordinate, that's less fragmented, and where care transitions, meaning from the hospital to home, or hospital to rehab, or hospital to a skilled nursing facility, that those transitions are closely managed.

We want to guarantee that patients have a strong source of primary care, and a medical community that's looking out for them, so that's a guiding principle of the work we're doing.

Last, to ensure that spinning distortions are corrected and pro-beneficiary cost growth is low.

Those are the priorities around which we try to do everything we're doing, whether it's in the Innovation Center, whether it's in Medicare, Medicaid, or through [inaudible]. One last principle or priority that I would add is we are trying to work very closely with the private sector, because we've learned a lot from private insurance, we've learned a lot from states, and we've learned a lot from consumers. We want to align, and I'll talk a little bit further about that, because a lot of the costs that we're seeing in the system overall, and I'm not just talking about CMS now, is because we are not aligned.

In the fee-for-service program, I would say that our areas of focus are around ACOs, hospital readmissions, bundle payment initiatives, strengthening primary care, linking

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payment to quality and efficiency, and this is obviously very important to us, and then building in prevention and wellness.

Then when we look at the Medicare Advantage programs, we're into trying to simplify the program and make it work better for seniors, particularly as we see, and I would be one of those entering the senior pool ever so quickly, be part of the bolus that's part of the problem, and creating strong incentives for quality improvement, and to encourage beneficiaries to seek the highest quality plan. You've obviously seen that with our Medicare Advantage bonus program.

We are also focused on dual eligibles, and I believe Melanie addressed you all earlier, but part of what we are doing in 2013 is implementing new coordinated care plans that are designed specifically to improve care delivery for people with limited income and resources.

While we are focused on these new payment innovations, our teams are also working hard to make sure that our fee-for-service payment systems are as strong and as accurate as possible. Our MA payment rates are based on fee-for-service; our ACO benchmarks are based on fee-for-service, and our payment bundles are based on fee-for-service. While we're creating a new system, we cannot abandon the current fee-for-service model, nor should we. We're trying to strengthen that, as well.

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The point of our payment innovations, however is we are trying to incentivize care coordination, reduce the provision of unnecessary services, encourage providers to become more efficient, and then focus on our internal controls and resources.

That's why some of our recent actions have been so important, they just don't respond to inappropriate spending in a particular sector, but they promote the care improvement and delivery reform goals that we're trying to achieve. Some examples of that have to do with the SNP payment adjustment, once we found we were in an overpayment situation, we immediately corrected and then we went back to, if you will, retrospectively look at our data to make sure we'd made the right assumptions.

Second areas DME competitive bidding, DME services have long been an issue, DME competitive bidding which now expands in 2012 and 2013 to more than 90 metropolitan markets, has a lot to do with continuing to provide high-quality services, but doing so in a cost-effective manner. The work that you'll see that we undertake around home health payment reform and ultimately hospice reform, which is part of the Affordable Care Act.

Clearly, the environment is shifting, I would argue has shifted, and I feel it every day when I talk to providers, to

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beneficiaries, when I go out in the public, people, it's no longer discussion of do we need to change, the discussion now is how do we go about making the changes and making the appropriate changes.

I appreciate the fact that this has been challenging for long-established business models. What we are trying to do is do this in a way where the industry, if you will, is moving with us. We obviously need to make the changes, but we're trying to do so in a way that does not derail; or make sure that we are able to move the system, and not that the system becomes even more fragmented in that process.

Critical to all of our efforts are making sure that we're paying for quality care. Under the leadership of Patrick Conway, and I think most of you know Patrick, he's been at CMS for about a year, and his leadership has been phenomenal. Where we're headed is lining up measures across all programs, current and proposed, with the idea that we would decrease provider burden, even reducing the number of measures overall.

Also, it's important because so much of our work is either inside Medicaid managed care, or Medicare managed care, that it also align with the private sector, obviously taking into account there are some population differences, but as we move forward with exchanges and the health insurance marketplace, obviously, it starts to cover all populations.

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We are trying to prioritize and implement measures aligned with the national quality strategy, and in order for this to be successful, we must select measures that matter, and that fill critical gaps. Aligning these measures and reporting programs such as single reporting systems for in-patient quality reporting, hospital value-based purchasing, meaningful use, ACOs, has been what we are about. By the end of 2012, we will have most, if not all, of those measures aligned.

We will also include aligning measures across Medicare fee-for-service, part C, part D, the exchanges, Medicaid, and as I said earlier, aligning with the private sector.

We are moving toward a smaller number of required measures and programs, and focusing more on outcomes and less on process. We are also working to maintain optional measures so that they can apply to a broad range of specialists, because we understand that that's important, as we are dealing across a broad diagnosis platform, if you will.

We believe this will ultimately not only maximize our quality in the system, but it will minimize provider burden, and cost.

We've already had several accomplishments related to this quality alignment. We have, as I said, lined across CMS programs, we have developed further measure selection, and we have removed and retired measures, something that I'll assure

you two and a half years ago was not exactly first on our list, so that's been a big culture change.

CMS and AUC [misspelled?] obviously collaborate on meaningful use in stage one, and we're in the process of collaborating on meaningful use in stage two, and for the first time ever, we have proposed fewer required measures in hospital in-patient quality reporting, again a big shift from the idea of more measures meant more quality, and I think we all understand that may not always be the case.

We process more than 1.5 billion claims annually, so obviously we're sitting on a lot of data, and that's the last area that Id' like to talk about.

We are working to transform and modernize our approach to data storage, to data analytics, and dissemination, and to create the necessary tools to reduce the cost of healthcare provided under its programs, whether it's Medicare, Medicaid, or CHIP. This is no small feat, because as you might imagine, these have been systems that have been developed over the last 40 or 50 years, and then there had been additional platforms and systems added, depending on what was passed in Congress.

Trying to come up with an enterprise-wide system will take some time, and we're actually working on a three-year horizon right now. Part of what we're doing and you may have seen the announcement a couple of weeks ago, or maybe it was

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last week, I lose track of time, about the data shop that we are establishing within CMS, and that's really the only way we see to make this work, is a team has to come to work every day, thinking about data and data analytics.

Thinking about how to simplify the process for physicians, providers and others, and making sure that we have the data we need to provide high-quality care, or to conduct research.

For example, groups of doctors and hospitals who take advantage of the ACOs are participating in initiatives that are being developed by the CMS Innovation Center, will be able to more readily access their patients' information, and this will help them better understand their patients, and provide more coordinated quality care at the right price.

This initiative also provides us an opportunity to develop a consolidated, coordinated approach to collecting, storing, and disseminating data. By harmonizing our programs, it will make these programs more efficient, and we'll be able to have more public data, which again, will then educate us on how better to control costs going forward.

We've already implemented several initiatives, such as the Medicare Shared Savings program, the Qualified Entity Program, which require new methods for data utilization and release.

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Further releases will require us to permit routine large extracts of data across multiple years, so that people are able to analyze cost across multiple care settings, allow for routine creation of customized analytic files, and accommodate large increases in the number of data users. Once we start to go public with data, we expect that we will have a lot of people interested in this data. By implementing this new initiative, we're going to be able to drive, along with the help of people like you, costs down to a further level without impacting quality, and in many cases, improving quality.

There are a lot of other items I could go into, but at the risk of going through a list and boring you all with the list, I'll stop.

I will say that last December, I'd assumed acting administrator position for the second time, and began my third year at CMS. I arrived at CMS right before ACA was passed, and have had a tremendous pleasure and honor to lead an extremely talented team, one that in addition to what I'll call the routine CMS work, has taken on many responsibilities that are truly game changers in how this country ensures the health of our people. We are now well over halfway down the road to 2014, and when we open the doors to the new health insurance marketplace, we will also be changing the way people shop and purchase health insurance.

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I mention this at the end of my speech, because everything I've touched on, everything we do, will also drive change in the private market, and in the new health insurance marketplace, whether it's better care coordination, better quality, or more transparency, people buying coverage through an exchange in 2014 will benefit from everything that we've learned and done in Medicare and Medicaid.

The bottom line is that we work every day to try to lower costs and improve quality. We're pulling every lever at our disposal, we would love to know if there are additional ones that you all can identify that we can work on, we're open, I like to think we've had an open-door policy in the last two and half years, and that's going to continue to be the case, because we're learning just as much from the private sector as we're developing in the public sector.

I do believe we're at the very beginning of this endeavor, but I believe we're also at a point where it's starting to make a difference. I want to thank each of you for your participation and your support in making it happen.

SUSAN DENTER: Thank you very much, Marilyn. Marilyn has about 15 minutes for questions, so let me suggest that we pursue a model that we have pursued previously, which is the up-ended tent card model, if you do have a question please

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upend your tent card, and we'll work our way around the room in a counter-clockwise fashion.

Marilyn, I'll take the moderator's prerogative of asking you the first one, and I'm going to stay on your last point about data. As you well know, particularly for those in the Medicare Shared Savings program, we need to have real-time data about the beneficiaries who are going to be attributed to them, but may also be using other providers is really paramount. How close do you think you will be able to get to actually giving those ACOs truly real-time data? They want to be able to know on the day that a particular beneficiary is at the wrong hospital, or in the hospital and shouldn't be, et cetera, and how soon do you think you'll be able to get there?

MARILYN TAVENNER: You know we started with the pioneers, that was the early group that came in, in January I think, I'm losing track of time, and it took us the first quarter to actually figure out how to try to get data to them timely. Obviously when we say demos, these are demos in every sense of the word, not only are they demoing the product, we're demoing our ability to get them what they need. Fortunately, they are a talented and patient group, so we now are in the process of applying data quarterly. Of course, everybody would like real-time, same-day information, quarterly will probably be how we start, over time as we are able to develop better

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data and better analytics, we have to move a little earlier. They are able to identify their beneficiaries and look at their beneficiaries' information on a quarterly basis, now.

AUDIENCE MEMBER: How real-time do you think ultimately you could get?

MARILYN TAVENNER: I wouldn't want to speculate on that. I hope we move to a point, and a lot of it depends on clinical systems and how we integrate physician systems and hospital systems. I think we're getting there. A big piece, I have a little meaningful-use commercial here, it has to do with intra-operability. Some of that is vendor dependent, and some of that is willingness dependent, and talent dependent. That's the idea is to move toward real-time.

CHERYL PHILLIPS: Speaking of data, and we know that the challenges with the dual-eligible population are just momentous, but one of them is the information sharing between both of the payers. As you talk about the data on the Medicare side, are there strategies, some of the innovations work looking at sharing the information with the Medicaid, which is predominantly on the state side, and that's often been the barrier on the providers of trying to deliver integrated care?

MARYLIN TAVENNER: We are working with states, particularly those states that are in demos. We obviously can supply the Medicare data and are willing to do so. We also

have been able to, part of what they're missing, what the state is missing has to do with part D information, so we've been able to work through that on a case by case basis. We need to get it to a more streamlined system, and then obviously we need to put some standards, if you will, around what the states will supply, and most of that will be part of the demo learning opportunity. These demos, there will be several that will come online in 2013, so not too far away, we'll start to actually look at data and sharing data.

MARY: Along the data sharing line, here being used for the ACOs, I'm thinking of other areas of the Medicare program, whether they're demonstration projects, I know that's been one of the concerns, not getting enough feedback to see how you are need to modify it. Other areas like how many Medicare beneficiaries are accessing the diabetes screening benefit. Could you give us a picture or outlook for other areas that the data will be used?

MARILYN TAVENNER: Sure, obviously in the Innovation Center, that would be the first part, because we're asking people to partner with us, go at-risk on some of these, like one of the ones that is out there right now is the whole bundle care, bundle payment kind of program, they obviously need to look at their data, be able to have a good feel about where they want to bid, or where they want to enter a grant or

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contract with us. That's the first area, the second area that you're talking about, whether it's diabetes management or preventive, we're kind of having to, if you will, you've seen our announcements around during that whole prevention screen, that's all been kind of, it's an automated process, but it's not an instant process. Those will be the first areas that we look at, prevention and other, and then from there start to dig into different diagnoses. It's been, Medicare has traditionally, I think we've all been traditionally a medical model, so it was easier to pull claims data, but it wasn't always as easy to pull screening data, prevention data, so we need to work in that area.

We will also need to harmonize some of our systems internally to make sure we're pooling all that data. It will take us some time to do so.

JULIE SCHOENMAN: Thank you, Julie Schoenman with NIHCM Foundation. I'll ask the obvious question and that is how many of these tremendous innovations that you have going would survive if the Supreme Court takes the ACA out completely?

MARILYN TAVENNER: Well I believe that if the entire law is struck down, obviously the Innovation Center sits inside the law. I don't want to speculate there because I believe the Supreme Court will uphold the law, obviously, and I think it's the right thing, but if you remember prior to the Innovation

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Center, there was a division of standards and quality and some research, so that, if you went back, that would be the mace.

SUSAN DENTZER: Just to interject on that part Marilyn, one of your predecessors Mark McClellan has observed that there is already within CMS a lot of demo authority—

MARILYN TAVENNER: There is.

SUSAN DENTZER: —and he posited, recently, that most if not all could continue forward, just renamed under your proper authority, do you think that that's right?

MARILYN TAVENNER: Yes, and Mark and I actually spoke at his ACO summit last week, and we had a discussion about this, there's a lot of demo authority that sits inside CMS, there's a lot that sits inside Medicaid, so there are still ways, but again, I think we're all believing the Supreme Court will make the right decision and will uphold the law and we'll keep moving.

KRISTINA LUNNER: Kristina Lunner with Leavitt Partners. On that point, I've heard that comment as well, a few times before, and that's heartening that some of these demos would be able to continue, but my understanding of ACA is that it included the term rapid, not rapid response, but the ability to flip it, to if it's working well, to move forward and that seems to be a distinction, and I'm just curious what

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your sense of timing and how that might roll out, assuming things move forward?

MARILYN TAVENNER: If you look at the Innovation Center, and I won't get the exact wording right, but it did allow that if you went through your measurement tools and basically got OACC [misspelled?] certified, then you could make a pretty rapid recommendation to Congress to the Secretary, that is a specific authority, so that is a new and a little unique. I think there's always been the ability inside, and authority to, inside of demo, to make a recommendation and a report back to Congress, but this was a little more direct route. You're right, and it's a very important tool.

SUSAN DENTZER: And your implication is that would go away if the law were to be—?

MARILYN TAVENNER: I'm not going to speculate on the law.

JIM GUEST: Hi, I'm Jim Guest from Consumer Reports, you're talking about the data I would really encourage, urge, persuade, whatever I could, that maximum transparency on the data that you do have around providers and around practitioners, I know it's somewhat of a controversial issue, but there's more and more talk, and the talk about how to both improve quality and reduce costs is to get more information into the hands of consumers so they can make value-based

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decisions, looking at both quality and price, and there's an awful lot of data that for many years, CMS has just not made available, and there were hurdles to getting it. From a consumer perspective, I'd love to have you minimize the hurdles so that organizations like my own or others really could get consumers information to make informed choices that would have a great benefit. I'd be delighted to come talk further with you about it at some point.

BARILYN TAVENNER: I would welcome that.

GRETCHEN ALKEMA: Good afternoon, Gretchen Alkema from the SCAN Foundation, and thank you so much for coming today and providing the opening remarks. One of the things that we think a lot about, in relation to vulnerable older adults who are seeking to stay in community settings, whether they be on Medicare solely or certainly dually-eligible, utilizing both programs, is that there appears to be a number of individuals who have both chronic conditions and functional impairment, functional challenges, and that there are not really good data systems right now, broadly within Medicare, to identify that functional status component. However, in a number of different data sources, we find that that's actually the component of individuals who are driving the greatest amount of costs, not just those with multiple chronic conditions, but that added layer of function. I'm kind of wondering, as you're looking at

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whether it be ACOs, wonderling [misspelled?], certainly care transitions, those other elements, whether they be in Medicare or certainly from the dually-eligible platforms, how you're thinking about incorporating that identifier of function, and really pushing those entities particularly in the private sector, to be thinking about the role of function when not only doing program planning, but also intervention planning at the individual level?

MARILYN TAVENNER: Your point is well taken, it is probably the area where we have the least amount of data, but obviously those patients are most at risk are those consumers are most at risk. Inside the duals is probably where we've done the most work, where we've actually tried to, and some states had already carved out that population so they could treat them, because the ability to function obviously has a lot to do with how successful they are living at home, staying in their community, so I think we'll probably start there, but we're going to have to look at all populations with that. Certainly as our population ages, it becomes a bigger and bigger issue. I think we'll get more data as time goes on, but well probably start with the duals and how do we work with states that are interested?

SUSAN DENTZER: Marilyn, we know you have to go, so we'll just ask you one final question, if we might, which is

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we're gratified to hear that the possibility that the Supreme Court overturning the Affordable Care Act does not appear to keep you up at night, so let me ask you what does keep you up at night? What would be, of all of this amazing array of initiatives that is now on your plate to carry out, and your colleagues' plates to carry out, what do you find the most challenging?

MARILYN TAVENNER: Fortunately, and I meant what I said earlier, I have a great team, and so that helps me sleep at night. But the second point, I would say that the things that I worry about most would be that inside the innovations center that we have very good evaluation metrics in place so that we have a good pre- and a good post-, so that when we are making recommendations about what is successful and what isn't, we're looking at it with very strict financial criteria, very strict quality criteria, making sure that our evaluations are well done, and that we have some, while we can't make decisions until you get a certain amount of data, that we have the ability to quarterly take a look and identify. Will Shrank runs that piece inside the Innovations Center, and so Will and I have spent a lot of quality time together talking about that. I feel comfortable there. I'm better about that one, and I think we've got a lot of good initiatives going on, although I

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would like to see us broaden some of our Innovations Center initiatives to other areas.

The other piece, obviously, the health insurance marketplace and making sure we deliver on exchange regulation over the next couple of months that we do everything we can to help those states that may not be willing to make a decision now but may want to make a decision either over the summer or post-November, so that we can be a helping hand for those states and keep them on track, because I think there will be a lot of state interest and states like running their own programs.

SUSAN DENTZER: Thank you for joining us, you consider us your very own senior patrol on healthcare costs, some of us more so than others.

MARILYN TAVENNER: Indeed, I would be part of that as well.

SUSAN DENTZER: Great, but thank you very much for being with us today.

MARILYN TAVENNER: Thank you very much.

SUSAN DENTZER: With that, we are going to turn to two presentations now, first from Karen Davis of the Commonwealth Fund, and then from Scott Serota of the BlueCross BlueShield Association. Let's go right over to you, Karen.

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KAREN DAVIS: Thank you, Susan. About 40 years ago, I gave a talk to the New York Academy of Medicine called Rising Healthcare Costs: Causes and Cures. Today, we would give our eyeteeth to have health spending at the level that it was in in 1971.

You might think I'd be discouraged by that steady upward trend in healthcare costs, but I'm always a person who finds the glass half-full, and when I look around the room at all of the expertise and experience in this room, I'm convinced if we all got serious about sharing what we know to work, we actually would slow the growth in healthcare costs and increase the value we get from our healthcare system.

It's a real pleasure to talk about solutions, not just problems, and in particular, what looks promising, the 1925 annual report of the Commonwealth Fund said that the role of the Commonwealth Fund is to distinguish the promising from the proven. I'm sharing with you some results as well as promising initiatives in their early stages, and it's available today in a blog from the Commonwealth Fund called What's Working to Control Healthcare Costs?

The Commonwealth Fund has a commission on a high-performance health system established by our board in 2005, currently chaired by Dr. David Blumenthal, and as Susan mentioned, he recently published in the *New England Journal of*

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Medicine, thank you Greg Curfman from the *New England Journal* who's here today, "Performance Improvement In Healthcare: Seizing The Moment." The basic argument put forth in Dr. Blumenthal's article and in the accompanying Commonwealth Fund commission report is that if you want to save money, you need to go where the money is. That's not an original thought, but it's true nonetheless, and we know that 10-percent of people account for 65-percent of healthcare costs, and really focusing on that population is the key to achieving genuine savings.

The second point that Dr. Blumenthal makes is that to attack that, we really need to use all of the tools that are now available in the toolbox, many of them brought to us by the Affordable Care Act. He focuses particularly on the importance of payment reform, primary care and delivery system reform, and health information technology.

We need to keep learning as we apply those tools about what components are essential, so if something fails, is it because we didn't combine it with the other elements that are important or we need to tweak the model, or do we need to apply it and target it on a different population or on a higher risk population, what are the conditions? Rather than it works, it doesn't work, what elements of it seem to work, what needs to be put together, how do we target those efforts on the right beneficiaries, and then as Marilyn just said, we need to have a

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rapid data feedback and evaluation, agreed upon metrics, baseline data, be able to track pre- and post-metrics of cost, quality, patient experiences, patient outcomes, as well as have appropriate comparison groups.

The leadership can come from the federal government, as we've heard from Marilyn and the initiatives at the Centers for Medicare and Medicaid Services, actually much of the innovation has come to date in the last decade from states and their Medicaid programs, and from the private sector including employers, providers, and insurers. I think what would really help us tackle this problem if there were collaboration among all stakeholders working together to share best practices and work together to have a combined impact on the healthcare delivery system, of all peers, for example, working in unison on these problems.

To begin with some of the initiatives, particularly at the federal level that are being spurred forward by the Accountable Care Act, I would stress, first of all, the importance of the comprehensive primary care initiatives that CMS is mounting, as well as a number of initiatives by state. Medicaid programs both rewarding primary care, paying at a higher rate for primary care, but also rewarding the formation of patient-centered medical homes, and really taking accountability for outreach to patients to ensure that they're

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up to date with preventive services, that their chronic conditions are well controlled.

Secondly, I would stress the importance of the bundled payment demonstrations that CMS has announce, that put together payment for hospital and post-hospital acute care. Those initiatives really give a major change in incentives that focus on reducing hospital readmissions, complications, and making sure that patients get the appropriate mix of post-acute care.

Third, the Accountable Care Organizations, both the pioneer ACOs and the shared savings ACO, and then in combination with those models of healthcare delivery rewarding through value-based purchasing, those that achieve high levels of performance on quality.

All of that needs to be combined with more transparency on quality and cost and meaningful use of health information technology.

Let me turn specifically to some of the things that Medicaid has been doing or that state governments generally have been doing. The Medicaid programs also have recognized that a few people account for a lot of Medicaid expenditures, about 5-percent account for more than half, and in fact, $0.83 out of every dollar in the Medicaid program goes to treat chronic diseases, not surprising since disability is one of the major criteria for eligibility, elderly as well as low-income.

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I think one of the longest-standing innovations that states have supported is the community care of North Carolina program one for which the most evidence is available, which consists of setting up network, organizations of providers that participate in Medicaid on a regional basis, and giving a per Medicaid beneficiary per month fee, not only to the primary care practices, but to the umbrella network organization, that provides the nurse care coordinators that support the primary care practices in that region, again evidence of reduced hospitalization. It started with Medicaid, the Blues in North Carolina have now joined in Medicare through its 646 demonstration authority has now joined in, so we'll begin to see the combined effect of all major peers in the state applying this approach.

The Commonwealth Fund is supporting the spread of that model to other states, a number of states again using the tools that had been developed in North Carolina.

Another one where we are funding an evaluation is the Vermont Blueprint for Health, again very much a regional approach starting with three communities. The state provides nurse care coordinators to all of the primary care practices in those geographic regions. They have gotten all of the major payers in the state to pay the primary care practices a care

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management fee, so Medicaid, now Medicare and the private payers are going together.

The preliminary evidence on reduced healthcare expenditures is in, as well as specific numbers on reduced hospitalizations and emergency room.

We are also funding the extension of the Montana Health Improvement project, again very much a nurse care coordinator team in the community supporting primary care practices. We were convinced to fund this on the basis of evidence of lower Medicaid costs for the conditions that they've focused on.

Missouri moving forward with health homes, importantly integrating behavioral health, and primary care showing savings at 16-percent per Medicaid beneficiary per month.

We are also funding an in-depth evaluation of the Illinois Medicaid Medical Home Initiative, again finding that primary care case management is working to reduce Medicaid outlays.

We've also been working with Commonwealth Care Alliance in Boston, they report, for example, closing hospital pediatric asthma wards because they have done a much better job of controlling pediatric asthma, not even needing those beds.

A number of things that states moving forward really ahead of the Affordable Care Act, very promising and early returns on those initiatives.

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Separate from that, we are funding a number of evaluations on primary care medical homes, some which are done by providers groups, others with help from private insurers or public programs. I sit on the board of the Geisinger Health System, and we have not been involved in funding this particular initiative, but two journal articles that have been published on their experience with the medical home model at Geisinger, and finding substantial reductions, again, in hospital admissions and a 7-percent lower per member, per month cost experience in their Geisinger Health Insurance Plan.

Mass General participated in Medicare's Chronic Care demo, again finding 20-percent lower hospital admissions and 7-percent net savings. I was particularly interested in the fact that the numbers were exactly the same in both the Geisinger and the Mass General experience, even though they are different models of care.

Guided care developed at Hopkins by Chad Boult, again demonstrating savings in these areas plus savings in SNF days and annual net Medicare savings of over $1300 per patient.

Another very important initiative, Group Health Cooperative of Puget Sound published in *Health Affairs* finding, again, major reductions in emergency room visits and ambulatory-sensitive hospital admissions to lead in the second year to overall net reductions in cost. We are currently

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funding an evaluation of the spread of the group health cooperative model to other regions of the state and somewhat other models of physician relationships to Group Health Cooperative.

Health Partners in Minnesota, we published a key study on their results, they were above the state average and health expenses, now 11-percent below the state average in health expenses through initiatives such as their diabetes control, and again, documented savings in hospitalization and emergency room visits.

Intermountain, again, another case study published by the Commonwealth Fund, their initiative finding a lower mortality, reductions in hospitalization with not surprisingly the highest savings coming from the highest-risk patients.

Commonwealth Fund is supporting efforts through the Institute of Healthcare Improvement in three states, Massachusetts, Michigan, and Washington, on interventions to reduce hospital readmissions, and have an evaluation ongoing at Pennsylvania state, and a finding, again, particularly in Massachusetts and Michigan, reduction significant reductions in readmissions for targeted high-risk populations.

An intervention that we're very excited about that's a little less well known, is how to keep nursing home patients out of hospitals by training nursing home staff, funding work

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by Joe Ouslander to spread this model, which started with about 25 nursing homes finding a 17-percent reduction in hospital admissions both by preventing conditions that normally give rise to hospitalization, but also helping nursing homes treat patients that have those conditions, whether it's pneumonia or other types of conditions.

As many of you know, the Commonwealth Fund also has a very active international program, also scanning that horizon for exciting interventions that have implications for us. They've had a very successful disease management program in Germany, finding through their major private health insurance plans, their major reductions in things like amputations, chronic renal failure, heart attack, strokes, and also overall cost savings through some very careful evaluations that have been done in that country.

Finally, one of the big differences I find between what we're trying and what other countries are trying is their approach to after-hours care, particularly the Netherlands leads in having a system of after-hours care so that people have alternatives to using emergency rooms, have a use of nurses doing telephone triage, they even have physicians doing house calls, again evidence accumulating on the effect on over a 50-percent reduction in emergency services, 12-percent

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reduction in ambulance calls through that type of organized cooperative off-hours care service.

Lots of evidence that things are working, it's important not to get discouraged when things don't seem to work. Some of them take time to keep tweaking the model, improving it over time. I think the basic bottom line which came out of a Randy Brown article in *Health Affairs* very recently, that it's important to have quick data feedback, it's important to assess impact, have continuous quality improvement. It's also important to implement these interventions in an economically prudent way, if you throw money at the solution it may swap the savings, so it's important to really be careful about how you price these interventions.

That's my note today, thanks.

Susan Dentzer: Thank you very much, Karen. Now we'll go to Scott Serota.

Scott Serota: Thanks and thanks Karen, for these great examples.

You can see my slid up there that says Blue Innovations: What's Working. I promise this won't be too much of a commercial, but I am supposed to be representing our brand, so it will be somewhat of a commercial.

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The short answer to what's working really doesn't rest in the examples that I'm going to give you, but really rests in leadership, trust, collaboration, integrity, inclusion. Those are the things that are working. A community in a local market, private sector, that views this not as a science project but as a sustainable change that has to survive over time. I don't want to speak for anybody else in this room, but I've been at this a long time, and I see different initials, I see different programs, at their core, fundamentally, we're trying to do the same things and that is to create an integrated delivery system where the parties communicate with each other on a real-time basis, focused on improving the health of a patient, focusing on the patient.

What has happened over time, because we've done this in fits and starts, and we've never really committed to change the delivery system permanently, we get outlasted. Those that have a vested interest in the system staying the way it is outlast those that are pushing for change. I think we've come to the tipping point now where we can't afford to allow the system to remain as it is. I think that is the greatest impetus to actually making change. The challenge now to the rest of us, to those of us that are pushing for the change, is to make the change permanent, to put those things in place that are sustainable for the long haul.

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I'm going to spend a little bit of time talking about what we're doing, and I'm really proud of the fact that we at the Blues have been leading this initiative for a long time. You'd expect us to be, we are the largest carrier in virtually every market. We have deep community relations, and it's time to take advantage of that trust that we have built up over 80 years in the business to make sustainable change, and we're doing it. We're doing it in increasingly innovative and transformative ways, and I'm going to give you a few examples of that.

I know it's not accurate to say we're doing it alone, because we're doing it in partnership with the networks that we operate with, we're doing it in partnership with the community, we're doing it in partnership with the employers, we're doing it in partnership with local and federal government, but we're doing it. And it's not about who gets the credit, it's about the impact, and it's about the sustainability, the impact.

We have three complementary strategies that we're really working with in partnership with our members and the providers. We're trying to change the incentives, again this is stuff you've heard before and you heard Marilyn talk about it and Karen talked about it as well, to align with those things that work.

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We have an incredible array of research and information about what's working, and how it's working, we should be incenting and changing the incentives in the system to encourage providers to know what the research is and to do it. To do those things that are known to work. It's incumbent upon us who have information to make sure providers have it on a real-time basis, at the moment in time that they need it, but we have to do that. We have to create incentives for physicians and others to do that. We need to partner with physicians, to give them the tools that they need to do the work that's necessary. IT, nurses, real-time information on their practices, their peers, their patients, what others are doing, what's working in the marketplace, at the moment in time that they need it. We have to be informative as rapidly as we possibly can, so that people can make those decisions. We have to be willing, as a community, and we certainly are as BlueCross BlueShield companies, to invest resources in giving providers the tools they need to make this change happen.

Third, we need to include patients in this and engage patients as part of the decision-making. We can't do it to them; we've got to do it with them. We have to create incentives for them, for us, to undertake wellness related activities. We have to be transparent in what's going on, we

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have to give them the tools to make the kind of decisions we would expect them to make.

They need to understand what their services cost, they need to understand who provides it in the most cost-efficient and effective manner, so they can make the right choices at the right time, for the right location. It's incumbent upon those of us that have that information to get it in the hands of the people who can use it to make good decisions.

Let me give you a few examples of what some of our plans are doing. What I'm always struck by when I do these presentations, particularly when I don't review what somebody else is going to say beforehand is the fact that we're in the same markets. We're looking at the markets in which change is being made, and a lot of the markets where the private sector is leading, the public sector is also in this business. If the public sector is leading, the private sector's in this business. So the markets are not going to be unique.

We're incentivizing actions and behaviors that we know will lead to better outcomes. We have data that supports this. Ensuring hospital safety procedures are followed, simple things that you would expect, but encouraging, reviewing, reminding, partnering with hospitals, can dramatically reduce infections, readmissions rates, and complications. Rewarding physicians for their performance, measuring them against nationally

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accepted standards, not creating proprietary standards, not recreating the wheel, but using standards that are nationally acceptable already to ensure that patients receive the right care at the right time.

Highmark is one of the leaders in this regard; it's our BlueCross BlueShield licensee in Pennsylvania, based in Pittsburgh, but our BlueShield licensee across the state. They have a program called, surprisingly enough, Quality Blue, I told you it wouldn't be that big a commercial but there is a piece of commercial in here, 81 hospitals and two-thirds of the primary care physicians in their network participate in this program. Its focus is to reimburse based on the quality of care that's delivered and the outcomes, again focusing not on the inputs, but rather on the outcomes, how are the patients doing? Technical assistance is provided to the primary care physicians in the hospitals, to support best practices in patient safety, best practices in care management, best practices on a whole host of facets of their business.

In addition to what you see up there, where we have prevented 42 wrong-site surgeries, reduced hospital-acquired infections, and saved $57 million and improved quality. It's not just about saving the money, but the outcomes are better. We're trying to prove that often-mentioned comment that we all make in passing, that quality care is cost-effective.

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Everywhere that we've done it, we continue to verify with real data that that's true. These programs are underway, and programs like this in 46 states. Blue plans are adopting these kinds of programs virtually all over the country.

We're also monitoring new approaches to care for patients, and we're having great success in patient-centered medical homes, and we're having great success in accountable care organizations.

These programs, as you know, align both the incentives and the risk to promote coordination amongst providers, and share responsibility for patient outcomes. It also gets providers to begin thinking about managing the care of a population, managing the care longitudinally, and giving them the tools on a real-time basis to understand what's happening, and allow them information on how they might be able to course correct.

We have Blue Medical Home initiatives underway in 39 states, in addition to here in the District, and in Puerto Rico. We have accountable care organizations in 29 states, and here in the District. We have multi-payer reforms that we're pursuing across the country, and we're also partnering with CMS.

We can't do this alone, we can't make the change sustainable if we're the only voice, as big as we are, if we're

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the only voice it won't be sustainable. We have to do this in conjunction with others.

I know those of you that were here before heard Andrew Dreyfus from Massachusetts talk about their alternative quality contract. They're having great success in that regard, it's an accountable care model, and they take responsibility in risk sharing really to the next level, holding providers accountable for that care of a patient population. Not individuals, but the population that they serve, and they're accountable for all the costs, the full range of costs, not just those costs which they deliver in their location. It is a much broader concept than we have done historically, and it really is showing outstanding results, and I encourage you, there is plenty that has been published on it, and again, Andrew presented here previously.

I'm going to share another initiative with you. This is from a BlueCross BlueShield of Michigan, and it's a statewide value-based program that covers 2 million members. It's the largest patient-centered medical home project in the country, it incorporates 850,000 actual patients. It encompasses 780 designated practices, 3,000 doctors that are designated as primary care medical home, primary care docs. These are front light care providers, and we think the importance of those providers is going to grow, not just the

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physicians, but all providers in that primary care facet. Primary care physicians will have to learn the skills that are required to manage other providers, so that there is an extension of this primary care medical home.

As a brief sideline from this, you know we can't possibly train enough primary care physicians fast enough, so we're going to have to rely on other providers to provide this service. We have to figure out models, which allows them to do that, and allows the physicians to extend their reach through extenders, allowing them to practice within the scope of their talents, trainings, and abilities, but allows them to reach more people. That's part of what goes into a patient-centered medical homes project.

Michigan also includes specialists in hospitals so that it is a physician center, a primary care physician centered model, but it really is an accountable care organization built from the primary care physician up.

Promotes and incents quality coordination and efficiency, focusing primarily on chronic conditions. It's had, as you can see on this slide, rather notable savings. Significantly fewer readmissions, and avoidable admissions, both which are of course important to not only cost, but hospitals are not the greatest place to be, so if you reduce

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admissions, you reduce adverse outcomes. We have a whole host of concomitant savings as a result.

More than $26 million in costs savings as a result of more appropriate use of radiology services, both in and outpatient radiology services.

Unnecessary ER visits are down, generic drug utilization is up. It's just one example, but it's proof of the point that if you invest in a primary care centered model, you can recoup your investment and reduce costs beyond your investment, and it should become the standard, not the exception.

Our goal is to spread these successes throughout our system, and we do that. Blue plans steal shamelessly, is what I tell them to do, from brother and sister Blues. If it works in one market, and it's sustainable, we provide toolkits for other plans to adopt those kinds of programs in their markets as well. There is no sense in reinventing the wheel, if it works, we ought to duplicate it, and we try.

I'd be remiss, it's not one of my slides, but I'd be remiss since I'm sitting here, not to mention CareFirst. CareFirst is truly a leader, that's the BlueCross BlueShield licensee that's here in the District, as well as a little bit of Virginia and Maryland. Their patient-centered medical home is truly remarkable and is doing really good stuff. At the end

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of their first year, the cost of care for their members that participated in the patient-centered medical home project was 1.5-percent less than they projected it to be, so it did better than they assumed it would do, and they assumed it would be about 5-percent or 4-percent better than the rest of the population, and it was even 1.5-percent better than that.

The primary care physicians who participated got an increase in their reimbursement level, so they were happy. Patients had better outcomes, they were happy.

What makes this program really unique is that they're taking this model down to small practices, one, two, three, four-man shops, you don't have to be a large group, because of the infrastructure that CareFirst is supporting them with. It has just been a terrific program, and I'd encourage you to learn more about it, and certainly we can provide more information, we're next door so we can get whatever we need. It is a program worthy of mention, and worthy of review.

Chet Burrell who runs that program has done a great job in that program, I wanted to be sure I gave him a plug. I just saw the data this morning and I didn't want to leave it on the table.

Let me talk a little bit about another ACO initiative, taking it to the other coast. This is one where we're suing analytics and information systems to show success. In this

case, it’s BlueShield of California, and it’s working with its provider partners, and it launched an ACO pretty much specifically for CalPERS, and as working, covering 40,000 CalPERS members in the Sacramento area. The goal, like all goals, improve quality, lower costs, and really from CalPERS’ perspective, they wanted a program that would allow them to keep the premiums flat. They just couldn’t afford any more increases in their premiums. The plan and the provider share responsibility for finding savings and opportunities, and they share risk for delivering on those opportunities.

The plan is BlueShield of California, helped establish an electronic medical record for these providers and other shared systems, so they could communicate better. This interoperability allowed them to reach out to the members directly, develop personalized care initiatives, targeted interventions for chronic care management, and it also allowed for more objective evaluation of provider performance, because we had data.

In-patient days are down, readmissions are down, a 50-percent drop in stays of longer than 20 days, and $15 million in savings in the first year. CalPERS was happy, they didn’t get a premium increase, so it worked. Again, the key is sustainability, but it worked.

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These best practices led to better care, more efficient use of resources, across the state the plan is now trying to leverage this model, so they're saying if it worked in Sacramento, why wouldn't it work elsewhere?

We're trying to do that; we try to do that frequently. I'm getting the two-minute sign here so I'll sew up. Before I leave IT, let me just talk about a couple of other things we're doing. We have an organization that we've created called Blue Health Intelligence. Blue Health Intelligence is our data warehouse, we have over 100 million members' data in that warehouse, it's longitudinal data. We use that data to help identify best practices, cost effective care, we focused on colonoscopies, finding the most cost-effective setting, we've been able to identify ineffective off-label use of expensive pharmaceuticals. We've done a whole host of things, and we're just scratching the surface on what can be done with a database like that.

We also have a program, again, part of my commercial Blue distinction, this program, we use standards that are identified by the experts in the industry, so the American College of Cardiology develops the cardiac standards, the orthopods develop the orthopedic standards. We then evaluate institutions against those standards for compliance with the standards as identified by the experts, as well as for value,

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that is cost efficiency, and we've again seen dramatic results as a result of those things that we're using. We've seen reductions, as you see up there, just by identifying those institutions which are operating at the standards as prescribed by their own professional society.

It is a program that again, we expect to expand on how we'd like to use this program, is to create incentives within the payer, from our side, within the insurance model, to drive patients to pick these facilities. Our reach is, again, across the country, we have plans in every state and every zip code, so we're trying to identify providers in geographic proximity to every zip code. We don't always find providers that meet these standards everywhere, so we'll have to work with those providers to help them elevate their standards, but we are committed to making these things happen. It's critical to us to make them work, and for our sustainability.

In closing, I want to emphasize a couple of things: One, it's going to take all of our efforts and all of these efforts to transform the healthcare system. What I said earlier, I really believe, this is not a project, it doesn't have a defined beginning and end, we won't wake up one day and say, phew, glad that's over, what's next? This is something that we're going to have to work on forever. We're going to constantly have to work to improve the system.

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National leadership, ongoing partnerships, innovation and creativity, trust amongst the parties, integrity, risk taking, those are all the cornerstones of what's going to make this work. I'm here to commit the Blues to do it, we've done it throughout our history, and we will continue to do it on a going forward basis. We cover 1 in 3 Americans today, so if it works for us, it's going to work for everybody, and we're committed to reach out to anyone interested to help partner with us to continue our journey. Thank you.

SUSAN DENTZER: Thank you so much, Scott.

We're now going to move on to a presentation from Paul Ginsberg on policy strategies to help change the cost trajectory. You have in your packets, I believe, the form of Paul's excellent paper. Really not just looking at what is already underway, as we've heard so much about already today, but putting forward what could actually be done in terms of policy initiatives at the federal level, at the state level, et cetera, that would encourage higher quality and more efficient care delivery, and lowering of the rate of spending growth. Paul, let's turn things over to you.

PAUL GINSBERG: Thanks Susan. I'm glad you have the paper. I want to acknowledge that that paper was done with support from the Alliance for Health Reform, and thus the sponsors of this meeting and the National Institute for Health

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Care Reform. This moves us into the notion of what can policy do to accelerate or solidify some of the terrific innovations that have been described by the previous speaker.

I want to spend a minute on just the nutshell about the urgency for cost containment. The way I look at it is that when healthcare is close to 18-percent of GDP, a trend of GDP plus 2-percenage points a year is a lot bigger problem than it was 13-percent, 10-percent, or when I started in healthcare, 6-percent of GDP. I think that's one of the reasons that it's so much urgent.

Clearly, this is a major challenge to federal and state governments, because their revenue growth over long periods of time grows roughly in line with GDP. Now they're increasingly at fiscal risk, as private coverage becomes less affordable. The subsidies need to grow even faster, to the degree that health spending per capita is growing faster than income.

The notion that rising premiums in employer-sponsored coverage might be paid by the employees, which is something that economists have had a consensus on for a long period of time, and nobody else believed. These forces are becoming much more apparent now. Really at an era when the overall compensation is not growing as fast as it would, so that there are many situations where there is nothing left for a cash wage increase at all, when you take into account the increasing cost

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of [audio gap 01:16:27] a lot of advantages going forward, and the vision for delivery system reform, which has been spelled out by all of our previous speakers, and I won't go through, what we've got going is that there is a real consensus from the provider community, the payer community, governments, that this is a direction that delivery should change, so if delivery is going to change, you need to have payment reform to bring delivery system reform into effect, because delivery system reform cannot go forward under a fee-for-service payment system.

You have to pay differently, you see the various payment tools listed from global payments of which ACOs are an example, and bundles of episodes, primary care medical homes, all of these tools can have a shared savings approach, at least for a transitional period, and these are the keys to pursuing the vision not only to motivate the providers, but to support them.

Because a provider is going to invest in managing congestive heart failure more effectively, but is still paid fee-for-service, is just committing themselves to years of financial losses, there needs to be a payment mechanism such as global payments which will reward or at least not penalize providers that make progress in pursuing those reforms in management of chronic disease.

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As you can imagine, it is very important to coordinate payers, because if you don't coordinate payers, you're really leaving providers holding the bag. If they're induced by a payer responsible for 20-percent of their patients to do something, but 80-percent of their patients are paid fee-for-service, they're not going to be able to go very far. There's really going to be coordination across payers, and an issue of coordination between the payment reforms and the delivery system reforms.

Where does policy come into this? I think we have to start with the role of Medicare and Medicaid. These programs are large enough to engage providers, because they're responsible for enough of providers' patients, I think they can inspire and engage private payers as well, and I think they have. Not every day of the year, in April 2011, when the proposed rule for shared savings ACOs came out, there were many doubts in the private payer community of can we really follow the Medicare program, because we're afraid that Medicare has come out with a model that no providers will engage with them on. I think that that's been gotten past, and there has been success in gauging providers with pioneer ACOs and shared savings otherwise. Medicare and Medicaid have a lot of credibility with providers that sometimes private payers do not.

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Steps have been taken in Medicare and Medicaid policy to facilitate coordination with private payers. The pioneer ACO contracts actually require the ACOs to seek out private payers for similar contracts. Of course, this is the essence of the comprehensive primary care initiative, and I think Karen mentioned situations where leading payers, private payers, the Medicaid program, and Medicare would all get together and pay the same way for medical homes.

We're really in a major era, as you've heard from the other speakers, of piloting provider payment reforms, and then pilots that have come from governments to me really differ from much of the history of demonstration programs, at least in Medicare. First of all, these pilots are pursuing what I would call the highest priority piloting opportunities as specified by the mainstream of Congress in writing the Affordable Care Act, as opposed to a member of a committee who lost out on a pet project and was given a demonstration as compensation, and of course we have the innovation center to really work on what's highest priority from the perspective of Medicare. These pilots are much larger in scale.

I think we can look forward to the current pilots refining the approaches for reform provider payments in gauging a lot of provider leaders, this is the very encouraging thing about the large number of organizations involved, and really

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for the entire provider community, pointing the direction for future payment changes.

I would say it's almost universal with the individual hospital systems that I talk to, is that a vision that reform provider payment is going to happen and that they very much want to prepare for it.

There are some real constraints on pilots, however, because pilots mean volunteers, and it really means engaging volunteers, and when you engage volunteers, you need to peg the payment rates to provider-specific spending in a recent historical period. You can't do pilots saying that, well, in this community we're going to pay this much, say, as an ACO rate, because you'll have a very unproductive selection process, whereas if you're very low cost, of course I can just continue business as usual and get a great reward, and if you're high cost, well I'm not going to go near that.

In a sense, you need to peg rates, and if you need to peg rates to existing experience, it means the upside for providers is fairly limited.

I think a lot of the providers engaged in these demonstrations are not doing this so much because it's attractive financially, at least in the short run, they're doing it because of their perceptions of what payment is going

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to be like down the road, and they don't want to waste this time or this opportunity to get ready for it.

I think similarly, even though the upside for providers is limited, I think the potential savings that can be achieved by payers is limited as well.

Clearly, this pegging the payment to a provider's historical experience is not viable for the long term. Some of these very promising demonstrations, I've started, with a smile, asking people, as Andy Dreyfus, this, recently: What's round two going to look like? What's going to be the basis for your alternative quality contract in round two? I got a very pleasant smile.

Basically one of the implications of this tide [misspelled?] with volunteers to existing costs, is that pilots aren't always the best way to go. Presumably, I believe there is some payment reform approaches that we know enough about now to not bother with the pilot stage but just legislate them into policy. I know as the Affordable Care Act was being debated, there are many people that believe that linking post-acute care with in-patient episodes actually was feasible at this time and should have just been pursued as a payment policy, there probably are others.

All of the issues I'm talking about, about the limitations of pilots, are not going to be an issue with the

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medical home pilots. The reason is it's not necessary to link them to historical costs. I think one of the reasons is, is that this is an added payment, usually on a per member, per patient, per month basis, to pay for services which we'd like to see provided but which we have not been paying for in the past. To me, the comprehensive primary care initiative from CMS, that can go on for a long time; it's not limited by these. That wouldn't have to go through these painful transitions that I'm going to get to on this slide.

You need to start thinking, and maybe I'm just jumping the gun in thinking that a lot of these pilots are going to be successful, but I'm very encouraged that Karen Davis and Scott Serota's remarks about the pilots that they've been involved in, that we will have a lot of success.

In a sense, at some point there's going to have to be a transition from pilots to standard payment policy, and providers are going to be very divided over the pace of transition, that some providers will be ready for transition, they'll see themselves as winners, and they'll want to get on with it, to be paid on a way that is not linked to their historical spending or costs experience, whereas other providers will find this very threatening.

Of course, there are ways to ease this transition, giving a lot of notice, and blended payments which is maybe the

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same thing as shared savings, but basically over a multi-year period, change the weights with the old historical costs to the new payment system over time.

Private payers can't pursue policy like this because they don't have the ability to just go to providers and say this is what we're paying you. They have to negotiate. Now, maybe this won't come up, because I would believe that most providers would be interested in keeping the methods that they're paid by private payers as parallel as possible with those used by the public payers, but it may be that government will have to pass some legislation requiring uniform payment methods, which I think Massachusetts has talked about that on and off, which sometimes is resisted as the first stage towards rate setting.

One point I wanted to make, which I think Scott Serota did, too, is we need not lose sight of the importance of engaging patients in payment reform. I've perceived a striking contrast between what's happening with private and public payers. In the private sector, you do see, in some areas, cost sharing incentives for enrollees to choose the higher value providers. This, in a sense, makes the tool more powerful. There's an opportunity for the payer to experience a shift in provider mix, provider incentives to do well can be stronger, and just as an aside, I want to mention that sometimes these

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things are done not with reform payments, but by doing the same types of calculations as to what the provider spending is per episode without actually changing payments.

The striking contrast is with Medicare, that has no patient, at least financial, engagements, and Medicare does not because Congress didn't want it to happen. In fact, even if Congress did want it to happen, there'd be this additional barrier they'd have to work through: Supplemental coverage, with so many Medicare enrollees not paying anything at the point of service.

I have a concern about the political risks from the lack of patient engagement. I'm sure that members of Congress are concerned about the political risks of engaging patients who may say; I don't want to have to pay more to go to this provider that is my favorite. I think there's also a risk from lack of engagement when some providers find themselves coming out on the short ends in these payment reforms, as opposed to having the situation where some of their potential patients are moving elsewhere, just to go to their representative Congress and say, my hospital has really been treated badly by the Medicare program, do something about it.

I want to say a few things about market concentration, because as the ACO shared savings rule was debated, there was a very significant discussion about whether this rule is going to

lead to additional provider concentration and the result would be higher payment rates for private payers. A perspective that I've recently developed is that the forces pushing provider consolidation are so much broader than the detailed specifics of the ACO shared savings policy.

A way I can describe it best is that when we talk about this vision for reform delivery, reform payments, this is a very frightening future for small hospitals, small physician practices, and it's not surprising that they want to merge with someone that's more capable of handling this. It may be that from the perspective of moving the system towards more integrated care, having a more consolidated system will be a plus, because it's really hard to imagine some of the smaller practices doing this, although a notable exception I want to make is that the Independent Practice Association in California and to a much lesser extent in Massachusetts, really are showing a model for small practices to remain viable under these circumstances. But these organizations tend not to exist in most areas.

The real challenge is, how do you pass on the gains in efficiency to private purchasers and consumers if payment reform and delivery system reform is going to lead to a much more consolidated delivery system? One approach, which we should go to first, is using the market to address

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consolidation, and employers and carriers are doing this, to some extent now by increasingly offering narrow network plans with a network of providers they may exclude, the most egregiously expensive providers, or tiered designs where patients make these decisions about higher or lower value providers at the point of service.

I don't see tiered designs as making much progress without legislation, presumably on the state level, although it could be on the federal level, to actually facilitate this. Massachusetts has pioneered with legislation basically telling hospitals they can't refuse to contract on the tiered basis or insist that they be in the preferred tier.

There are other steps that Massachusetts did not do, such as requiring a multi-hospital system or precluding them from having all or nothing contracting, so in a sense, allow the plans to pick and choose which hospital units in the system they want to contract with.

I think additional pressure on plan premiums is going to push these approaches. I think one of the reasons we're seeing it a lot now is the weaker economy. I think anticipation of the Cadillac Tax, change in the tax treatment of health insurance is a factor, and also the design of the tax credits for private plans that are offered by state exchanges in the Affordable Care Act is the fixed contribution approach,

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contribution is based on the second lowest premium for a silver plan.

In a sense, these are incentives to lower premiums that we'd never experienced historically, and I think they will make a difference.

Whether these market approaches to market concentration work I think will determine whether direct regulation is approached.

In closing, there are additional approaches to where I wish policy can address costs, I perceive that payment reform is at least in the near term the most promising approach, because it's consistent with a shared vision, and the path to success is fairly well defined, but other results have potential as well.

We certainly shouldn't be putting all of our bets on a single strategy. Many of the other strategies really are not at odds with the strategy of payment reform that I've put out.

Probably taking steps to change the tax treatment of health insurance is most directly related to provider payment reform, but I think two other areas that are probably the biggest where public policy can make a contribution, but beyond the scope of my paper are conduct of outcomes research in an effective manner, and initiatives that were very much at the beginning of health improvement.

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Thank you very much.

SUSAN DENTZER: Thank you very much, Paul.

Now we're going to move to a series of comments from our panel of so-called reactors, and as we have christened them before, these are non-nuclear reactors, but nonetheless they are extremely energized reactors who have been asked to address particular perspectives, in many instances perspectives that they have long shared as a consequence of their work with their particular organizations. We're going to start with Jim Guest of *Consumer Reports*, obviously very focused on consumers, so we ask Jim to address how important it is to put tools like transparency of information, data, on provider outcomes, provider costs, et cetera, how important is it to put those tools in the hands of patients? How important is it to make use of the tool of informed decision-making and harness the opportunities there to lower the cost of care?

JIM GUEST: I think the tools you're talking about, the transparency and information about providers and value and cost and all of that is incredibly important. It's important initially I think just for the quality of care and for informed decisions by consumers. This will have some impact on cost.

I guess a crucial point I'd want to make is that consumers are not the central place, I think, where you're going to get costs savings it's really with providers. I was

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struck looking at the decks ahead of time that Paul's deck includes the word provider 16 times, payer or payment 14 times, and patient or consumer twice. Then looking, Karen, at your examples of interventions and innovations, they all had to do with behaviors by providers. Scott, some of the things that you talked about, readmissions, and hospital acquired infections and so forth, again, all of those things relate to providers.

From a consumer perspective, clearly the kinds of system reforms that are being talked about and exploring the system reforms I think are crucial. When it comes to the patient and consumer information, the point that I want to make and then I'll stop and we'll be going back and forth in the dialogue, my concern, again, is that the information isn't available, which is why I asked the question earlier as far as CMS, it's really tough getting access to information, although it's there, about quality, about various costs and other factors that would be useful to have. We, ourselves, at *Consumer Reports* are finding there's a great receptivity to our information about how to save money on drugs, for example, or recently, this week or the week before, in our Massachusetts issue of *Consumer Reports*, had ratings working with the Aligning Forces folks in Massachusetts on 450 or so practices there, so there is information, and we find that our readers,

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and the people that we've reached for their information, find it useful, including with the Choosing Wisely program that I think folks are familiar with.

I think it's really important, it's important for quality, it's important for safety, it will have some impact on the cost of care, and then just finally, we'll come out again in about two weeks with what I think is our third set of ratings of hospitals on a variety of factors. We put it out there so consumers can make choices with regard to where they're less likely to get a hospital-acquired infection, or whatever it might be, but really I think that the impact of that, while it'd be nice to think consumers are voting with their feet, what I think the real effect of that is in getting the information transparent, is it affects the providers. They don't want to be low on the list, so I think that provides a real incentive.

As I was reading some stuff coming down on the train, I'll share it with you, it's kind of interesting. This is out of *The Institute of Medicine*, they said, "If other prices had grown as quickly as healthcare costs since 1945, a dozen eggs would cost $55, a gallon of milk would cost $48, and a dozen oranges would cost $134." Yes, we have a problem.

SUSAN DENTZER: Thank you very much. We're going to move now to David Pryor of Ascension Health, and Ascension, as

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you know, is the nation's largest non-profit healthcare system. When it confronts the problem of rising healthcare costs, it does so with very large numbers attached to it as well. David, tell us how an acute-care based system such as yours is adapting to the potential of the future reforms? And of course, the ongoing reforms, particularly the decline in admissions, and readmissions, and helping to drive those down even further, even as you focus on quality improvement, patient safety, et cetera?

DAVID PRYOR: For the record, we are 47-percent non-acute care by revenue, just as a record. As we think about it, I have five comments to make, and I would invite people to think about what is the goal that we're really trying to accomplish?

Yes, it's true, like Willie Sutton, who robbed banks because that's where the money is, that in the short term, if we want to address costs, we do have to deal with the issue that 50-percent of the costs are in 5-percent, the next 15-percent of patients make up the next 30-percent of costs, so you can't control costs unless you're addressing people who are sick.

The issue that keeps me up at night, however, is not that one. The issue that keeps me up at night is the fact that we have such an epidemic of certain kinds of conditions in this

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country, that what we could expect to see in longer-term costs could far outstrip, potentially, what we could save in short term. Unless we also have a way of keeping people from getting sick, and managing in that kind of way, I think we may have some real issues that we're going to need to address. If one just looks, for example, at the obesity epidemic, what that's going to mean for diabetes, what it's going to mean for downstream healthcare costs, simply focusing on only the people who have it today isn't going to take away that central issue.

The third point I'd like to make is really what I call the no-brainer, and we tend not to remember it. The no-brainer is to do those things that improve quality and lower costs. The CMS partnership for patients I think is focused exactly on things that make a lot of sense going forward, and all we're doing there really is scaling up already proven patient safety initiatives nationwide.

Notice, I'm not talking about these as saving costs, I'm talking about the goal is improving quality of care for individuals as we go forward, and I try to think about one example that would make the point. We have shared this with Secretary Sebelius and with others, but we've had, for example, in Austin, Texas, a 93-percent reduction in birth trauma over a 10-year period of time. That's taken the birth trauma rates there in Seton Medical Center from 3 per 1,000 live births to

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0.2 per 1,000 live births. That's substantially lower than the national average is, and across our entire system, as many of you know, we've got averages across all measures that are substantially lower than the national rate.

What we haven't talked about as much in that example would be two other issues: The prematurity rate within the iatrogenic prematurity rate has been decreased from 2.5 to 1.4, the annual neonatal intensive care unit charges associated with birth trauma have gone from 4.5 million before the implementation, down to 183,000 after implementation. The birth trauma costs for Medicaid patients have been reduced from $496,000 to $1,200. In fact, they've closed 12 NICU beds. That, in fact, didn't help them; we actually lost money on it, if you will. It doesn't really help them, but providers aren't doing it, quote, to make more money, they're doing it, in fact, because they want to improve the quality, and it clearly is an improvement in the quality.

The last two comments I'd make really relate to what I'd call the key challenge. The key challenge is, it's not hard to get providers potentially interested in providing integrated care, and remember, we are a system that has, at this stage, 2,800 employed physicians in [inaudible] hospital specialties, but we work with about 28,000 other physicians across the country who are in private practice.

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As you think about the challenges and so on, I don't think the issue is really about trying to get people into integrated care programs, because I think people will accept the fact that that improves the quality of care. The issue is how do you go from point A to point B, because we're trying to couple these pilots while we're still being paid for volume and trying to go and more forward on pilots where you get paid for value. People tend to practice in one way, systems tend to deliver care in one way, you can't simply layer on top others. The challenge for us is really about how do we do that?

We have taken our own approach to trying to understand that and have a number of different pilots that we're using to better understand that, so we have two of the pioneer ACOs are in our facilities, we've got other ACO models, some of the Michigan primary care groups among the largest providers, for example, in the primary care group are our people in those programs.

We've got as an example studies that we've done, also with private commercial insurers, for example, in Flint, Michigan, we're the largest provider of care for General Motors in the country, and the genesis of HealthWorks program that's been a Commonwealth study also has found that they spend 26-percent less on healthcare with our providers than compared to other competitors in the system. That group has now gone on to

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become a Medicare pioneer ACO. If you look at the impact on the potential cost issues to the hospital, it's really negative. It's not positive in any way, shape, or form in that context, there are some things that we're doing, I think, that may help mitigate some of that.

Our issue is really about saying how do we provide the right care for people, and the right quality of care for people? We have to figure out how to do that within the appropriate cost structure. The goal for us isn't so much the cost, it's the quality, and how we manage that.

The last point I'd make is we actually, as a system, are probably at risk now for about 700,000 lives across our system. It's not a trivial number of people that we're responsible for. 200,000 of those individuals are our own associates and their dependents, the people who work across our system. Our pilot for that was in Detroit, in a program we call SmartHealth, and in that program we were able to effectively show that the numbers were the same, 50-percent of the costs and 5-percent of the employed individuals, and so on. We were able to show that we were able to reduce in-patient admissions by 25-percent, ER visits down by 15-percent, and the overall cost trend for our pilot bent that cost curve by 45-percent compared to national averages, without transferring any of the costs to our associates. So still, the lowest cost

contributions on the associate part compared to others at the same time that the actual total costs came down, so those were a couple of examples that we're using.

The fundamental issue is one I bring back to whether or not you can just simply layer a new system on top of the fee-for-service system and expect it to work.

Thank you.

SUSAN DENTZER: Thank you so much. We're now going to ask Gerry Shea of the AFLCIO to address what he has the sense that the private purchasers are doing, or planning to do, at this point, to help lower costs. As well as whether these initiatives will involve at least in part, if not mostly, cost shifting to individuals, a trend we have obviously seen over the last several years.

GERRY SHEA: Thanks, Susan. Listening to the presentations, it is so striking to me about what an enormous amount of change is going on in the delivery of care. You think, and it wasn't so long ago we were arguing about whether or not we could measure quality, whether or not we could change things if we measured quality. We now come to the point where people basically accepted that we're going to pay on quality. It's really a sea change that's quite striking.

My second point is, however, on the other side of the ledger, that this is really not doing much of anything in terms

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of the cost problem. I'm not very optimistic that it is, even though I'm going to tell you we'll work on this.

The history here is just that we have cost-crisis fatigue if anything, we've been going through this for decades, and we continue to spend gargantuan amounts of money. Unless this money starts coming back to the people who have been paying the freight, the consumers and the purchasers, we're not going to be able to hold onto the private-employment based system as the backbone of healthcare. It is eroding very quickly, now, and that trend will accelerate.

Some of it is outright loss of coverage, employers withdrawing from the field; most of it as you know is just a huge cost shift onto individuals. We can talk about theories of consumer-directed care, and consumer sensitivity and so forth, but the simple fact of the matter is: One, that we don't have the infrastructure to make that work yet, Jim Guest's point. Two, for lots of people in the country, that's simply not nothing except unaffordable care. If they've got a $2,000 deductible as an individual, as 28-percent of people in small groups now do, and that is going up, this is not for average wage people in this country, this is not an affordable, a sustainable situation. When you put that on the top of the income situation and the inequality, this is just part of the problem.

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I think we've really got to figure out a way to do this, and I think it takes leadership from the provider community above and beyond what's already happened. I love Don Berwick, some of the talks that he has been giving since he left CMS about challenging his colleagues to really focus on showing that better care equals lower cost, and giving the money back to the people who are paying it, because that's what needs to be done.

On the positive side, the private purchasers who have been at the forefront of trying to push delivery system change, some of the national business groups on health and bunches of the individual employers, some of our union funds, are really redoubling our efforts to try to move into value purchasing. The changes in Medicare that are coming over the next year are just night and day difference.

Our experience generally had been, as purchasers, that when we wanted to do something innovative in payment, and we went to the payers, it just didn't happen. The payers would say to us, well, we have our business model on this, and we have our computers programed and we don't have a computer for you here in Delaware, we have a computer, it's the Minnesota computer, it runs the whole country, whatever it is. There just wasn't an ability to get the payers to act on the behalf of the people. That is changing, I credit that, but from where

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I sit, I have no confidence that without a very actively organized purchaser push that that is going to be sufficient to carry the say. People are making an effort to really expand beyond the innovators, the IBMs and so forth, and to try to get a lot of people recruited into there's just a simple thing of following Medicare's lead.

9-percent of Medicare payments are going to be tied to quality performance by 2017, that's a lot of money to move change in the system, but if you don't have private purchasers on that train, it is not going to work in the long term, and you're just going to continue to see this enormous erosion of coverage.

People have been gracious enough since one of the first questions, not to raise the Supreme Court decision. The change that is going on in healthcare is not going to go away, it can't go away, it is permanent. However, if the Supreme Court dumps the Affordable Care Act, the octane is going to go out of this tank, that's what's going to happen, so we'll go back to like, well, we'll do what we can, we'll putter along and so forth.

That's a pessimistic note to end on, but I actually tell you that the encouraging news here is that private purchasers really want to be very aggressive about this, in a way, because they sense a new opportunity.

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SUSAN DENTZER: Thank you so much. We'll move now to Anne Weiss of the Robert Wood Johnson Foundation. Anne, we know the old saw that all healthcare is local, RWJ has been engaged very actively in a bunch of local efforts around the country, public and private efforts, the aligning forces for quality, movement that you've been so intimately involved in really to engender as much enthusiasm in the stakeholder community to conduct a lot of the changes that we've been talking about, whether it's sharing information, improving quality, et cetera. Tell us about that, and tell us what the prospect is of success?

ANNE WEISS: I guess I'm the local color person here. We do have the experience of these 16 very, very diverse markets where they're really different dynamics, but all of the markets were working in our, adopting many of the kinds of interventions that we heard about from the panel today. In your packets there was a little description of what some of the payment reform pilots look like, but there's lots of different innovations going on. At the patient level, within the delivery system, and so on, in our 16 target markets.

Just to tell you the end of the story before I give you a couple of examples, I think here are some of the lessons that we draw from what happens when you roll the evidence-based interventions that we heard about earlier out in the local

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market with its own dynamics: One, is the importance of the collaboration with all the different kinds of stakeholders. It is impossible for a delivery system or a consumer advocate or a health plan on their own to make these changes happen and to make them stick. And this does not happen overnight, it takes time, it takes not only evidence that you can publish in journals, but the development of relationships of trust, and I know that sounds really hokey, but it also happens to be true.

You have to deal with the fact that most people's knowledge of these dynamics is very basic, and no matter how obvious it may seem to those of us who live with the evidence for a long time, you almost have to go back to first principles and talk about the fact that healthcare varies around the country, that there's a right way and a wrong way to deliver health care, that there's waste in the system, you have to start first to talk about quality, and only then to talk about spending and cost.

You have to acknowledge that for most people in this country, the fundamental fact about healthcare is their relationship with their doctor. That's where it starts, and anybody who ignores or tries to jump over that, does so at their own peril. We have found that time and time again.

The last thing I want to say before I give you just a couple of specific examples is that I definitely agree with

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Gerry that there are limits to how much we can dump this whole problem on patients and consumers, but I think it's a little unfair to say that it won't work when it's not clear that we've tried it, yet.

We have seen, in some of the most unlikely markets, much more impact than we ever expected on change in the delivery system, on demand from the purchaser and employer's side, from a few engaged consumers, not the ones who are fragile, not the ones who are poor, but a few people can make a big difference, and we ourselves have been surprised at that.

I'll just give you a couple of examples. I want to talk for a second about Cincinnati. You can go back five or six years, and there is this organization, the Health Collaborative in Cincinnati, they brought together a couple of the major national employers, health plans, a couple of forward-thinking primary care folks, and some consumer groups, and they worked with 20 practices to help them transform into patient-centered medical homes. Very early in the whole medical home thing.

Four large delivery systems in the market really liked what they saw, they liked the evidence about what they saw in terms of quality and costs, and they decided [inaudible] the delivery systems to adopt the medical home as the cornerstone of their whole ACO integration business strategy. Without

adding more money from philanthropy or a health plan or anybody else, they went from 20 practices to another 40 or 50 practices.

This in turn led to 75 practices in the Cincinnati-Dayton area being designated as one of the CMMI Comprehensive Primary Care initiative sites, one of only three in the country that aren't state-wide, now Medicare/Medicaid will be in there. A number of our speakers today have emphasized the importance of alignment with multiple payers. I agree that Medicare's participation will turbocharge all of this, but it didn't start with the announcement of the CMMI Comprehensive Primary Care initiative, it started half a decade or maybe even a decade before, with relationships among these folks who wanted primary care to be better in Cincinnati, and it did not start, by the way, with a very large expensive complicated delivery system, it started with primary care.

That's a bit of local color, about what it really takes to make these things go to scale. In the interest of time, I won't give a lot more specific examples, but I will say in a place like Maine, despite the fact that it's not highly competitive health plan market, it's not a highly competitive delivery system market, it's isolated, people don't really have a choice, we've seen enormous energy out of the purchaser and consumer community, and tied to really dramatic impact in terms

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of quality and cost. We see people Minnesota being able to do things with the spending growth in high tech diagnostic imaging that's really remarkable based, again, on this notion of the collaboration, of transparency, and payment reform.

I guess even though it's a grey day out, it is a day full of bright spots. All of us are filled, Karen's optimistic camp, too, I think there is a lot of hope but I think it's really important to understand that it is, when I worked in Washington decades ago, we used to say, boy, it's a big country out there, it's a big country out there, and understanding the different dynamics in how these things are going to roll out, and how they need to be tailored for local circumstances, to me, is critical to whether they're successful.

SUSAN DENTZER: Thank you very much, Anne. Now to Stuart Butler of the Heritage Foundation, to get us back to the discussion about what public policy can do at the federal level, in particular, at this point, to lower the rate of growth of healthcare costs. Stuart, with or without health reform, how do you see this playing out? And in particular how do you see the states taking more of a leadership role in lowering the rate of spending growth going forward?

STUART BUTLER, PHD: Thank you very much indeed, Susan. First of all I'm honored to be a charter member of a new

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classification of health analyst, a so-called reactor. It started here; you heard it here, first.

I think what we're trying to do, surely, I think we've all said in fair sways, we're trying to make essentially one-sixth of the economy, what is now one-sixth of the economy, the healthcare sector, somewhat smaller over time, and simultaneously make it more efficient over time.

The less we do both, we're not really achieving. I think what most people would think of is constraining costs; it's not just individual costs but also total costs. With that in mind, it strikes me that I would make three observations about how we think about a general environment of public policy that might move us in this direction.

The first is to think about the consequences of what I will call Butler's first law of health economics, which is that basically, total costs will rise to use up whatever money you budget to spend. If you're going to get total costs down, I think one piece of the equation, inevitably, is to look at those areas where it's appropriate to have some kind of real budget in for healthcare. I'm not sure that it's appropriate to have such a budget where somebody is spending their own money on services that they want, but I do think that in the area of public programs, in other words of federally-financed and state-financed programs, that moving away generally from

our more open-ended system of spending today, and what we will loosely call a budget, towards real budgets over time that are fixed over time, is a necessary component. You see it in the proposals not just for ideas like moving towards premium support in Medicare, or some kind of block [inaudible] in Medicaid, but also the idea of a tax cap in terms of reducing the subsidy, your budgeted subsidy, so to speak, through the tax system, but also any ACAs through the backstop of the IPAB to stick to a budget.

I think we do have to look very carefully at this issue of how you build in a budget, both to get your end result of total spending more under control, but also to reinforce the kind of micro-changes that we've been hearing about today, to put pressure and to give encouragement to this. That's the one first point I would make.

Second, it's very clear from everybody who spoke before that if we're going to get a policy approach that's going to be successful over time, both in terms of its actual effect but also its support, it's got to be something that encourages beneficiaries to seek better value for money. That does mean instruments, like the ones I've already mentioned, in terms of elements of putting a budget into place as well as caution, but it also means balancing this with the needs that individuals have to get access to an affordable amount of healthcare. It

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also means having an information system, and a system of engaging beneficiaries or patients, to get them to buy into the idea of seeking better value, and the incentives. I think what we heard from Steve Serota and others, and Paul as well, that that's an integral part of what we must do.

Focusing on how we can encourage better value for money through public policy, through the kinds of approaches of looking at direct subsidies, of premium support, and so on, has to be combined with these other elements if we're going to get public support, and if it's going to work.

The third point I would make, I think it is important as others have done already and as Paul already focused on in part of looking at pilot projects, to think about what is the process that will encourage and spur innovation generally, of the kind that we've heard about. Paul, I think, made clear that there are both pros and cons of how we see pilots today. If the pilot programs, as he mentioned, first of all can deal with large public programs Medicare and Medicaid, particularly Medicare, and they're really the only way to perhaps do that in a large way, but they have drawbacks.

I certainly don't feel, myself, that we are going to see the complete solution to how we spur and find innovation by having pilots from Washington and a bureau of innovations within HHS, I think it's very important to encourage other

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processes of innovation. One, as you said, that I want to focus on and emphasize is the role of states in this process, to encourage diverse approaches by states is a way of discovering if the information about what they do is properly shared, is to discover creative ways to solve problems of encouraging innovation.

I think also that it's important to think through how we can encourage states to do things such as looking at the regulations within their borders that might have beneficial impacts in encouraging the cost-saving innovation in the private sector, where the state itself doesn't necessarily realize directly a budget benefit. Len Nichols and myself and Dave Kendall are kind of kicking around some ideas about how can you encourage states, what kind of incentive systems encourage states to do things where the state itself doesn't necessarily have a financial gain, and yet in the private sector you can encourage greater innovation?

I would say finally that, in this area of spurring innovation, that there's no question in my mind that the role of information experimentation generated by the private sector and reported by the private sector is so important. Karen Davis talked about a number of those, kind of to get one thinking about the outer edges, the return of home visits, and after hours I think is a good example of that, which is not

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likely to happen from a federal pilot program, but is exactly the sort of thing that is going on, and needs to be reported about and shared.

I think *Health Affairs* has done a tremendous job in terms of raising people's attention to information that they might otherwise not come across that might be some clues to innovations down the road. Your piece very recently by Tim Jost [misspelled?] and others on [inaudible] the idea of using elderly, local people as sort of extensions of nurses, very much in parallel to what Karen was talking about, to get more community-based approach is to sort of [inaudible] information and that process of getting out this information is so very important.

When I look at the public policy side in general and what kind of environment generally to look for, it does strike me that you've got to think about the role of a budget as directly achieving cost control and sense of total spending, but also encouraging the kinds of innovations that we've been talking about. You've got to look specifically at how we can combine the necessary both protections and information, if we're going to encourage individuals through policy [inaudible] to be more attuned to value for money and to seek value for money.

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Also, we've got to think about the process itself of encouraging innovation at all its levels, the role of pilot, and other approaches at the federal level, how states must to only look at their own programs but can create a better environment in their borders to correct a few changes in others, and then also sort of the role of, purely in the private sector in terms of information and how we can make that better, and share it better so that people can understand what possibilities there might be.

SUSAN DENTZER: Great, thank you very much. I'm going to take a stab now at trying to recap the last couple of hours of conversation in about three minutes, in order to launch us forward now on our next task, which is to engage in some discussion that really continues to frame where do we go from here? Where do we move forward? What can this group do in terms of engendering specific conversations after today that will push things along?

To recap: We heard from Marilyn Tavenner at the outset of our session today the thoughts that she and others at CMS are having now about really asking the fundamental question of how do we use money wisely? What do we need to do in payment reform, moving from fee for service, beyond to use money wisely, how do we not overpay, how do we specifically look at the areas of pharmaceuticals and medical supplies and not

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overpay, how do we address overutilization, and how do we address administrative cost issues, and data sharing?

As she said, a particular goal of CMS now is to elevate the experience, she said, for Medicare beneficiaries in both Medicare Advantage and fee-for-service. In many respects that can be everything from encouraging Medicare beneficiaries to be very attuned to potentials of fraud and abuse, and expose that where necessary. Essentially motivating Medicare beneficiaries to seek the highest quality providers. Outside of the beneficiary side, dealing directly with providers, all the efforts underway at CMS to incentivize the coordination of care and to better manage transitions of care, particularly for the dual-eligible population.

Building up a very strong source of primary care obviously a big motivation at CMS, correcting some of the spending distortions that we see throughout the system, and working very closely with the private sector in all of this, ensures states, consumers, et cetera, realizing that far from all can be done on the government side.

She talked about how Patrick Conway and others in the department are working very actively to deal with the whole issue of measurement of quality, in particular measurement of outcomes as opposed to process, and to streamline the measures that are going to be used across the array of providers and the

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array of programs, so that we don't have 20 different measures in one program, 60 in another, et cetera, and in fact she talked about how CMS has recently retired some of the measures that were previously being used in the interest of putting into active life other measures.

She also talked very much about the importance of data sharing, and CMS' desire to be a better partner for the healthcare system going forward by doing more to put into providers' hands the best data and data analytics in order that they really can take action on utilization and overuse and so forth, and so on.

Then when we got to asking Marilyn the question about what keeps her up at night, you heard really two things: One is, are we going to have the evaluation capacity and the metrics in place to really understand all of these pilots and innovations that we are putting in place, and understand if they really have delivered on the potential to restrain the rate of growth or spending, or even lower costs as well as achieve the other quality and other objectives, and then secondarily her concern about getting the health insurance exchanges up and running and all the issues attendant with that over the next couple of years.

We then went on to hear both from Karen Davis and Scott Serota a lot of discussion about the various tools in the

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toolbox. From Karen's perspective some of the tools in the toolbox that the Commonwealth Fund has helped to support or evaluate, and then from Scott's perspective those underway at many of the Blues.

Essentially, we heard, again, some very common themes: Payment reform, delivery system reform, HIT, rapid data feedback, the need for evaluation, collaboration among pairs emerged as a very important theme, it can't just be, again, Medicare doing this, it has to be Medicare in conjunction with Medicaid, the states, et cetera.

We heard a number of examples on both sides from Karen and Scott, in Scott's case the Blue plans that were doing some of these things, for example some of the activities that Highmark has underway to improve quality in its system, and then on Karen's side from programs such as INTERACT, the program that is involved with keeping nursing home patients out of the hospital if at all possible.

Let me mention what Paul put on the table, which is summarizing that there really is a consensus here about what we need to do on delivery system reform and payment system reform, and I think that the comments that were made previous to Paul's observation really are very much in sync with that.

It is very clear, as Paul said, that Medicare and Medicaid can inspire and spur private payers to undertake some

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analogous activities, we're seeing that play out even now with respect to ACOs, I think there is something like two or three times as many ACO-like contracts being formed now on the private side, as there are on the government side. A case in point, where that inspirational activity seems to have borne fruit.

Paul did express the concern with respect to the pilots of what does round two look like, even if round one is successful, what do they do for an encore, in effect, after they've achieved an initial round of savings? He made the point that pilots aren't always the way to go, that successful pilots cannot always continue life as pilots, we're going to have to put things more broadly into, or essentially extend them throughout the system.

He talked about some of the risks that we're seeing now with respect to potential of market concentration and so forth, and ended up concluding that payment reform is the most promising tool we have at this point, to dive real change throughout the healthcare system and to lower the growth of rate of costs.

When we moved to our reactors, we heard a number of observations, starting with Jim Guest, a real belief that transparency and chair decision making can help motivate consumers to have a role in costs, even though they might not

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have the biggest role in cost, actually Jim seemed to be of the belief that we're going to see possibly more action.

I don't want to put words in your mouth, Jim, but it sounded as if you were saying payment reform is probably going to drive even more change than having consumers have transparent knowledge of say, prices in the healthcare system or what have you. Nonetheless, *Consumer Reports* is duly pushing as much as it can on that consumer awareness piece, through all of the data that you are publishing.

We heard from David Pryor that in the Ascension system, there are a number of initiatives underway. One is, as he mentioned, to put in place some of the no-brainers, he mentioned the partnership for patients which is really taking what we already know about quality, and safety, and applying it more broadly throughout the healthcare system.

He talked about some of the activities underway in elements of the Ascension system to, for example, reduce birth trauma, and actually in the case of the Seton Medical Center in Austin, achieving real results that actually resulted in the closure of 12 neonatal intensive care unit beds.

He talked about some of the activities, again within Ascension, with respect to the pioneer ACOs within the system, who are part and parcel of the healthcare reinvention that is underway. Also noted that, as a system, they are now at risk

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for 700,000 lives as a consequence of this, so making the point that the delivery system model already has changed very dramatically, even within Ascension.

We heard from Gerry Shea, making the point that the sea change that has occurred now within the private sector of paying on quality is real, as he mentioned union funds in particular redoubling their efforts to pay on value.

He raised the concern that if the Supreme Court for any reason jettisons the entirety of the Affordable Care Act, it's not so much that these reforms aren't going to go away, it's just that, as he said, the octane will go out of this tank, there will be somehow sort of a, I don't know whether we'd call it a cultural or other shiver that will go out through the system, that maybe we don't need to go after all of this after all.

We heard from Anne Weiss that the experience over at the Robert Wood Johnson Foundation, particularly through the Aligning Forces for Quality stakeholder collaboratives has been very positive in many respects, that there really is a lot happening in local areas, that people really come together first talking more about quality than they do about spending and costs, and that if you stick with that as a first principal and stick with another first principal, that for most Americans, healthcare means what's your relationship with your

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doctor, particularly with your primary care provider? If you build on that basis, really positive and in some instances dramatic things can occur.

She mentioned in particular the case of Cincinnati, where the Greater Cincinnati Health Collaborative has served as a focal point for bringing together a number of the stakeholders in the system who probably would otherwise not have come together, and did result in that area being named one of the pilot sites for the Comprehensive Primary Care initiative. I was just out there recently, myself, and they are very, very excited to get going shortly on that initiative.

Then we heard, as we wound our way to a close of reactions from the reactor panel, from Stuart Butler who put on the table the questions of where is it appropriate to talk about having a budget in the healthcare system? As he said it may not be appropriate to tell all Americans what they can spend collectively on healthcare. We don't want the government telling us to eat our broccoli, but it might be appropriate to have a budget on the public side of the healthcare system. He mentioned the tools that we already have underway, that we are starting to inch our way forward to do that, whether it be the excise tax that will go into effect in 2018 on high-cost health insurance plans, a more formalized tax cap that could be put in place, premium support in Medicare, the backstop of the

independent payment advisory board that is in the Affordable Care Act, et cetera.

He spoke again about the issue of encouraging beneficiaries to seek value for money and what we need to do further in that is an important discussion to continue to have.

He talked about the need to spur innovation generally, beyond the pilots that we have been discussing so much today, what do we do, broadly, throughout the healthcare system?

And then finally, what do we do vis-à-vis the states, how can we encourage the states to do things, particularly if the state itself doesn't have the prospect of an actual financial gain? Is there a way that the states can play a broader role in innovation that might engender greater innovation within states and across states?

I think that's probably as good as any place to start the discussion, because Stuart, I would love to just hear you say a little bit more about that theme? What is it that you mentioned you and Len Nichols and Dave Kendall are thinking about what some of the things could be that would energize the states to engage in innovation, even if they didn't get anything out of it from a financial standpoint? You suggest that there surely is something, what is that something, and how might we build on it?

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STUART BUTLER, PHD: To be disclosed I supposed, and we're still wrestling with this, but part of it is sort of what you might call permissive, in other words to make it easier for states that are maybe under pressure or are working with organizations and groups within their state borders. Len, particularly, is looking at some of the things happening in Virginia, we have the Governor's office working with the Chamber of Commerce and others, where they're seeking changes that in some cases, there's impediments at the federal level in areas like Medicare and so forth, that that would be one area.

I think what Dave Kendall is particularly toying around with is, is there some way of looking at the baseline for spending in healthcare generally where the federal government would actually directly provide bonuses of some kind to states that do take action, anything from looking at the certificates of need [misspelled?] from hospitals right the way through the gamut of things. That in fact would create a bonus system for a state that could show some improvement in the private sector, which of course will spill over into public programs down the road. There's issues there about how you set such a baseline, what's real, how do you measure it and so on, it's not a small thing. But trying to explore those areas is what we're trying to kick around.

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SUSAN DENTZER: Alright, thank you. We're now going to move into active discussion phase, again, let's stick with the tend card mode of signaling that you have a question to ask or a comment to make, and we'll move starting this way around the room. I see John Rothers [misspelled?] got his card up, so, John?

JOHN ROTHERS: I've been thinking about the congressional discussion, comparing it to ours, and there are four concepts I think that have dominated the health discussion on the House and Senate floor, and I don't believe we have mentioned them once. Premium support, prevention, drugs, and high drug costs, and medical malpractice. I think it's interesting to contrast the issues that get the attention of policy makers on the floor with the issues that we're discussing here?

SUSAN DENTZER: I guess we could also say that indirectly, David Pryor raised the prevention issue just by virtue of talking about the huge increase in chronic disease and obesity and so forth. We didn't specifically address prevention, but you did remind us that that problem is at hand, so thank you, David.

JOHN ROTHERS: What I'm trying to say is I think that in the public mind and in the political mind, prevention is

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often seen as the answer to cost, and I did not get that from our discussion.

DAVID PRYOR: That's what I was trying to raise by the question over what time frame? Because if what you address is all of the cost issues that are present in the short term, I didn't say it very clearly, obviously, but you miss the whole issue of what happens downstream. That also comes into play if we look at medical homes, because medical homes, for example, have been talked about as applying anywhere from 50 to 80-percent of patients would have medical homes, but clearly those 50 to 80-percent of patients don't have problems. So you're giving medical homes to a lot of people who quote, don't have medical cost issues in the present time, so the concept is of course, at some point, that you're going to prevent some expenses downstream, because you're not going to save any money on those people in that year. The issue is how do you fund that, and where do you go from there?

I don't see the discussion actually as not addressing some of those issues from the prevention standpoint, at least, we just, I don't think got underneath the surface enough maybe to really get it some of that.

SUSAN DENTZER: Is there anybody else who has a particular comment on this prevention issue? We'll try to address those. Jim, you do, and then Gerry?

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JIM GUEST: My comment was, I think essentially to agree with John and David, but to say it slightly different, since it is, if we look at 78 million baby boomers who are driving all of what's going to happen, at least a key part of Medicare and Medicaid, the fundamental issues are secondary prevention management of chronic diseases, and the answers to those are very little to do with the doctors or the nurses on the telephone or the hospitals, that has to do with people eating right, exercising, taking the right medication, not abusing substances, and being informed consumers of the system. It kind of looks like we're drunks under the lamppost looking where we see the light rather than really where the problem is. That's part of it, so that's about fundamental consumer individual behavior.

The second part, at least for baby boomers, is consumer expectations, what do we expect out of a healthcare system? Do we expect a system that will spend an enormous amount at the end of life and almost nothing in terms of secondary prevention? The issue of consumer expectations at a broad level seems to be not being talked about, maybe because we're kind of in our comfort zone of payment and delivery reforms, which is important, but I think there are other aspects of this issue that we need to address at a broader societal level if

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we're really going to do something about costs in the long term.

GERRY SHEA: I just wanted to make the point that prevention is a big deal in the private purchaser area. There are basically three tools that private purchasers use in the employment setting.

One is prevention and wellness programs, which has had resurgence in recent years. The second is some value-based benefit design which is putting in effective, targeted financial incentives for employee behavior and the right choice, which I would distinguish from the consumer oriented, here's the big deductible in the computer and you go figure it out.

It's very targeted, and is very effective in terms of driving behavior. The third thing is what's now possible because of the changes in Medicare, which is genuine value purchasing, that is whether it's ranging from focusing on the high-cost population, which is what the easy step that a lot of employers can do, to medical homes, to then actually getting into tying payment to quality, which is the more advanced state of this.

DAVID PRYOR: On this prevention point, with obesity and the like, it's enormous the potential, and we certainly ought to be working on it, but we're at such an early stage in

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figuring out a path to success, that that's why if we dropped everything else in favor of this, we would be reckless in the sense that we don't want to give up on it, but we have to realize that it's going to be a very, very long period of time before we figure out the path to success and actually start achieving a lot.

SUSAN DENTZER: You don't think just restricting the size of drinks in New York is going to do it, do you?

I want to make sure that I'm fair, that we have a fair process here, so does anybody else specifically want to address prevention before we move around the room?

CARMELLA: My comment is actually in regard to something David said, which has to do with patient-centered medical homes, which is I think we tend to lump together that this is primary care access, but if you actually look at the contracts that are being made and it started out very small, but it's much more, almost 20-percent of them now, are really looking at the top tier of the patients that are driving 10-percent or more of the medical costs and working with the providers to actually give them a larger per member per month fee, for those top percent high-intensity cases, to actually change the dynamics. I think we really are going to see some savings because they are targeting the right population with the right infrastructure support.

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SUSAN DENTZER: Thank you. Let's pick back up and move this way. Nancy, is your card up there?

NANCY: If you'll allow me, I'd like to make one official comment and then the rest be as an individual. You've all got to just play that little game. The official comment, to respond to Stuart's call for states to be the laboratories, CMS and the innovation center have heard that loud and clear, and it is entirely possible that even before the Supreme Court rules, you will see that there might be something calling for states to be very innovative and the Innovation Center might help them, with whatever they might come up with, so just stay tuned on that, and that's the end of the official comment.

The rest are as an individual. I came to this town after being with the AMA because I was worried about the large number of docs in small practices, and whether or not there was a path forward for them to transition to the new world order of payment and service delivery, because what was happening was some groups, like cardiologists, were moving to become hospital employees, others were banding together in single-specialty practices, or as you heard some successfully, some not so successfully into IPAs. You heard about the successful ones in California and Massachusetts, and there's one in my hometown of Buffalo, but what about the little guys?

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The thing that electrified me was when I heard the CareFirst presentation at AHIP, eight, ten months ago. It electrified me because that's a very quick non-threatening path forward, and I don't know anybody at CareFirst, just so you know, I don't own stock, I'm not on their board, it doesn't matter, but I've got to tell you, for a doc, it is a path forward, and we need every one of those clinicians in this country. Either that, or another way to look at engaging them so that they don't feel they have to be swallowed up, I think, is important.

The second comment is to appeal to all of you, because we heard Paul Ginsberg say that Medicare hasn't engaged consumers, well, Congress won't let them do that, and when we do, this is a town that is very poisonously partisan, and how are we going to deal with advanced illness if we collectively allow death panels to happen again, because whoever talks about being just stewards of finite resources can be in the eyes of the beholder painted as the person saying no. Now, if the person saying no is the government, like there's a great article in *The New England Journal* called "When Nice Isn't Nice," when the government does it, the accusation is rationing, when the insurer does it, it's of course the evil, for-profit insurer, you understand what I'm saying. Even if it's the doctor who's involved in an ACO, what's to keep a

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beneficiary or a member of a commercial plan from saying that doctor, from looking at that, is that doctor is trying to line his or her own pockets. We have to really engage in a way that, Jim, we're going to need your help, because consumers have to be actively involved in making those kinds of decisions, and not just feel or be treated as if they're passive.

My last comment is I think there's a lot of good will in this room, and I would say that a creative thing that we could do is whenever the Supreme Court comes out with its decision, I think we ought to have a wine and cheese party that day and say okay, now what? Let's do now what, whenever that day is, I guess, whenever it is. Thank you.

SUSAN DENTZER: Just as a brief commercial for health affairs, it won't be a wine and cheese party that day, but on July 17, we will have a major conference asking what the path forward is, and you will all be hearing more about that shortly, those of you who do not already know about it.

Let's keep going, Gretchen?

GRETCHEN ALKEMA: Thank you, and thank you for everyone who has made comments, it's nice to have this as the capstone discussion of the last several briefings.

I think the two things that have really struck me in this series of conversations but definitely culminating up to

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today is it really does matter about focusing on who are those individuals? We think about them as the high cost users, but what's really up underneath the hood on that in terms of their experience? I'll just bang my functional status drum again, in being able to have an opportunity of looking at that.

Here's why I bang that drum, is because while I think it's pretty safe to say that all of us here think about healthcare and health policy and delivery systems pretty much all of the time in some way, shape, or form, most people out there in the world don't. They're about living their lives, and even folks who are really, really sick are still about living their lives, and would rather probably not have to engage in the world in which we think about 24/7.

When they do, whether they can articulate it or not, they're seeking a solution to some kind of challenge that impacts their world. That challenge might be the shortness of breath and the chest pain that comes on very quickly, or it might be the consistent falls that are occurring and the broken bones that are following from that. Something has broken in their world that is about the way in which they live every day, and so that's that micro level engagement that then relates to how it bubbles up onto the broader sphere of healthcare delivery and costs, and I resonate with the comments that Jim made, in terms of what is that secondary prevention piece

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that's still about the solution that someone is trying to solve, and there were models discussed today about the solution set to engage people.

I think that as we think about this broader concept of what does cost mean coming back down to what does this really mean at that local level, and I appreciated Anne's comments about how it is about that doctor person engagement, but I think that most people experience that in the frame of love the one you're with, not that that's the person that they want to be spending all their time with. How do we think about what is really happening at that micro level and the solutions that people are seeking relative to solutions that health systems are seeking, and can we find a nice marriage between those two worlds? Thank you.

SUSAN DENTZER: Thank you. Brad?

BRAD: Thank you. I'm from Sutter Health System 24 hospital, I think we're the eighth-largest not for profit in the United States, and also I'm from Coalition to Transform Advanced Care or CTAC, and I just want to piggy back, Gretchen you won't mind if I piggy back on what you just said?

One thing that we haven't really gotten into any depth on today, I'm sorry David isn't here because he touched on it, is a lot of the 5-percent who spend 50-percent of, that's Medicare, or all health system dollars, are the sickest

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patients. Low-functional status and large number of diagnoses are two great ways to pick out who those people are.

I just wanted to also respond to what Nancy, you just said about death panels, being a physician who's been in palliative care in a hospice for 20 years of my third of a century in medicine, it's not only possible, we now have programs that can pick off the patients in this population and not treat them like providers treat patients, but to partner with them as people and discover what they really want, because as it turns out, the more seriously ill they are, and the more impaired their function is, the less they want to come back and see us providers, just to echo exactly what Gretchen just said. I think we have data now that shows that strongly in programs around the country. We will be working with CMMI to run this out.

I just hope that as the discussion moves on, that we include very specific programmatic approaches where teams can work hand-in-glove with primary care docs in the community and at home, together with folks in the hospital and folks in medical practices to really coordinate care for this population, because it's not just doable, we are doing it.

To wind this up, we're doing it on our own dime, because there is no easy way to get reimbursed for doing stuff that's not paid for yet, so we're paying for it ourselves as

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was stated, because we know what’s coming. For now, the systems are willing to do that, but I think some kind of interim reimbursement for advanced care, which you’ll be hearing more about over the next year or so, would be wonderful to have.

SUSAN DENTZER: Great, thank you. Tom?

TOM: Public policy bubbles can sometimes look a lot like financial bubbles. The common phrase seems to be, this time it’s different. I was listening to some of the laudatory statements earlier, the glass wasn’t just half full, it was positively overflowing. I just didn’t know whether the liquid inside was more solid or gaseous.

I do agree, it is different this time, we’re running out of money, and that’s what’s different about what might drive this to the table. I liked Paul’s paper, in a comprehensive way, [inaudible] when you’re comprehensive you have to be a little thin, so there are a couple of elements that he couldn’t get into in there, and there’s a tendency in talking about concentration and consolidation in markets that have a different type of aggregation bias, where we only think of things in terms of the big grand health plan, or the integrated delivery system as opposed to the pieces that are going on underneath that go into that aggregation.

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As we look at a different element of concentration and competition and consolidation in the context of the affordable care act, we don't pay attention to the way in which we may be setting up more of a symbiotic relationship of political interdependency between the few remaining incumbent survivors on the delivery system side or the payer side, and a dominant, federal regulator, end payer, on top of it.

I do think though that probably will be solved in a couple of weeks, so we don't have to spend too much time on it.

I will be constructive, because we've got a paper coming out tomorrow about concentration and competition in markets, and it suggests some other problems and solutions which I think Paul might be in some agreement with, we've got some abuses of most-favored-nation clauses in a lot of these contracts, which there's some anti-trust activity on.

There is an extensive abuse going on, some court challenges involving the creative extension of state action immunity, where the regulator uses a shield to allow the dominant incumbents to extend their monopolies, and although there is a lot of enthusiasm about bundling for clinically related purposes, there is, on the flip side of that, we have some dominant systems which bundle together services which are not needed for clinical integration, but allow the extension of a dominant market power presence to extend that pricing power

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broadly, and the alternative is to begin to allow those purchasing those services to buy the more a la carte in that situation.

Finally, we haven't thought about a different way to extend the locus of competition into more of an inter-regional type of approach to medical tourism. If the market's concentrated uncompetitive, can we think about ways to open it up for people to get those services from some other place in more of a virtual or broader market? I'll stop at that point.

SUSAN DENTZER: Great, thank you.

CHERYL PHILLIPS: Hi, Cheryl Phillips from Leading Age, and formerly from Sutter, but I escaped.

I wanted to think about kind of from the system's side, I am in awe of the cacophony of innovations, and I am truly excited, both from looking at it with a provider lens, but also as we look at the integration, particularly for aging services.

Although I'm concerned that we are creating an archipelago of innovations and lots of little clever islands that have very little land mass and are not really cohesive as continents, and so if we're really looking at all of these innovations to transform our delivery system and thus cost, I regret that I didn't have a chance to talk with Marilyn about that more.

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I think that's part of our challenge, is how do we create the connectedness? Truly, and Anne pointed out some wonderful examples about the local innovations the scalability of those local innovations and how they translate, I think is part of a huge uphill climb for all of us.

I also think, again, looking at the local innovations, much of what works has less to do with the acute care, the ivory towers as we loftily refer to them as, but much more what's going on in the community, including the social determinants of health, particularly for aging individuals with functional impairment, so what are their social network supports? Do they have housing? Do they have access to transportation and meals? Do those in fact become more predictors of cost in that functionally impaired group than some of their chronic conditions as stand alones?

I think when we look towards these solutions, how do we knit together these innovations in a meaningful way that truly can transform? How do we integrate some of the social determinants of health across a community in ways that are meaningful to truly translate to decreasing the cost curve?

DAVID PRYOR: Well I put this card up when I heard Stuart talking about budget constraint, and states, and I would like to offer a few comments about this.

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I once had the privilege of helping this country try to constrain costs with a planning framework and capacity controls, and I can tell you that the leadership of that effort recognized reasonably early on that you needed an overall budget constraint and we were on our way to having Congress think about that idea when the hospitals came to Washington with the E-buttons on, and you all may remember that initiative. So we didn't quite get there.

I was also reminded that the country once tried to turn to the private sector and after the Clinton health reform went away, the employer sector said managed care seems to be doing a good job with controlling costs, and we asked America's health plans to do this, and in good faith I think they made the effort, and we had the public reaction to this.

I think we have to do a better job of helping the American people understand that there has to be some constraint, Nancy I appreciate your comments about that. I think we haven't done well with helping them to understand that, I was at Academy Health when I was getting strong Republican leadership support for comparative effectiveness research, even a prominent Republican candidate for President was helping us with that effort, and after and August I'll never forget, we had death panels and a reaction to this. So I hope we'll find a way, Stuart, to use a budget constraint, but

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we've not been wanting to let the public sector do this, look at the reaction to the independent payment advisory board.

I do think we ought to elevate the conversation about a budget constraint, maybe elevate the conversation about Americans have to accept the notion of limits. I think there may be more willingness on the part of consumers to do that than we acknowledge.

I spent another career trying to help states with health care reform and voluntary approaches and state initiatives, and I spent the last year helping Alabama and I truly enjoyed working in a state that wants an exchange but probably would like something other than the Affordable Care Act, and have joined a suit to that effect, but want an insurance exchange.

I think there's a chance to work with states like that, but I just have to tell you that we picked a federal system with very unequal state or sub-national levels of government, and the states very dramatically, in their capacity to carry out these reforms, if this act were to go away, there would be some states that have the wherewithal to carry forward exchanges, but they would all miss the federal subsidy dollars, and in Alabama, given their budget situation right now, I just don't see where the money would come, and if we don't have a mandate, and we don't have voluntary subsidies, I know from

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personal experience it’s hard to get a voluntary system to work.

Maybe the new answer is premium support, and I’m prepared to listen to how that could be done. I thought I heard my third caveat, and maybe I feel some responsibilities for this 40-year career to reflect on what I’ve learned. But I heard the need for a consistent policy framework here, in which we could operate, and I think there were times when we had a consistent policy framework, and the parties were willing to work together. I haven’t seen it lately, but I do think we’re going to need national policy leadership, and they are going to have to come together and help us chart a course. It may not be everything that’s in this ACA legislation, but I do hope we understand and acknowledge that we have to do a better job with the delivery system, and we have to make a meaningful marketplace for people and the individual in small group markets.

I’ve enjoyed getting to participate, I didn’t speak until now, and I put this card up right after Stuart spoke, so I’m glad he came back in the room so I could share my thoughts about budgets.

SUSAN DENTZER: Thank you, David. Leah?

LEAH: Thank you. I actually just want to go back to John’s first point, way back, that was even farther back,

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David, about the fact that Congress seems to be talking about completely different issues that dominated this conversation. That has been my experience in every conversation I have here in Washington that those of us who are sort of in-the-know in the health policy world, we talk a completely different language than Congress, or, I would even add beyond that, my own family. What my own family talks about health care is nothing; they wouldn't understand a word of what we just said today. I think that is a huge concern. I think that the foremost problem, we are not going to move on the question of costs until the America public understands what's at stake and what their role is, and what decisions they have to make in their own life and how that's impacted.

Shoshanna Sofaer did a study recently that I thought was fascinating, she said to consumers, a focus group, she said "Here's five providers, and here's what they cost, which one would you pick? Not going to tell you anything else, which one would you pick?" Guess what? They picked the highest cost, every one of them. More is better, there must be a reason why it's higher cost, it must be higher quality.

There's a complete disconnect and misunderstanding. Part of that has come about because our health care system is structured with this model of third-party payers. We're protected and insulated as consumers from the price impact of

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the decisions we make. We never commonly know much about quality or safety, so I think that transparency is going to be critical, and transparency in a way that consumers can use, it's not enough to say, here's some information, it's got to be used. I think *Consumer Reports* as usual is right on top of it, trying to develop and put information together in packages people that people can use. I think we need a real market in health care; we've never really had that. Those are the kinds of conversations I think we have to have in order to move beyond where we've been for so many years.

SUSAN DENTZER: Great. Okay I think we're at the end of the 10 cards? Oh, no, John, okay.

JOHN ROTHERS: Just to add to my previous provocative, I think there are at least a couple of really big issues that we've not touched on at all. For example, the coming prevalence of biologic drugs and the costs associated with those, what are we going to do about that? That, to me, is a big challenge that we have so far managed to avoid facing up to. There's been a lot of talk about chronic illness, but these drugs aren't about chronic illness, these are very targeted, personalized medicine for narrow parts of the population. I just wanted to raise that as one.

Another that I think we've not given very much attention to is manpower policy, or perhaps womanpower policy,

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because the role of nursing, the role of social work, has to be much more prevalent, much more a part of the solution, and I guess that's subsumed under the medical home, but I wanted to be explicit about it, because that's a state issue that we need to really own.

Then finally, to David's point about consumer expectation and sense of limits, yes, this is a big problem. If we talk in terms of limits, if we talk about denial of beneficial care, we will not get anywhere. And yet, is there a person in this room who doesn't think that waste is our most prominent characteristic? Any audience that I talk to, the heads will nod, everyone has a story. I do think that we should be talking about waste, not about limits. Yes, we may have to get to limits at some point, but as the examples today have shown so many opportunities to save money and do better by attacking waste, I just don't see where the public is going to desert us if we stay with that.

MALE SPEAKER: We tried, with comparative effectiveness, to say 30-percent of what we deliver is ineffective and even harmful, but—

PAUL GINSBERG: Just a brief comment that a few times, the words transparency has happened as if that was always a good thing, and I think in the quality area it is a good thing.

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It's not every measure is a good thing, but we're getting there.

The point I want to make is when it comes to prices; the information consumers need is the difference in what they pay with their plan from going to different providers. If you want to give consumers a lot more information, which a number of state legislatures have done, the issue that Leah brought up about hey, if I'm paying hey same, I'll go to the most expensive provider, I think is serious, there have been experiments in the private sector that have been quietly withdrawn because of seeing that effect.

In a sense, I just want to caution people that focus on quality transparency, I think if we're going to engage consumers as far as financial incentives, we need to arm them with a lot better information about quality differences or value difference across providers. When it comes to prices, we really need to limit it to their finding out, presumably through their insurer, the different amounts they'll pay in going to one provider versus another.

STUART BUTLER, PHD: I can't resist responding to all the talk about limits, because it keeps striking me that when people talk about health reform, they keep talking about a shrinking pie. We're really talking about the most optimistic projections of health spending under an extremely successful

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health reform system would have health spending increase by 50-percent over the next 10 years.

Talking about messaging, why are we telling consumers or preparing to tell consumers that they need to live with limits when we're talking about a continual growth in the healthcare sector that nobody imagines we're going to be able to make negative, to eliminate. We're just talking about shaving something off the top of that.

I think the message has to be we have a tremendous amount of resources on the table to use for healthcare, don't you want to get the most out of those resources that you can? And instead of talking about waste, which of course, waste is what somebody else uses that I have to pay for. We talk about let's get the most out of our health system that we can at a reasonable cost, which is a rate of growth in spending that most industries would sign up for right now.

SUSAN DENTZER: And just to underscore that point, the CMS projections that we just published today show that even with the assumptions of the restraint in growth of health spending built into the Affordable Care Act, we're still going to put $400 billion more on the table into healthcare resources over the next 10 years.

MARY: It seems the challenge we've been talking about today is how do we take these one-off examples and make them

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system-wide, and something that has struck me, Scott you mentioned what I would call the intangible qualities of leadership, trust, collaboration combined with what I would say are the tangible changes aligning the incentives better. I'm not sure how you teach or spread the trust, the leadership, those qualities, and I'm just curious, Karen and others who have been involved in these local experiments, maybe Brad, the work you've done with your institutions, what is the relative importance of those two things?

MALE SPEAKER: From our perspective, I don't think you get to the second without the first. If you don't have a long-term well-established trusting relationship, you never get to the one-off experiments, because you can never get beyond the I have got to win and have got to lose sense of negotiation, so I think you have to start with trust and innovation.

How do you teach it? I don't know that you can teach it. I think you have to do it; you have to be that kind of a participant in the health care system.

I can tell you one thing you can do, and that's legislate it. You can't mandate it, you can't say you will be a team, you will collaborate, we've passed a law now you have to do it, that doesn't work.

I think the first thing you have to do is create a marketplace that demands it, and that to me starts with our

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customers as insurers, employers, and consumers demanding that kind of a market. It will be difficult when anywhere from 40 to 60-percent of the dollars that are paid are paid by the government, that creates a skewed artificial marketplace to begin with, so that makes it more challenging, but not impossible. But it takes history, and it takes time.

SUSAN DENTZER: Karen, and then Gerry, and then we will move to wrap up [interposing]

KAREN DAVIS: I think one of the challenges that we'll face is once we learn more about what works in the pilots is how to go to spread. I chased David Pryor out of the room to quarrel a little bit with his comment about the birth trauma and how Seton lost money on it, but it was the right thing to do, and that's what they're in the business for. I grieve with leading for what's best for patients, but I think the early innovators will do it, what's best for patients, if you tell others you're going to lose money if you do this, it's just very hard to get spread.

I do think aligning the incentives and jumping at the program-wide to payment reform is going to be required. I also think a lot about Everett Rogers, having grown up on a wheat farm Everett Rogers innovation spread with hybrid corn, and it's being able to visit your neighbors who've tried it, so your peers. It's peer-to-peer interaction going to places that

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try it, having them answer the questions on your mind that is conducive.

The other point that Rogers makes is you don't bet your entire farm on it, you try it first in one little field, and then if it works, you try it a little bit broader, so the ability not to go whole hog to something at once, but to be able to try it on a part of the business. I'm going more with the bundled payment, if you can try that in your orthopedic surgery unit and it works, and Geisinger did this, they started with coronary bypass on their global payment with a warranty all-inclusive fee, and now they're doing it for burs [misspelled?] and now they're doing it for knees, but they wanted to get experience with one part of the business before doing the all.

I think we're all going to have to think a lot more about what leads to successful spread.

SUSAN DENTZER: Okay, let's take these last couple of comments, and then we will wrap up, so Brad, and then Gerry.

BRAD: I just want to answer directly this trust issue. As a physician and as someone who's been battling for many decades to improve care, I have to be honest, I think, and I'm as scientific as anybody, I think what we have in this country is as much as anything else a spiritual problem around how we

treat people who are really ill, which is where a lot of our costs are.

I think that we believe that we can cure just about anything, and we don't ask and really listen to hear what the people, not the patients, this is before they become patients, what people actually want in their lives when they do become disabled, and they trust us to do the best for them.

I think if you want to find innovative interventions that increase quality, increase choice and save a lot of money, you have to start with communicating directly with people who are ill, and do what they say they want in their lives and let them drive their care, and after having done a lot of things to people that I knew they didn't want but it's what I was taught and it's how my community practiced, I think we now have programs and need to spread them that pay for themselves by going to the person to get them what they want in their life, which usually is not to go back to the hospital.

GERRY SHEA: Thanks, and I really do believe that it is the big federal programs that only they have the power to drive structural change, I think that's what we're seeing, but on the other side, I think there is a leadership role here in the private sector, in kind of an odd way. We've come to the point where we have a lot of the tools and then they're now dispersed quite broadly that allow us to help people manage their health

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and eliminate some of the waste and efficiency we've talked about a lot of that, a lot of them are now in the state of being products that insurance companies or health plans are offering, and they come at a time when most people in the country who have private health coverage, group health coverage, have not suffered the disaster that some of the figures that I was citing, about having the total on unaffordability, but we have all been sensitized to healthcare costs.

I think there's a moment here where the kind of approach that a lot of the private bridges that we're working with are taking of introducing new programs that include a strong element of personal responsibility related to costs, and as I said, targeted financial incentives, could really change the way the active population looks at the health equation from there point of view, that is not going to produce immediate change in the federal program side, but as generations evolve, it may well make a difference.

I think it's underestimated because it hasn't been going on for very long, but I can tell you, just dealing [inaudible] but this is a very powerful moment for people to act, and it's a very teachable moment for people.

SUSAN DENTZER: Well, you may have noted that the last item on the agenda was a 10-minute summary, by I presume by me,

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Ed, of everything that has been said over three sessions, and needless to say, that ain't happening.

I will give you the one-minute version, which is that over the last several sessions, we've had some extremely interesting and thorough discussions about the role of several factors in driving health spending, we've talked about the role of prices, we talked about the role of technology, we talked about the role of chronic disease and poor health status, we talked about the presence of waste in the system, and overuse.

Today, we have discussed, I think, three major lines of discussion have resulted. One is that we've put on the table that we have a lot in the toolbox already, we're trying lots and lots of things. Now, whether that is, to change metaphors on you, to go from toolbox to bubbles, whether we're having a bubble here, in Tom Miller's words, where we're all chasing the same tulips or dot coms or whatever is the equivalent in our current ideas about how we're going to constrain the rate of growth of health spending, whether it's a bubble or not, it's happening. To switch metaphors yet again, to use one that Cheryl put on the table, is what we have going on here a series of archipelagos, and if so, are they just isolated efforts to tweak the system here or there, or how do we knit them together into a whole continent, or, in Karen's words, how do we spread

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this, how do we spread these individual innovations more broadly throughout the system?

If there is a further agenda, I think, for this group or any like group going forward, it is probably that. How do we get maximum spread of the ideas that work, first of all how do we assure ourselves that there's not just a bubble, as Tom's words, but then if they turn out not to just be a bubble, if they really turn out to have traction, how do we spread them as quickly as possible?

The other very important thing that I think has emerged today is that its going to be very important to close the rather considerable gap in public understanding of what is at work here with some of this innovation and payment and delivery system reforms, and the current state of consumer awareness and knowledge about the realities of the healthcare system.

On one level it is helping consumers better understand what is actually going on, on another level, it is also listening very carefully to consumers about what it is that they really want, to echo the words that Brad used. How do we listen to what people really want out of healthcare, particularly in the days that they need it the most?

Two issues, how do we help them understand more about what is actual quality and value in the healthcare system, but also how do we listen more clearly and cleanly to them about

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what it is that they want, as I say, when they need it the most?

I think finally, just to close with Scott Serota's observation and Scott apologized that he had to leave early to catch a plane, this is work that is never going to end, none of us in this room would kid ourselves into believing that we'll finish this and it will be done, it is work that will constantly be going on. Karen, I think, mentioned her first conversation about healthcare cost containment back in the 1960s. We all know about the Hoover Commission back in the 1930s. It will never be over, this is work that we will be engaging in again and again and again.

I will just close by saying I can't think of a better group of people to be working with it on. With that, Ed, let me turn it over to you.

ED HOWARD: That's terrific, thank you Susan. Let me start by thanking Susan for an incredible job over these three meetings.

Bear with me, I won't take long, but I do want to say a few thank yous, first of all to the Kaiser Family Foundation for allowing us to use this wonderful facility for all three of these briefings and for allowing us to have webcasts of all three, and the one for this event will be on our website and on theirs within a day or two.

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Once again, the sponsors, all nine of them, have been terrific to work with, and thank you so much. The advisory group that we put together that John chaired has been terrific. Let me thank Paul and Jack Ebeler for doing an excellent job on papers that we have used, I think quite well, in this series. Paul and Karen and Scott and the other speakers in this series who have helped us get off to really good starts in these conversations.

While you’re filling out that blue evaluation form that I asked you to, let me ask you to join in thanking the Alliance staff, which has put in an incredible amount of work over the course of these past few months.

One final note, if you want to start discussing next steps, and you don’t want to wait until Susan’s event in mid-July, join us in the foyer immediately hereafter, for wine and cheese, how about that, as if on command, Nancy Nielsen’s reception has materialized, we have Tom Miller and John Rother, two very skilled lawyers you can ask about the predictions of the Supreme Court decision so you can jump off as if you already know what the result will be, and I really would hope that you could join us and celebrate the fact that the alliance has been trying to facilitate better understanding among very different viewpoints for the last 20 years.

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We even have a nametag for you in case you forget who you are and you've had too many glasses of wine before you go.

So thank you all, for coming, and thanks to everyone for being part of this.

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