



**Health Care Costs: The Role of Technology and Chronic  
Conditions Part 1  
Alliance for Health Reform  
May 29, 2012**

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**ED HOWARD:** My name's Ed Howard. I'm with the Alliance for Health Reform. First of all, the words of welcome from Senator Rockefeller, Bob Graham and the rest of our Board of Directors, but a word of thanks for everybody who began their post-holiday work period, as we say here in Washington, delving into one of the toughest and naughtiest problems that healthcare faces, which of course, is healthcare costs.

We're going to talk today about two of the most prominent aspects of that, that is chronic care for chronic conditions and the role of technology in healthcare costs. I want to thank first of all our friends at the Kaiser Family Foundation, Diane Rowland and her colleagues, for not only helping to support and sponsor this series, but offering us this wonderful facility in which to have the discussion.

You'll notice that we have configured the seats, those of you who are here for the first of this three briefing series, in a way that we hope will encourage everyone around the table. I see a lot of illustrious faces around this table to get into the conversation and we've reserved a fair amount of time for that to happen. So don't be bashful. I don't see any one around here who would usually be characterized that way. So we will look forward to contributions from everybody sitting around the square.

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Thanks also to everyone whose logo and name appears on the screens above you. We have had broad and very gratifying support from a variety of parts of the healthcare world and every organization represented there has been extremely helpful not just in financially supporting the series but helping us to plan it out and make sure we have the right folks around the table. .

Finally, let me just reiterate our thanks to our informal advisory board chaired by John Rother from the National Commission Coalition on Healthcare, who's also a member of our board. There is a sheet describing those folks in your materials, and each of them played a big role in shaping the series itself both the content and the format in a way that we hope will make this whole thing very productive exercise.

We're pleased and actually quite fortunate to have guiding us through this entire series: Susan Dentzer of Health Affairs, whom I will not say anything nice about because you know all the good things about her. We're just very happy that she's here to make sure that everybody gets a chance to make the contribution that they are capable of doing. Susan, let me turn it over to you and have a great discussion.

**SUSAN DENTZER:** Thank you very much, Ed; and good morning to all of you and welcome back to work. Those of you who are at our first session will know that when we open up a

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conversation about healthcare costs, it's very difficult to confine that conversation to a couple of discrete contributors to healthcare costs. We tried valiantly to do that in the first session and failed, I should say, miserably. We will probably do that again today just because, of course as we all know, there are multiple determinants of higher healthcare spending and these don't tend to exist in discrete silos; they very much interact with each other.

But once again, today, we're going to try to stay on a couple of discrete contributors to healthcare spending and healthcare cost to degree we can do that. As you know, as Ed said today, we are going to be talking about technology and chronic conditions as drivers of healthcare spending and healthcare costs. We, of course, are attempting to understand not just the role that these play in contributing to the healthcare costs and spending issues, but also in particular to start to discuss what is actionable. What could we actually do about these things?

Are there policy initiatives that would address them that would not contravene some of our other goals in having a robust healthcare environment that does address our needs? We will hear this tension throughout the conversation today as we discuss some of the potentially actionable policy solutions,

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but recognize that there are tradeoffs involved in embracing them all.

To get us started, we are delighted to have two speakers: Joe Antos from American Enterprise Institute and Ken Thorpe from Emery, to speak respectively about the roles of technology and chronic conditions. We are very happy to have Joe here with us today. He decided to have an authentic healthcare experience over the weekend in order to have a legitimate grip on his subject, but Joe managed to come back from a case of sciatica and be with us today. Joe, thank you so much for being here. We know it was only with considerable effort that you were able to join us and we appreciate that. So Joe, we're going to start with you. Joe has a presentation and then we'll move directly into Ken's presentation. Joe, all yours.

**JOE ANTOS, PH.D.:** Thank you. Okay, alright. Here we are. So, I promise to stay on the subject for whole minutes at a time. Technology. And, of course, you saw the picture of Marcus Welby. If you got up this morning and took a pill, you used medical technology and that's probably what almost everybody in this room did. I took quite a few pills. It didn't do much good. Rick get to work.

So, Rick is already taking me off of technology and out of my favorite topic. But Marcus Welby, that instrument that he

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is using, that was probably the best one that he had in those days. The reason he went to your home to visit you. He took that black bag. What was in it? It was a stethoscope, something that had been available since the Greeks, and basically nothing else. They have thermometers, too. Okay, good deal. Healthcare is not practiced that way anymore. I think mostly we could say, that's a good thing. So there's the contrast of Marcus Welby.

That is a proton beam therapy chamber. It's somewhat controversial, but the one thing you can be sure about is, it's expensive. It's always interesting to know how these things work, so here is a nice schematic. You can see that there are these various gantries to treat patients. The alleged power source is the cyclotron but, of course, we know that isn't true. The real power source, of course, is money. If we didn't have big demand for this kind of technology, we wouldn't spend the money.

It's the money that drives the system. So, I'm glad I got past technology, so I can now talk about economics. Now seriously, I'll go back to technology in a minute, but that's the point. It's, as Susan said, the various sources of healthcare cost growth that people have attributed over the years are not separable. In particular, they all have their root in either the supply of something or the demand for something.

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Since it's a market economy, it means money. In this particular case, it's both supply and demand. So anyway, here is something that I found in someone else's presentation and I thought it was very interesting. This does reflect the march of costs of technology and, of course, the march of progress. The traditional technology, which it's not clear that that's really traditional; the real traditional technology, of course, is something that caveman did.

So, this is really kind of advanced stuff since about 1910 or so, but we'll take it. You can see that over time, we've gone to more and more sophisticated equipment. Every time there's a new generation of equipment, it seems as if the cost is higher. Now, what I can't tell you for sure is whether this is in price adjusted terms but it probably doesn't matter. I think the impression is undoubtedly correct. When people talk about technology, they usually think about pieces of equipment. Of course it's not just pieces of equipment. It's essentially everything that a doctor does.

I mentioned drugs, obviously, that's part of technology. Equipment is part of technology. Not just the equipment that is in the hospital up against the wall or some big thing, but also the little things. The stethoscopes work a lot better these days; to pick on the thing that I mentioned that Marcus Welby had. But also, it's medical technique. I

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think that's part of technology, too. It's knowing how to do something.

Even if the basic materials are the same as they were 20 years ago, but you now know how to do it. That is an advance in technology and all of that adds to both the supply of services that are available to treat disease and diagnose disease, and also the demand for such diagnoses and treatments. Now one of the things that you'll see in the literature, which I've never particularly found useful— I'm an old labor economist at heart but technology, you'll see these studies that try to parse out how much of cost growth is accountable by various kinds of factors including technology.

Technology is that one thing that can't be directly measured. Although, I'd argue that the other factors that people usually point to aren't really all that measurable either. But everybody admits that technology is not directly measurable. And so, technology is usually treated as a residual. So it's not technology. It's the "I don't know factor."

So if you see somebody say, "Technology is responsible for 60-percent of cost growth over some period of time." Maybe. Maybe not. It's just not at all clear. As Susan said, technology alone is not a culprit; it's everything. But in the end, if there wasn't money to buy it and if people didn't want

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it and if doctors weren't prepared to do it, then that piece of technology wouldn't be used.

So it's more complicated than I think most studies are capable; most empirical studies are capable of dealing with. Okay, so when you have better technology, you generally have better care. Not uniformly, but over the vast span of time we see this to be the case. My example is cataract surgery. There's some evidence that a crude form of cataract surgery; there was literally somebody sticking, putting a stick in your eye; was practiced sometime in the Babylonian Era.

But more concrete evidence, there is some evidence in the 16<sup>th</sup> century of something called 'couching,' which is essentially sticking a fancy stick in your eye. That didn't work too well. Probably wasn't used very often and of course, there wasn't anesthesia at that time. So, you had to really want to do it. In the 60s there's - hundreds of years later, vast improvement in inpatient operation. We'd learned something about infection.

So in the 60s, we're far more capable of dealing with infection. That was a technological improvement, but it was risky. This was the kind of thing that you used a sharp knife, probably sharper than you are likely to find on the streets of Washington any evening, probably a little smaller, but it's the same basic principle. Essentially, because it was so risky,

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very few patients ever got it. It was always reserved for those patients who literally couldn't see out of that eye; often only had one operation. The idea was to extract the lens. After the operation, which was highly risky, they sewed things up and then the patient was held in the hospital room for at least two weeks with sandbags so they wouldn't move.

Very uncomfortable - not so many patients were willing to try it. Those who were willing to try it were absolutely at the end of their ropes. That wasn't that long ago. So then we moved to today and I'm not sure when today started, probably sometime in the last 15 to 20 years. We have a much more sophisticated procedure. Doctors are looking through microscope to make sure that they're cutting exactly in the right place.

They're using more - a sophisticated procedure to take care of the lens. They replaced the lens with something that makes you see better than you ever saw in your life. And even better, if you're a Medicare patient, which only the unfortunate few don't make it to Medicare before this happens, but if you are Medicare patient, they pick you up, give you lunch, zap out an eye; two weeks later, they do the same thing. So it's a food program. The fact is that better technology is generally consistent with more successful results.

If you have something that works better, you generate greater demand. Of course, although the price might be lower on

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a per patient case, you generally generate more spending. There is no guarantee, by the way, that the price will be lower because of the weird way that we price things which was certainly actually not all that well-explained the last time, but I'm going to claim that it was. So, overuse, underuse, misuse - these are the terms that everybody hears.

A great example has to do with treating a coronary disease. This is from a paper by Amitabh Chandra and John Skinner and they classified - actually using another study from somebody else - they classified different kinds of treatment according to their cost effectiveness and their cost. You can see that the way they did the classification, and I am sure anybody could have ample reasons to argue one way or another on any specific intervention, but I think the overall sort of pattern here is interesting that effective low cost treatments were, according to them, accountable for more than half of the mortality decline due to coronary disease between 1980 and 2000.

And of course, they didn't have the guts to say that anything was actually not cost effective, but less cost effective. Probably there wasn't anything that wasn't effective in a sense. The word 'cost,' I think is probably an issue here but you can see that, according to their categorization, the more aggressive treatments: stents, CABGs, cardiac rehab -

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they are much more expensive than aspirin, for example, that they account for maybe 19-percent of the mortality decline.

Now you want to be a little careful about this kind of display because you have to ask yourself something that they didn't ask themselves in the paper which is: What was the condition of the patient? Somebody who really needed a CABG, you could shove a lot of aspirin into their mouth on their way to the morgue. So it's not at all clear. This is, in fact, a kind of residual study. It's not very reliable either.

But it does say something about our use of services and it does imply something about the economic incentives associated with the complicated things. Aspirin? Who makes money off of that? Not even the drug companies. CABGs? Who makes money off of that? You know who they are. So, that's something to think about. Nonetheless, would you turn this down? Would you go back to Marcus Welby's day where they had heard about infection but they basically couldn't do much?

No, of course not, because the fact is that we want all of those things. I'm still sore over it because he hasn't given me the drug that's really going to help me but I'll give you 'til 2 o'clock. Okay, so what about evidence? Can we find out about evidence? Here's the study from Elliott Fisher looking at regional variations in medical spending, and this is an index called the End of Life Expenditure Index.

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So these are Medicare patients at the end of their life. I didn't read the article close enough to know how close to the end of their life they were, but you knew they were. So, pretty close. Look at the distribution of tests and procedures that were done on people close to the end of their life. Lo and behold, what do you see? Very few major procedures, quite a few more minor procedures, but a lot of imaging, tests, evaluation, and management.

That's where the money is for the very sick people. And obviously, that's where the money is for the not very sick people. I mean there's plenty of money in those fancy machines, don't get me wrong, but where is the real throughput? It's in the seemingly ordinary interventions that we're all used to and expect - that's where the money is. Okay. Well everybody says, "Well, let's do some effectiveness research and figure out what we really should be doing and don't do the things we shouldn't be doing."

The only problem is that there are an awful lot of things that we do and there are very few studies looking at what we should be doing. I don't care whether you look at the stimulus funding and you look at the billions of dollars that are going into Picori and other places. The research can't move fast enough, you can't spend enough money, you will never get ahead of it because things that we accept for granted, we do

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without question. Occasionally when we question it such as the on and off again discussion about the blood test for prostate disease, we get a lot of resistance because that's not the way we do it.

So is Effectiveness Research the way it's going to go? The reason for the experior [misspelled?] course is that it's probably more than 90-percent that we are never going to look that. That 10-percent or whatever the percentage is, is the small part - it's the glamorous part. In fact, it's the part that's already heavily regulated. It tends to the drugs and devices first, everything else last. That doesn't strike me looking at the previous chart as being the exactly intelligent way to allocate resources.

If you're going to read it, look at Effectiveness Research. Even worse, this wasn't supposed to be a diatribe against Effectiveness Research but I have always been skeptical. These are highly refined studies and so on, and so it isn't at all clear that they necessarily tell you what would really happen to the average patient in the average setting. That's a problem because that's what you really want to know, the answer to. Is it going to work most of the time rather than under ideal conditions?

Or is it not going to work? Because things that would work under ideal conditions might well not work under normal

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conditions. And of course, let's not forget about the patient because the patient might not be adherent either. And then finally there is the moving target. Professional judgment changes all the time.

Why is that? Well, partly because there are changes in the way you do things. Partly, our experience grows; we see more patients. That experience is accumulated, not necessarily systematically but it is. Our views, our professional views about what to do, changes all the time. So I think Effectiveness Research is interesting. It's going to make a lot of people a lot of money. I don't think it's going to have any substantial impact on how we spend the money. So can we actually spend our money better? I think there is some things we can do. Part of the problem is that, are there anybody in this country who actually pays for what they get?

Yes they do pay for it. Of course they pay a 100-percent for it, but they don't know. They're paying through indirect means. When they go to their doctor, their doctor can't really tell them how much it is going to cost them because the doctor doesn't even know what he's going to get paid. It's all a veil and this brings us back to P&Q, but that's where we have to focus our attention. We also focus our attention, of course, on better information.

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But if you don't know the price, you don't know much of anything. As I said in the previous slide, knowing clinical effect in this doesn't get you half way to knowing whether that's something I want because what you want to know is a value. So there are lots of things we could do. The Medicare program has tried lots of things. They haven't been very successful. They haven't been very successful because it is not the health program; it is a political program and political programs cannot make decisions.

They try, but they can't. I was tied up with the Centers of Excellence project. It was a great project. It worked perfectly and it was shelved. Coverage with evidence development is another great example. It seemed like a good idea at that time. The hard part wasn't setting it up to phase in coverage for something that may or may not work. The hard part is phasing it out. So what else could you do? Well, conservatives talk an awful lot about financial incentives, and I think this is a case where we do need to apply financial incentives to the whole system. So I will get into it, but sensible fee-for-service payment reform in Medicare and premium support could take us a long, long way.

Private insurance, I think, is the more likely place where you are going to see action in this along these lines - along any of these lines. Why? Because although they do

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ultimately report to Congress they don't report directly to Congress, and so there is a possibility of some progress in making hard decisions and try to make them stick.

But I've got to say that I haven't seen much evidence of that. As economic conditions tighten, as business conditions tighten, as the resistance of employers to higher premiums thereby necessitating to keep premiums not so high, necessitating higher and higher deductibles and copayments, I think we are going to see that begin to turnaround. I think we are beginning to see that turnaround among some insurers.

One theory that actually Chandra advances is that why don't we attach differential co-payments to Measures of Effectiveness. That sounds like a great idea until you ask yourself, can you really trust those Measures of Effectiveness? My answer was no, not really. I think it's too individualistic. But sure, the idea of value-based insurance design is sound one and it's being tried but it won't be tried in the Medicare program.

Providers, professional consensus, are actually what drive a lot of things. It's great to see this group of specialty societies recently put out under the banner "Choosing Wisely;" List of things that they strongly urge their practitioners to reconsider whether they really need to do those things - that's a good idea; new business structures that

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provide real financial incentives for physicians to rethink their style of practice - that makes a lot of sense - if we could find the right kinds of structures, I don't think we found them yet.

What about consumers? In the end, what's the consumer? It's a patient. I'm a consumer. If I could find the right thing for me today, I would go out there and buy it. I'd be paying for it with my own money. Chances are and I'd be delighted to do it. So what I'd like to know, what I think all consumers would like to know, is not just what is it going to cost me? A question that can barely be answered today. But also, how is it likely to affect me? That's really hard to get an answer to, and that is really the key to understanding how the technology works.

And then finally, what about expectations? I left that here for consumers, because in the end we don't change our views about what we demand as an absolute minimum. And Rick, I want to assure you it's complete truth immediately. But until we get realistic about those sorts of things, we will not get control over cost. Thank you.

**SUSAN DENTZER:** Thank you very much Joe. So as Joe said, technology as to both supply and demand. One of the things that we know we have an unending supply of right now are

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patients with chronic disease. So Ken, over to you to talk about that.

**KEN THORPE:** Okay, first of all, thanks Ed and others for inviting me. Pleasure to be here on this panel. Great to see everybody that we often don't see all the time. So welcome back to work. I am having a tough time making the transition myself, so I'm delaying this a little bit. I'm going to talk a little bit about another angle of this, but it's really not unrelated to what Joe's talked about as you will see in a minute. It always fascinated me that in healthcare some of the most fundamental big questions get the least amount of attention and study.

So about six or seven years ago, I went back and looked at some of the literature on what do we know from the published data about what's driving the growth in healthcare spending and really one of the last few pieces that I saw was a piece that Joe did. I guess it was 92, 93 Joe Newhouse. Looking at the time period between 1940 to 1990, and if you think about it that was a very different time period than the most recent experience that we have had. The number of uninsured over that time period went from 90-percent to 15-percent.

So clearly the amount of induced spending as our whole system changed over time was roughly related to changes in the structure of insurance and demand. As Joe has just talked about

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innovation, we brought Medicare and Medicaid on, and there's various estimates about what that contributed to the growth in healthcare spending. We had a whole bunch of really important new innovations that fundamentally train how we treat patients, neonatal intensive care units and treatment of low-birth weight babies, treatment for cardiovascular disease and so on.

So it is a very different time period. What I am going to spend my discussion on is really looking at the time period between early 1990s and today. I think the point I'll make is even during that time period, the year-to-year changes in what's driving the growth and spending is somewhat different.

But I'd really want to look at some of the long term drivers here that are more recent. You can decompose this into a lot of different ways. I have looked at this and tried to sort the data into sort of three buckets. Looking at the change in spending linked to the change in the prevalence of treated disease; looking at the change in spending linked to how much we spend to treat a case; and obviously the interactions between the two of those.

If you look at sort of the long term component here, let's say that late 80s to today, about 60-percent of the growth is linked to rising prevalence of treated disease. We'll go into what accounts for that. Some of that is going to be good, I'll argue. Some of it is going to be bad that we can go

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in and potentially do something about. So, just to give you a sense of some of the magnitude of the changes here and you can go down by medical condition and see the prevalence increases.

For each of these conditions, the factors driving the growth, are somewhat different. If you look at the treatment of cholesterol, mental disorders, those have obviously increased very dramatically. Much of that is technology related. We have new approaches for treating patients with cholesterol. We have new medical innovations to treat people with mental disorders that we didn't have 30 and 40 years ago. Diabetes, I'll come back in a minute and talk about that. That's almost all in incidents increase.

That's not really anything that has to do with increased detection. That's largely just more cases of patients with diabetics. This is a particular problem as we will see in the Medicare program. It's one of the key drivers of rising spending in Medicare as rising incidents of diabetes and other related cardiovascular diseases. So you can go down the list and see that there really are enormous increases in problems with treated disease. If you take a step back and say well, what's driving this growth?

Some of it, as I mentioned, is going to be things that we should be happy about. Some of them are going to be things that we shouldn't be happy about. The first one is, as I

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mentioned, diabetes. Our detection rates of diabetes really haven't changed much in the last 20 or 30 years. We're today detecting about 72-percent of total cases of diabetes.

That's gone up from the upper 60s, 10, 15, 20 years ago, but we are not doing a whole lot better in detecting diabetes. The treated prevalence numbers we see for that are really just incidents increases, not detection increases. The second one is obviously somewhat debatable and controversial, but there is no question that over time we changed the definition of disease.

So we've had a change in clinical thresholds for treating different types of conditions, particular cardiovascular disease. I think that most of the studies that I have seen that I've looked at that and think that that's a good thing. That's a more aggressive treatment of cardiovascular risk factors has been a leading cause of declining rates of cardiovascular mortality over the last 20 years. New medical technologies, obviously treatment of mental disorders, and Joe went through that, provide more tools for us to treat patients that we didn't have 30 or 40 years ago.

We're living longer, and so you are going to see some increases in the disease prevalence linked to longevity and changing definitions of disease. If you look at the definition of just something as simple as diabetes, that's changed a

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little bit over time in terms of the clinical blood sugar levels that kick off at a diagnosis of diabetes versus pre-diabetes. One of the things that's very different in this time period that we are looking at is increases in obesity.

If you look at the 1960s, 1970s, 1980s, that whole time period, the share of adults considered obese was about 17-percent. It really didn't change for about 30 years. So, clearly not a contributor over the time period that Joe was looking at to rising healthcare costs. It was just not changed; it was a constant. That's not the case most recently. So if you look at the long term trends here, and hopefully we are stabilizing it a little bit, it's doubled since the mid-1980s.

And if you look at some of the calculations, they're just linking or looking at how much of the growth in spending is due solely to obesity holding technology constant and holding treatment intensity constant. Depending on the time period you want to look at, it accounts for about 7-percent to 10-percent of the rise in spending.

CBOs did an estimate of it and they came up with 8-percent. Of all the things that we can actually quantify to Joe's point, we can't quantify the technology piece but the things that we can try to quantify. It is an important contributor. If you look at Medicare spending, about a third of the growth in Medicare spending over the last decade is linked

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to cardiovascular risk conditions that are in part lifestyle related, diabetes, arthritis, kidney disease, hypertension, and mental disorders.

The thing that's interesting about those particular conditions in the Medicare program is that those are largely conditions that are ambulatory treated with appropriate medication. Unless you botch it up somehow with the exception of kidney disease, you really have nothing to do with inpatient hospitals here. This is really issues dealing with ambulatory care, primary care, medication management. The ultimate irony of that is that traditional fee-for-service Medicare is really the only major payer, unless you are home bound, that has no care coordination.

So it just doesn't do it. We'll tell you have got a problem in your personalized care plan but we don't do have anything available to really engage patients in Medicare to help them manage these conditions. We have done some tabulation to try to sort these out in terms of spending increases over time. As I have mentioned, the share of spending increase linked to disease prevalence versus cost per case does differ over the time period that you are looking at.

The most recent couple of years obviously we are in an economic slowdown, and so we have slower rates of utilization and over the last couple of years, spending per treated case

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are more important explanation of rising healthcare spending. If you go back and look at these long term trends, it really is a disease prevalence increases that are driving it.

But if you try to drill down a little bit more in this and say, "well, if we can look at treatment intensity," meaning how much are we spending to treat a particular case of diabetes or heart disease over time, and how much of this is just due to increases in obesity, again holding technology constant. As I mentioned, about 7-percent to 9-percent is due to obesity alone.

If you look at the 1987 to 2001 time period, about a quarter of the growth in spending is due to increases in the intensity of treatment of how we're engaging and working with patients. Now some of that is due to changes in technology, clinical thresholds for treatment, clinical recommendations for how aggressive we should be treating patients - they're all bottled up into the same bucket here. But treatment intensity is a major component of this as well. If you look at both obesity and treatment intensity, anywhere from 20-percent to 30-percent of the growth is linked to both of those two combined.

So what are some of the challenges here that we face? We know that any given year that obese adults spend about 40-percent more in healthcare and depending on, there is a whole

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range of different estimates of how much is in the base of spending linked to obesity. I think that the last piece I saw was something around 20-percent, 21-percent is due to obesity alone in the base of healthcare spending.

Obviously as a productivity component, we spend a lot of time focusing on the healthcare piece but if you look at the total cost of chronic healthcare conditions. For every buck that we spend on the medical side we're losing about \$4 in productivity, so there is a bigger component to this that's really important.

Let me go back to my Medicare challenge here. In a Medicare program, if you look at age 65 and look at lifetime healthcare expenditures starting at age 65 and if you compare the life time spending of an obese adult versus a normal weight adult, and there is a couple of good models out there that have found these estimates: Anywhere from 20-percent to 40-percent more spending over the course of the life time for an obese adult at age 65 in Medicare.

So the point is, that this is a very different story than smoking. Smoking is a mortality discussion; this is a morbidity discussion, there is not really that huge differential mortality rates linked to obesity. It seems to me if you think about Medicare, there is two opportunities that I think that are important. One is to find ways to change the

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incoming health profile of people coming into the program because there are long term potential savings associated with having a healthier population coming in at age 65.

Let's just go back to the care coordination piece. I am sure Melanie will talk about this and they are doing a great job of trying to build more care coordination into dual eligible's. If you think about the opportunities here to put into place evidence based care coordination interventions. I think in programs like Medicare, they're enormous.

Over the next decade, Medicare is going to spend roughly \$500 billion to \$600 billion on readmissions that we could potentially prevent. So, that digs a question of why don't we build something into the program that is actually effective in doing this. The frustration is that we actually have interventions that are effective. So we have a program that Eric Coleman has developed some time ago out at the University of Colorado Denver that has several randomized trials that shows that we can cut readmission rates by 50-percent to 60-percent.

We have a more intensive advanced practice nurse model that Mary Naylor at Penn has developed that comes up with very similar results. Now that should just be a major component built into fee-for-service Medicare that would accompany this broader wellness package that we built in. So I think that

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there's opportunities here but we got to focus on I think two of the problems that we can actually do something about.

One is preventing and averting disease in the first place and love to have a discussion about some of those opportunities through things like the diabetes prevention program that I've written on; and second is to really build into programs like Medicare, evidence-based components of care coordination that we basically have decades worth of randomized trials that show that they work.

Things like transitional care, medication therapy management, health coaching, having an integrated care coordination model into the primary care practice. So, we know the elements that are effective. I think that we just need to find ways to integrate them and build them into Medicare. So with that, I will keep this short and I really look forward to the discussion.

**SUSAN DENTZER:** Great, well thanks to both of you. So we now have some time for clarifying questions if people want to ask questions specifically of Ken or Joe to draw them out on points they made. We don't want to get into a lot of deep analysis of what they said at this point or debate, but just again clarifying questions. If you do have a question, please introduce yourself briefly by name and affiliation and be sure

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to switch on your mike. So let me take a quick look around. If not, let me ask.

I will take the Moderators Prerogative then to ask one to you Joe. If I look at your slide that was labeled "High Cost of Advancing Technology," this is the one where you label X-Ray machine, et cetera. I look at current technology I see two items mentioned there, surgery robot and treated stent. Both of which recent studies have shown do not materially produce better outcomes for patients.

In fact, with respect to the treated stents, I think Johnson & Johnson's unit stopped making them because they were so clearly not just ineffective but problematic for patients. That underscores that we have a lot of technology out there that either does not produce better outcomes but yet costs a lot more or in fact can be harmful.

Of course, more broadly, the Institute of Medicine tells us about half of all of the medical interventions we engage in, there is no evidence that they work at all. So, I was curious as to why you didn't put even more emphasis on some aspects of technology assessment as being potentially of more actionable solution?

**JOE ANTOS, PH.D.:** Well, I think since everybody believes that I wanted to make the somewhat counterpoint. I'm not completely disagreeing with it, but somewhat counterpoint

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that what we are going to focus on is in fact the treated stent and actually less of the Surgery Robot since that's such a great marketing tool for big hospitals. And people want to believe that somehow putting a machine between the surgeon and their body is necessarily an improvement.

They really would like an improvement there because they think they could be seriously harmed or killed. But the fact is that we do have a tendency especially on stents for example, smaller things. We do have a tendency to look at those. For one reason, it's easier to examine the effect of the stent because it is a purpose. It doesn't have multiple purposes.

It is less dependent on the skill of the physician to place it, for example. There is some skill involved, but it's somewhat more singular product that is more amenable to testing. That I think is maybe the point I am trying to make that we have a tendency to examine the things that are easy to examine and not the things that are really hard to figure out.

And the hardest things to figure out are the things that are standard practice. So yeah, there is some hope for technology assessment. In my view, there is much hope in going from good technology assessment to sound Medicare policy, but there could be plenty of hope going from good technology assessment to good professional stent.

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**SUSAN DENTZER:** Ken, quick question for you. You have used the phrase 'treated prevalence' here a lot suggesting that you are distinguishing between just prevalence and treated prevalence. Obviously, we actually treat people. Can you disaggregate those two pieces? I mean how much of, for example, it's potentially possible? We're giving stents to a lot of people now for high cholesterol and there is a lot of debate about whether that is even the correct set of interventions. So, how much of this is treatment independent of actual prevalence versus treated prevalence?

**KEN THORPE:** Well, you know I am confused. It's not even happy hour so—

**SUSAN DENTZER:** Are you sensitive about these hard issues?

**KEN THORPE:** The phrase for me, "treated prevalence," is to distinguish the fact that we really are only engaging a fraction of patients that have different condition. So if you go back to my diabetes example, 28-percent of people that live with diabetes have not been diagnosed and don't have a medical intervention. So at some point, hopefully they will but at any point in time they're not. So that's the distinction. The other part of it is it's an important issue.

I try to distinguish in the discussion that there are components of prevalence that we could intervene and do

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something about and we want to. So issues around obesity and lifestyle and diet and exercise and things like diabetes that we can reverse the curve on.

There are other components of this where, if you go back to my slide and look at the treatment of cholesterol and hypertension, that are a medical call that says if we are more aggressive at treating those diseases plus we have the new technologies to do it, that it does produce better value; that we are reducing cardiovascular mortality; that we're improving the quality of life and so on.

So I think that's some of the stuff that David Cutler and others have been looking at the impact that Antihypertensives and cholesterol interventions have had are good investments. But those are also part of the discussion here is that we have changed and made a medical decisions and treatment decisions to say if we are more aggressive at treating certain types of cardiovascular risk factors that they do pay off.

**SUSAN DENTZER:** Yes, Brad.

**BRAD STUART, M.D.:** Brad Stuart at Sutter Health, Northern California where we're building Systems of Care coordination for seniors. My question to you is, I am a primary care doc for a third of a century and research as well. All of our discussion, and I am coming from a provider place, is

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focused on the providers. What about preference of patients, particularly seniors, who are in the start top list [misspelled?] near End-of-Life population where our data is showing now that they would prefer not to be patients?

They would like to be comfortable and stable and safe at home. I think we have systems to begin to do that but my question around the data is, we have a lot of studies now on effectiveness. In other words, is the treatment necessary and valuable?

What kind of data do we have on preference where we begin to know whether these treatments are actually wanted or unwanted, which to me is much less controversial than trying to decide what's necessary. You often can't know what's necessary until after you do it and it hasn't worked. It's not controversial to know that people really don't want this stuff and as it turns out, many of them don't.

**KEN THORPE:** Well, it's a great question. As I think about some of these different models of Primary Care and care coordination and to your point about just take Palliative care and giving people options and decisions about the type of care, how aggressive they want care to be towards the end of their life and Lord knows I don't want to bring up that panels. But that's a legitimate discussion that needs to be built into the coding and Medicare.

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It needs to be part and parcel of how families and patients and healthcare providers talk about options. I think that that's a classic example of working with patients to give them options and give them information and to be able to have the time to actually, from a physician standpoint, to talk about that is important. I am seeing more and more interesting Palliative care models come into place.

Hospice, again, is another important component of that. But having the time to have that discussion in a fee-for-service system is a real problem. I mean it's just not built into the coding, it's not built into the amount of time that physicians get to spend on counseling with patients on important decisions like that and it should be built into how we think about doing care coordination and primary care with patients to give them options, and then have the options out there available.

I'll give another example on the other side of this is, if you think about to me the incompleteness of the Medicare along this benefit, we built in a Welcome to Medicare physical, we are going to do a health risk appraisal, we are going to give you a personalized care plan that says you are overweight and pre-diabetic but we don't cover anything to do anything about it. Alright?

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So, I mean if you think about it, and there are programs out there like the Diabetes Prevention Program that the WISE and UnitedHealth Group have put into place that we have shown in the randomized trials, including community-based randomized trials, that they generate a 5-percent to 7-percent weight loss.

So that should be an option. It's built in to the Medicare program. They give people a choice of - Jeez, if I really want to make a difference in terms of changing lifestyle or improving my blood sugar levels, that should be a component of what Medicare covers. So on both extremes, we don't give people a whole lot of options because the way that Medicare covers policy works.

**SUSAN DENTZER:** See, Rick Smith.

**RICK SMITH:** Rick Smith with PhRMA. Question for Ken. Ken, you have referenced several initiatives around the cluster of chronic conditions that you identified as significant cost drivers. Can you speak a little bit to what happens to utilization and outcomes as these interventions take place? How does care change and what does that ultimately add up to in terms of outcomes, cost and so forth?

**KEN THORPE:** Oh yeah, I mean, that's a good question. You can look at the Prevalence Date in terms of how we are treating patients with cardiovascular risk factors and then the

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more important question is, what are we getting from it? Is it worth it? And a reference to David's work on this and others that I think that on balance that the more aggressive treatment of patients with cardiovascular disease is worth it - that we're getting improvements in longevity; we're getting improvements in the quality of life; that those are investments that not only are clinically driven but are generating better outcomes.

So those are sort of parsing my prevalence increases into the two components. Things that are good increases, things that we want to make investments in and should be happy about. That would be a series of them that we have done on statins and cholesterol, and then there is a series of prevalence increases that are bad that we should try to do something to reduce our incident increases linked to lifestyle and diet and exercise and smoking and so on, like diabetes. So, there're different issues and how we think about them I think are very different.

**SUSAN DENTZER:** Tom Miller and is your hand up there?  
Yes, Maria. We will come back to Maria.

**TOM MILLER:** Tom Miller, AEI. Ken, we've gotten quite good and clever at coming up with new names to call chronic conditions that occurred. We can find a technology and be able to throw at it. You have a list of the ones that have had greater treated prevalence. When you do your time series, what

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have we had any reduction in, in terms of treated prevalence? What's going off the list? I know you made great savings on smallpox, I'm sure. But beyond that, is it only an additive key to the keyboard?

**KEN THORPE:** Now, that's a good question. We've broken these into, I guess, we have 260 that we have looked at. I would say most of them are fairly constant. I mean obviously the big ones like heart disease and cancer were getting improvements in. The one that has been the biggest decline, which actually adds to a lot of the cost, is trauma. So the prevalence of trauma cases has gone down fairly substantially. So that's a big reduction but most of these have seen fairly substantial increases over time.

A lot of it, as I've mentioned, has been obesity-related and lot of them are related to these cardiovascular risk factors. The kind of the interesting thing is that if you look at the spending growth in United States going back to the 40s or 50s, I mean it's not that it's a whole lot different. It's been a 2 to 2.5 percentage points above GDP. I think that the factors generating those increases over time have changed.

Obviously you are not out of whack internationally either, but we have seen some differences in what's generating that delta. So if you look at the Medicare patient in 1965 versus today, they're very different. I mean the clinical

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profile is different of the patients. The typical patient driving and spending in Medicare today is overweight 70-year-old, that's a hypertensive diabetic with bad cholesterol, asthma, back problems, pulmonary disease and is depressed. That's the patient, and the problem is that those are all conditions that really require behavior change, engagement, appropriate ambulatory care - medication therapy management - nothing that Medicare does.

**JOE ANTOS, PH.D.:** Let me add something though. This is a pitch for technology. One of the reasons we have more treated prevalence on nearly everything is it's easier to treat. Also, there's the push for so called prevention which means earlier a diagnosis. So, it's a little hard to know where all these fit in but I really do think that the March of Medical progress has contributed considerably to this trend.

**SUSAN DENTZER:** So Mary Ella Payne and then I think Dan Callahan has the hand up as well.

**MARY ELLA PAYNE:** So should we be thinking now more about targeting hotspots or targeting populations or targeting industries? A lot of what we generally talk about is broad policy changes in Medicare and other areas, but certainly the obesity and other risk factors seem to be located in certain parts of the U.S., I would argue. Should we start to focus on those areas and maybe not have across the board sort of

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improvements, but in order to get given limited resources to think about that a little bit more?

**JOE ANTOS, PH.D.:** I'll take it. It's a good question. I'll give you my pitch on the Diabetes Prevention Program. So we have a population of 80 million people nationally that are pre-diabetic. We have a program that we know through 10 years of clinical trial follow-ups that has a cumulative reduction in the incidents of diabetes of 34-percent.

So it works at a point in time and we have a 10-year follow up study that shows it over time we can reduce it. UnitedHealth Group and YMCAs have put these into place now in 25 states. We can reduce weight by 5-percent to 7-percent. We can reduce the incidents of diabetes in a short period of time by 58 and for older population 71-percent. That program to be scaled nationally in the next 12 to 18 months for \$80 million. Not B; M. Why in the world don't we do that out of the Public Health fund?

That's just something that is an investment that we should do. We should build that one simple program in nationally, have it available so the small employers could use it, Medicare patients could be referred to it and exchanges - plans in the exchange could refer patients to this. Now, that's a simple example of something that we should just be doing because we know it works.

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I guess my point in saying that is that, we have a whole variety of interventions that would target these problems that I've talked about, that we have years of data to show that they work. Transitional care models, diabetes prevention program, we need to flip the switch here and get into implementation mode, not pilot project mode. We are not going to pilot project ourselves into a solution here. I mean, we need to sort of take things that we know that work, target them to At-Risk populations and we can make an enormous difference.

**MARY ELLA PAYNE:** You know that was my point. It's not doing more pilots about trying though to get those packages, services you know that works to the people who are at the higher risk in certain parts of the country.

**JOE ANTOS, PH.D.:** Right, I mean I live in the obesity triangle. So I mean if you just take the CDC data on obesity rights over time and looking at changes in Diabetes Prevalence, they're interchangeable charts—

**SUSAN DENTZER:** Trying though to get those packages and services you know that works to the people who are at the highest risk in certain parts of the country, but —

**KEN THORPE:** Yeah, great, I live in the obesity triangle. So I mean, if you just take the CDC data on obesity rates over time, looking at changes in diabetes problems, they're interchangeable charts. They're basically the same

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charts and so, you know, we have things that we can do right now that would make a difference, and it would just need, as I said, flip the switch and focus on implementation, and you can tell from what I'm saying, I have complete pilot fatigue.

Sure, we need more information, and we need to pilot some different projects, but we have so much data on programs that we already know that work, that we should just implement and build into how we do business in the exchanges. If you think about, on the exchange side, something that we're not really talking about, is that in the definition of essential health benefits, we have in-patient, out-patient, the usual services, but also a component certification for plans to be in exchanges for prevention and care coordination.

But what do we mean by that? What are we certifying and asking plans to do in exchanges on prevention and care coordination? Well, geez, there are some really simple things that would make a lot of sense that we would hope plans would do, like transitional care models and [inaudible] space lifestyle and programs like the DPP.

**SUSAN DENTZER:** Alright, Dan Callaghan, and then we'll move on to our reactor panel.

**DAN CALLAGHAN:** I'd just like to raise one issue that has not been touched on and that is, how do we – I'll take Ken's example of the 70 year-old with all of the things wrong.

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We talk a lot about coordinating care. The question is, how do you assess care with multi-organ failure or multi-diseases at the same time? We're very good at doing it at the same time, but if you get a team of physicians together and you're trying to coordinate them, how do they assess the overall work and their interaction?

**KEN THORPE:** I'll put my M.D. hat on for a minute.

Ken, I think this is a great example of why having team based care, and if you look at some of the health systems that do a pretty good job of that. Whether it's, you know, Marshfield Clinic or Geisinger, where you really are building teams that deal with multiple problems and you're really treating patients holistically, is probably the best way to go with this. If you think about, you know, let's take Medicaid, a good example.

Even in Medicaid, when we do care coordination, a lot of the care coordination still segments off care coordination into different buckets. You know, you'll have behavioral healthcare contracted out, pharmacy contracted out, you'll have acute care. You know, dealing with a patient that has all if those problems, so even coordinated care sometimes in Medicaid is not coordinated at all, it's really still fractured, so, to the extent that you, you know, continue to drive this towards payment reforms, that really move us towards team based care that really engages patients with a whole range medical

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problems is probably, I think, our best bet. It's certainly not for fee-for-service Medicare. That's not how the program works at all.

**SUSAN DENTZER:** Thank you. We're now going to move onto a series of short presentations from our reactor panel. These are non-nuclear reactors, but they are nonetheless very energized and will get through their presentations, I know, energetically, so we have time for a break and then a beefy amount of time for discussion. We're going to start with Melanie Bella from the Centers of Medicare and Medicaid Services, who is leading those efforts at care coordination for the dual eligible population. Melanie?

**MELANIE BELLA:** Good morning, thank you, Ed and others, for inviting me to be here today. I was trying to figure out why I was invited and then I, sort of, hit me in the face in a very obvious way, which is, I think dual eligibles are the poster children for high users of technology and high cost. And Bruce and Diane and others I think will get into the statistics around the prevalence of disease, but the fragmentation between the two programs just exacerbates the use of technology and the high costs that are driving the system.

So, I just want to spend a couple of minutes kind of on that beam of what is actionable and talk about a couple of actionable things that we're trying to do at CMS to try to get

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a handle of the opportunity to improve quality and cost for this population. And the first is all about data. Until we understand better this population, the subsets of the population, what's driving their care needs, but the utilization patterns are by very discreet sub-populations, we're not going to be as effective as we can be in developing new models, to improve new care coordinations, to improve transitions, to improve the use of long-term care services.

So there's a few things we're doing in that regard. One is I'm pleased to say that CMS now has an integrated data set, so Medicaid and Medicare are at the person level. It's not 2011 unfortunately, but we're getting there over time and it's really going to help drive our analysis as well as those of others in the room and other interested stakeholders.

The second is that we'll soon be releasing state profiles, so it'll be a state-by-state look at the demographics and the cost and the utilization, the costs, again, from an integrated data set perspective of the individuals who are dually eligible in that state. It's not meant to compare state-to-state because we're not controlling for the differences in the Medicaid program, but again, it'll be useful tool to get out there.

Another thing that we're doing that I think is very relevant to this discussion is looking at, the simplest way to

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look at it is, I think, a pathway analysis. So it's very different if you start on Medicaid and age into Medicare, versus if you start on Medicare and have some sort of functional and financial decline that makes you Medicaid eligible.

And the types of care coordination models of someone who would be, whose care would be improved by care transitions. I mean, all those things are highly dependent on what drove a person to be in the program, what their care needs are, who they trust to get information about those care needs, are very different depending on which end you start with, and so we're doing a lot of work in that area.

And then lastly I'd say, and those of you who are researchers will certainly appreciate, we're making significant enhancements to the CMS chronic condition warehouse so that we now have conditions for, diagnoses for serious mental illness, for alcohol use, for intellectual and developmental disabilities, and if we, again, are going to truly understand the prevalence for chronic disease for this population, by sub-populations, we have to continue to add to those diagnoses that are in the CCW, particularly those that are going to reflect things that Medicare maybe hasn't looked at so much as Medicaid has in the past. So that's a critical part of our effort.

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As part of our effort to work with states in this arena, we've been focused on making sure states have access to Medicare data for care coordination purposes, so we have tried to streamline a process that, while abiding by our privacy and confidentiality rules, allows states access to this data.

We have 22 states that have either received or in the process of receiving parts A and B and 20 states who have received or in the process of receiving part B, and when I talk a little bit about demonstrations, from our perspective, it's critical that states are requesting these data to show us that they have an understanding of their population and they can tailor their interventions and their demonstrations to the needs of those populations and they're very heterogeneous care pathways.

So the next thing I would just mention quickly, along, again, the theme of actionable are demonstrations. And I appreciate Ken's comment about, I think, pilot fatigue. We're getting all sorts of feedback on our demonstrations. One is, we're too big and we're moving too fast, and then we have others telling us, boy, it's about time, and can't you go a little bit quicker?

And so I would certainly understand the pilot fatigue. For this population, we have not yet tested. There is no evidence base for truly integrated, improved coordinated care.

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Particularly that that the bridges that the behavioral health and the long term services and support and the acute and primary. However, there are important components, the Naylor and Coleman models, the diabetes prevention.

We expect to see those things where they are relevant and for those populations in the demonstrations. We have the state based demonstration opportunity and that involves two models. One is a capitated models, on is a menagerie for service model. We have 26 states interested in pursuing one or both of those models at this point. Some states targeting a 2013 implementation date and others targeting a 2014 implementation date.

I do want to emphasize we expect to care models and care teams and care plans that are tailored to the different needs of the populations. And we've not done as good a job of that in the past as we need to. The needs of someone who is the prototypical Medicare patient that Ken described is very different than someone under 65 whose needs are primarily long term care driven, or someone who's in an institution.

And so understanding again all these varieties is a great opportunity for us to test in these new situations. And then I'm very excited, the other demonstration that we're doing is for dual eligible beneficiaries who are in nursing facilities. There are about a million of them in any given

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time. Potentially avoidable hospitalizations is a critical opportunity for improvement here. The churn between hospital and nursing home, largely driven by the misaligned financing of the two programs, is actionable, improvement in both quality and cost.

A CMS study shows that 26-percent of hospitalizations for duals are potentially avoidable. In today's dollars, that's about 8 billion dollars. It's just very poor care for patients obviously, so we have a demonstration going on targeted at beneficiaries and nursing homes, and we're very excited about that.

So in closing, I would just say I couldn't be a bigger fan of trying to develop evidence based models of care coordination and also looking at prevention. An area that we have not yet been able to focus on are the pre-duals. So the folks that 45 to 64, before they're coming onto Medicare, there's a huge opportunity for us to do care coordination or medical homes or care management to improve their utilization and the prevalence and the intensity of the disease when they get on Medicare.

And then the folks on Medicare, there's a lot of things we could be doing to prevent their decline onto Medicaid, and so far the financing and incentives between those two programs haven't supported that work. I'm hopeful that once we kind of

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get through dealing with the 9 million folks who are on the program, we can really shift attention to the pre-duals and doing a much better job of managing, I'd say, the progression of folks to dual eligibility status. So with that I will close and just say thank you again for being part of the panel.

**SUSAN DENTZER:** Thanks very much, Melanie. We're going to turn now to Joe Newhouse. Joe has often asserted that the U.S. is an outlier in health spending. How big an outlier are we really, if we are?

**JOE NEWHOUSE:** Thanks, Susan. This discussion somewhat reminds of Rushomon. How many of you have seen that movie? Not many. So, it's a classic Japanese movie and, basically, presents four different views of the same reality. And I think that's some of what we're hearing here. Now I noticed in the green book that you were handed once you walked in, there's the usual slide, which I'm not going to show you, on page 7, that the U.S. spends a lot more than everybody else, which Susan alluded you to.

What's less well appreciated, although Ken mentioned it in passing on my first slide, is that – how do I advance the slides? Okay, the, what I've done here is look at annual growth rates per person in real healthcare spending over time. So this is almost fifty years and the asterisks are by German – these are the G7, by Germany, Italy and Japan, because there's

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strange things about their numbers, not just that they're different.

Germany has reunification in this period. Italy actually doesn't start until 1988 and the OAC posted that most of that Japanese bulge is in the 1960s when their economy was growing 11-percent per year. But if I look at the other four, the U.S. actually is the highest, but not by a lot. Certainly not by nothing like the levels.

And then I'd like to go on and say when Cory Cello and I just participated in the Medicare trustees 75 year review, which you may think is a waste of time, but we were doing our civic duty, and in projecting 75 years, or even ten for that matter, it's really the growth rates that matter. It's the growth rates that are doing it federal and state and personal budgets.

I just did some, a calculation over the weekend of the Kaiser data on average family premium against median income, 2009 to 2010. That went from 22-percent to 28-percent. So the average premium, that's total cost, that's not out of pocket. So a family premium is now, for the average family insurance policy, 28-percent of median income, which is, I find is somewhat staggering number, so the inference I draw from that is that the rate of cost growth is going to slow down.

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I can't tell you now, but it is. Nothing grows to the sky, say, in the financial markets. So the U.S. and other countries, the other countries are not so different, at the least the UK, France and Canada. Here is the data by time. Ken alluded to these too. I've just arbitrarily broken things since the 40s.

What you see is some variation around that average, but usually something happened in those decades that departed a lot from the average. Medicare and Medicaid, the managed care introduction in the 90s, the recession in the last decade, but what's remarkable to me, and the reason I put this up is to give you some perspective that this issue of cost growth is a common across countries and, B, has been going on for a very long time.

So what I take from that is that, while the US certainly spends a lot more than everybody else, that must be something that's U.S. specific, but the growth issue must be something that's common to countries and to decades. Now I take Ken's point that things may have changed over time in terms of what's driving this, but I still think it's important to keep in mind that this is not – whatever is happening here is not necessarily a result of things that are specific to the U.S., which we naturally tend to get wrapped up in.

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The second point I wanted to make, which has also been alluded to, is we've actually gotten something out of all of this, growth and spending. You know, again, the usual line is we spend a lot more than everybody else and we trail the life expectancy, but if I look at the change in spending against the change the life expectancy, never-mind morbidity, things like cataracts and hip replacements, it's a remarkable change. Just since 1970, which looking around the room, most of us are old enough to remember.

You know, my students can't tell the difference between 1970 and 1870, but I can certainly tell the difference. So what's quite remarkable is that life expectancy is, like a lot of other things, subject to diminishing returns. It gets harder and harder to get an increment. And we grew seven years, which is a major achievement, I think, in my mind, as did other countries.

So again, this is going on everywhere. Now one can say, how much is this attributable to medical care? Well, this is kind of a busy slide projected up there. This is a graph from a study of several trials; it's in your handout. Or epidemiologic studies, I'm sorry. About what accounted for the change in coronary heart disease? And the darker bar on the left is what these authors attributed to treatment; these are in various countries, not just in the U.S.

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And the lighter bar are what's attributed to what are called risk factors, but the risk factor bar includes better control of hyper tension and better control of cholesterol, as well as the fallen smoky, which are the three big things, in the light part there. But the dark part is the higher tech treatments, and it's the decline of coronary heart disease is the almost all the decline in the gain in life expectancy these years.

So we actually did get something for all of this. Now that said, I think that what Joe and Ken have put forward about what to do makes a great deal of sense, and what Melanie has said makes a great deal of sense. But I would leave you with the notion that this is a rather, a very pervasive and long-standing issue about cost. Something is going to make it slow down because it cannot continue at historical rates, but how that will happen, I am not wise enough to know.

**SUSAN DENTZER:** Great, thanks so much, Joe. We're going to move now to Jim Fasules of the American College of Cardiology, and Jim, this is your chance to explain to us why all of this spending on cardiovascular disease interventions has been entirely worth it.

**JIM FASULES, M.D.:** I hope so. I want to thank Ed and I want to thank Mary Ellen, because you're probably as much responsible for me being here as anybody else, but I don't know

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if that's good, Mary Ellen, till after the comments, okay?  
Well, I guess we picked cardiovascular disease as the example, or the model of chronic disease here. Let me just say that I would also go into that and go into the data and take the opportunity to say that what a disease specific association can do that's actionable in what we've been talking about.

Right off the bat, one thing we haven't talked about, cardiovascular disease also has an effect on the economy. A net loss to productivity from anywhere to 300 to 400 billion dollars a year in lost productivity. Also, though from Dr. Newhouse's slides, in the last decade, we've had a 30-percent reduction in mortality from cardiovascular disease, probably from the treatment.

And I'd just say, from the data aspects, we have kind of be careful of what we pick, what population that we looked at because one slide looked at stenting versus medical maximum management and that really is in the elective case, we're not talking about doing stents in the acute MI case. That's well proven to be very effective and a little bit about the, also the stents, whether the drug alluding or bare metal, if you want to look at outcome as mortality, there's probably not a big difference.

If you want to look at outcome as whether you need to have another procedure, then there is a difference. So what

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I'm getting at is the data and getting the data also to the physicians is very important. And one of the things that we've done over the past 35 years is to develop guidelines that look at science and try to translate that science into what you should be doing.

And more recently actually taking those guidelines and developing what's called appropriate use criteria and we use those appropriate use criteria out of five recommendations and then choosing wisely, which are even mentioned. With those appropriate use criteria, you can actually set up some continuous quality improvement aspects with the physician.

And by giving the physician their data on what they're actually doing and what they see how they're doing against the norms and whether they're using the procedures that the investigations, the imaging appropriately, and you can actually get them to improve their care. We found that just giving a dashboard of how the physician ranks against their fellows in their practice in the community, in the region and nationally, as far as where they score for instance on nuclear studies for their appropriate use criteria, it will decrease their use about 15 - 20-percent.

Getting down into their range, we think it should be about 8-percent of what we would label as inappropriate use. Now of course you can't tell a physician not to do something

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because it's still, it's been mentioned, medicine is still a part as much as a science, but practicing the best science that you can, getting the data to the physician so they can make a better decision, part of that also with the appropriate criteria and choosing wisely is also the interaction with the patient.

Getting them to understand, it's already been mentioned, the shared decision making, where you're discussing with them ahead of time the options, so take coronary artery disease in an elective situation, you can have maximum medical management. You could have CABG or coronary bypass or you could have a stent in place, and each, giving that a tool for the physician to look and see which is the best that this patient fits in, and then see what the patient wants as well. And helping make that decision.

So I think that's how we've been looking at how do we decrease the curve. Now, I would say that actually, we've discussed the cholesterol and management of coronary artery risk disease, disease risk factors and management in California, we've looked at the data on both coronary artery bypass and stenting for coronary artery disease and it's gone down all in the last five years in California, and if you look at the CMS data, there's been a 10-percent reduction in last year, or actually the year before the last year, for both CABGs

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and stenting and actually reduction also in imaging, cardiac imaging.

And I think that's actually speaks towards the addressing of the risk factors. I'm glad everyone's looking at obesity, and Mary Ellen knows that I've worked on obesity when I was in practice in Arkansas. It gets to be quite hard, we were actually on the commission that set up measuring the BMI on the kids at the school. You could imagine when you had to do it so no one else knew what a BMI and sending them home and things, but we had a 33-percent prevalence of obesity in school age kids.

And by doing the measurements and taking the vending machines out of school, etcetera, we at least leveled that. Now we didn't impact the 48-percent smoking prevalence, or tobacco use, I guess it was as much dipping as it was smoking. The other thing is that when you do action on data and one program I'll mention is the door to balloon, which means when a patient with acute MI hits the ER, the door to the ER until they're actually blowing up the balloon in the artery to open up the vessel, we know that if you do that under 90 minutes, you save heart muscle and as a result, you don't have as much congestive heart failure, so you decrease the morbidity, the subsequent morbidity.

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Now we went from about a 50-percent, 60-percent in the ERs to about 90-percent of all ERs, hitting that and in hospitals hitting that number. And that probably saves two to three days of hospitalization, and also puts the patient back to work after three to five days as opposed to what we've mentioned when Eisenhower had his heart attack and was admitted to Fitzsimmons Army Hospital and he sat at the army hospital with a little heparin and a little morphine and a lot of prayer and they actually have his mortalized bed pan in the room there, but we won't go into that either.

And they have a little room for where he was at the hospital there now. But where did the savings go? The cardiologists didn't get paid anymore. So here's the program that actually had savings and we still haven't figured out whether the hospital got them through the DRG or the insured got them.

So I think whatever we do these models, we have to look at what Joe said, is that there has to be some incentives built-in so that if you're doing this extra stuff and paying for this data, and finally, the other thing we have is the registries that we can actually track the outcomes, maybe when the electronic health record to where it should be so we can do it that way, but data with disease specific procedure with specific outcomes over longitudinal time and that really tells

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us someone mentioned that the trials, they tend to be like most of us up here, middle aged, bald, white males, not all of us, but we are the obviously the trial people, the people in the trial and we don't reflect the makeup of society, but with the registry you see what we're doing and how we're treating.

So data, data specific, give the data to the physicians so the physician can add on it. And I would echo what they said with the greater physician and patient interaction with shared decision making. Thank you.

**SUSAN DENTZER:** Great. Thank you, Jim. So, Diane Roland, in your capacity, both at Kaiser Family Foundation as well as at [misspelled?] MagPack, you've done a lot thinking about these high cost patients and some of the challenges to delivering coordinated care and improving health outcomes and lowering the costs, so tell us about that thinking.

**DIANE ROLAND:** Thank you, Susan. Well, I always come to these forums and we talk a lot about the Medicare program and sometimes we talk about private insurance and we don't always, when we talk about healthcare costs, bring the Medicaid program into perspective. So I just wanted to remind us about why Medicaid takes care of a lot of people with chronic illness and why it spends a lot of its resources on that population, and of course, this is our most classic slide showing that one in four beneficiaries in the Medicaid program are disabled and

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elderly, but they count for 2/3 of the spending and a large reason for that, of course, is that there is a lot of long term care expenditure on behalf of those populations.

But let's focus for just one minute on that under 65 disability population for Medicaid and we like to talk these days a lot, as Melanie mentioned, about the dual eligible population, but there are 9 million people with disabilities on Medicaid who are not elderly and most of those people are not dual eligibles, only two million are dual eligibles.

So one of the real challenges in the program, and Ken alluded to it, is to get better coordinated care, better services to the disability population for which Medicaid hath whole responsibility and where it does have a range of services, care coordination, case management are actually part of the Medicaid benefit package and could be much more effectively used on that population with disabilities. And this is a slide that, of course, we're used to see in every part of our healthcare system.

There's only a few people who account for the majority of any spending and in Medicaid, the top 5-percent really account for a substantial share of that spending and the few people there that are children and adults are relatively small, though they are high costs, that really there is largely driven by the disability population. When we think about the disabled

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on Medicaid, we have to remember that they include a substantial share of the population with severe mental illness and it's often when you look at who is the high cost beneficiary, it's the combination of one or another of the disabling conditions combined with mental illness.

And so a diabetic, I think, can, they should look at this with someone with diabetes who is being treated with mental illness is much higher cost and is much less likely will follow the treatment protocols than someone who is just a diabetic.

So that is a real challenge, especially as Ken even alluded to, much of the Medicaid care coordination through managed care carves out mental health and manages it totally separately and now much of the drug cost is also carved out in many places so that you really don't have the integration for that disability population that could help.

But we are focused increasingly today the share of Medicaid spending that goes for the dual eligible population and as you see from this slide that there are about 15-percent of total Medicaid enrollment are people who have both Medicaid and Medicare coverage, but – and they account for 38-percent of overall spending and a huge part of that is long-term care services, but I'd like to point out that really if you're trying to manage that low income disabled population, there's

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another 10-percent of the Medicaid population that are disabled and few non-Medicare eligible aged that account for another 28-percent spending.

So I would say within the Medicaid program, we really need to look at how to really better manage and actually, there's an ability in Medicaid to do more on the preventive side, more on preventive services, more sending people to some of the kind of treatment programs, like the diabetes management program there, so the opportunity within Medicaid is broader.

And finally though if we look at the people who are dual eligibles, they really have a substantial share of chronic illnesses, 55-percent of three or more. But when I look at that, I also think, well, a lot of Medicare beneficiaries have very similar levels of functional impairment, I mean, it's different, but it's not so substantially different on chronic illness. It really involves really thinking about how you manage cognitively and mentally impaired, because that's the biggest difference between the dual eligible population for the Medicare beneficiaries occurs.

So in conclusion, we're really looking at Melanie's alluded to being able to put together Medicare and Medicaid spending, so in this analysis that we did with the Urban Institute, we looked at, within the dual eligible population, are there some who are higher spenders? And some who are

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lower? And we found interestingly enough, that if you look at the top 10-percent of Medicare spenders and the top 10-percent of Medicaid spenders, they're actually somewhat different people even though they're both dual eligibles.

And only about 100,000 people fall into the category of being a high spender in both Medicare and Medicaid, and that's largely because as we need to look forward at different ways to look at these populations, the subgroup analysis which Melanie alluded to was so critical because here you see that the top spenders in Medicare are really top spenders because of their acute care, utilization and those are services that Medicare can and should be able to better control, whereas the top spenders that end up on Medicaid, are often in nursing facilities and are also people who are using long-term care services in the community.

And they actually spend a little less on acute care because their big spending is on long-term care. So, in conclusion, I think as we look at and try to figure out how to better manage both technology and where there's not a lot of it on the long-term care side, so most of the technology control would come in looking at the acute care services, we need to also think about how to manage different types of chronically ill patients and how the two programs can either work together better or work better within each program for the chronically

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ill and I think that's where we will see better outcomes and lower costs if we can really zoom in on the disability populations and the difference by subgroup. Thanks.

**SUSAN DENTZER:** Thanks so much. Well, Bruce Chernof of SCAN Foundation, you've also been thinking a lot about the same group that we've been discussing, with the rising prevalence of chronic disease and the aged and the costs attended those. What else do we need to know about this population?

**BRUCE CHURNOFF:** Well, thank you, Susan, I really want to pick up on where Diane left off. I think those last couple of slides are incredibly important in our thinking here. As we wait for the slides to come up, almost there, folks, that looks good, terrific, so as I begin my presentation, I wanted to start in kind of a similar place, which is that you have to really look at the folks who are getting care and what their needs are and that really helps us think about targeting and building better programs.

And I think that building off this notion that the Medicare and Medicaid high spenders are different is an critically important thing for everybody to take away today. And my first slide which picks up on that point is that those with chronic conditions, that's only half the battle, those with chronic conditions and functional limitations together

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really drive a lot more of the high cost in Medicare spending and it we'll come to why that is in a second.

So chronic conditions that are really important, we spent a lot of time talking today about people and their diseases. Being defined by your disease, well, the reality is that function is an incredibly important piece of this. Your ability not only to care for yourself in a medical context, but to care for yourself in a personal context. And when you start to factor in this notion of function.

Function in the way you live your life, not the way you live your medical life, I want to pick up on something that Joe said at the very beginning and turn it on its head. Consumers are patients in waiting. Patients are people in waiting.

So trying to get back to the place where most people, even those people who are chronically ill, even those people who have cognitive impairments or serious mental, chronic mental illness, they're still people most of the time, they still spend most of their time out and about in the world and the world is not defined by hospital beds, ADPR functions, doctors' offices or call triage centers, and so thinking about the role that function plays in disease and the way that function plays a role in people's lives is incredibly important if we're going to look at how to build effective programs and target appropriately.

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And this chart simply goes on to say that when you add in functional impairments regardless of the number of chronic conditions, functional impairments is a really important cost driver in the lives of those with chronic illness, regardless of the number of chronic conditions that they have. Again, sort of echoing off of Diane's point, which is how do Medicare and Medicaid hold hands?

I know why you're here, because it's this, it's this slide. And who are the duals, who are the pre=duals? And what this slide starts to raise is this whole issue of the pre=duals, what does a good duals program look like? So when you look at individuals who have chronic illnesses and substantial functional limitations. Half of them are duals and roughly half of them are not, so these are folks who run the risk of spending down because their medical problems get them by the tail and becoming duals.

And I think in an environment where as we watch boomers start their retirement, we see folks with fewer financial resources than they might have had earlier on, this becomes a critical problem and a cost driver over the next 10 or 15 years for us. So when we in the SCAN Foundation start to talk with folks about what they really want, we decided that we would do almost twenty focus groups across the country last year and then a series of polls, and what we did was choose to talk with

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individuals who are 45 to 65 and really in a care-giving role for those who are 65 plus who are either care giving and care receiving.

And this represents a word cloud that just sort of looks at the most important language that folks used. And I think it's really important that we look at this because these are all individuals who could exquisitely describe either the care-giving or the care-receiving process, and, you know, I'm a general internist by training, I love the medical system as much as the next guy, but I would offer to you that there's very little medical stuff on this slide.

And with all due respect a lot of the great programs we've built, you don't see this riddled with disease management, palliative care, hospice. It kind of goes back to my earlier point which is function is incredibly important and individuals define themselves by the function they retain. And if you really look at the words that are up there like community and independent.

I mean, that's how people think of themselves, and so as we start to think about the kinds of solutions that we want, where does technology fit in? Why is this a technology talk? I want to leave you with a few points. And I the points really are that you have to really ask what's the problem that we're trying to solve here?

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So, there's very little evidence picking up on one of the earlier points that surgical robots add much value, so that the reality is that surgical robots, at least this point in time with the data that's available, solving marketing problem for hospitals, so if you're in a competitive environment, it's good to say you have a robot, and my friends who are surgeons love them, so it actually is, in kind of keeping your medical staff and in fact that's a different problem.

Solving a marketing problem is way different than solving a clinical care or care coordination problem, and so when we start to look at the population that has substantial medical problems, but substantial functional limitations, thinking carefully then about the problem you're trying to solve is key and it really may be that it's more of a low tech solve that we're looking at. So what's the role of the telephone and the pieces of technology that do work where there is evidence?

So things like remote patient monitoring and medicine optimization, those are places where a little bit of technology, a small investment can go a long way. So that's take home number one, so if we're going to introduce technology, what is the problem we're trying to solve with it? The second thing about technology is in this environment, in

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the environment that Diane described and what I'm trying to build on, technology is not an end to end solution.

Technology rarely solves any problems in the seriously chronically ill, functionally limited person's life. It is a tactic, not a strategy. So at the end of the day to just introduce a piece of technology is actually only going to get you costs and actually maybe more risks than benefits.

Most older individuals when they get sent home from a complicated stay get technology. The DME provider comes out and drops something off and, you know, if there isn't a substantial and robust care coordination plan there, whether it's being driven by the family or the healthcare system or others, that technology might bring more risk than benefit, so it kind of gets to the point that technology without a good care coordination plan, it is a questionable value.

I think that as we build systems and really Melanie a we think about the work that you're doing in the care coordination office, it's not just about the Medicare model of care in that sort of nice model of care way we like to think about it. It is the model of care coordination and the person centered care coordination that is going to be at issue here and so if you look at the states that are proposing, we would encourage you to look hard not just at the plan for the pills and the vats and the ins and outs of the nursing comp, but what

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is the plan of care that really supports people's goals towards retaining the function they have even if they have serious illness or have had some functional loss.

Now my last point thinking about one of the other comments in the audience is this issue of targeting. Targeting is really, really, really important. And you're not going to solve, and again Diane's slides really hint at this, for the high spending Medicare population, medically oriented solves you're probably going to take you a long way, and the really nice article that was published in Health Affairs that covered some of these data, sort of make the observation, that's the place where a medical home may make a lot of sense because you have folks with lots of doctors and nurses and pharmacists and others and kind of coordination the medical cats is half the battle, so that's a really good place to start, but for the Medicaid population where the needs may be more functional and community based, the model of care may look very different.

And the medical home may not be the solution because the problem with the medical home is, you know, we're glad to talk to you in a medical contest or come right in, we have a same day appointment, but for somebody's needs who may be functional and being drawn into the medical system, being medicalized may not be the solution. So we really encourage that technology be used in a targeted fashion. And what is the

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problem you're trying to solve. Are we really looking to solve a medical problem or a functional problem? Thanks.

**SUSAN DENTZER:** Thanks very much, Bruce. And now the Susan Reinhardt, now the Susan that we know who the chronically ill are, that their needs are all the same, and we've talked about consumer engagement or patient engagement or person engagement of shared decision-making. How do we bring all of those things together?

**SUSAN REINHARD:** Thanks, Susan. I think that you left the best for last because you want a patient perspective, which I'm happy to try to bring to this discussion. Can you hear? Is this on? Okay, so what I really wanted to talk about is this idea that I know Ken does such a great job, and I love his work, talking about the need to better patient and family self-management and the need for tools for that.

So, as we talk about who are the chronically ill, how they're spending their dollars, the technology that is certainly has to be used by the patient and family; what are the patients telling us in any model that we might develop or use? So, a couple of years ago, we, at the Public Policy Institute at AARP, conducted a national survey of both patients and family caregivers, and these were people with multiple chronic conditions, who had experience transition so that's the focus of this work. And we talked about what their experience

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was, what their concerns were, and just to cut to the chase, many of these patients and caregivers talked about poor communication.

So, as we're talking about the technology and the use of patient self-management tools, many of them didn't know that they even existed. So here's some of the data that I just wanted to show you that I need as the challenges, or what, at the end of the day, we have to confront, which is in one in four lack confidence in the healthcare system. They may love their doctor or their nurse practitioner, but the system is very overwhelming to them.

We know from other literature that the average person on Medicare has two primary care physicians, and five specialists across four different practice settings, so that's a little, a lot to take on, and to have some confidence that this is all going to work together. 30-percent that said as they went to visit their doc, usually their doctor, that there wasn't enough information there to even have a conversation. Family caregivers felt particularly that. 21-percent said that providers do not talk to each other, and this is really where it gets to be very tricky.

We talk about adherence, how important it is for patients to adhere to their Medicaid medical regimen, but they get conflicting information. One in four is saying they get

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different information from two more clinicians, and that they feel their own health is suffering because of that. Now this is the one that really got me when I saw this. You know, 27-percent said that they admitted, this is an admission, on a survey where you usually you don't want to admit things that you're doing.

These folks are saying that they had not done something that was recommended by a healthcare professional, like get a prescription, so in other words, they were non-adherent. Most of them, 32-percent said they didn't agree with what was being told. Now we need much more work and maybe some of this room know if there's more work on this, and I certainly want to drill down into this, but it's a serious problem.

We know, for example, adherence, more than 30 years of research that I've seen on community dwelling elders, and prescriptions for them, about 25-percent for them are inappropriate for them to begin with, and we know that poly pharmacy is a huge deal, so my argument for years has been maybe it's a good thing that many of these people; non-adherent. They may be saving their own lives.

So, I think whatever we do, we've got to talk about this in a way that makes sense to people. We also don't talk, I didn't hear anybody talk about health literacy, for example. And a few years ago, that was really hot and I think we've got

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to come back to the hot health literacy issue. I remember one of the cases, I think it was Pfizer study that looked at this, was a woman who, this isn't necessarily a chronic care condition, but a woman who was taking care of her child that had an ear infection and kept coming back and the ear infection was getting worse and worse.

And it was a liquid antibiotic, which she was putting in the ear instead of the mouth, because nobody showed her. She figured, ear infection, you know, put the medication in that. We also know from the work on hot spots, for example, in Camden, there was a gentleman there, many of you know this particular case. I think it's very telling, a person with diabetes who kept coming back into the ER, but there was a certain pattern and what's going on.

And finally someone said, well, let me see you give your insulin. Now why that wasn't done years before is beyond me, but that's the nurse in me I suppose. But what he was doing is he was putting the syringe, he had the bottle on the table, he was putting the syringe in and pulling up, instead of flipping the bottle. So, in other words, in the beginning of the prescription, he was probably getting the insulin he needed, but as the insulin, you know, as he kept doing it, he was just getting air and injecting air.

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So, it was like a big revelation that we know how to manage this person's condition. So this to me is getting into a health workforce issue, as well as healthcare delivery. Are we giving anticipatory guidance, which used to be fundamental to the art and science of healthcare. We keep talking about the technology, but there's an art here very deeply involved in communication and culture and outside of hospitals, what goes on, so we used to do anticipatory, like, you're going to find, this is going to happen, that when this happens, this is what you should be doing and we also used to do what was known as teach-back.

So, let me tell you how to do it and show me how you're going to be doing it. These are really basic interventions, Ken, I know you're talking about, these are basic skills that seem to have been lost. We did a focus group with caregivers about a year ago, these were diverse caregivers. And this is not uncommon, this is a gentleman, federal worker, pretty high level federal worker for a number of years, retired, went to take his mother home, he is a caregiver, went to take her home from the hospital and they said he's going to have to give these injections.

Nobody showed him how to give and injection. He's thought, okay, I'm just going to go home. He started, they were abdominal, they must've been Heparin or something, right?

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So, he goes home and starts giving this, bruising the whole body, not knowing what he's doing, and wound up taking him back to the hospital, in which case, the healthcare team in the emergency room said, what have you been doing to your father?

This is the experience of family caregivers. Well, it might've been good if you show me how to do this. So, there's a lot going on, I think with trying to get to that point where we're talking about confident, knowledgeable, skilled people who can be engaged, but they're got to understand what's happening to themselves so that they can do it.

**SUSAN DENTZER:** Well, with that, miraculously, we have ended this part of the program almost exactly on time. So let's take advantage of that and get started and go to our break and then we'll come back to a very vigorous discussion where we'll try to knit all these perspectives together and get to some more discussion about actionable solution. So enjoy the coffee break and see you back here in 15 minutes, 10 Okay, 10 minutes.

[END RECORDING]

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**Health Care Costs the Role of Technology and Chronic  
Conditions - Part 2  
Alliance for Health Reform  
May 29, 2012**

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[START RECORDING]

**SUSAN REINHARD:** Well welcome back everybody. We're now going to move ahead and engage in some brisk discussion, exchange of views. Hopefully again gravitate towards some actionable solutions that could make a difference in the rate of health costs, health spending growth and still get the other things that we want out of health care. So just to briefly recap what we've heard so far this morning.

First of all we heard from Joe Antos that technology is a factor both in terms of the supply of and demand for it. There has been some discussion about whether technology can directly be measured as a contributor to health costs. Often it's not and it's treated, as he said, a residual. It's the "I don't know" factor. If I can't explain it for other reasons, I call it technology.

Nonetheless as he pointed out we can clearly see the role of technology, again, a number of those historical examples of how technology has evolved over time. He offered a menu of some options. Some of which he thought had some possible workability attached to them and others which he was a little dubious about. One of those was compared to Fechner's research but that, notwithstanding, there's a lot that we can do even within some of the constraints that exist. For example, in terms of the Medicare program, he mentioned

coverage with evidence development notwithstanding the fact that Medicare is, as he said, a political program.

Some of these changes could be made or some of these tools could be used more effectively than they are now. And that there at least is some prospect of reining in some aspect of technology driven health spending growth that we don't want and don't need.

We then heard from Ken Thorpe about how it now looks as if 60-percent of the spending growth over the last couple of decades has been attributable to the growing treated prevalence of chronic disease. Much of this, as he said, is driven by rising obesity, whether it's diabetes or cardiovascular disease or other conditions that are linked to diabetes.

He spent a good amount of time talking about some of the problems that we've encountered with respect to these populations. Lack of care coordination, lack of use of interventions that we know work. He mentioned the diabetes prevention program and substantial evidence we have that loss of five to seven percent of body weight can halt progression of pre-diabetes to diabetes. And really, as he said, it should be a rather low cost intervention that can be rolled out rather broadly.

That plus care coordination, in many respects, he mentioned as a real force that could arrest some of the health

spending growth that has been attributed to those causes. We then heard from our reactors in sequence. Melanie Bella first talking about the dual eligible's who are in her view the poster children for this mix of chronic disease technology and costs.

And we heard, of course, about the number of pilots that CMS has underway now to look for ways to improve the care of those individuals. Decrease the churn back and forth between hospitals and nursing homes, et cetera and reduced rate of costs there.

We heard from Joe Newhouse that the problem of rising growth in health spending, those growth rates really is a problem that is ubiquitous across the world. And that notwithstanding the fact the U.S. has a higher level, the real issue is this rate of growth of cost. However, as he mentioned nothing grows to the sky. Joe was reminded of Herb Stein's famous comment things that cannot go on forever will stop. And you mentioned that we are probably going to halt this dramatic rates of growth and health spending.

You just don't know exactly how. We'd love to hear you perhaps address whether maybe we are in the midst of that stopping now with consumer directed health plans and higher deductible health plans and people not being able to afford



care and all of the other things that we know are a factor currently.

We heard from Jim Fasules of the American College of Cardiology about the beneficial aspects, really of a lot of the technology that we have adopted with respect to cardiovascular disease. Particularly as evident in the 30-percent reduction in mortality from cardiovascular disease just in the last decade.

Nonetheless as he pointed out there are things going on in cardiovascular care that shouldn't be done or done excessively. That led to the ACC's recommendations as part of the choosing wisely campaign. The five interventions not to allow your physician to suggest that you have. And as he noted that coupled with a lot of quality improvement efforts under way at various institutions where improving the quality of cardiovascular care and perhaps reducing some of the unnecessary care driven by certain technologies.

We heard from Dianne Roland about the very important fact that the high spenders in the Medicare program are different from the high spenders in the Medicaid program. Which is a recipe for developing a much more nuanced understanding about how to restrain excess costs and those two pockets of the population.

We heard from Bruce Chernof again much on that same theme that half of the Medicare enrollees with chronic

conditions also have functional imitations and half of them are dual eligible's but half are not. And we have to be very mindful, he said, of the problem that we're trying to solve. The problem as many patients see it is that they lack all of those words that he put up in his wonderful word cloud. They're not spending a lot of time thinking about how to get access to surgical robots. They're spending more time thinking about how to have independent dignified existence independent of as many healthcare providers as possible very often.

And then we heard from Susan Reinhard that patients and caregivers sense that a lot of the issues that they face in healthcare is due to factors such as poor communication. They don't feel that they are empowered sufficiently often to make decisions with their healthcare providers. They're also clearly lacking in health literacy. She gave a number of examples underscoring that. And that they too would very much like to engage in much more constructive dialog with their healthcare providers about how to have the care systems that they really want and that deliver on some of those wonderful words that Bruce mentioned in his world cloud.

So with that the floor is open now for greater discussion about how we move forward. Knit some of these issues together and continue to work on actionable solutions to press forward.

Joe did you want to answer the question I just briefly tossed out at you before we get going.

**JOE NEWHOUSE:** Sure. Well I would distinguish again between the level of costs and the growth rate of costs or this is the phrase that was fashionable a while back but I haven't heard a lot lately "bend the curve" on growth rates. So there's a lot of evidence that higher cost sharing, consumer directed health plans will reduce the level. There is not much evidence, if any, about growth rates. There's some evidence that the supply side interventions we're throwing out there will affect levels. They could affect growth rates. I could make a theoretical case, say well I don't think there is much evidence on that.

So I don't want to make that sound terribly negative, because at a minimum even if one just changes the level it buys time and frees up resources for other activities.

But since I think the growth rate is the issue exactly how to attack the growth rate. I think we're still doing a lot of trial and error.

**SUSAN REINHARD:** Okay.

**JOE NEWHOUSE:** That will be fodder for future health affairs articles.

**SUSAN REINHARD:** Yes indeed. Indeed. David Nexon.

**DAVID NEXON:** Just to sort of follow up on your question to Joe. I mean I do that that the understanding the differences between the sides is really interesting that we have far in away the highest actual level but a growth rate that is similar to other societies.

But in terms of a policy prescription, I'm not sure that there is quite as clear dichotomy. I mean if you can knock one percent off the level, for example, by reducing chronic disease or improving care coordination for the next 20 years, one percent a year then you cut the growth rate essentially one percent for the next 20 years as well. I'm not sure that from a policy point of view that distinction is entirely as important as it may be in terms of a scientific understanding the differences point of view.

**JOE NEWHOUSE:** I agree with that. That's what I meant by buying time and why I said I agreed with the prescriptions that Ken had put out about interventions. It's certainly worthwhile but I think the framework is to think about what interventions would change the rate of growth. It's not really something advice not to do something that we know will change the level.

**SUSAN REINHARD:** Yes Julie.

**CORI UCCELLO:** I'm Cori Uccello from the American Academy of Actuaries. So we talked a little bit about this

last month when we held this and this was something we actually talked about in our medical technical panel meetings. This level versus growth issue and we might be asking too much to say that something has a permanent long-term reduction in growth in thinking more along the lines of well there is going to be a series of shorter term reductions that when taken together will bend the curve.

So you know thinking about, we can't expect one thing to have a permanent long-term change of things and so how do we think about constantly evolving and moving forward with new changes all the time.

**SUSAN REINHARD:** So Stu?

**STU:** Let me go a little further than David and Corie just went. I'm not sure there is really a real distinction at all between level and growth rate because to say there is means there is some kind of mechanism that generates a growth rate in health spending. And I'm not sure there is. I think a growth and health spending just means a change in the level from one year to the next. So if you go back to what Don Berwick's been talking about lately, these wedges that what you get, what increases health spending is a bunch of decisions that are made every day and then they get made again the next day and the next day and the next day.

So there is not really a process that you can identify to kind of target the growth rate separately from the level of health spending. You need to look at the level health spending and address what's in there that you can then not have more of unnecessarily.

So I'm not sure that it leads us to a productive set of policies to try and separate those two things too much.

**JOE NEWHOUSE:** Actually I think there are mechanisms but the point – I think the reason to distinguished level and growth is that once you've gotten out inefficiencies and waste you've done it. And then you're back with some steady state rate of growth. So yes to David Nexon's point I can save one percent a year but, for example, I could do that by raising the deductible. But at some point it gets ridiculous. It doesn't serve the purpose of risk sharing.

Or I could do it by putting more risk on providers but once I've got a maximal risk on providers, I've done that. My two colleagues at CMS and I published a piece that is in your book on mechanisms to go to Stuart's point on mechanics and we talked about income changes over time, which are certainly common across the developed countries.

And we, this probably goes to Joe Antos's talk. We thought that accounted for 29 to 43 percent of the change in growth. And we thought that interacted with the technology,

again to the two Joe Antos's point. That interaction was another 27 to 49 percent. The insurance changes mattered less. I do think there is some in our data. And we're looking now across the OECD and the demographic changes now just a little bit. Now chronic diseases to go to Ken's point also increasing throughout the developed - well certainly diabetes is increasing throughout.

So that, I think going forward, that's also going to be driving the cost as he said. But again, I think all of these things are different aspects of the same reality. But I do think there is a mechanism that is driving the growth rates.

**SUSAN REINHARD:** See I think Dallas Salisbury had a hand up?

**DALLAS SALISBURY:** Yeah, just a quick follow up on that set of points is in work that Paul Francent's [misspelled?] been doing with the database that we now have that has seven years of data pre and post design change by a major employer, this goes both to Joe's point that it makes sense and to Joe Antos's point of this is where this is some "freedom of innovation" the most common change on the private side over the last five years has been moving to far more shifting to an individual high deductible, HSA, HRA, et cetera.

This particular company did all of that. It produced a, when one does the analysis and allows the analysis to have

all of the new entrants flow in, which based on looking at the literature as the way most of the analysis by insurers and others have been doing it. Then you see a not only an initial decrease in cost, but what appears to be a decrease in the rate of cost growth.

In this particular case the second you take out and do the analysis on a closed group basis, so all you're doing is following the individuals that were with the employer in the plan prior to the change. And then carry them through the first five years, you get a onetime shift down similar to the old managed care shift. And then the cost rate actually is slightly higher than it is for the "full population."

So we haven't been able to find other studies that have been making that closed group analysis process in it. There may be the appearance of good news out there that isn't quite as good vis-à-vis what is happening. The second point I'd make, which goes a bit to what Ken was talking about and others on the chronic issue. And I'll flip to an article, a fairly thorough piece that was in *Health Affairs* with lengthier piece that then followed it in the *Washington Post* on Lyme disease.

And if you take the state of Virginia where when the current Governor came in he for the first time appointed a Governor's task force, the Governor's task force came up with recommendations. The Governor said se shall enforce the



recommendations. The state health department began an immediate process of sending out mailings and creating educational requirements for all those licensed to practice in any way within the health system in the State of Virginia and the rate of test positive reported cases of Lyme in the state of Virginia has skyrocketed. As it is all at CDC the highest rate of reported growth across 48 states at the moment.

As it is becoming through Health Affairs, Popular Media, Gubernatorial Task Forces. That is a disease that the infectious disease society treats as an acute disease. It can be easily cured they say. And for those that think they have a chronic disease, who are in a wheel chair after treatment, who still can't chew after treatment et cetera, these are all deemed to be non-Lyme related and nontreatable.

Those who are told have MLS chronic fatigue system et cetera. So this goes to the dual eligible's, the Medicaid, the Medicare are one of the fastest rates of increase in granting of Social Security Disability and with it Medicaid coverage is, in fact, Lyme disease individuals who according to the infectious disease people don't have Lyme disease, but relative to the chronic conditions do.

Just to underline a number of the comments both on the treatment issues on the analysis and diagnoses issues and to the technology issue of testing the fact that Lyme testing as

the article in *Health Affairs* pointed out and elsewhere it's been pointed out is an extraordinarily ineffective, very high rate of false negatives test. And there is a tremendous need for advance in that area. But even with a lousy test, it is suddenly producing new costs that will push the cost growth curve as we move in this area.

So the employer side Joe I agree with you there has not been a tremendous movement if one looks at the magnitude of that system towards significant change, those that are making the shift to high deductible and in essence thinking they found nirvana. When you cut the data just looking at a constant population nirvana is still a long ways off but to the point raised by others, one time decrease of 17 percent before it starts going up again is not necessarily a bad thing. But then I'll add the final caveat.

HSAs as established under Federal law the data is not owned by the employer. And in fact, in most cases only one of the insurance carriers is structuring their products so that they actually can do an analysis that includes what is being spent out of the health savings account. And even with them, because the law allows the employee to owe the HSA provider bank and then there is no reporting back, there is the vast majority of research to date excludes from analysis what is being spent out of health savings accounts and treats that

spending that's not occurring. So the data on that whole area is exceedingly dirty.

**SUSAN REINHARD:** Comments anybody? Okay let's see Michael Barr [misspelled?] is next.

**MICHAEL BARR:** Thanks Susan I'm going to go in a slightly different direction if that's okay. It's been refreshing at least for me that we've been in a meeting about two and a half hours on the roll of technology and chronic conditions. That nobody has mentioned the phrase meaningful use, which is nice but I'm about to change that. I have a question for the panel and full disclosure on the health IT policy committee [inaudible] workgroup and their four subgroups now working on a different ideas for stage 3.

But I'm curious from the panelists whether they think stage one and the proposed objectives and measures for stage two are moving in the right direction in terms of helping us to improve our chronic conditions and manage costs. And whether you think so or not what would you recommend for stage 3?

**MALE SPEAKER:** Two words, total inoperability. Until you get that you can throw out meaningful use and this that and the other thing and say that the – but until you have the different EHR speaking to each other and the data being transmitted from the specialist to the primary care with two different systems, you can measure all you want but it's not

going to help us. It is still going to be inefficient for the practitioner.

**SUSAN REINHARD:** Bruce?

**BRUCE CHERNOF:** I guess the comment that I would make is so where functional assessment in all this. And again, as a practicing physician I get the value of all the little points that we love to collect but when you look at the population that both Diane and I showed data about and when you reflect through on Melanie's broader comments about her kind of current focus and the pre duals until we understand the role function and both physical impairment and cognitive impairment you can write prescriptions and stuff and you can do tests and stuff until the cows come home, but if you can't understand whether you can thread that data sat through the life of a fully built human being. That's a real problem. And I see that as being totally missing.

**SUSAN REINHARD:** Brad.

**BRAD:** In the spirit of specific recommendations to reduce cost and connecting the dots I want to follow up on something Bruce has been saying and that is the importance of functional impairment and it's not just because people when they can't function utilize it's the multiple chronic conditions plus functional impairment. Those just happen to be two of the most powerful predictors we have for mortality and

the bottom line really is that if you look at the population that has more than three chronic illness diagnoses and functional impairment. You're looking at people who are getting the near the end of life where spending is very high. We all know that in Medicare 28 percent of all Medicare dollars didn't go to patients in the last year of life. 30-percent of that 299 percent is the last month of patient lives and 80-percent of that is in the hospital.

I thought the articles that were supplied today are really interesting. The AMed News one who are the chronically costly healthcare is one percent, this is the population that we're talking about. As Ken mentioned, death panel rhetoric has kind of paralyzed the debate on what to do about these folks. But I just want to suggest that the managed care approach of targeting costs and thereby reducing utilization, there's a word for that and its rationing. And it caused managed care to be torpedoed across the country and we saw what happened in one of the graphs we call today.

I would submit to you that the targeting costs in order to reduce utilization in this high cost vulnerable populations is exactly a 180 opposite of the way we would to be going. What we should be doing is looking at the world cloud. Hospice, those of us who have been doing hospice for years know that you can be a day away from death and be very comfortable,

very functional believe it or not. Very happy at home, all the words in the word cloud are fulfilled. And we can target those kinds of personal preferences in order to drive reduced reutilization because a lot of these folks do not want to go back to the hospital.

If you start with personal preference and then reduce costs. That's the right direction and nobody is going to argue with that. Except for those who just think personal choice is just a bad word.. Out in the real world what people want should be driving what kind of care they get and we don't have mechanisms to make that happened. Except in a few places where we can train teams to be in the home and community to move the focus of care out of the hospital for this population to where it needs to be. Where the word cloud is fulfilled.

I just wanted to put in a plug - I'm a palliative care doc times 20 year and I do not think palliative care by itself is the answer because it is viewed by most physicians is an alternative to treatment. So it's either we treat and when we're done treating we turn it over to palliative care and hospice. That doesn't work I can attest to that you know with decades of frustration. What does work is to train teams to see what people want. And do nothing treatment and comfort care in a packages. We can do that and we are, I want to put in a plus for a CTAC, Coalition of Transformed Advanced Care,

which is here in DC putting in the process and measuring results on exactly what we're talking about.

I think next meeting it would be great to go into this in more depth because I do think it's away forward,

**SUSAN REINHARD:** Great, yes please Jim.

**JIM:** I've been talking to students about shared decision-making. Is there some other name for it long time and I would write down on a blackboard a utility function and then everything flowed. And I just went with my wife to see a lawyer about redoing our wills. And so I got to thinking about what one would say in advanced directives. It's very hard. We know from all sorts of studies that people are bad at complex decisions which just is, they're bad at probabilistic decisions, which just is, they're bad in emotional context which just is - I'd like to think I'm pretty good at that. But just trying to say either orally in writing to my wife or my children what I would want. There is such a vast range of circumstances looking forward that the simple kind of example we give people about the doctor says well you have an x percent chance of survival and by the way here is what will happen what kind of pain and suffering you go through it isn't like that and probably most doctors aren't very good at giving those probabilities anyway.

Well kind of all four bringing in the patient, I'd have to turn in my unique card to the economist if I wasn't. I think it's just actually very, very hard to do this in practice and then pretend that we're we've made a big advance. Now that's not saying some cases we clearly could do this. No doubt about that. But as one starts to push us and gets close to it I think it's hard. I'd be interested in what Brad would have to say about it.

**BRAD:** If I could respond I'd have to say Joe I agree completely with what you just said. As a doc in an office and in the hospital and the ICU or talking with attorneys as a one shot conversation on advanced care planning yields very little.

I think if there is a secret to this it's that as people get more and more ill within this period, if you're sitting at the table, you're not this sick, okay. The people we're talking about couldn't be here. They can't even make it to their doctor's office or to church. I mean they're very ill. Once you get that sick and move through your illness, if you have a trained team there helping you understand what the illness is about, and helping you understand what your real options are, one of which of course is 911 when you lose your breath at four in the morning, there is others as well.

The interesting thing about the word cloud is that the people who are the most ill have the capacity to live just like



the words in the cloud. But we teach them to come back to the hospital. We don't teach them to manage themselves to see what their options are. And we don't put help for them in their homes. And I think that's why I think what you're saying leads us to the place where we have to do better care coordination in the community and we have models and data showing that that works because you can't do advanced care planning when you're well. It is too complicated and when you're not down the decision tree far enough to know what's going to happen. Once you're that sick you do know what's happening and you've adapted and that's when decisions over time with trained teams make a difference.

**SUSAN REINHARD:** Ken?

**KEN THORPE:** I know I mentioned this is my talk but I guess I just wanted to reiterate that I think we can do three simple things, they're not going to solve the problem. But they are going to contribute to the solution set and they'd be inexpensive so we're not looking at something that's big expenditures.

One is on this prevention side, as I talked about, if you look at a prediabetic overweight adult at age 50. They have an 87-percent change of having diabetes during their life. If you enroll them in this diabetes prevention program I just talked about lifetime likelihood of getting debilities is to

62-percent. So that's a program we should just roll out nationally.

And then leveraged Medicare to refer patients into it. That's a program we could do for \$80 million. So that's less than ten percent of the prevention and public health fund next year. So I'd do that. I'd make it a covered benefit in Medicare. It doesn't have to be the DBP but it's something like that.

Second is that we have got to build evidence based care coordination into traditional fee for service Medicare. It makes no sense that that is the only payor that doesn't have any type of care coordination and as we've heard they own the chronically ill population. I mean that's what they are. And so we do know from a whole host of data from the private sector to randomized trials functions that improved clinical outcomes and reduced costs.

And I went through some of those like traditional care health code change, medication therapy management and so on and their evidenced based models across the board on those and we should just integrate into fee for service Medicare.

And the third thing that we can do is pay attention in the definition of the central health benefits for plans offering services in the exchanges about what do we mean by prevention and care coordination. We've spent a lot of time

with the other elements, defining what inpatient care is and so on, we're spending no time really thinking through what do we expect plans to do in terms to preventive services. And I'm not talking about clinical preventive services, I'm really talking about disease aversion.

And care coordination for plans and exchanges and I think that's a really important discussion to have with states, with health plans because there's going to be an incredible amount of transition of patients to Medicare to private health plans within the exchanges. And I just think that that is something that the state level we need to get out it. That obviously in terms of costs minimal, if any, but those are three things we can do right now. I think it would make a real important contribution to reducing hopefully both the level in trends.

**SUSAN REINHARD:** Ken I just want to follow up on your point about prevention and the diabetes prevention program. Because as you know a large share of the long term analyses of that program show that, notwithstanding the fact that many people do lose that five to seven percent of body weight a very large share of them actually gain it back.

Now there still is a benefit as you said in terms of the least delaying progression in pre diabetes to diabetes or causing it seize in some people. But it gets to this issue

that I think Joe Newhouse has put back on the table, which is that I think people do not operate in their best interest, which you are now quite aware from the field of behavioral economics and do we understand really enough about Human behavior to know that these interventions are going to have a lasting effect.

**KEN THORPE:** Well we know the two facts that I laid out in terms of the long-term likelihood of getting diabetes for somebody age fifty. Again, we're sort of paralyzed here without not doing anything without having year of randomized trials. Gosh, it's a good thing the private second doesn't work that day but Medicare does.

There is a ten year follow up with the DBP and we knew in eh ten year follow up that yes there is some weight regain after age 3 or 4, but that just means that we should focus on what can we do when you're three and four to reinforce it. I guess that's the first point, the second point that I say so what. It still has as 34 percent accumulative reduction and the incidence of diabetes within a ten year time period. So compared to doing nothing, we have 34-percent less.

**SUSAN REINHARD:** Alright so one of the elements on the table clearly then is adopted diabetes prevention program nationally and you said \$80 million a year costs.

**KEN THORPE:** I know we're not used to talking about Ms we're used to talking about Bs. But it's \$80 million – yeah I could ask for more. It sounds more attractive I guess and costs more I guess. But 80 million yeah.

**SUSAN REINHARD:** Jim?

**JIM:** I'd like to go back to Dr. Stuarts comment about end of life and issues and I think one of the things in teaching residents that we forget to do is we're teaching them the technology so they start using the technology and what we don't teach them is just because we can do something should we use something. That thought process. It's far easier to provide something in a setting of end of life or something like that without thinking then not doing it.

One you feel better because you're trying even if it's a hopeless case. So I think this also gets to the point. We've mentioned a little bit about patients centered medical home and some of us talk at the break about that is we need to look at understanding the use of the technology both by the primary care doc and by the specialist and make sure there is a coordination in the use of that technology.

Both in the setting of the first work up of the disease and then the setting at the end of life. Where a lot of technologies use it it's really not going to aid or help the patient and the diagnosis, the treatment or even the comfort

like you presented. So I think what we haven't looked at or discussed is actually getting back into the teaching realm of the medical schools and the residencies and understanding, getting them to understand the use of the technology better.

**KEN THORPE:** And to get them to work as teams. I mean as I look at any medical academic medical center we've got a school of public health, a medical school, a nursing school, a pharmacy school the school of social work. They're all going to see the same patient at some point during the course of that patients treatment. But there isn't a structure that really gets them to work together to think about how do we work collectively as at team to keep that patient from either getting that disease or helping him.

**JIM:** And I would just add there was an editorial I think in the New York Times a couple of month ago that internal medicine has to get more like pediatrics. My training is pediatric cardiology and believe me we had a social worker pharmacologist. They knew how to pull of the - I they were giving drugs how to do the bottle. They didn't leave the hospital until the parents could give the meds could give it appropriately. Even if cost the hospital an extra day it wasn't reimbursed the patient didn't go home until the appointment was made and our appointment was made.

**SUSAN REINHARD:** Bruce.

**BRUCE CHERNOF:** Well maybe to build on that a little bit. I think about my sort of limited public health training when I was in medical school. But it actually had a framework that said there were three levels of prevention, there was primary prevention and somehow most of the discussions I'm involved in these days seemed to focus on prevention in a very primary kind of way, which is all about preventing people from getting - you know care coordination is all about those other two kinds of preventions for people who are sick and possibly treatable and for people who are sick and treatable but not curable.

And so I think we need to get back to this notion that a really good care coordination plan is actually a form of prevention. It is a public health responsibility and it sort of missing - I'm sorry to sound so energized but it's really missing from these discussions. And at the end of the day I will go back to the question which is what is the problem we are trying to solve here.

And at the end of the day we have developed a tradition in late 20th century American medicine of introducing a pill or a piece of equipment in place of a good discussion. In particular in a situation when the outcome is functionally driven, not medically driven you're not going to fix the fact that this person had a substantial stroke and is not you

hemiplegic. So now you really have to focus on their quality of life and frankly, you know, I agree it's a medical school issue I mean it's an issue at every level in the medical system because there isn't a good framework for coordination, understanding what the person's medical and personal goals are.

That we continually substitute expensive, potentially very risky therapies in place of a thoughtful and evolving care plan. When you are seriously ill or have substantial functional limitations, it's not a fixed point and time discussion. It's like a mosaic that evolves. And you have to be willing to pull some tiles out and change them around when the image changes. So there is a larger discussion about how we use technology and part of why I think this kind of notion is Melanie you guys think about the work you're doing this notion of a really thoughtful care plan that is revisited over and over and over again. My one fear about the fee for service Medicare pieces it somehow will get a piece of code that says once a year you get a care coordination visit and then there is some little follow up code and it won't work.

I mean it just won't. So there is kind of an intensity in this intervention is really important and it goes back to the fundamentals of public health. Okay, I'm off the soap box.

**MALE SPEAKER:** Could I add to that jut very quickly?

In the interest of actionable steps there has been a lot of



talk about what's effective care, how do we change medical culture how do we teach residents. Our experience I think in a big 24 hospital system is the way to change medical culture is to change the structure of how the care is provided. And I have to say as a doctor that I don't think doctors are the answer. There aren't enough of us to go around with a grey wave that is about to inundate us.

The teamwork that we need are teams of other professionals that can work with us to extend our care to people who need it. The kind of people Bruce is talking about. I think there are models out there that provide that kind of care coordination. We have data that show that it works. That simple change in the structure of how care is provided just reengineering the system in that way would really equip us to do a lot of the things we're talking about today. And change medical culture in the process. Doctors want to be offloaded for caring for these people who can't make it into their offices anyway. They're too ill.

**SUSAN REINHARD:** We have some more cards up so let's go around the room this way. David Nexon and we'll work our way around.

**DAVID NEXON:** Follow up on the last couple of comments. A question really for Ken or Melanie or anybody else. On the issue of care coordination team delivered care, I think the

common wisdom now is that this is really an important way to get at this high cost population, but at the same time it doesn't seem to be as simple as simple as adding a paid benefit. It seems to require both a structural change and a cultural change for a lot of care givers. I wonder how we go about doing that in a program like Medicare or Medicaid for that matter.

**KEN THORPE:** You're right it's not a coding change. I sort of think about it the way that North Carolina and Vermont have go on about this in terms of building health teams that work with primary care practices. And the way I think you can do it the Medicare program and I would do it in conjunction too with the exchanges is basically that you would have to contract out like they do in Vermont with different entities and different plans service areas to have teams available to work with Medicare patients.

I would start off with them being voluntary. I mean the primary care practices don't have to use them. But our experience in looking at them in Vermont is they all do because I think Brad's point is that they are a natural extension of the office. They engage and work with the patients. They help them make sure they understand the care plan. The care plan is executed; they have questions about the care plan. They know where to go. Their nurses, nurse practitioners, pharmacists

are they doing the blocking and tackling and execution of the plans and they're not physician led they're nurse led.

So I think you could very easily have Medicare build these teams and have them available for others to use. If Medicaid and the state wanted to do it, that would be fine. A lot of state are doing this and there is a section 2703 in the Affordable Care Act that gives state and enhance 90 percent match to put these teams into place for two year. So I think in combination with that and Medicare maybe through the innovation center, which I know they're doing some of this, that would be away to start building capacity into the program and you'd expect them to do some of the functions that he's talked about. You'd expect him to do the functional assessment. You'd expect him to do some of the social functions. The medication therapy, transitional care coaching. Worked with them on health literacy issues. So we have experience in Vermont they do this with Medicare patients, in fact the teams are used to manage all the patients in the provider practice. The challenge we have is that like any type of care coordination program it requires an initial investment. So unless we're going to invest in it we can't get any of the healthcare benefits and we can't get any of the savings.

So I would hope through a combination of some innovation center money we can start just going. We've been

working with states to encourage them through section 2703 to build out the health teams through the Medicaid program and perhaps if you build some broad expectations into the exchanges about the types of function that you would hope to have health plans providing compete on, that would be a way to start moving more quickly down the field.

I know that if we don't go that direction and build some type of evidence based care coordination into Medicare, the debate about how to save money in the Medicare program is going to be the same one we've had for 30 years. And it's going to cut provider payments and increase cost sharing and increase age of eligibility. It's the same old same old and it's not going to really get at any of these fundamental cost drivers that we've been talking about.

**MALE SPEAKER:** Susan, could I just make a quick comment about building anything into Medicare? I think that Medicare's entire history proves conclusively that you really can't build common sense into Medicare. What you can do is provide incentives for health plans to use common sense but it's only been 45 years so far, we'll see.

**SUSAN REINHARD:** We're going to keep working our way this way and I'll come back around. Carmella we'll catch you up next I promise people, forgive me but you're so far away I cannot even read name cards down at that end.

**PETER BOWERS:** Not a problem, Peter Bowers I'm a medical director with WellPoint. So I appreciate this opportunity to speak briefly and my day job is payment redesign across our 14 blue plan so we cover one and nine Americans across the total blue is almost 100 million in lives.

And there are a number of different levels that we're using to change sort of his fee for service reimbursement because we've got to change the system that people are getting care in. And all the things discussed, patient preference, it's very important the supporting physicals with data, IT is going to help that in inoperability. But one of the levers and they're multiple levers that we're going to need to create is one that I like to call attention to that touches on both chronic care and technology. And it's something that's across all blue plans. It's almost a 100 million lives support this from a data perspective. So national costs comparison tool looks at over 200 comatities type of entities of health care services. Coloscopy. Joe you started with your cataract example.

Total cost of care for member went from door to door so includes everything that is associated. Profee facility, anesthesia and its very importative. Colonoscopy for example and heaven forbid Joe if you need an imaging this afternoon, all imaging for sciatica is one there as well so you can be

smart about where you spend your healthcare dollars and this tool is really important because as I think as we think about moving forward the amount of information that flows to help you make better informed choices is coming here so appreciate the moment.

**SUSAN REINHARD:** Great thank you. So we'll keep moving this way.

**KIRSTEN SLOAN:** Yes Kirsten Sloan for the National Partnership for Women and Families. I just wanted to touch on the care coordination that both Bruce and Brad referenced. Because I think this really is a critical actionable step but I would also caution that part of that care coordination team really has to include the patient because one of the things that consistently see is care plans written for the patient, care coordination done for the patient but when it doesn't include the patient, when there isn't an understanding of where the patient is coming from or what they are capable of doing, often times we fail. And so it isn't just to be nice to the patient, but this actually is a key to the success of a care plan or a care coordination effort that we're using shared decision making tools that we are using things like self management program, which consumers and patients are actually asking for.

But unless we engage them and the family care givers as well, I think we're going to miss and Susan's chart actually showed that that people don't adhere to the kinds of treatment regiments that they're recommending and instead we end up costing the system more. So if we can prevent hospitalizations, if we can prevent readmissions because we've included that patient and that care giver in the design of that care plan or the care management I think that is a good actionable step.

**HENRY CLAYPOOL:** Henry Claypool from HHS. I'm actually with the Administration for Community Living. Something Secretary Sebelius just recently formed at the Department and a couple of points. The point about really beginning a dialogue with an individual about what their future is going to be about when they're living with a certain condition or towards the end of their life. There is a whole population of individuals living within the community today with functional need. And I would suggest that that's a great place to begin to really start to reshape the dialog that occurs between the individual and the clinician or the patient. If we don't begin to pay, pay greater attention to those individuals that actually have the real life experience, living in their communities and involve them in shaping how the services and supports and the

treatments that they need are delivered to them. I think we'll continue to run up against the cost issues that we see today.

Just listening to the dialogue people are relatively uncomfortable with the idea of what their future might hold if they did incur a functional need. Again there is a group of people living with it day to day. We've seen modest advancements in the Medicaid program, made where individuals were empowered to take some a bit more involved in directing some of the supports. There are certainly limits to which individuals should be engaged and directing their healthcare services but there really at a critical juncture in terms of leading change. Another group that should be involved and I think back to Ken's point it's really a relatively modest investment because the community based infrastructure that is out there to serve this population is really under developed. And until we make some modest investments in this service delivery system, our medical system will just continue to strain to meet their needs.

There won't be a partner in the community based setting to make an appropriate handoff to when we want to discharge someone from the hospital and make sure that they get the services and the care that they need, so that they don't end up back in the hospital.



Unfortunately we have learned this through implementation of the affordable care act with the care transitions trends we're still making grants at HHS to organizations that are prepared to do this but we really know they're under developed and so for policy makers in the future looking at making investments in something like what the secretary has created in the administration for community living really might be a sensible alternative to try to continue to do this through a rigidly structured medical program that is involved in a political dynamic that's been pretty thoroughly discussed here today.

**SUSAN REINHARD:** Enrique.

**ENRIQUE MARTINEZ-VIDAL:** Thanks I'm Enrique Martinez-Vidal from Academy of Health. I'm the director the Robert Wood Johnson Foundation state converge initiatives program and I also want the State Quality Improvement Institute for several years the commonwealth fund funded where we worked with eight states on quality improvement delivery system reform just to give you a few more examples of what states are doing out there, Ken talked about Vermont and I'll add a point or two to that but undergo our state quality improvement institute, the state really wanted to focus on how to deal with costs. I mean they called it quality improvement but it was really how do we deal with costs. If you think Medicare, has problems just

cutting reimbursement and cutting services. That's what Medicaid does and they sort of tapped that out at this point. They're to the end of the rope with that so they're turning to another way to do this. Care coordination is a huge thing, delivery system reform, payment reform. A lot of states out there doing primary care medical homes trying to even get to ACOs in terms of Medicaid, Colorado is doing that even New Jersey is doing that.

Oregon which I'll give you a little bit more detail as well as a little bit of a vision at this point but they're really thinking broadly. Consumer engagement is huge piece of that not only financial incentives but also the education piece Susan was talking about. Health literacy was a big piece as well as sort of the wellness programs and how do you do that ahead of time how do you stop the costs from even occurring.

Health information technology was huge underpinning aspect to this bringing all the sort of how do you have the inoperable aspects to it that is critical. And then the metrics, the accountability for having this all. So that is sort of the overall package of work that we had done in a number of these states.

Vermont as Ken really laid out that's community health teams I think with a visionary aspect to what they did that was all built around the medical homes they're still trying to

figure out how to get to sort of the next layer out with specialists and hospitals. But they also had health information technology that underpinned the whole thing. Registries, inoperable electronic health records and accountability metrics and for outcomes.

The other just one last point, what Oregon is trying to do with their coordinated care organizations, it's still a bit of a vision but they have gotten CMS waiver to implement this. It's a huge undertaking, it's going to be Medicaid, the state employees, their high risk pool chip and they're hoping to bring in exchanges as well eventually when they get up and running.

It's really to sort of integrate and coordinate benefits and services. There is local accountability for health and resources allocation, standards for safe and effective care and global budget that's index to sustainable growth. They have a website that explains all of that. I would recommend that people go and look at the coordinated care organizations that Oregon is putting together. So that is just a few examples of sort of real work on the ground.

**SUSAN REINHARD:** thank you. Diane.

**DIANE:** I just wanted to go back a little bit to where Brad was about people ending up in the hospital in the last year of life and right in the last months. And sometimes we learn from research and sometimes we learn from personal

experience and we've talked a lot about the coordination of care which is basically a community but I think there is a different situation which I think we also ought to focus on which is that my mom had a really good primary care team and coordination when she was in the community and then she ended up in a hospital to be treated for dehydration and then she ended up in the hospital longer and longer. And the hospice took over and I couldn't get anyone to answer any of my question. And the hospitals kept trying over and turning over and I think that finally I got her discharged and brought her back home.

But I think that we can talk a lot about coordination of care when there're not in the hospital but we need to also be looking at that whole trend in the hospital towards hospitalists and what that means for the ability for the care to be managed.

**SUSAN REINHARD:** Thank you. Susan.

**SUSAN:** Hi yes I also wanted to mention around this in professional collaboration which is the foundation of care coordination and the infrastructure that was being mentioned down there are something's that are happening and some of this can be pushed form the public side and some of it is being pushed form the private side. So on the private side you have foundation like the commonwealth fund for example that has done

work on the merry mailer and the Eric Cullman but also trying to get people training in that I think that's really important. People who are out there not just the new students which is really very critical. And three is the Robert Wood Johnson Foundation do a tremendous amount of work. At ARP we're working with them on the institute of medicine future of nursing our work that has a high high priority on interprofesional collaboration.

We have 49 states with action collations that many of which are making this a high priority across the state, across the different disciplines. It's very, very challenging. We know that there has been efforts before to do this but you also have HRSA now tying funding for education of all professionals to enter professional collaboration. So there is lots of different things that I think our efforts in place that I think we should all be tiring to reinforce because it's got to be done from the ground up and we've got to change the culture among the exiting professionals.

**SUSAN REINHARD:** Great thank you. Bob Helms.

**BOB HELMS:** Okay, one of the major topics of today is technology but I've heard very little discussion about the process of innovation. I think we all sort of believe in songs that want to think that there is possibilities for improvement and innovation in technology. But a lot of the literature over

the years has complained with a system both private and public dominated by fee for service, that the incentives are more sort of cost increasing innovation, as opposed to cost decreasing or value seeking innovation, so my question to the panel is sort of, is this distinction important and as long we stay with - in Medicare and the private sector system dominated by fee for service, how do you get this sort of change in incentives for innovation into the system?

**SUSAN DENTZER:** Joe? Either Joe on this?

**JOSEPH NEWHOUSE:** No, I would -

**JOE ANTOS:** That Joe first.

**JOSEPH NEWHOUSE:** This Joe?

**JOE ANTOS:** No, you first. You have the right answer.

**JOSEPH NEWHOUSE:** Sorry, I - I spring for Joe.

Obviously incentives are important. I think there's an issue about - from the public financing or even the private financing point of view about how - who gets those savings, assuming there's innovation and savings occur, so Jim Fasules said there has to be some incentives for the provider. I would be - I'm somewhat concerned about market - increased market power providers, that they may appropriate most, if not all of the incentives or savings I should say, but that's obviously speculative. So, it - yes, I mean I think as risk gets pushed down toward providers and I believe that some - that should

occur to some degree, that would increase incentives for providers to demand cost saving innovation, but then who gets the savings?

**SUSAN DENTZER:** Okay, Brad, and then Carmella, and then we will wrap up.

**BRAD:** A couple of – a couple of points, around care coordination, we kind of talk about it, but we sort of assume that we're talking about coordinating care across space, geographically across settings. But to Diane's point, care coordination in my experience doesn't work unless you wrap together what happens in the hospital, what happens in the medical group, physician office and what happens at home and community. It is possible and there are models out there that bring all of those together, that's the only way to deal with hospitals who don't want people to come back again and again, they just have to deal with it when it happens.

So, care coordination across space is critical and unless it does that it doesn't work. But care coordination across time is also important, meaning – and this goes back to Joe Newhouse's point, when you're well why wouldn't you want to recover and do everything you can to do that. When you are super ill, their preferences change a lot. And tracking those preferences, documenting them, getting them into the HR and following them is coordinating care across time. And both of

those have to happen. And again there are models there that do that.

Now, the second point is financing. Again back to Joe, shared risk, shared savings probably is where we're gonna end up. We have to have providers sharing risk with payers and with Medicare, but you can't just jump over to get there, because we're in the fee for service world and it doesn't - you can't just go from here to there. We're paying \$20 million a year ourselves to put these teams in place in order to save Medicare \$2,000 per month, per patient. Now we're willing to make that investment, because we know we'll get at some point to shared risk and shared savings and we're talking with CMMI about doing that, but the little providers out there, their integrated systems can't possibly do that and nobody - not everyone's gonna become an ACO.

So our proposal would be, use these across space and time care coordination teams, to allow independent providers, hospitals, medical groups, homecare agencies, to become virtual ACOs. And I'd make that as a specific actionable proposal and then create interim financing to help people over the bridge to shared risk, shared savings. That's exactly what CMS wants to do. And there's got to be a way to pay for quality on the way, so yes you get paid for now, but you can't gain the system, you have to make outcomes in order to get reimbursed. So that's



gonna take a lot of talking, but I think there is a concrete way to accomplish it.

**SUSAN DENTZER:** Okay, Carmella, we'll give you the last word.

**CARMELLA BOCCHINO:** So, my comment actually goes back to the proposal that Ken put on the plea – Ken put on the table about, you know, prevention and diabetic care and unfortunately I have to agree with Joe Antos, Medicare is just this 800 pound gorilla that doesn't – isn't flexible and doesn't move like that. And they try to create programs, one size fits all, this is not about one size fits all. I mean I think as we've looked at what's going on in the private sector, we have a lot of physicians in this country that are in one and two doctor offices. They're gonna have very different needs and have different infrastructure that they need to build than physicians that are in groups or a part of an integrated system. And every time we have this conversation we sort of forget about them and I'm very much worried about them, because they need certain support if they're not gonna become a group, if they're gonna actually survive in this whole new environment.

And I also think we have to think of primary care very differently than specialty care. I found it really interesting that this was a meeting about technology, but we focused a lot

about primary care today. I'm not concerned with primary care in technology. The data we look at shows that technology is used and over used and misused more by specialists than they are by primary care. And so I think we need different solutions for primary care than what we do for specialty care. Specialty care is very much oriented to procedures and technologies.

And I'll go back to something Jim said, we do a good job of teaching physicians and training, how to use technology. We don't teach them when not to use technology, we don't teach them, and it's okay to say no. And that's a real challenge, particularly for a physician who has spent over a decade learning a specialty area, and they want to get out there and they want to practice medicine. And those to me are some of the problems that we have to grapple with. I think all the discussion on primary care today and care coordination and care transition across the continuum of healthcare is extremely important, but when I think of technology my radar goes to specialists, not to primary care.

**JAMES FASULES:** Let me — I'm gonna rebut you here Carmella.

**CARMELLA:** I'm sure you are.

**JAMES FASULES:** 30-percent of the echo's we read — I read at Arkansas Children's Hospital were ordered by the

primary care doc, they had zero yield, none were needed. And I'll refer you to the pilot program we did with nuclear studies down in Tenhaus 10 settings [misspelled?]. Yes, specialties order more tests, because we have - that's part and parcel of the modern stethoscope as Joe kind of mentioned.

At the same time if you look at the inappropriate rate of the specialist versus the inappropriate ordering rate of the primary care doc, which accounts for about 30-percent of the tests being ordered, it's 50 to 60-percent for the primary care doc and they don't need the test at all. They're trying to figure out what's going on with the patient and they order the test, because they don't know what's going on with the patient. The specialist orders the test in a patient already has the disease to make a decision and their inappropriate rate is doing it too often. It isn't doing it in someone who has the study. So it's two different aspects of the testing.

And again you can get about a 30-percent reduction on unneeded, completely unneeded testing, by just having the primary care doc call the specialist and say, you know, what's wrong with this patient, do I need to do this. And that's what our focus tool actually does. The tool sits on the electronic record and looks and says, is this an appropriate study or not. And if the primary care doc is ordering the test it says, call the cardiologist instead of ordering the test.

**BRUCE CHERNOF:** Maybe just to respond in a similar fashion, you know, I actually want to rebut the comment too, because I think you just crystallized what I view as an internist as one of the single biggest problems, which is this highly – it actually goes to the example, Diane, that you gave, this highly fractured medical system, where there's a plan of care and primary care. And there's a plan of care and specialty care, this sort of fractured patient centered, but only through one lens of the patient, it's like are you an outpatient patient, are you a subspecialty patient, are you an inpatient patient? That's the problem, you just crystallized the problem.

And the idea that there would be a gulf between the primary care, the specialist, the inpatient system, and then frankly all the community-based providers, including the family which we've not really talked about much today, other than one very important comment earlier. Yeah, and at the end of the day, sort of the failure of all the medical specialties to delegate appropriately, except when we choose to make the family responsible with almost no training, so I would just go back to this notion that there should be a care coordination plan that is person centered, not patient centered, particularly when you're talking about somebody who's chronically ill and functionally limited. And as long as we

have these little silos we're gonna have a problem and maybe that's almost a place to close on them, which is care coordination is in essence a technology that we don't really know how to use very well. I mean we all have - there are examples of how to use it well, but sort of getting that rolled out could be important.

**SUSAN DENTZER:** Well, thank you all for a terrific and vigorous discussion. I would note that depending on whether you are a glass half full or a glass half empty type of person, you heard a lot here that will send you one way or the other. I will say what I heard was we do have a lot of solutions, actionable solutions, frankly most of them are being tried. Now maybe it's a case of more, better, faster, but most of them are being tried. We heard about the increased need for end of life - better end of life care, end of life engagement. Just a quick commercial for Health Affairs, our June issue is devoted to a range of issues across what we call the care span, thanks to support from SCAN Foundation.

Please read a piece by Bruce Vladeck about dignity driven decision making, which I think is precisely what Brad Stewart and others have been talking about today, as a prospect for really making headway on that issue. We heard a lot about care coordination, we know a lot of these efforts are already getting underway or are underway. We heard about the role of

new – newly trained and empowered types of providers. Ken brought up the community health teams working in Vermont and elsewhere. We heard about the known successful interventions around the Diabetes Prevention Program the Transitional Care Program, etcetera, that clearly is a care of more, better, faster, because we know that these work, we simply have to adopt them and put them to better use.

We heard about the role of patient and family engagement, again clear evidence in the research that if you really engage patients or as we otherwise call them people in their care decisions, they get better care and they're happier with the outcomes. We didn't spend as much time on some of the things that were on Joe Anto's list, but we know that those are out there. Those are changes in private insurance, whether it's moved to selective provider networks, value-based insurance design, etcetera.

Joe, we completely left you alone on the notion of premium support in Medicare as being one potential, maybe that's for our next session. But I think again, just to close, we have a lot of evidence here that we have tools that work. And again, if you're a glass half empty person, we're not doing it enough, if you're a glass half full, at least we're trying. And so there's a lot of perspective here for some additional in roads to be made in whether again it's the level or the rate of

growth, we can – we have some evidence that we can make a difference. So with that let me turn things over to Ed. I think you're gonna say a word or two about the next installment in this series.

**ED HOWARD:** Yes, thank you, Susan. We are gonna start talking about solutions. We talked a bit about solutions today, but we knew we needed to tap your brains on that aspect of it as well. June 12th, which someone pointed out to me is a Tuesday, not a Wednesday, we'll be convening the third and last briefing in this series, in this space, but not in this time, we're gonna start with a lunch and go to a reception which will note the fact that this series is supposed to mark 20 years of activity by the Alliance for Health Reform. So, I guess we can take credit for the health system's condition over the last 20 years.

Let me just quickly thank our sponsors, our hosts and most particularly our panelists and speakers for an incredibly good discussion, I think, of an incredibly difficult topic. And before I let you go, could you please as you rise and collect your things, pull the blue evaluation form out of your packets and give us some feedback. And particularly give us some notions of what we might do next, following the wrap-up session in June to try to contribute to the dialogue that could get us some progress on controlling healthcare costs. Once

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again thank you all for coming and we'll look forward to seeing  
you next time. Bye.

[END RECORDING]