



**Issues and Future Directions for Medicare  
The Commonwealth Fund  
Alliance for Health Reform  
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ED HOWARD: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform and on behalf of Senator Blunt, Senator Cardin, our Board of Directors, I want to thank you for coming out of a beautiful spring afternoon in Washington to listen to what we think is going to be a terrific program on Medicare. What this program looks like today, what challenges and opportunities lie ahead for it and for those who depend on the program.

Now, in a few weeks we are going to mark the 50<sup>th</sup> anniversary of Medicare being enacted into law, and like a lot of 50 year olds, Medicare has already accomplished a lot in its first half century of life. But there are some warning signs of potential areas of concern too, and looking ahead a few decades, some substantial challenges. So, consider today's briefing a kind of working birthday gathering, where we are going to take stock of where Medicare stands, where it needs to advance, and where we might be able to look to Medicare for leadership in helping reform the delivery and payment systems for the entire healthcare system.

We are pleased to have as our partner in today's program, The Commonwealth Fund, a century old philanthropy established to promote the common wheel, the common good, and doubly pleased to have as co-moderator, Stuart Guterman, who is the Vice President for Medicare and cost control at Commonwealth. He also heads up the fund's initiative on advancing Medicare. He's been a top official at Medicare himself. He's served several stints at CBO and Medpack and he will also, since he knows a lot about this topic, get us started at the appropriate point with some useful contextual information about the program.

So a little housekeeping, you will see a hashtag there that you can use, on the screen, to Tweet if you are a Twitter person. If you need WiFi to do your Tweet, we are going to have the credentials up on the screen that you can use. Take your time and copy them down and use them. There is important information in your packets that includes speaker bios, more extensive than Stu and I will have time to give them. There is a one page materials list that you can use to go online and connect with. Not just the materials in your kit, but a larger collection of what we think will be very useful documents. Video recording available probably Monday on our website, [allhealth.org](http://allhealth.org), followed by a transcript a couple of days later.

Two things in your packets I want to call attention to; one green and one blue. You can use the green card to ask a question when we get to the Q&A part. There are also microphones on either side of the room that you can use to ask your question in your own voice. And the blue evaluation form. And, please, take a moment, think about it now, make a suggestion for a speaker, for a topic, in addition to giving us some feedback on today's program. We really want to be responsive to the needs of your folks and make these programs even better than they are.

As I promised, we are going to hear now from our co-moderator from our co-sponsor, Stuart Guterman. Stu?

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STUART GUTERMAN: Thanks, Ed. I'm thrilled to be here with such an illustrious panel. We will have some really interesting discussion, I think, and we will be ready to also answer questions from the audience. I'm going to -- as Ed described -- start out with a few contextual comments to set the table for the speakers on our panel.

We are celebrating Medicare's 50<sup>th</sup> birthday and it's -- 50<sup>th</sup> birthdays are always a good time for a quick look back and then a look forward and that is the way we are going to do this discussion. We can look at Medicare from three aspects. One is that it is a very important vehicle for coverage for the elderly and disabled population in the U.S. and that it plays a very important role for a population that really does depend on the program for access to needed healthcare. It is also -- and in Washington, I think sometimes Medicare gets overplayed as a budget line item and we have to remind people that it is not just a budget line item; it is a social program that is a very important and very popular and effective program. It is a program that is a big part of the federal budget and particularly a big driver in federal budget concerns in the future. Also, a big part of national health spending. Thirdly, and perhaps most excitingly, it is a platform for developing innovative payment [unintelligible] models, particularly now with the creation of the Center for Medicare and Medicaid Innovation.

When Medicare first went into effect, there are some very obvious things that happened. It increased health insurance coverage, because 50% of the elderly population, at the time it was passed, did not have health insurance and therefore increased access to healthcare -- and Karen will talk a little bit more about that, it increased, obviously, protection against healthcare cost for a population that clearly didn't have, by and large, high incomes or steady sources from income. It also decreased disparities in access to healthcare by race. That is very important. Remember, the year before Medicare was passed, the Civil Rights act of 1964 was passed and that was a big breakthrough in racial equality in the U.S. And Medicare was actually a very powerful lever in desegregating hospitals across the country, both in terms of access by patients, but also in terms of desegregating the staffs in the health facilities across the country. So it served a very important social role there as well. We tend to think of Medicare as kind of carved in stone and in some ways we feel like it is. Those of us who worked with the program, but it has evolved considerably over time. Medicare today really looks a lot different than Medicare looked in the first days after it was passed. Eligibility was increased in 1972 when the disabled population was added. First Medicare originally was only for people over 65 and so people who are disabled are eligible for Medicare two years after they become eligible for disability benefits. People with ALS are immediately eligible for Medicare and people with end stage renal disease also are eligible for Medicare.

Coverage was expanded in 2006 after a long and sometimes painful fight that some of you may remember. Drug coverage was added in the Medicare Modernization Act of 2003 and it began in January of 2006. The role of private plans has expanded over time and now some 30% of Medicare beneficiaries are enrolled to get their Medicare benefits through private Medicare advantage plans. There has been a succession of payment

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reform. Remember that when Medicare began it adopted predominant reimbursement methods in private insurance, which basically were cost based reimbursement, which included no incentive for cost control, in fact just the opposite. The more you spent, the more you got reimbursed. So beginning in 1983 with the perspective payment system for in-patient hospital services, otherwise known as the diagnosis related group (DRG) system. Then with the physician fee schedule in 1992, which certainly has been talked about a lot now with the recent legislation to repeal the SGR. Other perspective payment systems were put in place in the Balanced Budget Act of 1997 and of course the Affordable Care Act had a number of payment reforms including the creation of Accountable Care Organizations in the Medicare shared savings program. Then more recently, Medicare has set for itself a target for value based payments by 2016 and then by 2018. There have been a number of quality improvement activities, although first they were mainly aimed at making sure that care was appropriate, but they have evolved over time as well. Now, into the value based payment initiatives that have been put into place.

So it's a very much different program than it was 50 years ago. The Affordable Care Act was particularly important and it contained several important provisions to improve care for Medicare beneficiaries and also to encourage and reward changes in the organization payment and delivery and payment of healthcare, including the Center for Medicare and Medicaid Innovation. Then more recently, the Medicare Access and CHIP Reauthorization Act (MACRA) or the Sustainable Growth Rate (SGR) Repeal Law really accelerated the force behind payment reform in Medicare and we will see how that goes. I have been asked by one reporter, whether with the repeal of the SGR, we were done with payment reform. Of course the answer is, we have just begun. The law got the SGR out of the way, which was a major impediment to proceeding with payment reform and now we can proceed to do all the work. Medicare, although it has accomplished a lot, faces ongoing challenges, including rising expenditures with a retirement of the baby boom generation, the fact that medical science has turned a lot of what used to be fatal illnesses into long term chronic illnesses, so the needs of the population have evolved over time. Medicare still has multiple parts with different sets of rules and different sets of payment provisions. There are coverage gaps, there are still no limit on out of pocket costs in Medicare, there are high deductibles and co-pays, especially for people who are sick. Many people are surprised to find out, when they need long term care, that Medicare does not, by and large, cover long term care. Again, how to balance the role of private plans with the role of traditional Medicare, so that you bring out the best in both programs, is an ongoing challenge.

So we have a great panel to talk about some of these issues and more. We will start with Karen Davis and Johns Hopkins University. Karen, I won't go a lot into the bios of all of these folks, because we would be here for the rest of the hour doing that, but they have all got long and distinguished careers. Karen was, until the end of the 2012, the President of the Commonwealth Fund and she has had a long and distinguished career even before that. We have Richard Gilfillan, who is with Trinity Health now, but was the first Director of the Center for Medicare and Medicaid Innovation and he can talk about both his experience both inside and now outside of the public sector. And Sam, Nussbaum

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with WellPoint/Anthem and talk about the private sector payer perspective on the role of Medicare. So we will start with Karen.

KAREN DAVIS: We will focus mostly on the future, but I think it is useful to have the context of accomplishments over the last 50 years. It's reassuring that Medicare has always adapted and in fact been a leader in innovation as beneficiary needs have changed and as modern medicine and technology have advanced. I think it's most striking that Medicare was successful in dropping the rate of uninsured elderly from 48% to 2%. I think as we think about the Affordable Care Act, if we drop the uninsured rate of the non-elderly to 2%, our jaws would drop. So we are still a little less ambitious. We also know from Commonwealth Fund surveys that the elderly are less likely to report barriers to access to care and difficulties with medical bills or medical debt than are people under age 65. I think we all just saw a study yesterday, reporting that even those getting insurance under the Affordable Care Act health insurance exchange, about a fourth are reporting access problems. Medicare in fact, reduced the share of total expenditures paid out of pocket from 56% in 1966 to 13% today. Again, major financial protection not only for the elderly, but for their adult children. We have had a lot of advance in medical technology, modern medicine -- Medicare has contributed to that indirectly through its payment to teaching hospitals, graduate medical education, but life expectancy of people over the age of 65 has increased by five years. Whether you think Medicare caused that or not, it certainly gave beneficiaries access to the benefits of modern medicine. Medicare has also been a payment innovator. It started out paying the way private insurers, Blue Cross/Blue Shield paid. It's really led the way in the development of perspective payment, the DRG hospital payment system is not only widely used by private insurers, but used in over 40 countries around the world and certainly the resource based relative value fee schedule has been the basis for much of private insurance negotiations or payments to physicians and certainly we are all looking at the Center for Medicare and Medicaid Innovation and the next evolution of provider payment reform moving toward value based payment.

We have also read a lot about the struggles to get state health insurance exchanges effective. Medicare has its own health insurance exchange. It offers traditional Medicare, but also offers a choice of Medicare Advantage private plans and with the Affordable Care Act, now gives bonuses to four and five star Medicare Advantage plans that rate high on quality. Medicare has slowed the growth in spending; we are at a 50 year lowest rate of increase in Medicare expenditure growth, growing less quickly than the economy as a whole.

Moving on, that is not to say that there aren't significant challenges for the future. Certainly the fact that the Boomers are going on to Medicare and the rapid increase in enrollment in Medicare means that aggregate Medicare spending will exceed the growth in the GDP. So on a per capita, a per person basis, Medicare is slower than the economy, but in the total basis, greater than the economy and therefore likely to consume a greater share of the federal budget. But there are also problems with the adequacy of benefits, despite how well Medicare does in insuring access to care. Its benefits and how much it's

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innovated in payment -- its benefits are very similar in structure to what they were in 1965. There is a separate Part A for hospital, B for physician services. There is no ceiling on out of pocket costs. Obviously prescription drugs were added as a separate Part D with the Medicare modernization act in 2003, but because there was a high deductible, particularly for hospital care over \$1200, people buy something to go with Medicare; Medigap, employer retiree coverage, Medicaid for the very low income, but that leads to a lot of confusion, a lot of complexity, a lot of difficulty coordinating care and certainly high administrative costs. We have also been looking at the share of income that Medicare beneficiaries spend on out of pocket costs and on premiums. They are Part B premiums; they are over \$1200 a year. That is a lot. If you are at 150% of poverty, making \$15 to \$20,000 just to pay the Part B premium, Medigap premiums can be a couple thousand dollars, depending on where you live. Half of out of pocket expenses of beneficiaries are for non-covered services. Some of those are home care but also hearing aids, dentures, vision services.

We have focused a lot on the Boomers going on Medicare, 10,000 people a day going on the Medicare rolls. In ten years, those 65 year olds will be 75 year olds and they will have 90 year old parents. So the fact that Medicare does not provide services that help people live independently at home, is going to be a bigger and bigger challenge in the coming years.

So what can be done? First of all, I think the one priority for policy action is integrating Medicare benefits and offering a comprehensive benefit package through traditional Medicare that can compete with Medicare Advantage, putting, in my view, A, B, D, Medigap, all together, self-financing that with a premium that in fact our estimates are, would be substantially below what people who buy Medigap now pay for comprehensive coverage. In addition, sliding scale premiums and cost sharing similar to what we do in the Affordable Care Act, available through Medicare, directly from Medicare without having to apply separately for Medicaid. Right now, if you are a 64 year old covered by health insurance exchange plan, you are going to have substantially higher premiums and cost sharing when you turn 65 if you are low income, modest income, individual. Also, to structure cost sharing to give beneficiaries an incentive to get their care from high value providers participating in alternative payment methods. So eliminating the deductible if you get your care from a patient centered medical home, lower end co-payments if you get care from providers within network and accountable care organization.

So just to bring home the amount people are paying now for premiums and out-of-pocket, if you look at people paying more than 20% of their income for healthcare, between 100 and 200% of poverty, almost 40% of beneficiaries in that income range are contributing over 20% of their income in premiums and out-of-pocket expenses.

Turning to the issue of Medicare beneficiaries with complex care needs, those who have two or more activities of daily living, have physical functioning limitations, who are seriously, cognitively impaired or are high cost, those individuals find Medicare's benefit package particularly inadequate. So the idea is to test through Center for Medicare and

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Medicaid Innovation (CMMI), in an intensive way, a new form of care that goes beyond accountable care organizations (ACO's) to coordinated care organizations (CCO's) that are accountable for homecare that share in savings from reduced nursing home placement. So going beyond ACO, sort of just concerned with the Medicare benefit package, with care coordination. Obviously financed in part by beneficiaries through income related premiums and cost sharing. But the major goal would be to provide an expanded array of services that would prevent nursing home placement. Some people think this is a dual eligible problem; it is not a dual eligible problem. Only 29% of people with serious physical and cognitive impairment are covered by Medicaid. This is a problem of beneficiaries whose income is below twice poverty; even those above twice poverty, who could contribute substantially to this benefit, but who find it difficult currently to arrange such services. Stu talked about the challenges ahead for moving provider payment forward toward value. We certainly have the department's commitment. We have MACRA. But there is going to need to be more effort to really transform provider payment method so that in fact we get beyond a goal of 60% to really 80 or 90% of providers participating in these methods.

So, just to summarize. Integrating the traditional Medicare benefit package, having it compete with Medicare Advantage plans, sliding scale subsidies, testing a new Medicare program for beneficiaries with complex care needs through CMMI, reaching Medicare's value based payment goals, going beyond that, engaging private payers and state Medicaid to work in concert with Medicare and obviously to ensure adequate financing for Medicare over the next two decades. Thank you.

ED HOWARD: Great, Sam?

SAM NUSSBAUM: First, let me thank you, Ed, and thank you Stu, thanking the Alliance for health reform and the Commonwealth Fund for convening us today to talk about Medicare past and future. It's really important to also acknowledge my two co-panelists for what they have contributed over their careers to advance access and understanding of health policy and in Rick's case, to be the first leader of the Center for Medicare and Medicaid Innovation, which I think in many ways is one of the jewels of the Affordable Care Act, so thank you.

What I would like to particularly start with is thanking Medicare at age 50. Thank you, Medicare for providing, as Karen and Stu and Ed have shared, the opportunities for access, the opportunities to provide medications, to provide services for individuals who are living longer with chronic illness. And that really is one the highlights of care in our nation compared to even other OECD nations. While we have our affordability issues, we certainly have seen what a difference providing services can make.

So with all of that, that is so extraordinarily positive, why in many circles has Medicare been seen as not solving our nation's problems with cost and care coordination? Why it hasn't fully solved the integration of clinical services. Why are we using services inappropriately and have 30 to 40% waste and inefficiency? Why are quality outcomes

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not what they need to be? So that really is the theme that I would like to build on. How do we take and move forward with Medicare, so that we can actually achieve those aims for our nation. Importantly, it's not just achieving those aims, but the more that we spend on health services broadly in Medicare and Medicaid, the less we can spend on infrastructure, education and all of those social determinants of health that are so vital for our nation.

So my starting point is actually Secretary Burwell's announcement in publication in The New England Journal in January, which says that delivery system reform requires a new focus on the way we pay providers, the way we deliver care and the way we distribute information. And that is really the path forward. So we are going to talk about -- I will share some of the innovative payment models that we and others are advancing. We have talked about a goal of moving to value based payment and that goal of being 30% population payment and 50% by 2018. Our own organizations today is at 53% of our payments, is value based, but if you look at the more advanced payment scheme and models, those that are population health, those that are focused on really value and clinical and medical budgets, were at about 29%. But it's also how we deliver and integrate care. You are going to hear much more about that from Rick. And it's how we share information and how we can provide information at the point of care.

So, here is some stunning information and I have contrasted Medicare with the commercial population. For our commercial membership, and its 30 million, so it's the largest commercial membership in the nation. The top 1% drives 28% of cost. The top 5% is 57%. Care is highly concentrated; less so in Medicare, but still an important theme. But if you look at what those illnesses are, you see that they represent illnesses of care coordination, of aging, heart disease and chronic kidney disease and cancer. The difference between Medicare and commercial is that many of our high cost members on the commercial side tend to have systemic illness that is being treated with specialty pharmaceuticals. And this is an important theme because if you saw some recent information from the Center for Medicare and Medicaid Services (CMS), 4.5 billion was spent on individuals with Hepatitis C. So breakthrough therapies, yet, can we continue to afford those therapies? One of the important themes that we are advancing along with other private insurers is this concept of provider collaboration and as a foundation of this, we have built value based payments, but if you begin to look at what is happening in the market, you are seeing more and more vertical integration. Insurers are becoming delivery systems and delivery systems are building insurance products. And so that type of integration, built on a foundation of data, of care continuum, of successful reporting and analytics, I think can make a huge difference going forward. Our own landscape involves hospitals and physician organizations, but particularly hospitals that are blue distinction centers of excellence. That is an area where we can look at outcomes, we can look at better value, we can look at transplant in many other areas and that is where we, across the blues, send our members to. And that is an area that I think CMS needs to consider going forward. How can you get people to those centers of excellence? We pay for quality and safety and you can see this in this review, how much that we are doing with accountable care organizations and primary care physicians to make that difference.

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In fact, we have recently looked at our patient-centered medical homes and ACO's. This is all together. And this isn't just those early experiments with the most successful groups where we actually, like others, saw 10 and 15% decrease in cost and dramatic increase in quality. This is spread across the nation and what you can see here are very important numbers. You see savings of about 3%, but you see the way it was achieved was the right way. There are fewer in-patient admissions and in-patient days, importantly decreasing ER use. But one of the things that we did is we build this model. You had to have 32 performance measures that you succeeded on as a gating event, which to me is critical.

As we have delegated models and more bundled payments or capitated payments or population based payments, we have to make sure that quality and performance stays in the picture. For those of you who want to see more detail about this, here are some of the measures that we use. We also have to develop innovative care models and we have been privileged to work with one of our own organizations called Care More and evolve a new model of care. This is for the most vulnerable seniors, our most vulnerable Medicare population and it's built around a model of care coordination and collaboration. It's facility based, but as you can envision, it involves care teams. So nurse care managers, a physician called an extensivist who quarterback the care. Clinical care centers and all under girded by predictive modeling and IT and data analytics and longitudinal care. We look at those results and we see really spectacular performance and our goal working together should be to work to achieve this type of performance across Medicare, across the nation. I have shared some of it with you on the quality in diabetes and heart failure and end stage renal disease, but also look at the utilization measures in terms of hospitalization and length of stay, in some instances half of what traditional Medicare has been able to deliver. While readmission rates have fallen nationally -- and that is terrific -- fallen several percent, again, we are looking at opportunities to be in the 10 or 12% range.

Let me close with the theme of specialty pharmaceuticals, cancer care, because if we look at where costs are being driven, they are being driven in specialty pharmaceuticals and I know if you look all in, you say that 10% - 12% of all of our healthcare spendings and pharmaceuticals, on the commercial side it's closer to 25% and if we look at these new drugs and Medicare and I mentioned the breakthrough therapies in Hepatitis C, we are going to see this number dramatically increase. So if we look at cancer and we all know this, that one in three patients are not receiving the appropriate treatment that is consistent with medical evidence. You can see this 25% growth in cost. We can see oncology -- and this is an example where the unintended consequence of paying oncologists a markup on drugs has led to higher drug costs and selection of drugs in many instances that are based on those costs. More importantly, how can we keep up with the science and knowledge? So when you take and actually look at the last year's newer drugs, you can see with 13 new drugs approved -- and this was two years ago in 2012, most sadly, were not breakthrough. They didn't extend survival by more than weeks or several months. Yet, if you look at that average cost. So that is what we have to do. One of the models that we are working on and we are working with CMMI, is this idea of, how do you pay differently for cancer or other care. In our instance, what we have done is we have

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worked with some of the nation's leading oncologists and cancer centers, developed care pathways and if you follow a care pathway, our approach is to incent that by paying a very significant monthly fee that actually democratizes payments, so you are not looking to pay and get your revenue through a 6% increase in drugs, but really on better care.

So in closing, I wanted to give you some real world examples of what the future can be in terms of care management, care coordination and how we can take that additional 30% of poor quality care. Care that is not delivered because we can do a far better job in coordination and make that difference. I want to make a final comment, it's one that is for our industry and that is the level of collaboration today between the private sector and CMS HHS, is outstanding. The work that we have done together, as you know, on CMMI, from the past and what we are continuing with, Patrick Conway on working very much on cancer models or comprehensive primary care models or having the right performance measures. So that is the future -- together -- coming together to make care better for all Americans. Thank you.

ED HOWARD: Great, thanks very much. We are going to turn now to Dr. Gilfillan.

RICHARD GILFILLAN: Thanks Ed and thanks Stu and thanks to the organizations for having us here today and convening us and giving us a chance to talk about Medicare's 50<sup>th</sup>. I think, Sam, you reminded me, in thanking CMS, that kind of begs the question like, who or what is Medicare? And in a human sense, it's -- I don't know, what, Stu? Seven, eight hundred people sitting in Baltimore? Another 300 or 400 spread around the country in regional offices? I'll bet in that collection of folks, there is at least one person who was there at the very beginning. Right? Do you think? It's not Liz Richter who has been the head of Medicare for some time and who leads a remarkable set of public servants who really have a strong, strong sense of loyalty, ownership, of the program and a sense of responsibility for the beneficiaries. So I think it's important to take a moment now and as we all have said, and recognize at 50, a government program isn't something that exists on its own, it's actually dedicated federal employees who work really hard and they are very smart, who operate this program year in and year out. So let's give a round of applause to those folks who are CMS.

[applause]

Thanks. So let me tell you a story about RBRS for a moment. I was in Philadelphia at the time in 1992 and I think it was the fall. It was like three months after it was rolled out at CMS and we were busily copying the CMS fee schedule, moving from what had been a crazy usual and [inaudible] charge kind of payment system for private insurers. I was working for Independence Blue Cross and converting it into an RBRS fee schedule. And we sat around, we had people working night and day to kind of come up with the numbers and then we sent them out to about -- probably 7,000 private physicians in Philadelphia. We all got a number of calls, but I had two that were really interesting, I thought. One was from an ENT doctor and he said, "I'm looking over your new fee schedule and I see that you are going to pay me \$350 to take out tonsils. Is that correct?"

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And the prior fee had been something on the order of \$1,000. I said, "Yes, that is correct." He said, "Okay, I just wanted to check." He said, "I think I would rather ride my bike." True story. And he did. He kind of exited our program. These programs have real effects when you make these changes. Another one, my favorite, was from an ophthalmologist who said, "I just got your new fee schedule and I'm looking at what you are going to pay me for cataracts." It was around \$900 and before that, he was getting \$1900 for taking out a cataract. Ten, fifteen minutes of work. He said, "Did you leave off a digit?" I said, "No." He said, "Okay, well, thank you very much." And hung up. So the truth is and I think Karen is correct, Medicare has been very innovative and has lead the charge over the last 50 years in making payment changes and we in the private sector -- and I worked in the insurance business for 20 years or so, like Sam. We shamelessly copied because you can't be out there with wildly divergent ways of doing business when you are all dealing with the same group of doctors or hospitals or other providers, right? You have to kind of align and when things get aligned, you know, it makes sense from a physician's standpoint or from a hospital's standpoint, even from a payer's standpoint. We piggyback on the group, the DRG group that Medicare put out there, we can all use. So you get aligned.

We have over these last 20 or 30 years, with some of the new payment systems, you know, we have got fragmented payment systems in the sense -- two degrees of fragmentation -- benefit structures, the programs within CMS that Karen mentioned and Stu mentioned, I'm not talking about that fragmentation. I'm talking about the fragmentation of paying for units of service through different payment systems -- international public private partnership study (IPPPS), outpatient prospective pay service (OPPS), resource-based relative value scale (RBRBS), all of that stuff. The result is, we have a delivery system that is totally adapted to being paid for fragments of care. And now we say, well, you know, in two years, how come all those pioneers haven't saved more money? Well, guess what? They built a system of care over the last 30 years that has been oriented at delivering something entirely different. A lot of services. We are really good at it. We have institutions that are built around that, right? And I was just -- the last two days I spent my time with about 100 CEO's of hospitals -- we have 85 hospitals in our organization and other entities and I spent time with 100 of them and we are going through our plan about how we are going to make this change. And it's a giant change because we have 2300 physicians who work in those 89 hospitals and they are used to getting paid for fragments of care. And we are used to getting paid for fragments of care. And guess what? If that means a patient gets two bills because they happened to see a doctor in one of our office buildings, that is just the way we learned to do it. Provider based billing, a remarkable thing.

So here we are at a time where now we've done a great job in a lot of ways and in the way we have built our payment systems and the way we have delivered care. Care has gotten better and people are living longer and actuaries have new tables demonstrating prolonged life expectancy. But it's wildly expensive and inflationary, we can't afford it and now we are facing the prospect of changing a delivery system that has adapted to doing it this way and saying -- and at times here in D.C., we say, well, why won't you

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just produce coordinated high value care? What is the matter? Well, you know, we are doing some other stuff and if you want us to do that, we have to stop doing the stuff we have been doing and start doing some new stuff and if we are going to do that, you need to give us the support to do that, right? So the way we frame this in our system is we have said -- you know, we started saying, oh, we are going to become population health managers and do all that. Then we thought, you know, we've got 89,000 employees and 88,850 of them didn't see themselves in a population health world. They are delivering great care to people who are sick in hospitals or in doctor's offices and we had to reframe this. So that is one reason we talk about it this way.

The second way is, we went at some of this in the '90s and we didn't have foremost in our minds that we have to build a system that is for people -- the people we serve -- the patients we serve -- not for us as providers. We don't want to make that mistake again. So we call it "building a people's centered health system". It goes acute care and that system will do population health management and it will address some of the unlining determinants of care in the population. So that is how we are going at it. All of it, success defined by better health, better care, reduced costs for the populations we serve.

We have a whole plan, we have 17 initiatives, we are trying to roll it out now. Our hospital folks say, that's great, we are behind in everything, but this takes time because guess what, we are taking care of sick people. We are taking care of injured people. We have hospitals in Philadelphia responding incredibly to the tragedy up there this past week, right? Those are the same people that we are asking to transform the way they are delivering care. So we need to be mindful, when we come out and wear our policy hats, that this is real stuff, real people caring for folks out there. Caring for our relatives. We need to have a good perspective about what it means to change all of this stuff.

We are doing a lot of different things, as Sam pointed out. We have got some new joint benches, we have got a bunch of ACO's, Accountable Care Organizations now in 21 states and we have about a million and a half people that are in those. We are doing bundle payments, a lot of that. We are doing clinically integrated networks and that is a lot of change. So you say, what is ACO's, what does that mean? Well, you call together 100 primary care physicians in your community who are working 12 hour days and you say, well, let's all get together and build a clinically integrated network and an ACO. So what it amounts to is you have a meeting at either 7:00 am or 7:00 pm, get them all in a room and start talking to them about this stuff, while they are still worrying about whether or not their office practice is going to survive or whether or not the SGR fix is going to get done.

So I'm just trying to give you the flavor of what happens on the ground with all of this stuff and it's real and it's complex. Now, there will be savings, as Sam pointed out and we have to be mindful of the fact that the savings are not just there to be taken out of the system. We need to reinvest in doing things differently from what we are doing today. This is a very specific problem. In the '90s, in California, private insurers put medical groups at risk. Said, here is a percentage of premiums. 85% of premium, go knock your

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socks off, deliver great care. And they did that. They realized that private insurers said, well how about we decrease premiums? We've got these providers locked into a contract, so maybe next year we can actually decrease what we charge our customers and grow market share, right? And -- great idea. Well, the 85% of premium that year becomes 85% of a lower premium the next year. And what happened? It imploded because at the end of the day, people didn't have enough money to take good care of people and people weren't getting the care they needed. That in my mind is equivalent to the conversation that we are having right now with CMS, where we talk about whether or not they rebase ACO rates and they take the savings out. The whole point is -- the point I would like to make to them and others, and we have, is they need to leave the savings in. CMS has been a great partner. They have transitioned lots of systems, there is all sorts of things they are doing at Sandpoint and Karen mentioned, the secretary has identified timelines -- two different sets of payment mechanisms. Value based payment in CMS terms. Here is a little extra on top of your fee-for-service payments. Here is two or three percent more. Two or three percent less. Alternative payment contracts, we are going to hold you responsible for meeting a target -- a medical expense target and quality targets. Two very different things. The 30 and 50% targets have to do with the latter. There is lots of issues that are out there, we need to talk about with CMS and hopefully we will convince them to make the basic proposition that they are offering, stronger, so that we have the ability, the business proposition, so we have the ability to reinvest.

Regarding alignment of the private and public sectors, a bunch of us, in talking, realized that there wasn't a mechanism for employers, payers, providers and consumer folks to come together and think about this transformation to a different kind of healthcare system. And so we organized a group of folks from different organizations reflecting those different segments and said, let's create a task force that actually works together to kind of create a more explicit timeline and standard ways of actually interacting so that we can speed the process of transforming our care system. And we agreed, as part of that, that we would set a goal of having 75% of all of our business in contracts that reward us for delivering the total cost of care. So these are the organizations that are participating, there is now 33 and more coming. Very active in providing lots of input into CMS. We came up with some basic guiding principles that all of these folks signed off on. You have them, I think, and I won't go through them one by one. I think the key issues, as I look forward, in my mind, for CMS and for Medicare, I would say while the folks in Baltimore do fabulous work, they are great folks, but they don't have line of sight into the outcomes that they are producing and they don't look at them. And so for me, I would say let's think about CMS becoming accountable for population health outcomes. Let's give them information. Let's have a performance program for CMS employees, for Medicare employees, that says, your targets for this year on a cost basis, on a quality basis or a patient experience basis are these. And let's actually create an accountable health support system, if you will, within CMS, so that they understand the changes that they are trying to make and engage much more concretely in the discussion about what it takes to transform our system.

Thank you all very much and I look forward to questions. Thanks, Ed.

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ED HOWARD: So now you have an opportunity to get into the conversation. There are microphones on either side of the room to which you can repair. There are also green cards in your packets. If you write a question on there and hold it up, someone from the staff will be happy to grab it from your fingers and bring it forward. Stu, do you want to get us started with a really tough question for this panel?

STUART GUTERMAN: I wanted to take this opportunity to plug a new initiative that the Department of Health and Human Services has rolled out that really dovetails with the activities that Rick is talking about in the private sector and it's called the Healthcare Payment Learning in Action Network. More and more you will notice that we have a lot of representation from the private sector here. I think it's recognition that Medicare is part of a broad healthcare system and the problems that public and private sector payers face are common, because they deal with same group of patients and the same group of providers. So based on that, since we have some folks who are Hill staff here, policy makers, what -- I would ask each member of the panel, what are the most important things that Congress can do to help facilitate this -- both alignment between the public and private sector and movement in the directions that you have all described. And Rick, do you want to start off?

RICHARD GILFILLAN: A couple of thoughts. One, working within the government and going back and forth in the private sectors, it's an interesting experience and what I came away with is the belief that markets are effective and good in lots of different ways, but there are times when we need to create markets and adjust markets and I believe that, as Karen mentioned, the Medicare Advantage marketplace is great. There is a problem with how we pay rates in Medicare Advantage that may get more costly than it should be, but the exchange works great. So to me, I think -- but when we go deep, when government goes deep, deep into prescribing specifics around what the metrics should be or exactly what the timeframe should be on things, it freezes, it creates the effect of freezing the status quo in place. So the first thing I would say is, I would love for both the administration and for the Congress to recognize that they need to be sophisticated in thinking about the dynamics and how they interact with the marketplace and stay high level. To me, a good example would be having 32 metrics for ACO's to me, is way too much. We should have five to seven simple patient reported functional status outcomes or something like that and recognize that, hold us accountable, sure, give us time to make them better, but don't try to get into prescribing 30 to 50 different ways that we should -- that allow us to teach and perform to the test as opposed to staying high level. So I guess I just offer that to staffers and say, there is a role for government, it's better to be high level, better to be market oriented, I think, make sure to build safety net activities, stay at that level, don't go deep and let us let the marketplace be innovative in responding.

KAREN DAVIS: I would say the number one thing would be to share savings with beneficiaries. So we have thought about shared savings as saving them between the federal government and the providers, but we haven't explicitly talked about sharing savings with beneficiaries. So how would one do that? First of all, eliminating the Part B

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deductible for people who get their care for patient centered medical homes. That is the first step. I would also suggest lower premiums, if they use a network of high value providers, those participating in alternative payment methods. So I think getting serious about thinking about how we lower premiums, lower cost sharing, for beneficiaries that are also reinforcing the pressure on providers to switch to this new method. That requires information on how value providers, how does a beneficiary know which hospital is taking a bundled payment for the orthopedic procedure that they need? How do they know who is getting good outcomes for different types of cardiac procedures? And in fact, we are not even very far along about asking beneficiaries to designate where they are getting their care from an accountable care organization, from a patient in medical homes. So really getting serious about thinking about the beneficiary part of this. Information, designating sources of care, effectively tiered networks with reduced cost sharing if you are getting care from high value providers.

SAMUEL NUSSBAUM: And to build on the comments that Karen and Rick have, I think it's about letting innovation in the private sector flourish -- there are many new models of care. Access to retail clinics, access to telehealth services and often regulation, while wise and brings a lot of power to making sure that care is safe and is done in a responsible way, I think sometimes it can be used to not always endorse that type of innovation, which we need to have to get greater access care. I think the other pieces that, healthcare historically has not been consumer focused. We don't have timely information on quality safety and that is really where I think, CMS, private sector and others can guide far better care. To me, we have to finally make a commitment and that is a statement that we have 30 to 40% of care that is not adding value, that can be achieved differently and that is where it will take, I think, a lot more rework of the delivery system to achieve that and that should be driven by both government interest and private interest.

RICHARD GILFILLAN: One other point of clarification. We just did the SGR fix and we went through like ten years of crazy distorting discussions and policy debates and adjustments that had real impact, because someone put a language in a bill ten years ago with a formula that became law and therefore told us what we had to do for all those years. Then we ignored it and the whole debate became, how do we go about ignoring it? So again, I guess I sit here and I think, please, from a legislative standpoint, trust your folks who are running a program, liberate them, give them support, give them some direction, but don't think that the right way to create an innovative program is to be deeply prescriptive about pieces of the program that are legislated. Legislation is very different from administrative. Just a thought that may be unconventional.

ED HOWARD: Please identify yourself and try to keep your question as brief as possible.

AUDIENCE MEMBER: Thank you so much for an excellent panel. I'm Amy Grace; I'm from the Office of Senator Brian Schatz from Hawaii. The senator has been very interested in telehealth and how we can use it to improve patient care, to decrease cost, to reach the underserved and we are looking at ways we might be able to reform Medicare

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payment policies in order to expand telehealth services. I was wondering how you think how we could best do that and also what Congress can do to facilitate using telehealth more broadly.

SAMUEL NUSSBAUM: Thanks for your question, I think there are a number of telehealth companies and if you have watched what they can do now, you will see how one that we are working with and the brand is called Live Health Online, it's with American [inaudible] company that we have invested in. We are providing urgent care through an array of physicians through telehealth. I think when we look at mental health, substance use disorders and the absolute need for more and more professional capacity there, particularly in rural areas, telehealth can solve that. So the answer is -- and you know this is occurring at the state level; we have had many states that have moved in highly progressive ways and allowing telehealth. Others have said that a physician, health professional, needs to actually have a relationship with a patient, have hands on. I think we have to think very differently and the state legislation and federal legislation needs to recognize new forms of access.

ED HOWARD: Yes, go right ahead.

AUDIENCE MEMBER: I'm Dr. Carolyn Poplin; I'm a primary care physician and also a Medicare beneficiary. I have been very happy to see how many places accept my Medicare that did not take my federal employee Blue Cross/Blue Shield. My question for Karen is, you say in your first slide that many of our innovations have been picked up by foreign OECD countries and I was curious to know which they are and for Dr. Gilfillan, what are the five measures that you would like Medicare to insist on for ACO's?

KAREN DAVIS: [inaudible] supply you with a list of countries, but over 40 different countries -- Australia and a number of the providences --

AUDIENCE MEMBER: Not countries, innovations. Which ones have they picked up?

KAREN DAVIS: So I was talking specifically about hospital payment innovation, physician payment innovation. So I think those are the main ones. When I look the other way, I think its primary care. I think the patient centered medical home has a lot of its roots in other systems that have tried that. Certainly other countries led in the IT adoption. Got there before we got there. So the more recent value based payment, I think we are a bit ahead of other countries, but you can find global payment examples in Germany, certainly the UK in 2004 started bonuses to GPs for reaching quality targets. So I think we can all learn from each other and for too long we have kind of been fairly insular in looking at our own experience. But certainly primary care, the kinds of tools, information technology, evidence-based. We have got [inaudible] Outcomes Research Institute. But again, I would say other countries are ahead of us on that. The UK with the National Institute of Clinical Excellence. Obviously other countries are way ahead of us on negotiating pharmaceutical prices and reviewing pharmaceuticals. We taught [inaudible] specialty drugs, other countries have a different approach to that. Really

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looking at, what is the value added of new pharmaceuticals before deciding to add them to formularies.

ED HOWARD: Rick, in the context of the question about the number of measures and what the specific half dozen or fewer than that you might recommend, I just want to note for the record that just a few weeks ago, the Institute of Medicine issued a report in which it identified -- I think it was 1700 different quality metrics that were being used by one or another part of HHS. I don't know whether you have to get from 32 to five or 1700 to five, but how do you do that?

RICHARD GILFILLAN: I confess that after participating in the discussion about the 32 -- the 32 start out -- you may recall a 66 or something like that right in the first NPR for NCO's and Patrick Conway, I think, did a great job leading that refinement over time and I think in the industry, you know, we have gotten used to kind of thinking of things that way and it's great to have -- how many measures do we have on Uber about the quality of your experience? And I know healthcare is not transportation, but I talk with Chris Casell at times about this and I'm not an authority on what those metrics ought to be, but I would think there is a way for us to ask people, what is the -- how did your functional status -- how you are doing now compared to when you went into the hospital. Or for all the hip folks, how are you doing at 30 days or 60 days? Tell us how that has worked for you. Look for those kinds of measures that are straight forward that we can -- that are based in the patient. And you can do analytics and CMS can publish -- and as they are doing a great job of, put that out there, let people do analytics, let them figure out whose got the best hemoglobin A1C control and all that. But don't prescribe the use of beta blockers after a heart attack for ten years and drive people to go from 97% to 99%. That is my concern about telehealth. It seems to be with telehealth, what we should say is, it would be great if we could get past the state limits -- the state specific limits on medical licensure and I don't know how we can do that legally, constitutionally and stuff, but that is one area of focus, it seems to me, where legislation could help. It could help for legislatures to say to CMS, you know, stop using all of these other criteria that are limiting the use of telehealth and monitor it, period. Not -- don't go a whole lot further, right? So I guess that's -- I would say that -- and talk to Chris Casell and others in the IOM and say, let's agree on a small number that are out there that are meaningful, that mean something to patients and that are comparable and use those for payment purposes and then put other analytics out there that people can decide to pay attention to or not pay attention to. Is that pretty good ducking of your question?

AUDIENCE MEMBER: Yes.

SAMUEL NUSSBAUM: I think I can very briefly tell you a very positive story on this front. Many of the health plans are sitting with CMS and medical professional organization today and looking at those core sets of measures including what we need more in terms of patient reported outcomes, to try to really focus for physicians, for providers on better, safer care. So there is actually, after a field of dreams of decades, there is actually some pretty strong progress and you will be hearing more about that.

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KAREN DAVIS: A bit of a contrarian. I do think that people want information about their own condition, so I was struck by Dr. Nussbaum's finding that one in three chemotherapy patients receive treatments inconsistent with medical evidence. So if I'm a breast cancer patient, I want to know the names of those centers. I want to know the five year survival rates of each of the centers that I might go to for my care. So having an aggregate measure about what I recommend my provider to my friends and families, I value that, but I think people are going to want to know pretty specifically -- do I have a better chance of living if I go here than if I go there? And who is on the cutting edge and who is it taking 17 years to diffuse the latest technology? And I just as soon not have my cancer treated there.

STUART GUTERMAN: Let me point out that we could go a long way to reducing that 1700 different measures to a more manageable number, just by looking at the measures and finding out which ones are essentially measuring the same thing, but just measuring it in different ways. So a lot of that number is beefed up by the fact that different insurance companies and Medicare and different agencies in the U.S. government are all asking the same question, but asking it differently and requiring different reporting to answer that question. So it would be easy to hone it down somewhat. And then the other thing is just really being more clear about what it is we want to be buying from healthcare and we kind of tend to look at things backwards. We say, okay, how much do we want to spend? Then what do we want to spend it on? It would go a long way to making things clear for both providers and payers, to kind of decide what we want from our healthcare system and decide that we are going to pay for that.

RICHARD GILFILLAN: I hear you Karen, and the problem is that there is an endless set of that. Right? The metrics change and the meaningfulness of it changes. So again, go back to the notion of a higher level approach. How about if we finally say, CMS says to the five -- or not five, the 20 odd specialty societies, here is the money to put together a registry that people can voluntarily report to and you, specialty society, agree on what they are going to be, put them out there and create a marketplace, right? Now we have a marketplace high order, but not necessarily us getting it -- as the policy folks getting into actually freezing the metrics and identifying the metrics, particularly through legislation, which I know it happens sometimes, but more through the regulatory process. But I would say, focus that way and liberate the market and make us, as providers for instance, compete. I think -- well, I will stop there. Thanks.

AUDIENCE MEMBER: Florence Fee, I'm Executive Director of No Health Without Mental Health and I would like to pick up on a statement that Dr. David made that the Secretary of HHS has authority to spread successful CMMI payment methods to all interested and qualified providers. I would like to focus in on that and talk about a specific CMMI project from the frontlines and what we are learning. Our non-profits, working with healthcare systems, eight of them across eight states that are involved in the COMPASUS Project -- COMPASUS standing for Care of Mental and Physical and Substance Use Syndromes. And it's a CMMI project to test the best of the best of

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collaborative care model, which treats mental health, common mental health disorders and primary care. And the results -- it's been running for the last three years, what the results are showing, they will be made final this fall, is that this is a real issue of what -- and some of these are healthcare systems like Mayo and Kaiser and AIM Center in Washington. There is great variability, variation in the health outcomes of this model. It is highlighting the importance of provider leadership. It is highlighting how hugely important the workforce issue is because this is a CARE innovation, which is going to transform primary care, so how the entire medical care staff reacts to that and embraces it. So I just wanted to get your thoughts, Dr. Davis and the other panelists, what can CMS and also the Congressional groups like the Help Committee and Energy in Commerce, how can they support the actual implementation of innovative to allow such a diverse array of medical practices across the country to be able to implement these innovations? Thank you.

SAMUEL NUSSBAUM: If I could begin by speaking to that. First of all, thank you and for those who have not seen this model, it is also called Collaborative Care Model. I think initially Dr. [name] at University of Washington, the head of Psychiatry and it's a model that has been shown in about 70 different studies including the CMMI work, to truly make a difference, because what people don't realize is not only your mental health needs not being met, you pointed that out, but individuals who have mental health diagnosis or substance use disorder diagnoses have about three times the medical cost as others and these models have worked. But I will give an example. First of all, and others will tell you, the secretary has the opportunity to look at a successful program and implement it, but in the private sector, we have implemented it in many of our Medicaid programs. We are looking to implement it in that medical home model that I showed you. Because its an example of innovation flourishing, the results are out there. It works and why not explore and export this as in as many settings as can be done?

KAREN DAVIS: Well, I'm excited to hear about it and hope to learn more about it. I think one point that is a little off to the side, but you have triggered, is the importance of engaging patient advocacy organizations in the development of these quality metrics. So I was struck by Dr. Gail [name] appeal to professionals to establish registries and the metrics that matter. But I think it's also important to get that patient advocacy element in there as well. I don't know enough about COMPASS to be directly on target, but I think at some point we may need to look at whether the CMMI authorizing legislation needs to be broadened a bit. I mean, we all know that ten billion dollars over ten years, that's a great that it does provide the secretary with authority to spread successful models that are deemed by the Office of the Actuary to improve outcomes, quality patient experiences or lower costs without harming the other, but I think in some of these areas, and mental health and substance abuse may be one, there is so much unmet need that really, to provide good care, you have to spend more. I think that may be true on this complex care beneficiaries with physical and cognitive limitations where they are going to need non-medical personal services or daycare services to be able to continue to live independently and support for family care givers. So, can that be done at a budget neutral way? Improving quality of life at no additional cost? Or is there some additional cost? So I

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think the first thrust may be to broaden the CMI authority to -- because we have got to get ready for the major increase of the number of people with Alzheimer's, for example, and what are effective care models for those patients? And not just be limited by the way this was set up initially.

RICHARD GILFILLAN: A couple of points. One -- and I agree with Karen entirely that any work that we do, has to include patient advocates and we call doing that -- we have what we call people-centered time outs in all of our design work, where we actually bring that perspective in, in a number of different ways. So, I agree with you entirely, Karen. So Pioneer was declared a success and they said, okay, now we are going to move some of those findings into SSP, presumably. That power is there to make a program scaled nationally. There is a lot of debate within -- there has been, about how to interpret the language in the statute. If bundled payments are successful and declared successful, right, two options for scaling national -- one, you say, okay, we have a national program, who wants to bundle payment for care improvement type of approach? Sign up here. That is approach one. Approach two is to say, DRGs are done. We now pay for care this way. Mandatory versus involuntary, if you will. Unclear how people are thinking about that language, I think. I would note that people thought that if they were going to take the latter approach, they would need to go through the reg process and you will notice in the IPPS this year, they asked for comments, right, on scaling bundled payments. So I suspect that that is out there. The interesting question about COMPASS and it's great to hear that it's gone well -- and the whole question with the innovation grants that were done to relatively -- the small ones, was whether or not they provided a sufficient evidence-base for the actuaries to make the determination that it was saving money, and/or flat on costs and improving quality. That was unclear. The good news is, I think Pioneer, their opinion on Pioneer demonstrates that the actuaries are pretty broad in their thinking and their analysis as you would expect them to be. They are really smart people by the way. And the people at CMS and they are really good. So they thought broadly. The question will be, as they look at a COMPASS result, which is one of the innovation grants, a small number of cases, small end, but will they factor in the other 70, declare it a success and feel that they can actually leverage off of that to scale it nationally with a new payment model? Or will they say it's successful enough and now we need to do a larger test? I don't know the answer, but I think if I were you all, I would be probing real hard and asking them questions around those issues.

AUDIENCE MEMBER: My name is [name] with the Pakistani [inaudible] and my question is to Dr. Karen Davis. While the Pakistani economy is taking off, they want to follow these two models -- Medicare and Medicaid and they are being a little critical because, this is my personal opinion, there is an [inaudible] organization, it is the Pakistani American, there are thousands of members and I was in there [inaudible] and I learned how one doctor ripped Uncle Sam so hard that he became a millionaire by stealing money, basically. And then sometime [inaudible] American tax reform, a [inaudible] organization and what I learned from [inaudible] and what I learned from American tax reform, Medicare and Medicaid are just kind of redistribution of [inaudible] taken from very hard working people and giving it to poor people. While

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Pakistani government is considering these two models, I just wonder that, if these poor countries -- I mean, Pakistan is a relatively poor country, can afford these kind of Medicare and Medicaid program for their own people. I just want to tell you a little story. I was in high school when I had pain in my ear. I went to the hospital and they put something and I was recovered and two days after that, I learned they put water in my ear. So if that system is so efficient, then shouldn't the U.S. follow Pakistani model rather than a poor country should follow American model? Thank you very much.

KAREN DAVIS: Well, I'm not sure I totally got that. When people say that we can't afford an aging population, I tend to look at other industrialized countries -- Pakistan obviously may not be a case in point, but they have much higher shares of their population who are elderly and yet, they spend half per capita what we spend on healthcare. So I think it's a matter of the way we go about organizing, delivering and paying for care. It's not just redistributing wealth from the rich to the poor.

ED HOWARD: We have time for questions from the two folks who are at the microphones now. Joyce?

AUDIENCE MEMBER: Joyce Frieden from Med Page Today. Obviously outpatient care is a big part of Medicare, so I'm wondering if any of the panelists can say how they think an outpatient practice might look different in say, five years, because of all these changes. Also, if any of them want to address the issue of financing Medicare, I think Dr. Davis touched on it a little bit, but is it a concern and what are people looking at?

KAREN DAVIS: Well, I will let others address your first question on outpatient practice and it's future, but in terms of financing Medicare, I think the main thing we have learned from the CBO and Office of the Actuary projections in 2009, is that we can't project very accurately 10, 20, 50, 75 years out and we probably need to focus on the next 10 to 20 years and forget about 75 year forecasts. So I think all of us are aware that if you compare either the [inaudible] of the actuary or CPO projections of Medicare spending over a ten year period, what they estimated in 2009 is one trillion dollars higher than they are now projecting for the years from 2011 to 2020. So off by one trillion over that ten year period in projected Medicare outlays. So I think in that context, it doesn't make sense to worry about 50, 75 year projections. So what is the prospect for the next 10 to 20 years? We know that Part A solvency has been extended for 13 years -- from 2017 to 2030. So we got 15 years on Part A. We know that Medicare is now growing at the lowest rate on a per capita basis that it's grown in 50 years. What we don't know is why and whether it's permanent or whether it will resume. I think it makes sense to kind of figure that out before having major changes. I personally think it does relate to the transformation of the healthcare system that we talked about, a good bit of which preceded the ACA, but the ACA certainly accelerated that type of change and everything you have heard on this panel. So let's see how far we can get with improving the movement toward value based payment, reorganizing care, moving care out of office visits into telehealth -- that's not just a rural issue, it's an efficiency issue. A lot of people just as soon deal with their doctor by email or Skype instead of making the trek into the

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office. So, how much room can we get through greater efficiency before we worry about how do we raise taxes or cut benefits or shift costs to beneficiaries?

STUART GUTERMAN: Let me also add to that on the financing issues, before we get into the other question. There are two points I would make. One is that we as a society have made a decision to reduce more elderly people, but we seem to have trouble with the price tag for that decision. We really ought to think that if a growing part of our population is elderly, that we ought to face the fact that that's going to have some ramifications as to how we allocate resources in our society. The other is that when we portray Medicare financing as an intergenerational equity issue, I would point out that unlike many other different groups in society, the thing about generations is that people who are young now, aspire to become elderly one day. So we are not talking about us versus them, we are talking about us now versus us later. And I think that is a more productive way to think about how we view the Medicare program in the future.

SAMUEL NUSSBAUM: Your first theme of outpatient care, technology is revolutionizing how care is delivered. So whether we look at hospital at home, whether we look at telehealth, it will be vastly different. We look at our medications that can be now given orally versus infusion and it's interesting, if we consider some of the hugest variation in cost of care for Medicare, is post acute care. We realize that there is opportunity every step along the way and it will be guided by some of these models that delivery systems, when they are accountable for the total cost, will find ways. Rick and his Trinity College are going to find ways to move to more efficient, effective and more patient centered models of care.

RICHARD GILFILLAN: The only think I would add to that -- that is really true -- I think it is going to be widely innovative in very positive ways and one critical part of that, I think we are just going to see different people providing services and I think we will see the emergence of much more use of advanced practice nurses, other community health workers, etcetera, as we really get out there and I realize that there are new ways to actually impact the total cost of care and improved quality that we haven't really understood. So I think that to me is one of the most exciting parts of where we seem to headed in addition to the technical stuff.

AUDIENCE MEMBER: Andrew Mychkovsky at Care First Blue Cross/Blue Shield. You have talked a lot about incentivizing care coordination and value based payments and I would like to ask the panel what their thoughts are on the chronic care management codes. How can we balance the effective incentivization of care planning, but also as mentioned, have an accountable sign of light to the payments that are being provided and assuring that the care plans being created across the nation provide some sort of ROI to the community and the Medicare payers at a whole.

KAREN DAVIS: It's a bit of a cop out to say we need to learn more, but I think when you get to chronic care management, there are models that are getting good returns and models that aren't and we are learning that nurses embedded in primary care practice

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have more of an impact than call centers or people who aren't perceived by patients as to be part of the primary care practice. So, I agree that we ought to not just open up a whole new code of payment, but really target providers that need certain performance standards on effectiveness.

**SAMUEL NUSSBAUM:** In the models that many of us are talking about, the one I shared was one on shared savings. If you start having more and more codes, whether its for care after a certain time, it's for care coordination, you are in many ways basically reinforcing this use of services and a fee-for-service model that hasn't achieved what we hoped to. So there is nothing inherently wrong with the code that is for care coordination, but wouldn't it be better to have shared savings off of a global budget, looking at avoidable rehospitalizations. To me, that is the real answer as opposed to determining when that code will or should be used and I think again, it strikes me that the more sophisticated that we become there, the more it will take away from where we ultimately have to, which is a new payment mechanism.

**STUART GUTERMAN:** Let me point out that the Commonwealth Fund actually has several initiatives where we are looking for successful models of dealing with what we are calling high need, high cost population. So watch that space because we will be coming out with some reports that look at those models.

**RICHARD GILFILLAN:** I think it's a classic case of an overreach and there is a simple way to do this, I think. I applaud the intent. The intent was to find ways to support care coordination and I think that is great for Medicare people. But to put a reg out that says its going to be this, if you can submit that with this frequency and for these kinds of people, but you have to do this and they have to have been here before and I don't remember all of the details of what came. Contrast that with a simple statement or a simple rule that says, we are going to provide \$10 per member, per month, for every Medicare beneficiary, to primary care practice and we are going to be looking at the total cost of care and five quality measures and see how you are doing and if you are not in the top X percent or you are in the lowest percent or we don't see any improvement, you are not gonna get it. What I fear is gonna happen -- I have already heard the conversations, right? Oh, let's see, I need to put a process in place to capture the code, to document it here and do that. It's just -- it's a great intent gone in the wrong direction.

**ED HOWARD:** Well, we have heard a lot today about the direction Medicare should go and perhaps will go and I don't think it will be the last time we address this question over the course of the next couple of years. I want to thank our Commonwealth Fund and particularly Stuart Guterman for their participation in putting this program together in a very thoughtful way. Thank you for taking the time on a beautiful day to be part of a very useful conversation and ask you to do two things for me and I don't think you can do them simultaneously. I want you to fill out the blue evaluation form and join me in thanking the panel for a great presentation.

[Applause]

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