Pathways to Universal Coverage: Payment Reform Strategies for Containing Costs
Alliance for Health Reform and The Commonwealth Fund
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ED HOWARD: — be on time today. My name is Ed Howard, I am with the Alliance for Health Reform and on behalf of Senator Rockefeller, Senator Collins, and our Board of Directors I want to welcome you to this briefing on the way we pay for healthcare and how changing the way we pay for healthcare fits or doesn't fit with move to reform the healthcare system in general.

Now, a lot of exceptions you're going to hear about some of them today, but most healthcare in the United States is still paid for through a fee-for-service method. Each individual service, procedure or test, physician visit is reimbursed if you're lucky, right?

Now, there are the analysts and policy makers with a whole lot of different viewpoints on how to reform this system seem to be coming to a rough consensus that reforming the payment system is an essential ingredient in getting better value for our healthcare dollar, in getting a handle on cost growth in general and improving the outcomes of healthcare interventions. There is somewhat less than unanimous agreement on how the payment system should be changed to reach those goals and today's briefing is designed to explore some of those proposed changes.

Our partner and co-sponsor in this briefing, the Commonwealth Fund has commissioned or actually carried out some

of the most thoughtful and useful analysis of the reform implications of payment policy change. I also want to say a special word of thanks to Susan Dentzer and her colleagues at *Health Affairs*, a leading policy journal in the United States, for making available this Value in Healthcare volume which collects a number of thoughtful papers including one by one of our lead-off speakers here that is based on discussion at last spring's Princeton Conference.

Now at this point I'd like to call in the Commonwealth Fund's Karen Davis who is in her own right one of the country's leading healthcare analysts and who will be co-moderating today's briefing. Karen?

KAREN DAVIS: Thanks, Ed. Thanks for hosting this seminar and thanks for inviting a terrific audience today. It's great to see the room packed but that also means that there is a lot of work done by the Alliance of Health Reforms staff in pulling this event off, so many things to do and you're able to stand for them.

I might just make a few general comments to reenforce those that Ed has made and the first is to think about payment reform in the context of health reform whose goals include improving access to care, improving the quality of care, and slowing the growth in healthcare costs. Now that may seem obvious but too often when we come at the issue of payment, in this town, we're really talking about the federal budget and

how to achieve savings and then sort of close the gap in budget deficit through Medicare payment reform.

I think it's important to think about payment reform in the broader context of the objective itself. How that can be a tool for changing the delivery of healthcare services and improving quality, improving access to care, as well as, addressing the economic concerns that help [inaudible] costs. And I think it should – the other mind shift is to think about payment reform not as just affecting the price of getting service, again, we pay for recommendations for the Medicare Payment Assessment Commission about updates, so we need time to get focused on updates.

But, I really think when we talk about payment reform we need to be thinking about how incentives can leverage change in the way healthcare is organized and delivered to – for the benefit of patients that have better access to care and improved quality. The third point I would like to make is I think it's really important to have a comprehensive approach that thinks simultaneously about access quality and cost. It doesn't just work on the issue of cost, again, in any budget cycle; in any economic situation there is a tendency to focus exclusively on cost.

But the real difficulty with thinking about that slowing the growth in cost without addressing the access problem is that you run the risk of squeezing those who are

least able to pay out of the healthcare system. Obviously if you're under economic pressure as a provider organization cutting back on uncompensated care, care to those who can't pay is one strategy that you may be forced to pursue. As they say no margin, no mission.

So, even those that are very committed to serving the uninsured and those who can't pay find it tough in any era of provider payment change. So it's important to think about this in terms of also covering the uninsured and making sure care is affordable for people.

And then the final point I would make is how important it is to think about not just those aged 65 and over covered by Medicare but how do we change incentives for those in the working population, as well. Again, trying to do things just in Medicare will not have the impact on the healthcare system that trying to do something more broadly.

Obviously Medicare can be an innovator, Medicare can lead. But in the end Medicare can't do it alone and it's important to think about reforming the broader context of the way in which providers are paid across all forms of insurance coverage. So with that I'll turn it back to Ed.

ED HOWARD: Great, thank you, Karen. Just a couple of logistical items, you have in your packets a lot of background information including biographical info on all of our speakers to supplement the very modest introductions they're going to

get here. Tomorrow, you will be able to, that is to say Monday you will be able to view a Web cast of this briefing on Kaisernetwork.org for which we're very grateful. And in a few days you'll be able to see a transcript, both on Kaisernetwork.org Website and on the Alliance Website. You can even download a podcast if you know how to do that.

At the appropriate time you will find green cards in your packet to use to write a question on. There is also some microphones, one here and on in the middle of the room, that you can use to talk your question through and a blue evaluation form that I hope you'll take the time to fill out before you leave. Enough, we have, as Karen noted a terrific lineup of people both expert with Medicare and expert in the healthcare system in general.

And we're going to start off with Stu Guterman. Stu is an Assistant Vice President of Commonwealth for their Program on Medicare's Future. He has done extensive MedPAC and CBO and before he joined Commonwealth he was Director of the Office of Research and Demonstrations at the Centers for Medicare and Medicaid Services, in effect overseeing a range of studies and demonstrations involving Medicare's payment methods.

He's going to kick off today's discussion by outlining for us the payment recommendations contained in the report *Path to a High Performance U.S. Health System* that was recently

issued by Commonwealth's Commission on a High Performance health system. Stu, thank you for being with us.

STUART GUTERMAN: Thanks, Ed. As Ed mentioned I am going to talk about the payment reform policies that were recommended in the Commission's report. I can start out first by giving you an overview of the context of those payment reform recommendations. The Commission set out to address the – fixing the three-legged stool of healthcare to address problems with access, quality and cost of care.

And as Karen mentioned those three aspects of the healthcare system are, A; all broken in the current system. And B, all need to be fixed together to be able to be most effective. The Commission developed a five strategies and under those strategies they've recommended several changes in the healthcare system to improve access, to provide affordable coverage for all, to align incentives better in the healthcare system, to improve quality and health outcomes and to provide better, more patient centered care.

And they also called for leadership and collaboration to achieve this because everybody's got a stake in this and everybody's got things that they're potentially weary about changing. And so everybody's going to need to chip in and contribute to this process. We modeled a set of policies to recommend – to represent the Commission's recommendations and I want to summarize quickly some of the impacts that we modeled.

On the access issue I think the best representation of what would happen under the Commission's recommendations is that you would get from a point where currently we have about 48 million people uninsured projected to go about to about 61 million. And these projections were made before the latest rounds of economic problems we have, to down to about four million people.

That is basically coverage for everybody in the United States but there – the modeling assumed that there were just some people that weren't going to be able to be reached from the system. But we think that over time because every time you have contact with the healthcare system you would be enrolled there would be even a greater impact on coverage for healthcare.

In terms of healthcare outcomes, this chart summarizes the changes if we could achieve what we have identified as reachable benchmarks for – on preventative care, on reducing unnecessary admission and readmissions to hospitals and so on. These are things that are represent a massive potential for our healthcare system to increase its value to the population of this country. And the impact on cost is represented in this chart. We are currently at $2.6 trillion in 2009 by the end of the next decade we're projected to increase to $5.2 trillion in healthcare spending. The total impact of the Commission's

recommendations would be to by 2020 reduce that amount to $4.6 trillion, still a massive amount of money.

But it represents that wedge between the top two curves and this graph represents a total accumulative reduction in health spending over this period of $3 trillion that can be used elsewhere in the economy in the healthcare sector to cover some of the expenses incurred in achieving these improvements. So, focusing on the payment reform, this chart has been in several Fund and Commission publications. It represents the inner relation between organization and payment.

The main message to draw from this is that there – is that we need to move from the fee-for-service system that dominates our healthcare now to payment systems that reward taking broader accountability for patient outcomes and care and also for high performance in terms of efficiency, as well.

And to recognize the fact that we have an array of different organizations in healthcare delivery system and we could apply a more bundled payment to each of the steps in that array of healthcare. The other – the main point to take away from these payment reforms is that the purpose of these payment reforms is not to reduce payments.

It is to encourage a reorganization of the healthcare system so that costs increase more slowly, as well as, quality increasing for the patients that the system serves. When we modeled the set of representative policies you end up with

between 2010 and 2020, an 11-year period an estimated savings, reduction in national health expenditures of over a trillion dollars from these payment reforms.

And the payment reforms include enhanced payment for primary care that is higher updates for primary care services, payments to encourage adoption of the medical home model which, you know, offers better coordination of care for their patients and bundle payment for acute care episodes is what we modeled.

That is to extend the payment bundle that's paid for from the hospital stay and hospital services, which is currently embodied in the PRG system that Medicare pays according to a broader set of services, eventually including both the hospital stay and 30-days post discharge from the hospital and also acute care and also physician services in the hospital to really encourage providers to work together to manage both the costs and the care that their patients receive.

We also had several policies in that we modeled that we called correcting price signals which would adjust payment updates for providers in high cost areas relative to the national median. We would also implement a couple of policies that were suggested by some work that was done for the Hamilton Group on prescription drug pricing. And we would eliminate the overpayment of Medicare Vantage Plans in the Medicare program.

These are policies that are soon to apply to Medicare, Medicaid, a new public health insurance plan that would be

available through a health insurance exchange that's part of the coverage set of recommendations. And would assume eventually to be adopted or at least policies that achieve the same kinds of ends being adopted in the private sector, as well.

Now why do we need to do these things? Well this is one of several graphs that have by now become famous representing the Dartmouth Atlas Analysis of variation in both quality and cost. This is pretty graphic, literally a graphic representation of how – why the variation is in cost across areas in this country and without any corresponding effect, apparently, on quality. And you can measure quality – you can measure outcomes, quality by any of a number of measures and you get the same kind of relationship.

And a very nice table that was produced in an article by Glenn Hackbarth who is a member of the Commission, also the Chair of the Medicare Payment Advisory Commission lays out pretty clearly what drives variation in spending. We looked at the risk adjusted standardized spending for chronic obstructive pulmonary disease and several other conditions but in particular these numbers show that really what drives – there is wide variation between the highest cost and lowest cost areas in terms of spending on this condition.

But you see from the extreme right hand column here that the bulk of the variation is in the number of readmissions

in these areas and in the cost of post-acute care in these areas. So that really drives the recommendation to bundle care because you really need to make the hospital more responsible but also have the ability to be rewarded for taking responsibility for the patient once the patient leaves the hospital, as well.

And you need to have post-acute care facilities brought into this decision so there is more continuity of care for people who need care in different settings and from different providers. And then the final point this chart shows the trend both currently projected and under the Commission's recommendations we modeled them in payments for hospitals and for physicians and you see here that while spending decreases relative to current projections it does increase over time.

We're not talking about shutting down the healthcare system. We're talking about reducing accumulative spending from $42 trillion that's currently projected to $39 trillion over the next 11 years. If there are people who think that's not enough money to spend on healthcare for as – and without trying to improve quality, as well, then I'd like to hear the explanation of why that's true.

We're talking about reducing spending on healthcare from a 6.7-percent annual growth rate to a 5.5-percent annual growth rate compared with 4.7-percent for GDP as a whole. So, again, we're talking about healthcare continuing to grow as a

part of our nation's economy just not quite as fast as it would have otherwise. And I'll wrap up there with acknowledgments to Karen and Cathy Schoen, Steve Schoenbaum and Kris Stremikis who contributed to the paper and to the work that has gone into this. Thanks.

ED HOWARD: Thanks very much, Stu. Next we have Dr. Robert Berenson who is a Senior Fellow at the Urban Institute and one of the country's leading Medicare experts. Talents he drew on back in '98 through 2000 when he was in charge of Medicare payment policy, basically, among other things at CMS. He's a physician, he's an internist, he's served on the White House Staff. Today we've asked him to flag some of the concerns in the leading proposals and things we need to think about as we look to reforming healthcare payment. Bob, thanks very much for being here.

ROBERT BERENSON: It's a pleasure to be here and a couple years ago I was here and we were talking about paper performance and that's certainly a worthy topic and has a role in all of this. But I was sort of scratching my head and saying why are we talking about how we're going to spend the 2-percent at the margin either in rewards or penalties and not how we're spending the 100-percent. And in a couple of years this has all changed now.

It's impossible almost to go anywhere in town without a meeting on payment reform. I applaud that and I want to make

the point that it's the right topic but it's not necessarily easy. And so I am going to be bringing up a couple of the practical issues partly wearing my old hat as a CMS administrator and looking at how this stuff might play out on the ground a little more.

So that's what I want to do in my ten minutes. Fee-for-service clearly has gotten a bad reputation. And I'd say my first sort of points up there is deservedly so. It promotes volume growth, self-referral opportunities, economists argue about how much physician-induced demand occurs. But it certainly does.

Fragmented care, each let's say physician can be providing terrific care but there is and there is coordination but it's only because of a professional duty to coordinate, not because the payment system in any way is rewarding that coordination. And a second problem that has occurred, I think, in advertently to some extent in Medicare and certainly occurs in private payments is that prices are distorted in relationship to underlying costs which in turn distorts, and I should have said provider behavior not just physician behavior.

In fact, I give credit to the Center for studying health system change of which I'm a consultant for going out and identifying the numerous examples of where hospitals, in particular, but also physicians sort of determine how they are

– what they're going to emphasize in the services they provide by basically identifying winners and loser services.

And so service line strategies that hospitals have adopted really could go after the lucrative services. And so when I'm talking about distortions it's in relationship to underlying costs. There are winners and there are losers and as I'm going to argue that's not inevitable. Fee-for-service actually can be a useful part of a payment system and, in fact, it can promote desired behavior if you can identify and define that behavior crisply [misspelled?].

And so, for example, in organizations that pay on cap what we used to call capitation, that's become a dirty word. In addition to the per member per month payment because there was a perception that vaccinations were being underperformed. Now there is often fee-for-service payments specifically for those vaccinations to ensure that they happen.

So, fee-for-service can and should be part of any payment reform. In fact, there are some physicians who maybe should be paid fee-for-service. We can talk about that more. So, here very quickly are the reasons to spend some effort improving physician fee schedules. The alternatives while conceptionally better are not easy. Getting fee-for-service prices will help set the conditions needed for other payment reforms.

I did an interview with an administrator of a multispecialty group practice who basically said your fee schedule from Washington is making it impossible for me to recruit cardiologists and dermatologists and he listed some other specialties because they're making so much in fee-for-service reimbursements that they don’t want to participate in a multispecialty group.

So you need to get the fee-for-service prices better. And also the fee-for-service prices often are the building blocks for how you construct the episode payment or the capitative payment. And indeed there have been examples of success. The deficit reduction act limits on imaging even though the radiologists may not have liked it actually in the first year of its implementation reduced prices, reduced the rate of volume growth, led to a 13-percent savings for the program.

I think it was actually a, even though it was done in the middle of the night and people weren't sure exactly what they were accomplishing, it actually worked. I would argue. Now there are opportunities to improve the physician fee schedule. After 17 years we're still too reliant on estimates of the components that go into these fees. It's time we actually had real measurements of time, et cetera that go into these fees.

We can adjust where there is rapid volume growth. We can identify those are probably winning services or they may be in which you can make some adjustments and CMS could be doing what in essence the Health Center Change was doing which is going out and hearing from hospitals and physicians. In this case physicians where are the distorted payments, which are the services that seem to be winners.

And finally, I know this terminology of value based purchasing has come up. I actually think it makes sense to adopt it in a broader sense. A value-based purchaser would be asking in the physician fee service schedule are we getting enough – what services are we getting too much of? And what are we not getting enough of for the population we are serving?

And I would say if you ask that question you would come to the conclusion that we are not getting enough geriatric services, we're not getting enough care coordination services to the extent that prices matter in terms of what people do. Why don’t we modify prices somewhat to try to get a better mix of services for the population we're taking care of.

Now the next topic and this is a complex one and I've got about a minute and a half to do this. Bundles, they exist already. We pay a case rate for a hospital is a bundle payment for the case. We now pay home health agencies a 60-day episode for the episode of care. We used to pay each individual visit

that was made. So that's the concept of what these bundles episodes cases are.

Just a point of clarification it is important to distinguish between bundling payments of different providers, let's say hospitals/physicians or hospitals and post-acute care facilities and paying a – paying over time to a single provider or, perhaps, too that bundled set of providers.

The former attempts to align incentives essentially to defragment care amongst different silos. The latter attempt so internalize to the provider the benefits of greater efficiency and decreased resource use. So when you pay a hospital a case rate it now has a reason to be efficient at least within that case.

But bundles have some of the problems as pure fee-for-service and it important to distinguish between aligning incentives and providing identical incentives. So, for example, providers under bundled payments still have an incentive to generate reimbursable bundles, reimbursable units of reimbursement.

Right now, and I also will agree you heard from Stuart that rehospitalization is a particularly opportune and ripe area for public policy to reduce rehospitalization rates. Hospitals now have a negative business case for putting in systems that actually reduce rehospitalization. They get paid for keeping beds full.

So we should change how we pay hospitals but the question is whether – if we just align the incentives of doctors and hospitals whether we have accomplished anything if in fact some of these readmissions or indeed initial admissions are inappropriate to begin with.

So if you set up a bundled rate for a hospitalization with the doctors and the hospitals. But in many of those situations the – that hospitalization or that procedure is inappropriate and we know a lot. There is a lot of literature out there on inappropriate services. You've now aligned their incentives to be efficient within the bundle but you haven't actually done anything as to whether that service should have been provided in the first place.

It works better when you've got a good handle on appropriateness. Let me go to the next one, very quickly, there is no time to get into the details. But there are political and technical challenges to episodes. Who gets the money? In some places where there is alignment of interests where physicians, perhaps, are employed by the hospital you can give the hospital the money and they can distribute that with the docs.

In other places there are wars going on between hospitals and physicians for control over the global health delivery system, and it's hard to imagine, sort of, the political environment where the docs, for example, would accept

the fact that the hospital's going to take the money and distribute it.

There's a lot of technical challenges that we could talk about, if you're interested. Ultimately, where we should be going in the ideal world would be the population-based payment. It's generally called per member per month. I put down PPPM because we're not necessarily talking about members, we're talking about people. But an organization that's being paid to take care of a population, and you're going to hear about Geisinger in a second, if we had lots of Geisingers around, what we do is we fundamentally change the incentive.

Now a hospitalization, instead of a profit center, becomes a cost center. The pay that the organization is paid for that population, regardless of how much services are being used, you can address provider fragmentation, depending on the level of the payment. If it's at a system level you now, theoretically, have everybody working together.

Conceptually this approach, if you have large enough organizations, you don't necessarily need a health plan intermediary. You could probably be contracting directly with an integrated delivery system under this approach and not have to have to pass it through a Medicare Advantage Plan with the costs associated with that intermediary.

There are technical challenges here, in particular, the challenge of making sure underservice is not provided and you

can detect it. However, I think we've got some promising results from the CMS Physician Group Practice Demonstration, and the possibility that instead of full risk bearing by these organizations, shared risk with the payer—in this case, CMS—might become a viable model.

And finally, two final slides. In the end, we need to consider doing hybrids of all of these approaches. Each have their strengths and weaknesses. So, for example, the medical home—and we're trying to figure out exactly what that is—but it really is to improve the primary care patient-centeredness activities that physicians needs to be providing, as well as more care coordination for patients with chronic conditions.

Theoretically you could still pay fee-for-service visits, but because the care coordination services can't be crisply defined in a CPT fee-for-service context, it is frequent phone calls, it is conversations with Social Service workers with other physicians. That doesn't lend itself for fee-for-service.

Perhaps that becomes a per person per month fee to the practice, and you can even put in some public reporting or pay-for-performance for how well that practice is doing. Pay-for-performance actually can be used with any of these other payment systems to try to protect against some of the untoward side effects you'd want to prevent.

And then finally, to re-emphasize the point about alignment is not necessarily the same as providing identical results, I'd like the concept of bundling the payment for the hospital and other parties to try to provide an incentive to decrease re-admissions.

But here's another way. If you can't quite get there, you make it less desirable for hospitals to have a re-admission. And indeed there's this urban legend around that hospitals under Medicare are not paid for a re-admission within 31 days. I've seen it stated authoritatively by experts in the field that Medicare doesn't pay for a re-admission. In fact, they do.

In rare situations the intermediaries may find a quality problem and deny payment, so my argument is if an urban legend can cause behavior change, which it does, why not actually pay the re-admission at a variable cost rate? Maybe that's 50-percent of the DRG, so the hospitals have an interest.

And if you can't get the physicians to be part of that bundle, create this as an area where you can create a CPT fee-for-service code for the physician's role in the hand-off from the hospital back into the community.

I can define those services. So, you theoretically have a doc being paid fee-for-service. You have the hospital now with an incentive to decrease re-admissions, and then maybe

even providing direct support to—QIOs and Medicare are working on this—to directly support community caseworkers, social workers, disease management nurses to act as coaches to actually participate, go the discharge planning, go to the patient's home. And those programs reliably reduce readmissions 25 to 40-percent.

So the point I'm making here is that you can mix and match. There are some barriers to just flow implementation of people's sort of perfect notions of a new payment model. But we can make a lot of progress and need to. Thank you very much.

MALE SPEAKER: Well now that Bob's told hospitals that they do get paid for re-admissions, we'll have to evaluate the impact of that statement.

ED HOWARD: Thanks very much, Bob. I apologize again for having to leave, but I could not leave you in more capable hands than that of Dr. Karen Davis. Karen? Thanks very much for doing this.

KAREN DAVIS: And as a member of the Geisinger Board of Directors, it's a particular pleasure to welcome to the panel Dr. Bruce Hamory. He is the executive vice president and system chief medical officer emeritus for Geisinger. He's in charge of their research institutes and medical education activity.

For those of you not familiar with Geisinger, it's located in Central Pennsylvania and is an integrated delivery system, and one of the most respected in the U.S. And I think particularly what Dr. Hamory will bring to us is some real-world experience with advanced payment methods, so that we'll move from concept and theory to reality. Bruce?

BRUCE HAMORY: Thank you very much. Good afternoon. I'm going to show you four quick slides on Geisinger and make a couple comments, and then go into a couple of experiments that we've tried. And since this is a 10-minute limit, which I'm going to try to adhere to, I'm not going to give you much detail on the experiments. I'll rather talk about the lessons learned.

As Dr. Davis mentioned, Geisinger is an integrated health system formed in 1914 by a gift from a then-86 year-old woman, who gave $1.5 million to form a hospital. And in her deed of trust said "This is to care for the working man and his family."

So we have had a patient-centric community-based orientation since that time. We are a very integrated system. We comprise a very large employed provider group of about 740 physicians, plus 400 advanced practice nurses, P.A.s, CRNAs and others, and several hospitals and a set of insurance companies.

The insurance companies in aggregate account for about 28-percent of the provider business. The provider business

accounts for about half of the insurance companies' members. And so we have had some very interesting ways to model the effect of changes that our provider group makes with its integrated electronic medical record with the community-based physicians who do not have electronic health records as sort of a control group.

As I mentioned, we provide population-based care to about 35 very rural counties in Pennsylvania. Roughly 25 to 30-percent of this population sees a Geisinger provider every year.

We have been recognized over the last number of years for our integrated patient-centered care, our leadership in the use of healthcare information technology. We do have, and have had for 13 years, a state-of-the-art electronic health record with patient portals, referring physician portals, electronic images, and all that good stuff, which we'll talk about in a minute.

As was mentioned, we participate in the PGP Demo, and we have had a system of bundled payments for certain acute care in-patient operations. Now up for about three years, as an arrangement with our own health plan I will note, have been unable to sell that to other insurers, although those discussions go on. I will even talk about why that might be, if you wish. And we have had an experiment-up with medical home, which we call Patient Navigator, now for 2.5 years which

has shown reproducibly now over roughly 30 primary care sites up, including two non-Geisinger sites, reductions of 20 to 25-percent in Medicare admissions to hospitals, and a reduction in cost of about 6-percent sustainable, and reproducible as it comes up.

Some sites have actually seen reductions in Medicare admissions of as much as 50-percent. And the byline there is that if you are a small hospital and 80-percent of your admissions are Medicare, and 50-percent of them go away, you have changes to make.

And if those Medicare admissions are going away because they were not necessary or because the care can be provided on an ambulatory setting where the patient's eating better food at home and sleeping in their own bed, those changes need to be made. The Geisinger health plan here, a lot of regional reach, a lot of non-Geisinger providers. So what's needed to get this done for healthcare reform?

Well underlying basis, several of the speakers have said, people have to have insurance. Now insurance is not access. I think probably everybody in this room has healthcare insurance. Those of you that live in Washington have a Blue Cross plan. And when I talk to you and you call your doctor, you can't get in, in less than six weeks. My guys can see you in 24 hours for a primary care visit, for any reason.

That's access. But it requires specific leadership and specific organizational design to get there. Insurance does not get you there. Health information technology is needed as an enabler. Governance that allows money to be moved between doctors and hospitals or between insurers and hospitals and doctors, in ways that make sense to improve the care of patients and families is needed. And this will require some stark action in some of that.

And this gets to the concept that others have mentioned of accountable care organizations that can take responsibility for delivering high quality care and improved value. And I would note here, with all respect to others, that I think largely the elimination of widget-based payments will be required.

Now, as Dr. Berenson said, I mean, some of that may still be needed, but at the end of the day, if we simply sent people to do more and our ability to specify the right thing changes over time. So I will just call to your attention yesterday's *New England Journal*, where something that doctors have been pushing, which is PSA tests for old guys like me, has shown to probably be not the right thing to do.

So if you embed that in legislation and new data comes out, you know how hard it is to change the law. Electronic health record, necessary but not sufficient. Electronic health

records have to be accompanied by serious efforts to redesign care in the primary care site and in the hospital.

This is not training that doctors have. It is not once and done. It requires going back at it. I mentioned bundled— if electronic health records are the basis for chronic disease care and do provide the basis for feeding back in real time at the end of the week or at the end of the day, or during the visit, the correct care for doctors.

Okay, acute care, we call this proven care. It was started in a paper world before we computerized the hospital. So electronic records are not needed for this, although they're helpful. It involves a bundled payment which includes the physicians in the hospitals and requires the embedding of best-practice evidence-based medicine for each step of the care.

That includes whether the care is appropriate. We found in the instances that we've tried this, that it reduces complications even in places that start from very good quality by external metrics.

So cardiac surgery for us is a premier program. It was among the best in the state on the statewide data. Still reduced complication rates 50-percent, reduced re-admission rates 50-percent, cut costs. And this is a bundled payment with our health plan that includes all related complications for 90 days following surgery. So it incents following the best procedures and taking care of the patient.

That value, however, has to be shared between the purchaser and the provider, because it does, you know, there are systems that you have to set up to do this so it doesn't just all disappear. Although the dollars could be reduced over time.

Medical home, we call Patient Navigator. This is a cooperative effort between our health plan and our primary care people. The health plan provides the analytics to talk about high-risk patients, identify those. Our health plan has actually taken people out of their telephone care coordination center, embedded them in the primary care site.

And those, ladies and gentlemen, are responsible for tracking the patient from the hospital, making sure their medications synch up, that they're not taking two of something, that they get their medication prescriptions filled, and if they can't, help get them filled. And then they get them in to see the doc within five days after they leave the hospital.

We've also had to design better ways to take care of people in nursing homes and to really re-engineer those handoffs and follow-ups. So this is not, and I repeat not, simply a few extra dollars for the primary care doctor for them to learn skills that they have not learned and don't have time to do. This is putting additional staff with defined responsibilities and expectations in the office, adding some

bucks to the office, and then a bonus payment at the end of the year if quality metrics are hit.

And those quality metrics are increased number of visits to the office, certain CMS and other outcome measures that are NQF approved, and patient satisfaction. And we find dollar savings, as I commented.

So this requires additional staff. And I think the point of this slide is that value creation in this system is an explicit expectation and set of processes. It's not a hope. And it's not, you know, "Guys, here's another 20 grand a year, please do better things." It is very specific.

So health policy implications. People need health insurance. Please include regional plans. Geisinger is a regional plan which has been innovated. I think formation of accountable care organizations, in my term, integrated systems, should be facilitated. Others have spoken about those.

The definition of a medical home currently employed by NQF needs to be enhanced. Right now it sort of says well, you've got an EHR and you have a registry and you try to do good, and it needs to be a little more explicit.

Health information technology is needed, but again, how it is implemented and the need to keep educating people and changing it over time must not be lost. Those are ongoing costs that are not usually included in the capital costs of buying a system of new equipment.

We do need comparative effective nurse research which has been funded, in part. And I think, very importantly, outside of a dozen or two organizations in the U.S., Geisinger may owe Intermountain Health, Kaiser and some others.

Many people do not yet understand how to do this work, and so training, particularly of the current and next generation of nurses, physicians, hospital administrators and others is really needed. And we shouldn't lose sight of that. Thank you.

KAREN DAVIS: Thank you, Bruce. And I failed at my first task as timekeeper and set it so the speakers got an extra minute for every minute that they spoke. So I'm going to delegate that to someone else, and to welcome Dr. Nancy Nielsen, who is president of the American Medical Association. She's a practicing internist in Buffalo, New York. She's a nationally known expert on issues of patient safety and quality issues. She also takes the lead in the AMA's Voice for the Uninsured campaign.

In addition to her medical degree, she holds a degree in microbiology and she's agreed today to give us a sense of how practitioners in healthcare look at some of the proposed changes in payment methods. Dr. Nielson?

NANCY NIELSON: Hi, everybody. The most important thing you heard is that I don't live in Washington. And I'm here to try to help you understand what the physician

perception is of some of the very well done work that you have seen presented so far.

The closest I get to the White House is at the White House Summits, and the signing of SCHIP. Although I will tell you that the White House called my office on Wednesday, and the secretary lost the call. Yes, it was a stunning moment in my office, just so you know.

You may know, I hope you know, that the American Medical Association agrees with the president that healthcare reform is a priority. I hope you also have seen what we have done on the Voice for the Uninsured campaign. This is not new for us, but we became very visible about it because we got tired of everybody talking about the uninsured and having the annual Week for the Uninsured. And the numbers got worse.

So we really have taken a pretty high profile approach to the uninsured, and we have been pleased to have met with a number of the administration officials.

Just last week Zeke Emanuel spoke at our National Advocacy Conference here, as did a representative from Geisinger, presenting some detail on the medical home that you just heard Bruce speak about.

We had here in the city last week leaders from all over the country, in every specialty in every state. And it was important for them to understand what's happening in your town, and what may be about to happen. And to try to make sure that

those who are in leadership positions are not too far out in front of their troops. Now that's really important because the last thing anybody needs is to have the troops rebel when something gets done and so we have some leadership challenges, but I think you can understand that.

Physicians want to change. They're really pretty unhappy people right now. A study, worldwide study of physicians shows that American physicians are the most unhappy in the world. They are drowning in demands and there are some bad people but the vast majority work heroically every day. It's, I think, really important as we talk about people who gain the system that we remember that that's not what's happening across the country. It's happening in isolated places and it needs to be dealt with.

We do know there needs to be change. We do know that there needs to better coordination of care. You've heard from Bob and from Bruce and Stu about this. There is no question about that. It isn't rewarded right now and of course, you don't pay us for everything we do. You don't have to pay us for everything we do. On the other hand, when you deliberately don't pay us for some things it does send a pretty powerful message. I mean, you know, you understand what I'm saying. We all, we're all humans.

It's very important to remember that the vast majority of practices in this country cannot immediately form into a

group like Geisinger or the Mayo or Scott White in Texas. They can't do it. So, you are looking at an awful lot of physicians in this country who are practicing in what is termed onesies and twosies groups under four. It is a real challenge and to try to say to them that well you should align yourself with a hospital and let the money go to the hospital and then you guys figure out how to divvy it with the hospital.

They will tell you we've been there and done that and it didn't work so just, you just need to know that there is not an enormous amount of trust that that would work. However, physician practices absolutely want to improve. They want to adopt HIT and the new infusion of money to try to make that happen is going to be very powerful as we try hard to improve quality for patients that we care for.

The third bullet down there is an important one and that is we would hope as this town proceeds towards some sort of payment reform that you recognize that clinicians work in different circumstances. So until we have proved the value of some of these models, piloted them, and surfaced unintended consequences, hopefully, there can be some flexibility in how practices can adapt.

Do they want to? They absolutely do and if we all treat physicians, not like people who are trying to get away with something and meet their income expectations, but people who are really working hard for their patients and appeal to

what is absolutely motivating them which is their professionalism and not distancing them to do professional things, which is part of the problem that you've heard about.

I will mention that physicians are very concerned about their ability to band together even to do quality incentives because of some anti-press issues. We have asked that be looked at and people are, hopefully are listening.

The specialty societies have stepped up and they step up more. They have determined appropriateness criteria. As you hear about the comparative effectiveness, which by the way we are firmly and unequivocally behind, firmly and unequivocally behind the generation of that evidence, it's really important to use the specialty societies because physicians trust their specialty societies.

They do not trust the government, you may have noticed that. They do not trust Congress, you may have notice that. And you need to know that they also clearly do not trust health plans, insurance plans. They don't but they do trust their specialty societies and they have done a very good job I would point to the American College of Cardiology, the Society for Thoracic Surgery, the American College of Surgeons, among many others, and you know that.

It's very important that data on performance be fed back to the clinicians so that they can improve because this is really not just about a report card. This is about improving

care at the point of care. That's what we want. Help us do that as we go forward with our reform efforts.

Well, there are a number of things, you've heard them mentioned. I'm not going to go into them. You've heard about the medical home accountable care organizations. We need to pilot those. We need to see what works and it may be just some will work in some areas and some in another, in certain rural versus suburban versus urban, et cetera. That needs to be surfaced.

We've talked about the lack of trust between physicians and hospitals when it comes to bundling. Can we reestablish trust? Of course. But it really is important to make sure that we try this and see how it works first. The HIT is going to important. Comparative effective is critical. We think that there may be a problem if it's a one size fits all immediate shift in payment.

There are absolutely problems with the payment, with the fee-for-services system and everybody knows that. It's also important as you've heard others speak to talk about giving incentives for coordination and quality. I think you can simply read through this. There's no question every American should have health insurance. There is just no debate about that. Let's as a country figure out how to get there in a way that is physically responsible. And let's just do it. Let's just do it soon.

When it comes to how you're going to pay physicians, they want to be paid for the things they went to school to learn how to do. I will tell you yesterday was Match Day throughout the country, you may know that. Every graduating medical student found out yesterday at noon where they're going for the next three to seven years of their life.

My medical school has 140 graduates, exactly four of them matched into family medicine, exactly four. That is a real problem. What are we going to do when everyone has health insurance and there are not enough primary care physicians to take care of them? It is a very serious problem and you can't do this overnight.

Beyond college, beyond college it takes a minimum of seven years to grow a fully trained physician in anything, any primary care specialty or anything else. A minimum of seven years beyond college and in some cases 11 to 13 years.

Be careful about enhancing primary care at the expense of the other specialties. That’s the quickest way to divide the house of medicine. You’ve seen it happen before. It’s a strategy that’s been used before. It's not a smart strategy. It makes everybody unhappy and everybody hates everybody. And by the way, they will hate Washington a lot.

This deals with the supply. There are – every workforce study that’s ever been done has been wrong. So we just know that we need more clinicians. We need more nurse

practitioners. We need more PAs. We need more physicians and we need to figure how to get them here.

Then this is my final slide. Let's indeed invest in prevent, in care coordination and making sure that everyone has health insurance, that HIT does what its suppose to do which is not just to have a computer. We all have computers but we don't have what we need, the interlock verbal standards that will allow us to embed the quality measures and track the quality measures, the registries that will allow me to push a button and bring up all my diabetics and see what their hemoglobin A1Cs are.

That’s what we need. We need to test the payment models that you’ve heard eloquently described here. Liability reform is a topic for another day but I got to you, the docs are very convinced there is an awful lot of defensive medicine going on and it doesn’t add to clinical care.

Then finally, there is no doubt that we need to get better value for our healthcare dollars. We can do better as a country. We as profession intend to do better. We ask for your help. Thanks very much.

KAREN DAVIS: Thank you. Thanks to our panel. So with that, we'll open it up to questions. If you want to send questions up, we'll take them, and if you just have a microphone brought to you, we will do that as well.

Meanwhile, don't forget your evaluation forms that are in your folders. Why don't I start with some of the cards that have come up? The first had to do with the effectiveness of pay for performance programs, citing the Premier Demo, the recent survey by the Leap Frog group. They seem to suggest that there's evidence of improved quality that is their evidence of savings. So what do we know about pay for performance? Stu?

STUART GUTERMAN: Well, there – in preliminary results that Premier folks have put out related to the demonstration, it does seem that they have been able to cut length of stay, which doesn’t save Medicare money, but also reduce readmissions, as well as improving quality of care. But I think – so I think there's promise there and certainly you'd have to convince me that it’s a bad thing to pay for what you want as opposed to paying for what you don't – more of what you don't want, which is what our current system does without pay for performance.

I think though that there is a limit to how, you know, there have obviously been some studies that have found that have more mixed evaluations of pay for performance incentives, specific ones. But I think we need to take it into account like Bob – a point that Bob's raised that , you know, we're talking about always at the , you know, improvements at the margin for a system that’s really kind of rotten to the core.

So, you know, we need to take into account. It's kind of like, you know, trying to road test a Model T Ford before the roads were paved. You come back and you say boy, this really, you know, it doesn't have much of a future, because you can't drive it when it rains, after it dries, the roads are rutty and it's a really bumpy ride, doesn't really take us anywhere. You know so you really have to envision these kinds of policies in the context of a better performing health system. That's why all of these changes are kind of important to address together.

BRUCE HARMORY: I might just add to that, I think if you look most of the programs are paying structural things or what I think you could characterize as minor improvements. So having a computer, measuring hemoglobin A1C as opposed to, which is a measure of controlled diabetics, as opposed to controlling the hemoglobin A1C. I think that people with the demo that we're part has clearly shown progress in advancing quality variables.

Some groups have shown an ability to save money. I would say that, that experiment I view is still positive but on going. The three-year results are due in the next few months. The project has been extended into the fifth year. I know our medical home stuff didn't kick in at our place really until the end of the third year and really in the fourth year, so I think it will be a bit before we know.

ROBERT BERENSON: If I can also mention just very quickly. It's important also to distinguish, to identify the fact that measurement has cost to it. You have to get it right. You have to often do special data collections and so, on this issue of rehospitalization which I think most of us agree we have to address. There's just avoidable rehospitalization that we could deal with.

One approach which has been promoted is to measure every hospital's readmission rate and then provide public reporting and pay for performance or maybe penalties for the negative outliers. I'm suggesting and it may be premature to put it in the whole system yet, you just embed new incentive in the payment system, which is all hospitals don't get a reduction payment for readmission. You don't have to do as much in the way of measurement, have pay for performance.

You're embedding a new incentive. Clearly you need a higher threshold for going in that direction. I mean a higher threshold of knowing what you're doing, so that you don't have untoward side effects but it is a different approach. You can try to get the same result of reduced rehospitalizations one through pay for performance and public reporting, the other by changing basic incentives in the system.

NANCY NIELSON: Let me just comment quickly. The AMA has had guidelines on evaluating pay for performance programs for probably four or five years. What we want to be careful

about, and in general, I think in many places, they have worked. I don't know if they have saved money because I think that was originally the question.

What we are very concerned about is that we be looking at quality first and that we not in any way disincentivize the taking care of difficult patients. You really have to be careful about that. We want to be held accountable for what we can control, but if I give a prescription to a patient and that patient, now forget Medicare for the moment. Let's assume the patient has a commercial health plan and the co-pay for that prescription is so great that the patient can't fill it. Then it's time we are all accountable together for what is not working in the system.

KAREN DAVIS: Well, we've got a lot of interesting questions, so let's start here at the microphone. Introduce yourself please.

JOSH SEIDMAN: Josh Seidman from the Center for Information Therapy. This question is primarily for Dr. Harmory. You talked about HIT as an enabler and being a necessary but not sufficient took in the patient center medical home and thinking about one of the most, one of the biggest provider incentives that the government has ever developed, which is coming out of the American Recovery and Reinvestment Act for provider incentives for HIT adoption.

I'm curious if you have specific suggestions for how to define meaningful use of an EHR and particularly given your emphasis on the use of a patient portal. It's an important part of Geisinger's. If you have specific suggestions about those kind of provisions that would be important to ensure effective, efficient care management and better health for patients.

BRUCE HARMORY: Thank you for the question. I think it's very on point and there are certainly at our place, Jim Walker, who is our medical infomatician, more confident than I would answer it but I think there are a number of key things.

One as mentioned by some of the other panelists, it has to connect to something else. So you know a standalone system in a doctor's office that only has information from that doctor's office, doesn’t link to lab work from the hospital or wherever they get lab work done, doesn’t link to the pharmacy, it would be – is not sufficient.

I would be optimal if there were a way to receive feedback from the pharmacy about other medicines the patient is getting because most patients see multiple. They may not all be on the same system and whether or not the patient picks the medicine up, which gets to Dr. Nielsen's point.

We know that 30-percent or so of prescriptions are never filled and by six months, its 80-percent or some huge number. So some metrics are that. I think there are certain

features of it, does it alert about dose interactions? Does it have a function that allows a registry, again to Dr. Nielsen's point? Who are my diabetic patients? Are they coming in to see me?

But again I think that the first item is does it link , you know, is it part of a regional health information exchange or have ability to link to some other database with the appropriate protections. And then last and not least, you know, at least ours, Kaisers, the ones that many other people, you do have an ability for the patient to come in, request appointments, request med refills, look at their problem list, print their drug list, print their list of immunizations and those sort of things that simplify life both for the patient family and the office.

KAREN DAVIS: Let's go on the back, the first one back there, why don't you introduce yourself?

JOHN GREENE: Thank you, Karen. John Greene for the National Association of Health Underwriters. Dr. Berenson, I was hoping you might be able to clarify one of the slides. It says medical home payment could be fee-for-service for medical services and PPPM for medical home activities. Can you just clarify what you mean by that dichotomy between medical services and –

ROBERT BERENSON: Yes, I can. As traditional medical services, which for primary care physician would be offices

visits for the most part, but could include minor procedures, that would still be paid through the Medicare fee schedule, presumably. Perhaps reduced, that's a question.

Then the activities of medical home, which, you know, there have been attempts and CQA has the prevailing ones who define what those set of activities are, but much more robust communication with patients through phone calls and secured e-mail. More communication with other physicians, providers, community services, keeping patients self management skills, so a whole series of things like that, which I argue do not tend themselves very well to fee-for-service.

I mean you can't reimburse for every phone call for lots of reasons, so a package of those services would be then compensated through a monthly payment. We would need to assure that those services are being provided in some way. And there are different ideas about how to do that, but that would be notion. Pay fee-for-service for the established office visits and a monthly fee for activities that we think are good medical home chronic care management activities.

KAREN DAVIS: Thank you. I'm going to take one of the cards to Dr. Nielsen and questions every bias toward proceduralists in the Rock Committee.

NANCY NIELSEN: Well, the bias toward procedures and proceduralists have long predated the formation of the Rock. I mean if you think back. Think back. I mean some of you are

not old enough to remember, but some of you I think are. In the old –

KAREN DAVIS: You may not remember the Model T?

NANCY NIELSEN: In the old days, in the old days when there were only the Blues, you know kind of the indemnity health plans, maybe you don't know this but if a patient came – when I started my practice 30 years ago, when a patient who had a Blue Cross Blue Shield came into see me, if the patient came in for a physical, I didn't get paid. They had to have a diagnosis. There had to be a problem. There was not – I mean the one thing that the HMO movement did is it taught us to put our priorities in the right place. Let's value prevention.

So this business of always paying better for procedures is way long before the Rock ever got formed. There has been criticism of the Rock. They have identified misvalued services. They have also identified some misvalued services in CMS has not adopted those recommendations. So absolutely, there is a bias still in this country toward proceduralists.

Here's my only point. You could blow up the Rock. You could put in something but let me tell you what you're going to have to deal with. You're going to deal with the workforce issue in this country because what you don't want is every ophthalmologist to hang it up and retire. Who is going to operate on your cataract? You can't do it. You've got to look at this and make some gradual changes. Everyone is agreed.

Primary care is undervalued. Something serious must be done there.

KAREN DAVIS: We'll take the first person here. Introduce yourself.

MEG VORCE: Thank you, Karen. My name is Meg Vorce with the Advisory Board. First I'd just like commend all the panelists for excellent presentations. Many of you talked at a high level about accountability and the commission on high performance health system that some of you helped to create.

There is also affection on accountability thing; shared accountability for resource use was favored among many healthcare opinion leaders. My question in relation to bundle payments is twofold. First of all, how do you recommend holding healthcare providers accountable for the use of resources in patient care? And secondly, I'd like to hear any of your opinions on gain sharing between hospitals and providers. Thank you.

KAREN DAVIS: Stu, do you want to take that?

STUART GUTERMAN: I'll start out. I'm sure there are other opinions on this too, but first I want to make clear that when we talk about financial incentives, there's a tendency to talk about them as if they're something to be imposed on providers to get them to do what we want them to do. And I think that’s the wrong way to think about financial incentives.

I think the better way to think about financial incentives is that they are a way to change the system of rewarding for the things we don't want and punishing for the things that we do want. And to really free up providers to do the things that we think they really want to do, which is to treat their patients best. If we have a system where providers where that’s not the motivating force behind provider behavior, we have bigger problems than we can take care of with the kind of reforms we're talking about here.

But I think we don't. I think providers do want to take good care of their patients so the idea is to figure out as Nancy said, to figure out different ways that those things could be applied depending on what the organization of care is like in the area, what the particular organizations you're dealing with are structured like, and to get together with providers and figure out how we can support the kind of behavior that we'd like to see and that they would to see. And then put the payment system in place that encourages that kind of behavior.

KAREN DAVIS: Okay, Bob, did you want to –

ROBERT BERENSON: I'm sorry, briefly; again my preference would be for accountability at a large integrated group level because that group is in a better position to assess the performance of its physicians and other clinicians than a distance third party payer.

So, I'm all for trying to figure out how to promote more Geisinger-like organizations recognizing the diversity of the system. but 20 years ago when I was doing primary care capitation, my HMOs were assessing how I was doing on cost management and it wasn’t done very well because there is no risk adjustment going there for measuring acuity of my patient, there were a number of sort of technical problems.

But conceptually I think we are in a much better place now actually. We don't necessarily have to assess the downstream spending for each individual physician. We might want to assess the number of avoidable emergency room visits and hospitalizations associated with a primary care practice. There are some areas that we actually can I think do assessment on the cost side.

We can – certainly we're in a better position now than we were then to measure some basic parameters on quality. And I think we also need to much more routinely assess patient experience with care. We now have good questions.

Commonwealth has used those questions in doing their cross-national comparisons. The question to a citizen after hours, do you have a – I don't know if this is exactly right. Do you have a place that they know you and you can, if you have an urgent problem, where you can call and have somebody responsive who knows you is a great question as to assessing whether a medical home is really responsive to their patients?

So, I actually think we are in a much better position on cost, quality, and patient experience to begin to assess accountability even down to the individual practice level, although again, I'd state my preferences to aggregate it at a much higher level.

BRUCE HARMORY: Just, I guess one other comment, just to second what Dr. Guterman said. You know, I've never met, and I know you didn’t imply this either, a physician, a nurse or any other healthcare professional who went to work saying I'm going to hurt somebody. Everybody starts with good intentions.

I think what the incentives need to do is to make that simpler to obtain. You heard a number of things around that. The accountability pieces come around metrics and around performance to metrics, and around, if possible, a little additional reward for hitting those metrics. They're positive reinforcements not negatives. We've got lots of negative reinforcements now. We've malpractice issues and you know various state boards of professionalism and so forth.

So, I think it's around restructuring the payments, which helps restructure the organizations to make it easier to accomplish what both physicians and their patients and other care providers want to get done.

KAREN DAVIS: I'm going to try another one of the cards with commends the AMA's Voice for the Uninsured campaign but

ask that AMA also has guidelines and encourage physicians to accept Medicaid patients.

NANCY NIELSEN: Sure, I always like the yes but questions. We commend you but here's the zinger, right? First of all, people who are uninsured don't have Medicaid, by definition, right. I live in New York. In New York, the Medicaid program covers a number of services; many patients wish that they could have Medicaid.

There is an answer that you need to go and you should know because it was in the President's budget. That’s the formal answer. Then there is a heartfelt answer. And let me if I can, I'm going to try to quickly give you both. In the President's budget there is a line in the budget that says if public programs pay significantly less than commercial insurance, what happens is the costs are shifted to the commercial insurance and it raises the healthcare costs for people who have insurance. That is the formal answer. We have to know that. We have to got to have everybody with health insurance.

Now let me give the heartfelt answer. Some of you know a little about me but I want to tell you my story. I went to graduate school in this city. I was at Catholic U. I had two babies during three years of grad school like you do if you go to Catholic U, you understand.

And what you don’t know is that the student health insurance that I had specifically excluded pregnancy. And it specifically excluded family coverage. So guess what, I had two babies at Providence Hospital and I went to public health clinics and I am so grateful for that safety net.

When I years later went to medical school I remember taking my kids in to see an ENT doctor and seeing a sign on his wall that said we do not accept Medicaid. I was outraged. I was outraged because I had been poor. I had no insurance. And I was really outraged.

So I started my internal medicine practice and I to KAY all comers. And I was in a large multi specialty group. And I did that because I didn’t want to worry about the finances. Well let me tell you something there was somebody in that group worrying about those finances. Because when I got so many Medicaid patients that I wasn’t able to make the payroll of my office staff I had to stop taking Medicaid patients. It was one of the saddest days in my life.

But now here's what I did. Didn’t do it right away because I didn’t know how, but two years later I left that multi specialty group and started a new group in association with the hospital and here's what I did. I said you know what I want to be empowered to take care of any patient that wants to see me if I have time to see them.

So you pay me productivity but not on the money you collect on the services that I rendered. And that was the last six years of my practice. It was the most empowering that I have ever experienced. And so I share that with-- ever doctor can't do that. I was in a town where I could do that. But it's not easy. So the real heartfelt answer is no margin, no mission and it is tragic. But the president has it right in the budget.

KAREN DAVIS: Okay, we're going to go to the very back if you'd to introduce yourself.

MALE SPEAKER: I must be missing something. I did not pay for registration and got a free lunch. So I want to thank you. I want to thank Commonwealth for bringing us all together for this purpose. I have a question.

KAREN DAVIS: Particularly introduce yourself then.

MALE SPEAKER: I have a question then maybe a comment. Fee-for-service, rewards for volume and we all go to medical school-- I'm from Yale. From medical school with good intentions but humans are human. So there for when you're rewarded for volume you can figure out what happens.

On the other side if you pay for capitation or salaries become socialized medicine then you have less excess, human being human. Is it possible to have a hybrid in which you pay 60-percent fee per service and 40-percent tie in with the electronic medical health record which is an enabler to reward

them for pay for performance, for quality, for outcome and for being a good steward of the healthcare dollar. Is that possible?

KAREN DAVIS: So schizophrenia.

NANCY NEILSON: The answer is yes. Some commercial plans are already doing that. And I think that's what Bob described.

ROBERT BERENSON: Yes, and the other report I'd make is the rewarding volume. There are some doctor groups who may have or specialty groups who make the correct statement that they don’t sell preferred. They respond to referrals from others.

So a pathologist isn't generating their own specimens for the most part. And it may be appropriate for a good pathologist in a community to be paid fee-for-service for doing that. The radiologists make this case and I think they're largely correct, that they don’t generate volume because they're receiving referrals from others. For primary care docs where we want to be promoting a whole different activity not related to acute care management but chronic care surveillance and proactive work.

What you're suggesting makes perfect sense of having a mixture of fee-for-service, capite, and per member per month. I, with, Steve Schoenbaum and Allan Goroll, I've written that maybe some practices could actually get a single payment

without fee-for-service. That's an alternative. I think we need-- to me the bottom line here is that can't anymore have a one size fits all payment system in Medicare or amongst private payers.

KAREN DAVIS: Dr. Harmony?

BRUCE HARMONY: I would comment we've doing this for 12 years. And it requires a leadership group that is sensitive to patient need and can adjust this. So that it's not, you know, it's not like setting up a train schedule that just then runs forever. Somebody needs to worry about whether the tracks are clear and all that.

But yes the hybrid model in large part based on what Dr. Neilson described which is a roughly benching salary to work RVU. So that it is PAIR neutral and you're not penalizing your pediatricians and obstetricians and family practice folks for seeing Medicaid or no pay patients. And we have a 20-percent incentive of which in half is quality metrics so that we can also embed and encourage certain behavior that is already incentive by group practice culture.

But yes those are very possible whether you can in fact do that with a piece of legislation for the country as a whole I think is a different matter. And I would suggest would be left up to these you know PHOs or physician groups or accountable organizations or whatever mechanism you want to

call them. To figure out on a local basis because you do have to keep the specialists and the primary care guys happy.

You know we have neuro surgeons and orthopedic surgeons and other people that are very highly paid in our group along with others who are paid well but more modestly.

MALE SPEAKER: Yes I agree with the – comment if I may. I agree with Dr. Neilson, President of the AMA, that about 700,000 doctors in the country, about 100,000 of them are in so-called institution like a Kaiser clinic. Those are things like the hybrid will work very well but unfortunately there are about 600,000 the onsies and twosies. And those where the difficulty come and I think the other comment from one my colleague where physician Dr. Neilson she mentioned about electronical medical records.

The way I understand it, having studied this for the last decade. Is the blockade is done by the industry. The industry of electronical medical records they the one into operability so that you can buy their product. So it's a little financial.

The technology has come now where it is very easy to have interoperability and bypass all that blockade. And for what Dr. Neilson mentioned pull up all her patients who are diabetic and who has not has an A1C or A1C higher than six it can be done.

So look out for that new technology in the summary no different than you have yahoo. I have hotmail. You have AOL. And yet we can communicate. The technology is here and is practically free. So I think we with that enabler we would able to do the hybrid, thank you.

KAREN DAVIS: And I think, thank you very much and for people who've worked on this IT issue for a long time. I think we are beginning to make a breakthrough with the American Recovery and Reinvestment Act. Committing significant resources the announcement today that Dr. David Blumenthal designated to head the office of national coordinator for information technology. Gary, would you introduce yourself?

GARY CHRISTOPHERSON: Gary Christopherson, former CMS, DA and DOD one point then one question. Point is that really thinking about health we ought to be thinking about sort of refining our terms. One it isn't patient centered it's really person centered. Second is it's really not a medical home it's really a health home. We ought to be thinking about terms we want to use to get to the point we want to get to.

We want to go back to the issue of sort of what you all have argued pretty consistently as a group is that we want to move more toward integrated approaches. I'm not going to say integrated systems per se the formalized more but more toward that direction.

We seem to be caught between or heavily caught between it's either one model or the other we can't sort of find in between. The question is with the new-- our kind of money coming through PHRs, PHRs all this kinds of things change. With different models whether we can go to this more what I call virtual health systems.

We actually created one back in 1977 inner city Milwaukee to deal with inner city health being a public or private sectors. So the question I think to you all as a group is how do we use in between models. Models that don't require necessarily formal structures but don’t leave us locked into these strictly onsie, twosie models. In terms of their – and sort of more of virtual systems organized a tier group of people.

KAREN DAVIS: So Bob you want to take that on. How do we get to more integration from where we are today?

ROBERT BERENSON: Yes, well let me do two things, one is on your point about terminology. You know the healthcare home instead of the medical home. I've seen a recent article that Murray Ross is the lead author on.

Who many people here know, in which focus groups of seniors say, in fact there was one person said medical home, nursing home, funeral home, do the whole term probably needs to be reconsidered and in fact this is a very interesting article. It has a whole bunch of other terms that we're all using like

comparative effectiveness that are really misunderstood by the public. But I take your general point.

I think there's a model that hasn't gotten much attention. It still is alive and well because I just been there in Southern California and California the IPA, which has onsies and twosies. But there is an organization, an accountable organization that the places I interviewed they were buying electronic health records for a number of their practices. They were doing quality management. They were doing utilization management.

I spoke to one head of a large medical group who said he had thought his wrap around IPA network was a transition model to get people used to this and they move into the medical group.

His current data is showing that they do just about as well on cost and quality but have higher patient satisfaction scores. And he's thinking that maybe this isn't even a transition model maybe it's a real model.

So I actually think we can move towards population-based payment with a range where there are hospitals and physicians who are tightly aligned because the docs are essentially employed by the hospital. They are in a position to do this kind of thing.

Where we have the multi specialty group practice, where we have IPAs. I think we could be moving more quickly in this

direction without having to go necessarily through these intermediary steps of bundled payment.

KAREN DAVIS: Dr. Neilson?

NANCY NEILSON: Let me comment on that because that's exactly right. The IPA model is the way to do it, but there are some barriers to clinical integration. And we have asked the administration to look at perhaps loosening those barriers. It's a real high bar. It's very tough for practices to do this.

In my hometown of Buffalo there is an IPA there are only two IPAs that are really up and running. And one of them are essentially people in solo or small group practices. And they have joined together. And I only know about this because my sons their chief data analyst so I hear about it.

I mean what they have done is astonishing and they are able to gain share but there are some real impediments to the vast majority of people doing that. We would hope that those of you who are involved in looking at these issues will looking at perhaps removing some of the barriers to clinical integration.

Because I got to tell you we are where we are with practices right now. You are not going to make everybody a Geisinger or a Mayo tomorrow but you could quickly, quickly move as Bob has described.

KAREN DAVIS: Remind everybody to fill out your evaluation forms. Take another one from the card. And that is how do we address the geographic variation in cost, Stu.

STUART GUTERMAN: Well there a set of things that we can do that directly and indirectly affect costs. On the direct side one of the aspects of the payment reform proposals. In the commission's report the path to high performance U.S. health system is to give updates based on the geographic variation in costs and areas. So high cost areas might get lower updates than low cost areas.

But that changes payment and it certainly provides and incentive to, for providers in those areas to reconsider how they provide care. But I think the key thing is the kind of support you give for the changes in provider practice and that includes comparative effectiveness.

The comparative effectiveness main value of that for this system is that it allows people to make smarter decisions about how to provide healthcare and what health care to provide. And since it's been shown that a lot of what drives the variation in health care costs in different areas is the mix of services that are provided. And mostly the services about which there's not a lot of evidence as the effectiveness of providing more evidence would allow people to make better choices as to how they configure care.

And other policies like health information technology, improvements in coverage, they all provide a mechanism for disseminating the kind of information that makes providers, patients and payers better decision makers.

KAREN DAVIS: Thanks we're going to take the question there at the microphone. Yes, introduce yourself.

NATHAN: Hi my name is Nathan. I work for an organization called National Health Council. My question heads back into the comments Dr. Neilson made regarding the overall percentage of Medicaid patients she could take in her practice.

I was wondering if these speakers were familiar with the reports that just came out from first of all MedPac the annual marks report and second of all the Milliman Report and the discrepancy in the conclusions there.

If you're not familiar with the conclusions basically it's been the central focus of the debate in the last three hearings I've been to. The Milliman Report saying that the low payments from government programs specifically Medicaid and Medicare lead to cost displacement and an increase, a subsequent increase in premiums to private insurers.

And on the other side the MedPac Report saying that government payments are just fine to provide efficient and proper care. That can actually lead to better health outcomes than private insurers which there was some conclusion there, saying that it lead to inefficient use of resources.

KAREN DAVIS: All right if I could take the prerogative of changing the question. Since I don't think we are going to solve the cost shifting debate right here. And ask the panel if they think we ought to be moving toward at least narrower differentials in payment rates across providers.

NANCY NEILSON: You mean among specialties.

KAREN DAVIS: No I'm really talking about there's the Medicaid level of payment. There's the Medicare level of payment. There's the commercial level of payment. Should our policy be designed to try to narrow that differential across payers?

NANCY NEILSON: Well I think that would be helpful. For you know many years I got paid New York Medicaid rates for an hour long physical were $11 for a new patient, $11. For any repeat visit it was $7. I mean for 20 years, now how can you do that. How can you really do that? So there has to be some-- I mean there has to be some justification for making sure you can keep the doors open.

Remember physicians give uncompensated care nobody's talked about that today but they do. They do throughout this country they do. Let me shift it to a hospital if you don't think that cost shifting goes on try going to an emergency room with no health insurance and look at what your bill is. And don't tell me there's not cost shifting of course there is.

KAREN DAVIS: Bob?

ROBERT BERENSON: I just want to absolutely endorse the concept of acknowledging differences. And some-- economists argue about is it cost shifting or is it just straight price discrimination.

The reality is that in some-- well nationally private plans pay 20 to 30-percent more than Medicare rates and Medicaid in some states is 50 to 60-percent of Medicare. Those kinds of differentials cause lots of what I was talking about earlier, behavior distortion, when you have DISH Hospitals that are trying to survive in say Southern California.

They're making it only because their dish payments they have large uncompensated care burdens. They're getting 50 cents on the dollar for MediCal. And you've got other hospitals that are much better payer mix and are getting much multiples above Medicare. And that's not a good health care system. And I think we need to moving towards narrowing those differences.

NATHAN: Okay when you're talking about narrowing those gaps specifically what I'm – my perception of what you're saying, is that we need to be having the government programs up their payment levels towards private insurers and that's – am I wrong there.

STUART GUTERMAN: Let me make a couple comments on the point you've raised. One is remember that the biggest

discrepancy in payment rates across payers is for the payment rates that providers get for patients who are uninsured.

So one big step towards equalizing payment rates would be cover people who are uninsured because then there's payment attached to them. And if you look at the effect of the uncompensated care pool in Massachusetts before they had their universal coverage initiative, you know, found providers strangely talking about competing for uninsured patients because there was payment attached to them now.

In fact, unfortunately the payment that many providers got from uninsured patients was much higher than the payment they got for Mass Health patients and Medicaid patients. So there is certainly a discrepancy there.

Secondly, one of the reasons that many public payers pay less than private payers is that there are limited tools available in the current fee-for-service system to control total expenditure. That's really the bottom line and you take something like the SUR mechanism which has to come up when we're talking about payment reform.

The SUR mechanism is simply a system that tries to control total spending by cranking price per unit down because there is no way to control the number of units. If you had a better way to control the number of units by having broad accountability for healthcare you wouldn't have the kind of pressure to crank down on prices per unit that you have. And,

in fact, prices would be on much bigger units that are more meaningful in terms of healthcare.

Thirdly, when people talk about cost shifting they look at payments relative to cost. But they forget that there is a denominator in that figure and that is costs. You can say that Medicare pays less than hospital costs in the aggregate but you have to look at whether the costs that are incurred are appropriate, as well.

And you have to ask the question whether public programs should be chasing high cost increases if those cost increases are higher than they should be. So you have to kind of look at that aspect too.

KAREN DAVIS: So, Bruce the last word.

BRUCE HAMORY: Yes, I think just to put the point on this. This last point, I think is very important and also very relative to the previous questioner about health as opposed to medical. And I think we should not forget that a lot of – that a number of emergency room visits and hospitalizations among uninsured and under insured people result because they do not have access to primary care and to appropriate preventive care.

And so I think there is another piece of this which I think in Dr. Guterman's paper and others was explained. So it's a multifaceted issue.

KAREN DAVIS: And with that again let me encourage you to fill out your evaluation forms and turn those into staff and join me in thanking our panel.

[END RECORDING]