



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

**The 15th Princeton Conference: Can Payment and Other
Innovations Improve the Quality and Value of Health Care? -
Day 2
Council on Health Care Economics and Policy
May 29, 2008**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

STUART ALTMAN: I hope all of you enjoyed dinner last night and learned a little about the rest of the world, and somehow they are able to do things that we are sort of slowly catching up to.

We have a packed day and I know many of you have travel plans, so we really do need to keep this system on the road and moving along. But before I go further, I do not think I need tell a group like this that meetings like this just do not happen, that it takes a lot of work, and I want to single two people in particular, who have really made this conference work.

And I do not mean Chip and I, [laughter] we kept getting in the way. [laughter] but Howard Isenstein works with Chip and Federation and you have seen Jeff Sussman running around making sure all the stuff is working. So, these two individuals really deserve a special round of applause.

[Applause]

In addition, Mike Dunin [misspelled?] of our staff is responsible for the council's activities and then our two assistants out front of course, who you have seen over the years, Pat Eloise and Ann Cummings, [misspelled?] I just cannot say enough thanks for everyone and for those of you have helped

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

us put this program together as expert panels and stuff like that, I really want to extend my really best.

We will try to move this along, depending on how we do, whether we have time for a break or lunch or stuff like that, we will have to see, [laughter] I am making no promises. So, we have been talking a lot obviously, about the payment system and now it is about time we really focus in on it.

And again, I am really pleased to introduce Susan Nestor Levy, who many of us remember as Susan Nestor in her years in Washington and now she has sort of moved up and gotten bigger and more important and powerful and she is the Chief Advocacy Officer, oh good, okay, I can deal with that, for Ascension Health and I really want to thank Ascension Health for helping make this, and so I am going to turn the program over to Susan.

SUSAN NESTOR LEVY: Thank you Stuart and I just want to add my thanks to particularly Stuart and Chip for continuing this great tradition and Robert Wood Johnson. I think it is something that some of us remember from the beginnings and I think it has been a tremendous contribution to policy. So we have really enjoyed being a part of that.

As Stuart said, and Chip said yesterday, where is the beef? I think this is the beef now. We are going to talk about what do we do about transforming the payment system?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And let me introduce our panelists, Stuart Guterman who many of you know is Senior Program Director for the Commonwealth Fund, and he is responsible for their program on Medicare's future based at Academy Health in D.C. In that work, he works on Medicare issues and Medicare's role, in achieving a high performance health system. He does all of the work on current performance and improvements to the Medicare program. Prior to that he was at CMS in the Office of Research Development and Information, prior to that at CBO, and prior to that at Deputy Director of MedPAC and ProPAC, which is where he and I first got to know one another and had the pleasure of working together. He has an A.B. in Economics from Rutgers and an M.A. in Economics from Brown.

Next to him is Dr. David Pryor, my colleague, Chief Medical Officer of Ascension Health. For those of you that do not know, Ascension is the largest non profit hospital system in the U.S. Prior to joining Ascension, Dr. Pryor was Senior Vice President and Chief Information Officer for Allina Health System in Minneapolis, and prior to that he was President of the New England Medical Center in Boston.

He spent the first 15 years of his career at Duke University in Durham where he served as Director of Cardiology Consultation Services Section of Epidemiology and Biostatistics on the Duke Database for Cardiovascular Disease Clinical

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Program Development. He is a graduate of University of Michigan Medical School and did his medical training at Pennsylvania Hospital and his Cardiology Fellowship at Duke.

What Dr. Pryor will do is give us the on the ground prospective. He has been in charge of a strategy called Health Care that is safe with the goal of zero preventable deaths across the Ascension Health System of 67 hospitals and 100,000 employees and I think he will give us a very interesting perspective on that work.

And, our final panelist this morning will be Bob Galvin. Dr. Galvin is Director of Global Health Care for General Electric. In addition to his responsibility for GE's \$3 billion annual health care spend, he oversees GE's Clinical Group, which is 215 clinics in 30 countries and leads health policy for the corporation.

His current role he focuses on market based health policy and financing and has a special interest in performance measurement payment reform, assessment and coverage of new technologies. Many of you know he is the co-founder The Leap Frog Group and the founder of Bridges to Excellence. He serves on numerous panels and commissions and has received a number of awards for his ground breaking works.

So, let me turn it over to Stuart first, and then we will go to each of reactors.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

STUART GUTERMAN: Thanks Susan. It almost makes me think as people review the number of places I have worked, that I start thinking well it really looks like either I cannot hold a job [laughter] or I am very old, or both [laughter] so, I will let you draw your own conclusions.

But I am going to talk today about how to use the payment policy to transform the health care system. And keep in mind all of the discussions you heard yesterday and particularly your favorite approaches. And what I am going to try to do is present a framework that some of us have been thinking about, for how to fit payment policy and organizational reform together so that they can really sort of be synergistic and so that one can encourage the other to evolve to a higher level, which I think is what a lot of what was discussed yesterday in all of the sessions.

So, first a little background and I am sure nobody here needs, and I will just go through it fast. We have the most extensive health care system in the world. Everybody has their own ways of presenting that, this is a way that the Commonwealth Fund is fond of presenting it. When we look at other countries we spend more on health per capita clearly than anyone else. And so all the problems you heard about, all the challenges you heard about yesterday are felt in spades in this country.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Another representation of that is our bending the curve graph, where here you have two lines. One leads to the \$4.4 trillion or doubling of health care spending over the next ten years. And the lower line is what spending would be if we held the line at the current 16.2-percent of GDP.

And a lot of what as you think about where we want to go in the health care system, I think a lot of the problems that are faced are problems of trying to establish the correct baseline. Having worked at CBO for sometime, we did a lot of thinking about that then.

But I think a lot of health care thinking has to do with sort of focusing on the correct baseline and this graph sort of represents the discrepancy, the different ways of thinking about this because you can think of \$4.4 trillion which is what is currently projected as the baseline, and certainly providers do.

And when you talk about having a more streamline system and a system that uses resources more effectively, you are talking about spending less than \$4.4 trillion in 2017, and providers look at that as being money that comes out of their pockets.

I would look at \$3.6 trillion as an alternative baseline, and I would phrase the people who have sort of complained about the difference between the \$4.4 and the \$3.6,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

by saying basically for the health care system we have got, why indeed should we be paying you that much money than the lower baseline?

And I think we really have to shift thinking that way, because as long as people think that money is being taken out of their pockets when we stop spending profligately and inefficiently, then I think we are going have difficulty getting to any kind of change.

This kind of pressure builds up and always feeds back on households. We see here the trends in national health expenditures, health insurance premiums, workers earnings and out of pocket spending. And you can see here that health insurance premiums have gone up considerably faster than worker's earnings have.

And much is made of the fact that out of pocket spending is a smaller proportion of total health spending, but one thing we have to realize is that it has gone up much faster than worker's incomes. So, there is pressure being put on households from every direction. Their wages, their health insurance premiums and also their out of pocket payments even if they have health insurance.

So, how do we stack up in terms of access and quality? I have to relate an anecdote. I was testifying before a committee in the last Congress, and there was a set of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

speakers, somebody from CBO, somebody from GAO and myself. And we all sort of took turns showing measure after measure of how the United States health care system does not measure up to what we would like it to measure up to.

And at the end of the hearing the Chair of the committee summed up by saying, well I think what we have heard here is that we have the best health care system in the world, and we do not want to mess around with it. [laughter] So, I think it is all a matter of perception, but we still need to make the point and it is not a derogatory point, it is pointing where we need to improve our system.

The Commonwealth Fund did a national score card for the American Health Care System and got an overall score of 66, which is not acceptable from I do not think anybody's perspective, except maybe that chair's prospective.

Now we have a graphic that sort of summarizes the framework that I am going to be talking about. On the vertical access the left hand vertical access, we have different approaches to payment. Roughly as you from the bottom to the top you get towards increasing degrees of bundling, it may not be Mona conically increasing, but you are definitely moving from less bundling to more bundling as you move up the vertical access.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And as you move across the horizontal axis, you have a continuum of different kinds of organizations and this is consistent with kinds of discussions that we were having yesterday. And as a point that was made several times yesterday there is a relationship between the type of organization and the type of payment that it can handle, and also a relationship between the type of payment that is made and the incentives for forming different types of organization.

And the overall way I would describe this framework that we are presenting, is basically that you want to move up this hill that we have depicted here, and what you want to do is successively start out by recognizing that there is currently an array of health care organizations and different organizations can take a different amount of say, more evolved payment system. And that try to cater the payment system to the existing organization, but at the same time try to present incentives for moving up that slope to evolve to a higher form of organization as well.

So, you can build carrots into the system, for instance, to convince people to move from fee for service, the current toxic fee for service system which is the way was described repeatedly yesterday. You can start out by having some incentive to coordinate care more, by building in a medical home type payment model you can further bundle to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

global primary care fees which would involve bundling all of the primary care services.

But not making the primary doctor responsible for specialty services, but certainly being willing to share any savings that they were able to achieve from managing their patients more efficiently. So moving towards the physician group practice demonstration model in Medicare, then move on the global ambulatory care fees, which is just a bigger bundle, and again, steadily increasing the size of the bundle and what you can do is build in a gang sharing methodology.

So that if you really believe that more bundling leads to more efficient behavior you can decide that you are going to share more of the savings as you successively move up this hill. And that will provide incentives for any practice that can do so to try to form either real or virtual organizations that can take these greater bundles.

So, I have described basically the framework that we are talking about here. The underline philosophy here is that you start out by recognizing that there is an array of different kinds of organizations and you basically try to make different payment models available to those different organizations on a voluntary basis, with incentives built in to choose the most bundled payment that you can handle as a practice.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And then further build an incentive that so that if you are only capable of accepting a certain degree of bundling at the current time, that you have an incentive to try and move to the next level because it behooves to do so, because you have more control over the kinds of revenues that you can generate. And clearly that is where we need to go.

You cannot mobilize a national guard and herd all the doctors into one office building and call them a multi specialty group practice, it is not going to improve the efficiency of the system. But you can provide incentives that steadily increase as you become more like the kind of practice that Steve Shortell was taking about, that Mark was talking about that move you toward more coordinated care for the patient and more efficient care for the system.

And if you picture this in the context of Medicare, which I tend to think of things in, you can view Medicare as being a basis for the sort of initial testing of this kind of approach and you can also view Medicare as a basis for evaluating these different kinds of models to see what works and what does not.

You also have to have some underline system reform, and I think this is a role that the federal government might take or the federal government with private payers because I think it benefits them as well. You want to have built in

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

accountability, you want to have performance measures now, and you can have pay for performance built into these systems, but now you are not relying solely on pay for performance to change behavior.

You are relying on pay performance to reward physicians for providing the kind of care that you would like to see. Physicians and hospitals and other providers as well, for providing the kind of care that you would like to see happening, and also to make them accountable for that type of care. You want to have real transparency.

I often observe that when people in Washington, especially talk about transparency they are really talking about putting a black box inside a Lucite box and they declare transparency. There is a long way we have to go before we really achieve true transparency where people can get at information, not just data, but useful information for decision making in a context where it really can be useful in helping them make better decisions, both providers and patients.

You need to have information technology. I think we need to start to view health information technology like we viewed the interstate highway system. Where it is very difficult to get a real handle on just how much benefit health information technology can offer in a system now where we are

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

basically the equivalent of rutted roads and we are trying to figure out whether the car will actually work.

All of the performance measurement, all of the payment systems work easier if you have health information technology, and of course you do not have real transparency unless you have systems that can produce the information that is useful for better decision making.

And finally, comparative effectiveness because if you are going to have better decision making you have to have some targeted efforts to produce the kind of information that you need to make better decisions, including clinical decisions and including coverage decisions and including payment decisions and including utilization decisions for patients so that patients know what array of treatments they have available and what their choices are and what their potential outcomes are.

And we know very little of what we have got now and if Beth McGlynn is right and Americans only get 55-percent of the care that we know they should be getting, it seems to me that if we double the amount that we know we might still double the amount that they get that we think they should get.

So, that is basically the outline, we can start with Medicare by fixing how Medicare pays and trying to move Medicare successively toward more bundled payment and payment that rewards the kind of behavior that we would like to see,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

rather than just more and more expensive and more technologically complex, but not necessarily better.

And for the broader system we can expand access, we think that universal coverage has to be a basis for improving the health care system because if for no other reason, and there are lots of reasons to do this, but for no other reason than if you come up with better policies.

If everybody is under the umbrella then everybody is effective by those policies and you do not have the kind of leakage that you have now with implicit cross subsidies across payers that really distort the kind signals that what we like to call a health care market transmits.

So, I would like to thank Karen Davis who is thought this out with me and my other colleagues at the Fund who have worked on these issues along with us, so thanks. [Applause]

SUSAN NESTOR LEVY: Thanks Stuart. Dr. Pryor.

DAVID PRYOR: Well it is a pleasure for me to be here today and as I listen to the different perspectives, I also am optimistic perhaps because of our experience, and I will elude to a couple examples. And as I thought about it and I realized that everyone here knows that to the optimist the cup is half full, and to the pessimist the cup is half empty. And to the engineer of course, the cup is twice as big as it needs to be. [laughter]

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I am not sure exactly which of those I fall into except I suspect that it is probably the optimist. And as I reflected on the excellent work from the *Guterman Davis Paper*, and I thought about what is the experience of Ascension Health that would be potentially relevant. And I thought back to the goal that we set in 2002 to provide excellent clinical care with no preventable injuries or deaths occurring by July of 2008.

And we set an initial metric for that which was to reduce mortality among patients not admitted for end of life care by 15-percent. That would translate in our system to avoiding 900 deaths.

I am also optimistic because we far exceeded that goal. We far exceeded in fact, most of the goals that we have set. As an example, we deliver approximately 75,000 babies a year in our system, and our neonatal mortality rates are around one per thousand, our birth injury rates clinically reported using the same definitions that AHRQ uses are well less than that, both of those are well less than the national averages.

So there is certainly a lot that can be done even without the payment reforms that we are talking about. And I think that a lot has been done by a number of systems across the country.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So, as we reflect on this and we think about what is in critical, in terms of trying to align incentives across the system, so that we are providing the goals and the care that we want to receive. I thought that it might be useful to reflect for a moment on the fact and make three examples of things that I think are critical that are not necessarily only related to payment reforms. If we use only payment reform strategies those by themselves will not be successful in providing us with the systems we want.

It is three examples of that from our experience. One example that I think we are going to discuss a little bit later today, really refers to the critical infrastructure, the information infrastructure that has to be in place to enable every patient to receive the right kind of care at the time that care is needed.

Think for a moment about the fact that nearly every medication that a patient fills, or every laboratory test that they have, is in fact sitting in an electronic data base somewhere and yet that information is not available to practicing clinicians or emergency rooms for the most part when those patients show up. Think for a moment about the mistakes that occur because of that. Think for a moment about the redundancy in testing and the cost that are associated with that, simply because that information is really not known.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And as we reflect on the issues that are around payment reform, I think it is important also to make sure that we do not have unintended consequences and that we enhance the credibility among the provider community by demonstrating and focusing on some of these other areas as well. We think that there is going to have to be a substantial investment in the information infrastructure and also dealing appropriately with HIPPA concerns in order to make the kind of system available.

As a second example, of issues that I think are key, we have recognized in our system that the key to improving outcomes often depends upon appropriately recognizing errors or near misses or other events where they occur and being able to appropriately look at that information and learn from it across our system, that requires adjust reporting culture. And as we think about what it takes to create adjust reporting culture we are very supportive of the recently enacted Patient Safety and Quality Improvement Act because it offers systems like ours the opportunity to create a constructive environment in which to address these medical errors. Creating that culture of safety is absolutely essential if we are going to have the improvements in quality that we all want to see.

The last element that I would like to mention is another example other than payment reforms. Is really to make sure that we enable effective consumer participation in the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

health care decisions. There needs to be transparency. We have heard that eluded to with respect to treatment options and likely outcomes.

And it is essential for us to figure out how to properly empower patients to be full partners with the providers in making those decisions. And while payment policies can drive providers to focus on appropriate efficiencies and quality outcomes, it is important that patients are given the opportunity to apply their own values into the treatment decision process.

Let me conclude with just two other observations, around the focus and the issue. The first is really at Ascension Health we would say that there are four goals of the system. We have talked clearly about two of those goals, which is improving outcomes at the same or lower cost. We think there are two other goals. And those two other goals are to improve the experience for the patient, and also to improve the experience for the providers working in the system. So we think the issues are really around achieving those four goals.

The other issue that we think is key is again just to reflect on patient experiences as we try and maximize that. Those payment reforms and strategies must be accompanied by approaches that enable patients with their clinicians to engage in value based decisions about their care. This is only

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

possible if we make the information about care and the options available accessible to patients when they need it to share fully in their decisions.

We think that payment reforms can help move us towards the health care system in which patients are enabled to participate fully in decisions about their care. We think that Medicare is a good place to start, and we are very supportive of strategies around episodes of care and other approaches to trying to link those policies together. Thank you. [Applause]

ROBERT GALVIN: Good morning and thanks for asking me to speak here today. I am sorry I missed yesterday, and I am glad to be here today. I am going to spend a few minutes somewhat reacting to Stuart's talk, but more talking about some practical issues about how you create change in the payment system and in the U.S. health care system.

I am going to start out with the assumption that there is really no whether, we should change payment system. I think a lot of people are agreeing that we do need to change the payment system. I am not going to spend time talking about in what way we ought to change it, because I think that is time for another discussion.

But I am going to talk a little bit about how change actually occurs and given what I think is the urgency of changing the payment system an idea about how we might change

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

it. So you can kind of see the title I do think our payment system needs is CPR, and that is a defibrillator. I should say for those who do not know me, though I work at GE, I am not on the commercial side the business.

I am not selling the defibrillator, [laughter] by the way do we not make defibrillators, but I am on the employee side and I am a health care purchaser. So, may of you know me, but some of you do not, so I just realized you might think I was marketing a defibrillator, [laughter] I am not, that is actually what the business would like to do to me most of the time when I do not pay for their innovations, but not the other way around.

This is my single comment on whether it ought to pay, because I think Stuart's charts are great. I am lucky enough to be a part of that commission that Commonwealth funds. But I think it is pretty succinct. I like when I travel around, whenever I can to talk to practicing doctors in communities, in addition to the leaders that I see. And this is the quote that keeps resounding.

I heard this several years ago. And I think if we think we are going to get a lot of improvement and people have to commit economic suicide to do it, I think we are fooling ourselves. So I think unless we radically change the payment system we are going to see some aspects of excellence and I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think Ascension tells a great story and we know those exist in the country.

But I think we will see what ARK showed in its report that came out a couple of months ago. A few percentage changes of improvement, some places where it went back overall mild improvement, but a steady increase in how much it costs.

So, I think to me that is the whether story. This is just a chart I have shown before. It is just how purchasers, employers try to map out a strategy for change. This is actually now ten years ago, and it was really the idea that we wanted to keep the population healthy, but we really did map out this idea that post the managed care collapsed, this was the late 90s.

We thought there was a real pathway and opportunity to go on transparency and measurement and that was really what the Leap Frog Group was about, and I think we actually had some nice progress in the country on that.

It was then really to move to incentives, both on the consumer side, but particularly on the payment side to providers and Bridges to Excellence which some of you might have heard of was an idea to begin kind of the payment and then it obviously, I think all leads to what David just talked about which is clinical reengineering, and that is what the point of payers ought to be is to set up the right incentives so that

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

you free up providers to do the right thing and then obviously the holly grail of better value.

I think we are really stuck on payment reform, and I will show you why on the next slide. I do would point out at the bottom right the optimist, Artie Millstein [misspelled?] and I created this chart in 1998 actually, and we headed out to 2008 we thought we would reach the peak. [laughter] So we hedged a little bit from 1998 to 2000 when the century turned and now I just have question marks out there. But so I think you just get humbled the longer you are in the system.

This is what we have tried to do in payment reform, and I think this is what is leading my thought that we really need CPR. And so I mean there is a lot going on, I mean it is actually pretty exciting. I think the number of people from different sides of the sector that are all agreeing that payment reform is very important.

The Quality Chasm had a chapter on it, a recommendation on it. MedPAC has been very bold about what they think should happen. I was on the IOM panel where we put out the rewarding provider performance as were some other people in the audience, which I think was also very bold, and we have action. So we do have the last survey I saw that Leap Frog does, I think Commonwealth supports it on the compendium of pay for

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

performance in the private sector was 160, it is probably 180 now.

Medicare depending on how you want to count the demonstrations and really this is the physician side now, not the hospital side. There is 12 if you want to count paying for reporting. That is a lot of activity in a system in about seven or eight years. But I asked our finance team at GE to look over kind of our own performance, and to what extent was all this action, all this activity, [laughter] all the stuff I do out here making a difference in how we pay, and it was pretty humbling.

So in the states we spend \$2.5 billion a year and it is a stretch to say it is less than 1-percent, because less than 1-percent gets you pretty low. But it is less than 1-percent of our payment is actually being based on performance. So if all of our employees and their family members going to all the doctors and the hospitals and all the facilities in the country, less than 1-percent of it is actually based on performance.

I asked them to project out several years to see are we just at the low part of a curve and we are about to take off. So we talked to the health plans with whom we do business, and of course we are so big and in 50 states we do business with a lot of them and we could not find any projection even being

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

wildly optimistic that got us above 1-percent in five years.

So that is when I took out the defibrillator because I think at that part you do not have to be a clinical doctor to know that there is barely a heart beat going on there. [laughter]

And this is what it feels like to me to try and change the health care system. I mean obviously that is smaller than I am, the little guy, but when you are trying to make change in the system I just feel like that. But I think you cannot give up or the guy is going to fall on you. [laughter]

So I think we have got the kind of a cycle of inertia, and I do not know where Joe is, but I have used this chart before around performance measurements. It is either I have one idea [laughter] and I keep repeating it or this is a truth in our health care system and the way it works.

And I think particularly under Scully I think particularly under McKlellen [misspelled?] and I think a lot of people today in Medicare really get this and really believe they want to change the payment system. But they do not have the support of Congress to do it and I think we see that year after year in the Medicare payment bills.

So they basically say, I do not have support for substantial reform. You would think that the private sector ought to catalyze this that is one of the benefits of having kind of a private sector in health care. But what the health

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

plans say is I do not want to get in a food fight with the providers, I am just going to let CMS do what they do and then I will follow them.

You go to providers who I do think really feel the brunt of this and they really care about quality but that is the quote that I showed. No one is going to commit economic suicide, it is just not going to happen. And then it ought to come back to kind of employers, consumers, I mean we represent our employees in this. But really what you hear on my side is, yes of course I want more value, I have been screaming about it for 20 years, but I do not know how to change the payment, this is way too complicated.

So I think for the physicians in the room we have one of these nice rhythms, circus rhythms we call them in the heart, David you are a cardiologist, and that is what we have. And I think we are trying to make some efforts and I think there has been some change, but I just do not see a substantial way to get out of this.

So, how do we get out of it? And that is why this is just a very practical commentary. I do think at the end of the day the system is not going to change until Medicare changes. So, I think in a way my thinking is and we did this in transparency also. Somehow you have got to position Congress from being able to say to CMS, do not move so fast to say,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

hurry up. And I think the private sector can have a catalyst drawn, we cannot change the system but I think we can catalyze.

So, I think this is how I think it works. You know CMS they attempt payment change, Congress goes, what are you thinking, slow down we do not have any support from this. If you can get the private sector to catalyze and that would mean broad base support, not just from big businesses, but from labor, from consumers, from our employees you have a concept that make sense and I think in a way transparency and measurement made sense.

And you make it from the beginning adaptable to CMS so it just is not something that can work in companies. You then hopefully get to the point where Congress says CMS, what are you thinking, hurry up. There is a great idea out there and you are not adopting it, and then they execute payment change.

This has happened before I mean I think we have good examples. In the past 15 years or 20 years I think managed care the good parts, not the commercialization of managed care and some of the issues that has brought, but the idea of actually managing care. I think measurement and transparency we talked about you see what is happening now.

I mean ten years ago would you have thought that CMS was going to spend, I think it was \$2 million to take out ads in I think 50 cities to entice elderly to go look at

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

comparisons on hospitals, not just on satisfaction but on performance. That is quite amazing. I think that disease management, although it has not quite panned out yet, I think that was another good example of an idea. And I think early P for P, I mean Bridges to Excellence we actually designed it in a way so that it could become and it a demonstration project, it is one of the 12.

So, if this at all true how do you do it? And so we are working on this idea that maybe the defibrillator we ought to use is also called to CPR, but it is the Center for Payment Reform, rather than Cardio Pulmonary Resuscitation. And it becomes kind of a nidus in a platform for change, and it really does three things.

And one of it is, because I do believe in transparency is establish a national score card. We have now at GE written contract language that we got all of our plans to sign that they are going to start reporting to us how much of the payment they do on our behalf or their book of business, we do not care, that is actually performance based.

Because I think shining a light on something is the first step to improving it. I am very taken with the idea of a rapid learning system and I do not know if Glen is in the audience or not. But I really like the whole idea and I think when you go and I travel a lot. When you go from town to town

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

across the country it is quite remarkable that no one has any idea what is going on in any other area, and there is some very good ideas going on.

I think RWJ through aligning forces, there are a lot of efforts to connect, but there is no one specific body that really tries to connect and this is not as much peer reviewed literature as it is the Grey literature. Because when you actually look at what changes in marketplaces, it is the peer reviewed stuff, but it is the Grey literature, it is the experience, it is kind of the trusted anecdotes that you can count on.

And I am amazed in the third pillar is the facilitate coordination between the sectors. We have at least four markets where Medicare has a demonstration, health plans each have different pilots they are trying. And employer coalitions are doing something and none of them are talking to each other, I guess unless they are in one of the aligning forces, with RWJ they are just not talking to each other.

So, the idea of this a center would simply be a catalyst. It is again, how do you create the idea, how do you make real change in a private sector, but how do you really get that big dog to bark in the end, and how do you straighten out that lack of proportion between the sumo wrestler and the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

little kid trying to push him up. So, with that that is it.

Thank you. [Applause]

SUSAN NESTOR LEVY: Opening it up for questions, Chip.

CHIP KAHN: I guess I am a little concern Bob that to get the big dog to bark you got to have [inaudible] and although I have heard a good description of the it is a world of possibilities, if you look at the history of Medicare payment, since 1983 other than DRG's, which I think have had incredible affect, positive affect.

And almost every other [inaudible] have been either a failure or close to it, or was great disgruntled about it, but not by providers necessarily and pay for performance as it has been discussed in [inaudible] the margin, but I do not think you have the metrics there to argue, you could go to even more than a few percentage points because we are not talking about actually pay for performance there, we are actually talking about extra pay or supplementing pay if you measured well or a bunch of measurements.

So, I am with you on the big dog barking, but I am not sure what the barkers want. The other thing about it that concerns me, or I think is an issue is that what you are basically asking for is the government which tells people what they are going to pay, does not negotiate. They basically put in place a new payment system,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And so in terms of single payer, it seems to me that the implication that is that without having a single payer or maybe heading for the single rate if the private sector is going to look into the government to set the rate. And actually historically we see with DRG's and with RB/RBS, even though DRG's was not really accepted by the private sector it was really [inaudible], but RB/RBS was accepted but then they used their own multiplier.

So I guess I am with you except I see those two issues, with one we do not have the methodology and two even if we did, are we ready to go to what can amount to single payer, in a sense of single payer methodology.

ROBERT GALVIN: Yes, thanks Chip. I would say first of all, before there were DRG's there were no DRG's. So, I mean starting one of these things before you have a set of ideas does not mean you are not going to come up with a set of ideas.

I think part of what we are not going to get to. I do not think pay for performance in the way we have done it based on fee for service is the key. So I think we talked a little bit whether it is blended payment, more global payments, Prometheus that RWJ just founded which is another way of trying to do some global free payment. I think there is some very, very good ideas out there.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I think that again, I think the pluralism of the system is great, I think there are some good ideas, I think there has been a limited ability to bring them together. So, I agree there is no one idea now that can do it.

Secondly I would say in terms of the single payer [laughter] I am not looking for that, and so I am not looking again and I think it is good feedback, but what I am trying to say is for the big dog to bark does not mean that kind of it creates a single payment system and everyone follows that.

I think there and if you look back at Stuart's chart that he showed where you kind of matched the payment system to kind of the degree of provider organization and some other factors in the market, I think you end up with a whole set of different ways to pay, not a single way to pay, that might differ market by market. Now maybe Medicare goes it way and the private sector includes that payment system among others. But I am not looking for a payment system.

SUSAN NESTOR LEVY: Stuart, you want to just expand on that a little bit?

STUART GUTERMAN: Yes, I think that is an important remedy, when you look at the payment systems that have had maybe not the kind of success that they were expected to have. Many of them really had either RB/RBS is a perfect example. Where the RB/RBS does what generally what it was suppose to do.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The problem was it still left with emphasizing the fee for service, individual service based payment system. So you set rates and then it had on top of it a mechanism that basically tried to control volume by ratcheting down individual service rates which sort of is doom to failure and that we are sort of reaping what we sowed in the early 90s.

But if you look at the DRG's, that was really the one attempt to bundle payment. I mean the first attempt to bundle payment and it did change the way people think about things. And the fact that I would not say the private sector even rejected DRG's, I mean I think they sort of actually ran to adopt the DRG's in the initial days, and then sort of found other ways to use them in combination with or replaced it with other things.

I think one of the things that we need to do is to really emphasize the public and private partnership and the roles that Medicare and the private payers can pay and work with the providers to develop payment systems that are more appropriate and they could adapt it over time, because that is what you need to do. You cannot just put something in place and have it carved in stone and say this is going to work forever, because it does not work that way.

SUSAN NESTOR LEVY: Larry did you have a follow-up.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

LARRY: I think your earlier chart, Bob, is long enough [inaudible] organization and seems to me that these payment methods [inaudible]. I know my experience is based on conventional organization, but the importance of that is not so much that organization or even the ones like it, but whether or not you can begin to break through those kind of motivations and to businesses. I had different organization structures.

Because it seems to me the question [inaudible] conference is all this is very powerful and very useful, but if you do not have a good team by having people who have heart disease in the hope that you can resuscitate them with a defibrillator. You try to get the right structure in place and I am wondering whether or not there maybe some ways to put in this payment reform to talk about structural reform which then creates [inaudible] to whether or not we can move toward organizations like the ACOe or like other forms of integrated care by public policy that advantage those players in the system in various ways. I just think to me that is the only way [inaudible].

SUSAN NESTOR LEVY: Why don't we have everybody briefly comment on sort of the need for public policy around the overall structural changes, which I think is what Larry is putting on the table here?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

STUART GUTERMAN: Well, yes I think was exactly the point that I was trying to make was that you need to do, we tend to get into policy debates, we tend to get into arguments about what is going to work, which policy is going to work. And we have to get away from that and look at the set of things we need to do and not waiting for one to see if it works in order to do the next thing, but to really do these things together.

And I think our Commission on High Performance Health System is really focusing a lot on the fact that it is the delivery of health care that needs to change. Payment as your right, payment as a tool. We have to look at it to as not a way to get providers to convince them to do things differently, but a way to let them do what they would like to be able to do.

And you can look at it as getting the payment system out of the way, not imposing a payment system on people, but designing payment systems that are more organic to what providers are trying to do and different groups of providers can do different things and you ought to have flexibility in payment systems to be able to encourage them to do the kinds of things that they can do, and then to encourage them to be able to do more as time goes on.

SUSAN NESTOR LEVY: And, David would you touch on also the kinds of structural things inside an organization that you

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

have put in place to make that happen, because I think Stuart referenced that that it is not only public policy but what can you do to really encourage this kind of behavior?

DAVID PRYOR: As I reflect on listening to the conversations, sort of two classic quotes come out. The first is "every system gets the results that it is designed to achieve". The second is that "culture eats strategy for lunch". Where you find people, put together good strategies that consistently fail. The problem is not in coming up with another good strategy the problem is an understanding what it is in the culture that prevents those strategies from being effectively implemented.

SUSAN NESTOR LEVY: David, I think you need to pull that microphone up just a little.

DAVID PRYOR: Okay, is that better? Yes.

So the two quotes, the first one you heard. The second is "culture eats strategy for lunch" and as you reflect on that, I like the graph that Stuart, I like the graph that Steve Shortell talked about. As we talked about evolutionary approaches that are evolutionary, not only for payment reform policies that has to be in place and that will be required, but also evolutionary that lead towards the kind of culture change in the kind of changes that are necessary in order to get the system actually functioning and working.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And as you reflect on that, there is an enormous amount that has to occur. We are not using the information properly that is currently available. We do not have the right decision support systems. We have not engaged patients in the decision making process appropriately. We have not necessarily even adapted the learning's across the system.

In our own system for example, we have set up affinity groups and other approaches where learning's can be shared across an entire system. But it is still an evolutionary step for how you begin to create that kind of learning network across a system as we talk about it. So, I think that the structural changes are required, but they are likely to be evolutionary and as we think about how we do that, we should be thinking about how we also encourage the other changes that have to occur within the environment.

SUSAN NESTOR LEVY: Bob, you want to comment briefly and then I want to go to Kathy.

ROBERT GALVIN: Because Larry, I have been thinking a lot about this and I have a worry and I am not sure I have expressed it before. Which is I do think that providers and organizations have more capacity to improve and I think that is what you are saying by structural changes, right. And should payment policy and public policy help them come together?

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I can tell you in experience as a buyer is other than two parts of the country, the markets that we are in and I can name about 25 of them that have organizations that have come together they act more like cartels and the pricing that we are having to pay for, [laughter] culture eats strategy for lunch pricing kind of eats efficiency.

So I think they probably have better quality going on, but the pricing pressures we are facing means that things are in the end ironically and in an unintended way less affordable for our employees, because that is who pays in the end. And so I just think there is an extra texture there.

SUSAN NESTOR LEVY: Thanks, Kathy.

KATHY: Yes, I just wanted to put on the table the thought, because I spent a lot of years in payment reform. But one thought I have had for a long time is why not use payment reform as a reward, so in Medicare the tradition is when you reform payment it is reformed for everybody. Why should it be?

Why not say, we are going to reward those systems through bundled payments, greater flexibility, the ability to pay for services that are not otherwise covered by Medicare. To develop and support a different mix of providers within a payment stream, but only for those systems that meet certain criteria that we think are important to move the value issue and the quality issue down the field.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So whether it is the adoption of HIT if it is a certain infrastructure that really generates continuous learning. Why not use it as a carrot, rather than as an entitlement? So Stuart, I do not know if you were going there, but I noticed that back to the original, the first panel which is about how do you stimulate system ness. You have got to reward system ness in some way and I feel like when we have done payment reform in the past it has been for everybody. And I am not sure that is what we want to do in the future.

SUSAN NESTOR LEVY: Stuart you want to.

STUART GUTERMAN: Yes, that is absolutely how when we show that sort of slope and want to move up that slope to sort of what I described as a more highly evolved organizational and payment system. That there need to be carrots at the end of each of those successive steps so that you make it attractive for providers that can to organize in a different way. To be able to provide better, more coordinated care.

And in the Medicare context, which I know you have worked in most of your life, one of the problems is that nobody trusts Medicare in the end, so you have rules and they have to apply to everybody and they have to be designed to the least common denominator.

And we need to get away from that, you need to be able to give, I mean I ran into this when I was with CMS in

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

designing demonstration projects. Where Medicare says we want you to take this great leap with us, come hold my hand we will jump off the precipice together and make the system better. And then at the end they say, oh by the way you go first, [laughter] because Medicare is not allowed to take any financial risk really especially these days.

And you cannot have evolution without sort of being willing to go that step, at least go that step with the folks who are suppose to be your partners.

SUSAN NESTOR LEVY: Let me go to this side of the room.

CHRIS KOLLER: Hi, I am Chris Koller the Health Insurance Commissioner in Rhode Island, and I want to start off of Bob Galvin's cycles of inertia slide and my experience with private payers is Medicare sort of defines the bounds, but often it is the standoff with the providers. So Medicare kind of provides the script, but it is easier for them to simply sweat a little bit, state of the status quo and pass on the cost to you as the purchaser. I am trying to look at ways to get the commercial payers to innovate off of a relatively sort of bounded script if you will to get some leverage out of it. Are there potentials, rather than wait for marching orders from Medicare, wait for Medicare to find the norm.

SUSAN NESTOR LEVY: Excuse me for interrupting you, we have got about five minutes left, so if you can -

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

CHRIS KOLLER: MedPAC or something like that sort of defining a range of innovations that could work off, so we are not sort of waiting in sequence for Medicare to define the rules.

SUSAN NESTOR LEVY: We have a couple of comments and hopefully have a –

ROBERT GALVIN: That is one of the objects of that center, the CPR would be to define kind of a strategic framework and a conceptual framework about what we want from payment reform and those would be the bounds. So, yes.

SUSAN NESTOR LEVY: And also –

STUART GUTERMAN: I wanted to make one point. There is a leverage point that we have with private payers that I think is largely undiscussed and that is the lack of universal coverage, because private payers and all the people who pay premiums to private payers bear a lot of the cost of uncompensated care in terms of the extra payments they have to make to providers and I think there is some potential there if we had universal access to health care and if we had coverage for everybody.

We need to be aware of the fact that there is a lot of money that gets freed up, money that private payers are paying now explicitly that can be used maybe as leverage to improve the payment systems and to maybe to cushion some of the risk

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that they feel they would like to take if they shift the way they do things.

CHRIS KOLLER: And I would also point out another leverage point is state based rate regulation, which is another way to get the payers to the table.

SUSAN NESTOR LEVY: Let me, go ahead.

MALE SPEAKER: The DRG reported to Congress in '82 went at great length to talk about bundles, and I think the reason DRG's work is they define a bundle, they define it precisely. If you read any numbers that CMS, what they really do is talk about how to bundle a payment. Until somebody can figure out what the next bundle a payment is I do not think you can have payment reform because you cannot pay for something if you do not know what it is you are paying for.

So until we have something that is the next kind of bundle very carefully described, very carefully outlined, I do not know how you can have reform. You have got to have the bundle, you have to know what you are paying for then you figure out how to pay for it. If it is kind of a [inaudible] you will never get the next step in payment reform.

SUSAN NESTOR LEVY: Who has to react to that?
Everybody agrees. [laughter] Then we go way to the top.

MALE SPEAKER: It sounds like you are describing public infrastructure with a public benefit that comes along with it.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And if that is what you are describing, perhaps the next bundle looks very much like something that utility would do. Define the public good and then go to, whether it is private markets and securitization at advanced rates, or public lenders.

But what you have described what sounds an awful lot like a public utility or a public infrastructure with a public good to it and that suggests all sorts of ways of bundling infrastructure into the rates in where that is different from, say IME and then going to completely different funding sources than we usually do.

SUSAN NESTOR LEVY: David, you want to.

DAVID PRYOR: Yes, from my standpoint I would tell you that I think the key bundling issue that has to take up the current fragmentation in the system. It is not about bundling groups of services at this level. What has to happen is that we have got to figure out a way of delivering upon care across the continuum of care that provides the right kind of care for people and get away from dealing with it at each individual component.

STUART GUTERMAN: And I would like to focus on particularly your use of the word, public. Because I agree that it is a public issue, but public not in a sense of government, public in the sense of being of interest to everyone.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The 15th Princeton Conference: Can Payment and Other Innovations 44
Improve the Quality and Value of Health Care? - Day 2
Council on Health Care Economics and Policy
05/29/08

SUSAN NESTOR LEVY: Thanks very much. Let us thank our
panel. [Applause]

[END RECORDING]