



Where is the US Health Care System Going: Can We Improve Value?

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Opening Session Dinner Night One: Value – What is Value and How Do We Improve It?

Alan Weil, Editor-in-Chief Health Affairs (Moderator)

Don Berwick MD, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

Bruce Vladeck, Senior Advisor, Nexera, Inc.

In the opening session of the 23rd Princeton Conference with Bruce Vladeck and Alan Weil, Don Berwick defined value as the degree of match between the work that is being done and what is trying to be achieved. He continued to say that in healthcare, the metric of value is when hospitals actively seek to be empty. In response, Vladeck highlighted the difficulty of defining and assessing value. He argued that on the micro level it seems simple; pay for more effective services and avoid things that don't work. But at the macro level value is often linked to outcomes that are complex and subjectively related to things like the "feelings" of patients. Payers like the idea of value-based purchasing but providers hear "we've found a way to pay you less and make you feel guilty about it."

Berwick agreed that the idea of value-based purchasing has been kidnapped; he made the case that we need a better production design and that payment changes are driving providers to "tick boxes" rather than work with patients. He argued that we already spend enough on healthcare and as a result have limited resources for education, infrastructure, and other critical needs. Vladeck suggested that simply changing the financing system will not improve value. Weil noted that money and financing is one dimensional, but the challenge to deliver services more efficiently is multi-dimensional.

There was agreement that system redesign needs to focus on primary care with fewer resources devoted to volume-based specialty care; but achieving this shift is challenging. Weil suggested that most of the reforms being considered may yield 1-2% savings, but more significant declines will only be achieved through reducing unnecessary care, and also addressing social determinants of health.

The discussion concluded with panelists suggesting that some sort of global budget is necessary to control costs. There was some pessimistic hope that states may be moving toward trying this first. It will require changes to ERISA and Medicaid waivers, and it's possible that there will be even more failed attempts before there is success. Finally, Berwick suggested that we need to start with increasing the number of integrated plans like Kaiser and that may be one pathway toward a single payer system.

Welcome

Dr. John Lumpkin, Senior Vice President – Programs, Robert Wood Johnson Foundation

Dr. Lumpkin talked about RWJF's focus on building a culture of health in America. This includes a shared sense of the value of health that translates to how we live our lives. There are major disparities in life span and health outcomes based on education, race and neighborhood. We need to get greater value for the \$3 trillion we spend on services each year or we won't have the resources to focus on social determinants of health. RWJF is pleased play a role in hosting this conference and the important discussion of value in the healthcare system.

Session I: Health Insurance Exchanges: Values and Concerns – Lower Costs, Limited Networks and Higher Out of Pocket Expenses

Jon Kingsdale, Managing Director, Wakely Consulting and Associate Professor, Boston University School of Public Health (Moderator)

Jon Kingsdale kicked off this panel by describing some of the persistent challenges in implementing the Affordable Care Act. First and foremost, one of the chief complaints about the ACA is that it is too “insurancey” and that while the goal may have been to empower individual retail consumers to drive competition in the individual markets, significant challenges remain. In particular, the wealthiest 1 percent remains concerned about the increased tax burden. While progress has been made on coverage, there are still significant concerns about such things as the individual mandate, rising premiums, narrow networks and high out-of-pocket costs.

Trish Riley, Executive Director, NASHP

To put things in perspective Trish Riley recounted the challenges of the individual market prior to the ACA – insurance was unaffordable for many and deductibles were often very high. Under the ACA, the individual market may be imperfect, but the subsidies, affordable individual plans and limits on exclusions make insurance accessible to many who weren't able to get it before. Riley pointed out that among the mix of states using state-based and federal marketplaces, state-based marketplaces are generally doing better than the federally funded marketplaces at enrolling Medicaid beneficiaries, retaining enrollees and reducing churn.

Riley stated that a considerable number of those who remain uninsured in 2016 are eligible for subsidies. Of those who are not eligible, 15 percent are unable to enroll due to immigration status and the rest are ineligible because of income or because they have access to employer-based plans. Generally, marketplace enrollees look a lot like Medicaid beneficiaries. While the start-up of exchanges were a challenge, now systems are up and running with better decision support tools and outreach to consumers. Riley is optimistic for continued success despite ongoing concerns about affordability, high deductibles, the family glitch (family subsidies are based on affordability for an individual plan which makes coverage unaffordable for many low and moderate income families) and ongoing legal challenges to the ACA, but it still beats where we were by a long shot.

Justine Handelman, VP for Legislative and Regulatory Policy, Blue Cross Blue Shield Association

Handelman noted that BCBS is in exchanges in 46 states. While they are committed to the program, it has been a real challenge, particularly because for the first two years they had no data on which to set initial premium rates. Now with actual claims data, premiums can better reflect risk. Early uncertainty in court rulings, challenges of healthcare.gov, changes to risk corridors and changing rules about grandfathering-in plans threw off insurers early on. Marketplace enrollees had 19 percent higher costs in 2014 than those with employer-sponsored plans. Further, special enrollment periods are being used by individuals to only sign up when they get sick, and rules allowing people to go three months without paying premiums before being dropped all hurt insurance companies and will tend to push up premiums.

Medical loss ratios kept premiums from getting too high, but the level of loss in the last few years is unsustainable. Going forward, premiums will need to better reflect actual risk, coverage trends and account for rising prescription drugs costs and the health insurance tax. Handelman noted that the temporary reinsurance program will end despite the fact that it is 100 percent paid for by private funds. Marketplace plans were initially priced low, so when evaluating new premium rates it will be important to look at total price, not just percentage increases. BCBS and other insurers are committed to affordability and healthcare delivery reform. Plans are moving toward value networks and will continue to innovate to develop more affordable options through tiered networks.

Margot Sanger-Katz, Reporter, New York Times

Margot Sanger-Katz focused her remarks on how markets are functioning in particular, are they lowering costs and expanding access, and are they serving the people they were designed to help? She described that the answers are mixed but overall the markets have been doing better than anticipated. According to recent Kaiser and Commonwealth Fund surveys, people are comfortable using exchange sites, satisfied with the quality of health plans and report having improved access.

It is challenging to ask people to shop for a product that is so complex. Most people don't actually know much about health insurance. Navigators have been helpful, but changing insurance products each enrollment period often lead to more confusion. For example, tiered network plans have led to significant uncertainty about what doctors or facilities are in or out of network. These plans place the burden on consumers. It appears there is also a high degree of plan switching and eligibility churn, which can drive competition and lower costs, but also lead to increased confusion on the part of the consumer. Medicaid churn also appears to be common leading to coverage gaps and instability. This also presents a challenge for insurers who have little incentive to provide prevention services to an unstable enrollment base.

Overall, it is a mixed bag. Narrow networks lower costs and patients are increasingly comfortable with them but there are ongoing concerns about access and transparency. Total out of pocket costs are too high and as incomes go up, subsidies are reduced and people are paying a larger percentage of their income. Overall, the ACA has reduced financial stress but significant challenges remain.

Discussion

There was consensus among the audience that there is innovation in benefit design and delivery system redesign but these efforts are not aligned. The panel agreed, suggesting that there is an opportunity for providers to take the lead in this effort. There was also consensus that more clarity and transparency around insurance products is necessary and we need to make better use of insurance brokers and navigators to improve literacy particularly among low-income enrollees. Justine Handelman reiterated that in order to be sustainable, plans will need to be innovative on benefit design and in particular learn from Medicaid managed care plans who found success with this patient population with tight networks, drug formularies, chronic care management and negotiations with providers. She highlighted that over the last few years, BCBS has lost \$4-5 billion in exchanges.

Session II: ACOs and Social Determinants of Health

Audrey Shelto, President, Blue Cross Blue Shield Foundation of Massachusetts (Moderator)

Shelto began by highlighting that health is largely determined by factors outside of the scope of the medical care system. Social determinants of health are the major factor and include poverty, nutrition, education, housing, the environment and job opportunities. Investments in upstream resources could mitigate downstream costs and improve overall health and quality of life. With the expansion of ACO models, global budgets and capitation models, this raises questions for the medical care system. What is the evidence-base for particular interventions? Who should receive these interventions? Should systems make or buy these interventions? Who should pay for them and who gains a return on these investments?

Lauren Taylor, Harvard University

Lauren Taylor suggested that there is strong evidence supporting investing in social determinants to mitigate downstream healthcare costs. There is moderate and emerging information about which interventions have the strongest evidence-based impact, and there is need for more research in this area and an even greater need to determine how these services should be operationalized.

Taylor highlighted findings from her study with Elizabeth Bradley on health and social services spending in OECD countries. The US has the smallest ratio of spending on social services to medical care and this ratio is a better predictor of health outcomes than health services spending alone. Recent work by Taylor and Bradley reviewed evidence on effectiveness of various interventions and found that housing for chronically homeless, nutrition support programs and case management had the strongest evidence base. Questions of how to operationalize these services remain, in particular how to manage the changes in payment, how to identify high-risk enrollees, and how to provide services and/or vet potential partners.

Taylor concluded by suggesting that the development of ACOs presents an opportunity to bring health and social service delivery under a common organizational umbrella. She recognized that the provision of social services is beyond the traditional scope of health systems but argued that it may be in the financial interest of some ACOs to ensure key services are provided – particularly full-risk, Medicaid ACOs.

Rick Kronick, Professor, Department of Public Health and Family Medicine, UCSD School of Medicine

Kronick agreed that spending on medical care is crowding out investments in other types of social service supports. He suggested that we should not lose sight of the progress that has been made. For example, despite criticisms of the use of payment reform to drive improvements in the delivery system, we have made a very real impact on patient safety through the non-payment program, the readmission reduction program appears to be having an impact and we have seen a slow down in the growth of per beneficiary Medicare spending.

He picked up on many of the themes raised by Taylor on the importance of addressing social determinants of health within the medical care system. First, while the evidence for some of the interventions to address social determinants of health is strong in some places, more work is needed before making significant investments. Second, this issue is further complicated because the time frame for the return on investments that address social determinants is quite long. Lastly, the link between improvements in overall health and reductions in health spending over a person's life is still unclear. One possible way to address these issues is to shift medical systems to more risk-based contracts that are structured to reward them for population health as well as individual health outcomes. He concluded by suggesting that the challenge of addressing social determinants of health is really a political one and that significant change won't come until we focus the policy discussion on these issues.

Dan Tsai, Assistant Director Mass Health & Medicaid Director, Commonwealth of Massachusetts

Tsai began by describing the importance of addressing nutrition needs for complex dual eligible beneficiaries and the challenges the current system faces in doing this. He described the experience of the Massachusetts One Care program, which integrates Medicaid and Medicare benefits for the under-65 dual eligible population and the challenges the state has faced in bringing the programs together. One example of these challenges is that care coordination means very different things in different programs so getting to a common practice is difficult. He also noted that without sustained investments and new capital it is really hard to expect organizations to provide services not previously defined as a covered benefit, such as care coordination. He used as another example the provision of services to stabilize nutritional needs of individuals in the One Care program. Massachusetts is currently working on a Medicaid waiver to support new Medicaid ACOs within the Medicaid program that partner with community-based entities. Enrollment in the program will be monitored by the state with clear expectations and oversight.

Tsai argued that it is important to move payment models away from fee-for-service (FFS) and get the new payments models right. This requires providing explicit guidance to newly formed ACOs to help them change behavior, and providing system-level investments to support providers and help community-based social services organizations to get involved in this effort.

Garen Corbett, Director, California Health Benefits Review Program, University of California

The mission of the California Health Benefits Review Program's research is to provide independent research and evidence-based analysis to the California legislature. In this effort, they have examined public health interventions and the case for expanding funding to improve social determinants of health. Corbett defined social determinants of health as the conditions in which people are born, grow, live, work, learn and age. Health is shaped by the distribution of money, power and resources and it is impacted by policies that impact economic stability, education opportunity, physical environments, and healthcare services, as well as social context.

California is doing considerable work at the county level on social determinants of health particularly through the Medicaid program. For example, Sonoma County is an accountable care county with considerable incentives to address social determinants of health. The San Francisco Bay area is the center of considerable research on social determinants of health; however, improvements are constrained by a lack of data and the reliability of that data. In particular, the data on return on investment is in short supply.

There is some important data coming from the CA Health Investment Data, but this is just one piece of the puzzle. Another challenge is the availability of state-level resources under a progressive but fiscally responsible governor. Support from private foundations and through federal waivers has helped people to start to work together.

Discussion

There was widespread agreement that the medical care system is not the ideal way to address social determinants of health, but in the absence of more direct action is a necessary place to take greater action. Bruce Vladeck pointed out that it can be difficult for healthcare organizations to work with social service agencies as the size and growth of the medical care system has often been at the expense of social service programs. Dan Tsai reiterated that the impact of social determinants on healthcare costs is very real and the health care system will need to do something to address them or else face poor outcomes, especially under global budgets. There seemed to be consensus that at its core there is a significant political barrier to directly addressing social determinants of health. There are some positive examples of ACOs investing in this work and with better outcome measures, clear partnerships between health care organizations and social service agencies, and financial incentives to support improvements to social determinants of health this may be a way forward.

Session III: The Growing Aged Population: Improving the Hospital Experience of Older Adults

Terry Fulmer, President, John A. Hartford Foundation (Moderator)

Fulmer described the magnitude of money spent on medical care annually. She argued that the lack of care coordination is a significant problem. She focused on the need to better examine the benefit versus the harm of the medical care we provide, particularly in the end of life. She argued that health care needs to be more person-centered with a real understanding of patient needs and wants prior to unwanted interventions.

Julie Bynum MD, Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth University

Bynum argued that the aging population is increasingly diverse and that this needs to be taken into account particularly for patients with dementia or multiple chronic conditions. Some unnecessary services are being provided, while effective services are often missing. The good news is that number of people receiving hospice care has gone up, but many who could benefit from these services are still not receiving them. Further, while progress has been made to reduce unnecessary readmissions, there is still a lot of variability across hospitals and providers.

Traditional Medicare patients in the fee-for-service program are spending an average of 17 days a year going to doctor and provider visits. Beneficiaries with 2 or more chronic conditions spend 33 days annually going to providers. This is equal to a part-time job. Care is often uncoordinated and it's often the case that primary care is not the most visited provider. This pattern of service use is not only costly but redundant and confusing and contributes to poor quality outcomes.

Susan Block MD, Director, Serious Illness Care Program, Ariadne Labs and Professor of Psychiatry and Medicine, Harvard Medical School

Block stated that most adults with serious illness rate their healthcare as poor and most of the care provided at the end of life doesn't take place with a family physician. Patients are not asked what is important to them about end of life care and are often not given a meaningful prognosis with which to make informed decisions. As a result, families are confused and unsatisfied and patients often spend the last few days of life in an intensive care unit (ICU), even though they want to stay home and the ICU provides little value. In total 25 percent of Medicare spending happens in the last year of life. Further 90 percent of beneficiaries say they want to stay home yet only about one-third of them do. This is a quality issue and patients aren't getting what they want.

Block called for a low-tech intervention – conversation. She stressed the need to encourage, pay for and support provider/patient conversations on preference for end of life care. She praised recent regulations on advanced care planning from the Centers for Medicare and Medicaid Services (CMS) and pointed out that 90 percent of patients want physicians to initiate these conversations but less than 1/3 of hospitals have routine systems in place for these conversations to take place. There is often no place in the electronic medical record to document patient preferences around end of life. We need to be more proactive with patients about these conversations and not wait until the last few days of life. A shortage of qualified providers further complicates the issue. There is currently a deficit of about 11,000 palliative care providers. The baby boomers are aging and we are not ready. We will need to rely on primary care and other specialists to take better care of patients. We check with patients about drug allergies countless times but end of life conversations aren't happening or given the same priority. Block argued that it's a cultural issue that end of life care isn't seen as a quality issue.

Jennifer Wolff, Associate Professor of Health Policy and Medicine, Johns Hopkins Bloomberg School of Public Health and Division of Geriatrics and Gerontology, Johns Hopkins School of Medicine

Wolff talked about the high value of care being provided by the family caregiver workforce. While the professional workforce is highly paid and trained, family care giving is untrained and unpaid. Family care givers serve as both care coordinator and care giver. This work is invisible, relentless, stressful and takes a toll on the caregivers who forego a lot to provide these services. In total, 15 million unpaid family care givers provide an average of 28 hours of care per week.

Face to face communication with patients and families is critical to supporting these caregivers. It is important to establish expectations and goals for each visit and clarity around the family care giver role. 29 states have enabled the Care Act. More research needs to be done to quantify the care provided by family care givers and understand the gaps in coverage. We need to insure that the ACO model doesn't exacerbate the problem by shifting more work onto unpaid care givers.

Discussion

Block reiterated that hospice needs to be available upon request for the last 24 hours of life. We need to do more to provide help in transition management with nursing support for patients leaving the hospital with different degrees of function. End of life conversations are not happening and there is a shortage of

palliative care providers. There is a critical role for social workers and clergy members in supporting this work. We need to create better incentives for team care, and to date ACOs have not systematically included social workers. Block argued that longitudinal relationships with one person are critical, and maybe we need to think more broadly about reimbursement as a policy lever. She described a trial funded by Partners around end of life conversations which would not have happened without the global budget of the Pioneer ACO model. The intervention consisted of three steps 1) Improving tools to predict which patients are going to die, 2) Reminding providers that patients are eligible for conversations around end of life preferences and 3) Reimbursing doctors for having these conversations. 90% of patients wanted to talk about end of life goals and had a good experience with the program. They found that these conversations only took 20 – 25 minutes. She discussed the importance of cultural competence in this process and described new initiatives to understand how to have these conversations in a number of diverse settings.

Session IV: Behavioral and Physical Health Integration: Improving Value and Access

Connie Horgan, Professor and Director Institute for Behavioral Health, The Heller School for Social Policy and Management, Brandeis University (Moderator)

Horgan introduced the panel by putting the renewed focus on behavioral health in perspective. She highlighted the importance of policy changes such as mental health parity, coverage expansions under the ACA, and the emergence of ACOs, which are moving the delivery system toward more integrated care with a greater emphasis on primary care. She suggested, however, that there is a lot more work to be done to truly integrate these two systems of care.

Benjamin Druss MD, Professor and Rosalynn Carter Chair in Mental Health and Director, Center for Behavioral Health Policy Studies, Rollins School of Public Health, Emory University

Druss suggested that the field of behavioral health has been internally focused for too long. Mental health and substance abuse services are looking outward and becoming more mainstream within the healthcare delivery system. These conditions are becoming understood as chronic conditions from which function is impaired. The challenge is to treat symptoms and optimize function, which includes efforts to do things like help people get and keep jobs. These patients often have medical co-morbidities that often are under- or poorly-treated. These patients have an average of 2.2 times higher mortality than the general population and potentially 10 years of life lost.

We need to move past the term integration, it's very abstract and suggests an idea of systems being pushed together. We need to think about recovery and focus on the patient experience. Recovery means, rather than focusing on symptoms, we need to focus on patient concerns and function.

Connie Weisner, Professor, Department of Psychiatry, UCSF and Behavioral Health and Aging Section Chief, Division of Research, Kaiser Permanente Northern California

Weisner described the Kaiser Permanente Division of Research as a place where researchers are embedded into a "learning healthcare system." Population-based studies are used to support innovation in

primary care and the treatment of substance abuse disorders. Kaiser screens and treats moderate substance misuse problems within primary care. Specialty care is available if necessary but then is monitored by and in partnership with primary care.

Weisner cited research showing that alcohol and drug problems affect the health of dependents and family members who also have more health problems and higher healthcare costs. The good news is that when the substance abuse in the family is treated, the health of family members starts to look more like the average. Research also shows that screening, brief intervention and referral to treatment (SBIRT) works but it hasn't been fully implemented.

SBIRT is an evidence-based method for improving health outcomes. Kaiser currently screens 86 percent of enrollees for unhealthy alcohol use. The brief intervention is only provided to 62 percent of those that screen positive. This type of intervention is associated with lower blood pressure, lower HbA1c (blood sugar) levels for diabetics, generally better health, lower rates of emergency room use and hospitalization rates. Efforts are being implemented in the Kaiser system to better educate physicians and other providers to make it easier to use these clinical guidelines.

Rhonda Robinson Beale MD, Senior Vice President and Chief Medical Officer, Blue Cross of Idaho

Robinson-Beale highlighted the drivers of cost in behavioral health: practice variation, uniform preference, supply and demand, and new technologies. There is little room to increase patient costs and we already have expanded payer costs. Payers are moving toward performance-based payment strategies, shared savings, bundled payments and global capitation. Medicare is increasingly shifting toward paying for quality.

The cost of services for people with behavioral health issues start much earlier. At age 14, they may be 50 percent higher than average and 75 percent higher at 25. We need to look more closely at performance measurement, and systems to support alternative payments and accountability for behavioral health providers.

Ken Thorpe, Robert W. Woodruff Professor and Chair Health Policy and Management, Rollins School of Public Health, Emory University

Thorpe suggested that integrated models of care are the most efficient way to treat chronic disease, which accounts for 86 percent of total health care spending. The largest increase in healthcare costs comes from patients with multiple chronic conditions. For example, people with mental health conditions account for 44 percent of total Medicaid spending. Full-person, team-based care has been found to be more effective than dividing patient care up and managing each condition separately. Treating individual body parts ignores important interactions. Payment reform will help facilitate care coordination and the implementation of a full person patient centered collaborative team approach to care.

Thorpe described how Vermont community health teams work together to execute care plans for people with chronic conditions in the state. All payers in the state, including Medicare, use these teams. The program doesn't cost patients or providers anything. A per member per month payment is made to the managing care team which include an interdisciplinary group of providers including social services. This is

part of a Centers for Medicare and Medicaid Innovation (CMMI) demonstration project that was recently evaluated by RTI. The results show that for every dollar that Medicare has invested, they saved about \$4. This needs to be brought to scale and replicated, just like CMS has been able to do with the diabetes care program.

Discussion

The discussion opened with a warning from David Mechanic that integration of mental and behavioral health far too often just means giving medication in a primary care office. The current movement toward integration should not be seen as “dumping” patients with very serious mental health issues on primary care physicians. We have a major workforce shortage in behavioral health. Many psychiatrists don’t take Medicaid and many of them spend most of their time treating less seriously mentally ill patients. Even with mental health parity there isn’t enough enforcement. Examples of well coordinated care for the severely mentally ill do exist, but this type of coordination is hard to scale. We have made large advances in treatment and thinking about care coordination, but we still have a long way to go.

Audience members added that the use of metrics is essential to drive improvements in mental health, yet only 10 percent of mental health professionals use standardized instruments. There are NCQA performance measurements and the wider use of electronic health records which is helping. Provider input is essential to the development and use of these tools. Kaiser has made it easier for physicians to do the right thing and standardized tools only after the doctors agreed that it was the right approach.

Session V: The Path to Value-Based Payment: Where are we now and how should we proceed:

Rob Mechanic, Senior Fellow The Heller School for Social Policy and Management, Brandeis University (Moderator)

Mechanic described the growth in alternative payment systems in the Medicare program. Traditional Medicare spends about \$520 billion annually, of this about \$150 billion goes to Medicare Advantage, about \$90 billion go to ACOs, roughly \$10-12 billion is paid through the Bundled Payment for Care Improvement (BPCI), and \$2-3 billion through the Comprehensive Care for Joint Care Program. The Medicare Access and CHIP Reauthorization Act (MACRA) creates new incentives for physicians to participate in alternative payment models and to develop new physician focused payment models.

MACRA repealed the Sustainable Growth Rate (SGR) formula and replaces it with a new pay-for-performance model called the Merit-based Incentive Payment System (MIPS) program as a quality incentive. Beginning in 2019, MIPS will give physicians bonuses or pay cuts based on their composite quality scores that are made up of quality, resource use, health IT and clinical performance improvement measures. The average rate of growth in Medicare physician fees is virtually flat under MACRA, meaning that most physicians will have to participate and perform successfully in APMs in order to maintain current levels of inflation-adjusted Medicare revenue. Medicaid and the private sector are also moving toward alternative payment models. For example, in Medicaid over half of the payments (56%) are some kind of managed care and Medicare Advantage, for example, there are between 8-9 Medicaid ACO programs.

Jeff Spight, President, Collaborative Health Systems, Universal American

Spight, who oversees 22 physician-led ACOs around the country, cautioned that we still don't have a clear standard model for what an ACO is. He said, "if you've seen one ACO, you've seen one ACO." There are physician-led ACOs, health-plan led ACOs, and hospital-based ACOs. They are expensive to operate and need to have scale in order to take on risk. Physician and provider groups that seek to go in this direction feel a lot of pressure to align with a partner with capital such as a hospital, insurance company or venture firm. The model is attractive to providers because it promotes primary care provider independence. However, flaws in the current ACO model design create financial uncertainty, threatening the sustainability of the ACO model an even greater challenge. It seems like every week CMMI releases a new program. While it's great to try new things, there is concern that this diverts CMMI's energy and resources away from ensuring that current models evolve quickly towards a sustainable path.

To date, the Medicare Shared Savings Program has had mixed success. Some ACOs have gotten lucky with their baseline numbers, but overall it seems to be a poor business model. The next generation of Medicare ACOs will be better and more informed because of this experience. This is bipartisan support for the model so regardless of the political climate in 2017 there is a good possibility it will be extended.

Tom Scully, General Partner, Welsh, Carson, Anderson & Stowe

Scully suggested that ACOs are a good idea with a broken financing model. Provider groups and hospitals have lost millions of dollars as they've moved toward a more value-based system. The faster we can move ahead with bundled payments and include more services in bundles the better. The ACO model may not work going forward but it is training doctors and provider groups to live under risk-based contracts. He considers ACOs a great concept but an economic disaster. The Program for All-inclusive Care for the Elderly (PACE) program is the ultimate bundle. It was a successful program but has proven hard to replicate. Currently, about 60 percent of doctors work for hospitals and they don't like it. He argued that most physicians would like to get into risk-based contracts without becoming hospital employees. He also argued that most of what CMMI has done over the last 8 years has been based on Republican ideas. He lamented that if the Republicans do well in November they may repeal the ACA and then spend 3-4 years slowing putting many of the same policies back in place and rolling back much of the progress we have made. He argued that we need to educate people that directionally, we are headed in the right direction.

Dr. Frank Opelka, Executive VP of Health Care and Medical Education Redesign, Louisiana State University Health System and Medical Director of Quality and Health Policy, American College of Surgeons

Dr. Opelka said that physicians in general and surgeons in particular are increasingly specialized and increasingly employed by hospitals because the burden of managing their own practice has become too great. He argued that many surgeons suffer from measurement fatigue. Surgeons are okay with measurement if it helps them improve their practice, but currently there are so many measures and great skepticism about the relevance of most measures to the actual quality of patient care. He argued that we are still very primitive on the science of improvement. In order to move improvement science forward, we need to teach it more in medical schools. He noted that the top 50 health systems in the country are focused on quality improvement but the majority of the delivery system still isn't working on it in a systematic way. He argued that if we want physicians, and surgeons in particular - to take on financial risk

we need better data and more transparency. This will enable physicians to make more informed decisions. There is a tremendous risk for physicians to take on risk contracts, particularly without the backing of hospitals. Generally, the American College of Surgeons is supportive of the move toward more and bigger bundled payments. But the system is still fundamentally based on diagnosis related groups (DRGs) and relatively value units (RVUs), which pay providers more the more services they provide, regardless of the value of those services. We need to get the incentives aligned if we really want to truly reshape the health care delivery system.

Discussion

Rob Mechanic pointed out that payment reform has moved forward on two fronts – an episodic or bundled track and a population-based or global budget track. They both work in certain situations but there are price distortions and financial uncertainty when they overlap. Tom Scully argued that people respond to incentives and once the incentives are clear, people will figure out how to work under them. Right now the ACOs are losing money because the incentives are based on a two-year look back based on bad data. He argued that bundles will drive change faster. Jeff Spight agreed that we need to move toward bigger bundles, when they stay small they really look too much like DRGs to drive change. Don Berwick asked Scully to name three changes he would make to the ACO program. Scully's response: 1) Bigger bundles 2) No two year look back and 3) Put in risk corridors. Stuart Altman raised concerns that in the current environment more physicians are going to go into concierge medicine in the Medicare program. Jeff Spight argued that physicians need a better way to transition from fee-for-service to risk-based contracts more gradually under MACRA. Scully also pointed out that the Medicare Advantage (MA) program has been successful to date and capitated MA contracts may become more appealing to physicians. Physicians have been moving toward hospital-employment is because they don't have the knowledge or capital to manage risk contracts – but many would rather not work for hospitals. Scully added that there is a role for private capital and with better data and measurement physician groups can figure out how to be successful under new payment models.

Dinner Night Two Session VI: Political Forecast – The Possible Impact of the 2016 Elections on the Health System

Bob Blendon, Richard L. Menschel Professor of Health Policy and Political Analysis and Senior Associate Dean of Policy Translation and Leadership Development, Harvard T.H Chan School of Public Health, Harvard University

Blendon provided insight from the latest polling on the presidential race, what the public is thinking about health care and the Affordable Care Act, and what might happen under a Trump administration. He began by suggesting that Donald Trump is not a unique phenomenon. He fits into what would be called the nationalist movement in Europe. He's anti-immigrant, anti-free trade and anti-interventionist. This movement is distinct and separate from the conservative party that is might be more concerned with spending on entitlement programs and fiscal policy.

Few people actually vote in primaries and as a result the messages are increasingly targeted to voters on the extreme edges of both parties. For example, the Bernie Sanders movement is having a measurable

effect on the politics of this election cycle and pushing the Democratic Party to the left. Blendon also made that point that political year election turnout is for greater than in off-presidential election cycles and that this tends to favor Democrats in presidential years and Republicans in off years.

Blendon dismissed three common myths:

1) Everyone hated Medicare when it was being implemented and eventually everyone came around, so therefore the ACA is safe: Actually, Medicare was a bipartisan effort with significant Republican support. Physicians were initially opposed to it before it made them wealthy. In contrast, the ACA was a highly partisan issue from the start and the House has voted 60 times in 4 years to repeal it.

2) “Keep the government’s hands off Medicare”: Actually, seniors know that Medicare is a government program. What they believe is that they have contributed to a special account in Washington and this money funds the program. They don’t want that money diverted to pay for other things including the ACA.

3) People hate Obamacare but support the Affordable Care Act: Actually, the polling shows that the American public doesn’t really know what the Affordable Care Act is, especially in the south. The average voter does not credit the ACA for any of its benefits, but will blame it for inevitable premium increases.

The country has never been so ideologically divided. When asked if health care should be a universal right 78 percent of Democrats say yes and 83 percent of Republicans say no. In reality, health and healthcare do not rank at the top of priorities for either party. Most people say yes, when they are asked if addressing healthcare is important, but when unprompted only 11 percent of Republicans and 12 percent of Democrats suggest that it is a key concern. Nevertheless, whoever is elected will take action on healthcare because the issues are important to their base. Trump will repeal what he can of Obamacare and then most likely replace it with elements of Obamacare and call the whole process “really great.” It does seem like there will be some bipartisan action on reducing prescription drug prices because as an issue drug prices poll very high with voters of both parties. A single payer system does have significant support but that support erodes when it is linked to anything other than a very small tax increase.

Session VII: The Role of States and Regions in Health Reform

Karen Feinstein, President and CEO, Jewish Healthcare Foundation, Pittsburgh Regional Health Initiative (Moderator)

Feinstein started the session by highlighting the importance of state and regional innovation in the midst of national gridlock. State-based and regional multi-stakeholder organizations are more neutral, ethical and bipartisan. She argued that the worth of value-based purchasing will be derived from the bottom up. Research at the ground level is essential to uncover gaps and identify best practices.

Marc Bennett, President and CEO, HealthInsight

Mark Bennett spoke from the perspective of a quality improvement organization (QIO) where the goal is to improve quality and value. He reiterated Feinstein’s assertion that change happens from the bottom up and local ownership is critical to sustaining meaningful reform. He stated that the health care system is rooted in

stability, resists change and seeks to snap back to a comfortable status quo. Change requires moving a number of levers at the same time. This might include shared clinical data, coordination of health information technology (HIT), transparency, feedback, work-flow process and design, and consumer engagement. CMS has become an active partner in bringing about change and has never been a better partner. The potential of health care system improvement is greater than we think, but we have to take advantage of new technology. We need to create an environment to support change at the community-level and prepare for where we need to be in the future. We need to have respect for the limit of rules and incentives without caution rules can become bureaucracy and stifle change and innovation.

Ann Hwang MD, Director for Consumer Engagement in Health Innovation, Community Catalyst

Community Catalyst is a healthcare consumer advocacy organizations active in 40 states. Their mission is to engage consumers in health care reform and delivery change with a particular focus on vulnerable populations. Community Catalyst focuses on state-level reform for a number of reasons: it allows them to “put many eggs in many baskets.” States offer a lower barrier to entry, states dominate healthcare when it comes to vulnerable populations, and there is more opportunity for innovation at the state level. Hwang gave an example of the work of Community Catalyst informing the Ohio demonstration program for dual-eligibles. They talked to thousands of consumers about what was happening and kept in touch to provide feedback. In the end the program was more effective in meeting the actual needs of patients and their families. She argued that it’s time to change the culture of healthcare and put the consumer and their needs front and center.

Chris Koller, President, Milbank Memorial Fund

Koller highlighted the lessons learned from his work on All-Payer Claims Databases:

- 1) The importance of having an overall goal around population health.
- 2) The distinction between the “what” and the “how.” It’s left up to the public sector to define the “what” but the “how” needs to come from payers, providers, consumers and advocates.
- 3) You need to have a neutral convener, someone with local trust who can bring the parties who might not trust each other together.
- 4) Incrementalism – You have to have trust in the partnership and you can only build trust by doing things together, in particular things that are achievable.
- 5) Governance is really important – in particular getting consensus. It can’t just be the state government saying this is how it’s going to be.
- 6) Data needs to be structured to recognize and promote culturally appropriate care.
- 7) We need to understand how federalism works. Vermont is not Alabama and never will be.
- 8) Alignment – True partnerships are based on mutual need. We can align and not do anything, but we need to get better together through competition with transparency and measurement.

Dennis Scanlon, Professor of Health Policy and Administration, The Pennsylvania State University

Dennis Scanlon talked about how regional health improvement collaboratives (RHICs) can serve as a neutral convener. There has been tremendous growth in RHICS through a number of funding mechanisms. He then shared what he has learned from researching RHICs:

Providing public good is hard. Balancing the role of the neutral convener with the work of payment reform can be a challenge. These organizations are fragile because often they are funded with the expectations of certain deliverables that don't move the organizations in the way they want to go. Free riders, or people who benefit from this work with contribution, are another challenge. The ACA has created a lot of opportunities for RHICs. Relationships with state governments can be very productive but they come with their own challenges. Sometimes there is competition among these neutral conveners because they are competing for funding and resources.

Discussion

The audience pointed out that funders want to understand the return on investment of their programs, but the challenge is knowing which programs drive change, particularly at the state level. Another audience member asked about the dynamics that drive quality improvements in states and regions. Ann Hwang argued that consumers can drive quality, but we need physicians to take leadership on the efforts to include consumers in the conversation. Members of the audience also pointed out that there is a lot of variation across states in the level of infrastructure and support for this type of work. Chris Koller suggested that you start with investing in public health agencies.

Session VIII: Latest Trends in Health Care Spending

Stuart Guterman, Senior Scholar in Residence, Academy Health (Moderator)

Stuart Guterman introduced this panel with the good news that healthcare spending growth hit a 53-year low in 2013, however, spending from 2014 – 2024 is projected to grow at a rate of 5.8%, increasing the share of GDP from 17.4% to 19.6% in 2024. Projections are made with significant uncertainty. Guterman argued that it is difficult to know what price of healthcare services are although more data is becoming available. But health care spending is not a trend that just happens - the real challenge is to understand what factors are driving health care cost growth and what to do about them.

Guterman discussed how we might accomplish the goal of tying healthcare costs to GDP growth. Can we maintain quality while controlling costs? Can greater coordination be achieved without the adverse effects of consolidation, and can incentives and policy be consistent across public and private payers? He challenged the panel to think about the range of options to achieve cost control including transparency, payment reform, competition and/or regulation.

Charles Roehrig, Altarum Center for Sustainable Health Spending, Altarum Institute

Roehrig was more optimistic than CMS in predicting that costs will rise 1 percentage point faster than the nation's Gross Domestic Product (GDP +1). Health spending relative to GDP is important, and the share of growth in excess of the GDP means that a greater share of resources are going to health and less to everything else. From the 1980s to 2007, Roehrig observed that the underlying path was a continually declining excess growth rate from GDP+4 to GDP+1.3. But in 2007, the recession started and in 2008 we were at GDP+3 and in 2009 we were at GDP+6. This change was caused by a decrease in GDP more than an increase in health spending. So now the question is, are we going to continue at the lower rates we saw between 2010 – 2013? In total, 71% of health spending is on health services, 13% on products (mostly pharmaceuticals), 7.7% on administrative costs of health care delivery and the balance is on the administrative cost of insurance.

Roehrig's prediction is that health spending will remain stable at GDP+1. CMS estimates it closer to GDP +1.4%. His optimism, however, is tempered by the growth in healthcare jobs which have increased in 2015 – 2016. The next question is if we are at GDP +1, what rate of spending growth is sustainable in the long term? The faster health spending goes up, the greater the burden on the federal deficit, and if you look out to 2035, what growth rate will keep us on an adequately balanced budget, even at GDP +1, we face record high taxes and record low spending on non-health resources.

Geoffrey Sandler, Senior Director – Health Policy, Aetna

Sandler highlighted the role of private insurance companies in controlling healthcare spending. Insurance companies have blunt instruments such as benefit design and utilization review. They aim to improve quality, better engage consumers, lower costs, and improve overall health. There is also a role for private insurance companies to experiment with value-based insurance design, contractor bundling and risk-based contracts. These types of contracts, however, are based on providers ability to accept risk and insurance companies ability to insure and reward quality.

Sandler suggested a need for stronger alignment across payers, both public and private. Currently providers are operating in four categories of payment: FFS, FFS with a link to quality and value, alternative payment in a FFS body, and population based payment. He also addressed the role of employer-based insurance going forward. Many thought that with the ACA employers would drop coverage and move employees to the exchanges, but this hasn't happened. In reality it's not just about the money. Health insurance continues to be an important part of total compensation and is critical to attract and retain employees. In practice, employers are using new benefit designs, tiered and narrow networks, centers of excellence and working to get employees more engaged in their own health. Going forward there are still some issues to sort out: taxes, the role of public and private exchanges and how will benefit packages look going forward.

Discussion

Stuart Butler said that the data presented suggests that healthcare is recession proof and that ultimately controlling spending in the long-run will come down to controlling prices and utilization. The key will be to develop and refine strategies to reduce prices. Stuart Altman suggested that the discussion was missing a

conversation about the ability of government to control what it spends and how long higher private payments can continue to make up for lower government payments. There seemed to be consensus among the audience that higher prices are really what separates the US from other countries in terms of spending. Further there was agreement that pharmaceuticals are a big piece of growth and the role of the government in controlling pharmaceutical prices may be the next big debate in healthcare.

Session IX: Pharmaceuticals: Can or should we do anything about rising drug costs? – The Value Proposition

Julie Stoss, VP Government Relations, Kaiser Permanente (Moderator)

Stoss suggested that pharmaceuticals are a key cost driver in healthcare and we need to focus more on the value proposition of these products. There is clearly a value to individuals, a value in the context of healthcare in general, but what about the value to society? She suggested that health plans and payers can't fix the problem but that we need the government to regulate prices, more immediate market-based solutions, and engage drug manufacturers to share cost and development costs. She argued that we need to re-frame the value debate to include the prices that are necessary to sustain innovation, but no more sky is the limit on prices.

Uwe Reinhardt, James Madison Professor of Political Economy, Professor of Economics and Public Affairs, Princeton University

Reinhardt stated the basic model for value creation in modern capitalism is either to produce new value or to redistribute existing value. He suggested that much of the investment in the American economy creates wealth by redistributing existing value, which in practice shifts money around without creating new products. Pharmaceutical companies have been increasingly doing this. Looking at the industry you see them increasing prices on existing products and reducing the amount of money they invest in research and development.

The alternative to current trends is value pricing in which we pay more for "better" quality products. Reinhardt described that currently value pricing in the pharmaceutical industry is akin to asking someone in the desert how much they would pay for a bottle of water. This is not politically smart and inevitably legislators are going to start questioning why pharmaceutical companies are charging so much for drugs. So far the industries response has been that the money goes into research and development, but we know that isn't really the case. He argued that we need to reward risk taking in the pharmaceutical industry, but there needs to be a limit to how much we are willing to reward. As a society we need to determine what that limit is.

Caroline Pearson, Senior Vice President, Avalere Health

Pearson sought to bring some reality to what can actually be accomplished around controlling pharmaceutical prices. Media coverage on the topic has increased 5-fold in recent years and specialty drugs are the biggest driver of cost. She argued that we have long-tolerated astronomical prices for orphan

drugs because there was a small patient population, but Sovadi broke the mold in terms of applying that kind of pricing structure to a more common drug. Insurance companies didn't adequately account for these types of price structures in premiums, and so premiums have spiked but they will return to regular growth levels.

She outlined some strategies that the government can use. The Obama Administration has already launched some initiatives such as the Medicare drug dashboard, Medicare Part B demonstration and increased transparency around prices. Clinton has proposed to "do it all", while Trump has been opaque about the particulars of his plans but assures voters that "they will be great." It's important to remember that there are powerful interest groups at play, and we are unlikely to see a meaningful solution without engaging health plans and the pharmaceutical industry. We need to look to solutions that are market-based and more acceptable to all parties, some of which she outlined in the chart below.

		Pharma	
		ACCEPTABLE	UNACCEPTABLE
Plans	ACCEPTABLE	Innovative Contracting FDA Reform Risk-Adjustment	Dramatic Reduction in Exclusivity
	UNACCEPTABLE	Restrictive Co-Pay Policies	Heavy Price Controls

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Len Nichols, Director of the Center for Health Policy Research and Ethics and Professor of Health Policy, George Mason University

Nichols pointed out that early on pharmaceuticals were developed for the public good. Now, we need incentives and we grant fixed term monopolies to spur innovation. Nichols argued that we have policies to promote competition and promote innovation, but that we are currently out of balance. We are tilted toward innovation. He also highlighted some potential policy solutions: use reference pricing, binding arbitration for truly unique drugs, enable Medicare to negotiate on drug prices, restrict the use low-value drugs, and potentially tie the grant of exclusivity to launch price.

Discussion

There was some concern that the focus on controlling launch price as a policy intervention would lead to larger year over year increases. The audience also raised the question of the anticipated impact of the tax on Medicare Part D. Nichols suggested that putting the incentive on picking the least expensive drug isn't necessarily best clinical practice. Reinhardt argued that the incentives in the program are misaligned and we need to be reevaluated. There was agreement that this program may be a step toward reducing misaligned incentives for doctors to use more expensive drugs but that more needs to be done. Reinhardt urged people to look at materials developed by the Institute for Cost Effectiveness Analysis (ICER) around the Sovaldi price negotiations and cost-effectiveness analysis <http://icer-review.org/>. Another policy option discussed was drug importation, as other countries get better drug prices through negotiation. There was no consensus on the long term impact on price and drug innovation. The panel agreed that pharmaceutical costs are at the top of both parties' political agendas and as a result action could be taken over the next

year or two. Possibilities include limits on out of pocket costs and Medicare may be given some kind of authority to negotiate on prices and the private sector needs government to take the lead on this but they will quickly follow suit.

Conclusion

In concluding Stuart Altman highlighted some of the recent achievements in light of the persistent challenges. It is a major accomplishment that the rate of uninsured has been brought below 10 percent. We have seen growth rates and rate of spending at the lowest level in decades. The health care delivery system is changing with promising innovations. Safety is getting better. Innovation is happening in healthy aging, behavioral health is moving into the mainstream and it is increasingly linked to overall health. It should be considered progress that even health economists are starting to talk about the importance of social determinants of health. We need to recognize and celebrate these successes, while addressing the persistent challenges in an uncertain political environment. Prescription drug prices are rising rapidly, the trajectory of change and the balance of responsibility between the government and the private sector is uncertain. The government and the Medicare Payment Advisory Commission (MedPac) in particular needs to stop being defensive. Government programs have held physician and hospital costs down, but in the long run this could come at the expense of beneficiaries of these programs. Private payers have become the ATM machine of the health care system and this is a real issue. High deductible health plans and out-of-pocket expenses are hurting consumers and costs need to be controlled at a more global level. How the US confronts these problems will be determined by what happens in the next election for President and the make-up of the Congress.