ENGELBERG CENTER for Health Care Reform at BROOKINGS

STATE HEALTH REFORM SERIES

Advancing Multi-Stakeholder Delivery System Reforms at the State Level: The Need for Stronger State/National Partnerships

Engelberg Center for Health Care Reform at Brookings
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Event Summary

Reducing the number of people without insurance coverage remains an important policy priority at both the state and federal levels. However, current financial challenges and budget shortfalls mean that in addition to expanding affordable coverage options, policymakers must continue to seek ways to improve the delivery of care – and at lower costs.

An October 8, 2008 forum co-hosted by the Engelberg Center and NASHP brought together state and national perspectives in government and the private sector in an effort to identify specific ways that more robust state-national partnerships can help accelerate and improve reform efforts at the state and regional levels and also inform national policy. The event was led by Mark McClellan, Director of the Engelberg Center at Brookings, and Alan Weil, Executive Director of NASHP. Participating in the event were Karen Ignagni, President and CEO of America's Health Insurance Plans, Reed Tuckson, Executive Vice President and Chief of Medical Affairs at UnitedHealth Group, Herb Kuhn, Deputy Administrator of the Centers for Medicare & Medicaid Services, and other distinguished panelists representing state and federal administrative agencies, health care provider groups, and the business community.

The purpose of the forum was to highlight examples of states that are taking multi-stakeholder or multi-payer approaches to improve the overall delivery of care, examine lessons learned and common themes that have emerged from these efforts, and identify opportunities for building on best practices. Panelists offered specific ideas for developing an enhanced partnership with national public and private stakeholders that may help most effectively advance the goals of health care delivery reform, and identified key components of a more robust state/national framework for delivery system reform, including the need to build evidence around efforts to contain costs and improve quality through greater alignment and standardization of cost and quality measures, and the need for greater improvement and innovation in care coordination, accountability, and provider reimbursement.

WELCOME AND INTRODUCTIONS

Mark McClellan and **Alan Weil** kicked-off the event by providing context on prospects for health care reform at both the state and national level. Dr. McClellan noted that despite the recent turmoil in the financial markets, and despite the current cost challenges facing state and federal governments and our health care system today, a growing number of broad and committed efforts are underway to reform health care around the country. Along with short-term steps to tighten state budgets, states must continue to pursue long-term solutions, including efforts to achieve sustainable and affordable coverage and drive delivery system change. Still, the challenges to getting there are great. While we have seen important advancements in a number of technological innovations, improvements in biomedical knowledge, and evidence that better treatments are coming along for the future, growing evidence shows that our health care system isn't delivering as effectively as it could. There is inconsistency in the use of evidence-based services. Coordinating care for chronic diseases in an increasingly complex and fragmented delivery system is difficult. And rising health care costs threaten not only the feasibility of expanding coverage for more Americans, but also the affordability of health insurance.

Dr. McClellan noted that while choice and innovation are important, some issues in health care benefit from having multiple payers and stakeholders working together, as even the largest payers alone only account for a small part of both our nation's health care costs and the delivery systems in any particular area of the country. By finding ways that payers can share common ground to solve common problems in the most innovative ways possible and establishing common measures for quality and cost, we can help our entire health care system perform better.

Alan Weil discussed the need to address misaligned incentives and noted that efforts to improve the health care system will require a change in these incentives. Strong efforts to realign incentives in the health care system will result in important implications for many providers and patients; we must consider how those incentives might overlay on current practice patterns given the variability around the country.

With respect to national prospects for reform, Mr. Weil cautioned that despite tremendous leadership from CMS and others at the federal level, and the interest of the Medicare program in serious efforts of demonstration, the odds of a national consensus on how to more effectively pay for health care remains small. Consequently, we should continue to look to state and local efforts to help refine our sense of what a better system of incentives would be and to help answer the question of how to actually bring about those changes. As major purchasers, regulators, data collectors, and sources of consumer protection, states bring a unique combination of roles to the discussion and are at the forefront of bringing together multiple payers to effect change in how health care is delivered.

Still, states can achieve much more if they conduct their work in the context of a national framework and if they have the support of the federal government in clearing away some of the barriers that they face – both with respect to the relationship to Medicaid and Medicare and with respect to the role that national private payers and national delivery systems play in the system as they interact with states. There is much that we still need to learn about health care reform. To the extent that we can apply lessons learned at the state level to define our reform strategy at the national level, we should take advantage of states as laboratories of reform.

STATE VOICES: LEARNING FROM STATE EFFORTS TO PROMOTE MULTI-PAYER DELIVERY REFORM

Joan Henneberry provided an overview of Colorado's staged-approach to health care reform, including their efforts to expand coverage, promote health information technology, and establish medical homes. The state is trying to work past political challenges and begin addressing delivery system reform; this approach has led to two parallel efforts in Colorado. The first effort focuses on improving the current public health insurance programs through expanding outreach for Medicaid-eligible children and establishing medical homes, and the second on utilizing the State's purchasing power to drive broader changes through value-based purchasing.

Challenges thus far have included stakeholder – specifically consumer – resistance to change and sustaining financial support for the programs. One way that Colorado has addressed these challenges is by engaging stakeholders from the beginning so that they are sharing in the gains – better quality and lower costs – and are more willing to accept losses to revenue downstream if it means achieving improvements in care and care delivery.

Allen Dobson described North Carolina's approach to health care reform as one that aims to develop community-based initiatives and capacity through local physical-led organizations built on primary care and case management. Beginning with the Medicaid program, the state took an active role in managing the health of its patient population and established new public/private partnerships with providers that include shared responsibilities and accountability to control the budget and improve care. The state's well-documented cost savings have been achieved largely through their quality improvement efforts, not through reimbursement cuts. Thus, *Community Care of North Carolina* acts as a clinical program as opposed to a financing mechanism.

Dr. Dobson encouraged states to more directly engage providers in establishing shared accountability relationships and to engage national payers through establishing multi-state collaborative initiatives. North Carolina is seeking to collaborate with Medicare through a Section 646 demonstration that will bring dual eligibles (those qualified for both Medicaid and Medicare) and eventually the Medicare population into their program. Though the approval process has been long and challenging, the state recognized that, because Medicare is a significant player and great opportunities exist for quality improvement and cost containment in the dual-eligible and Medicare populations, it was necessary to engage Medicare in order to bring public and private payers together in a meaningful way at a state and local level.

Challenges to this effort have included the need for patience both with respect to the limited scope of states' one-year budget cycle and the lengthy 646 demonstration approval process. It is crucial to both maintain a long-term vision in light of delayed returns on investment on multi-year efforts and reinvest savings back into the system. States need a more efficient process for moving demonstrations, pilots, and waivers forward; for many, by the time these initiatives are approved, the political window has already closed or narrowed.

Craig Jones provided a brief overview of the broad-based health care reform initiatives in Vermont that aim to address both coverage and care delivery through expanded public access programs, integrated pilots, health information technology, and prevention efforts. Legislation passed in 2007 to authorize the creation of medical homes has been critical to reform efforts in the state and has marked the beginning of more systems-level change. Through several integrated pilots, the State is examining how health care is delivered in a primary care setting and how this system is financed. As part of this integrated effort, both Medicaid and commercial payers in Vermont are paying clinicians and practices based on how well they operate in accordance with national standards for a medical home. Medicare is not contributing financially to this initiative, and its share of the

payment is being subsidized by the commercial payers and Medicaid. Gaining commercial-payer support presented an initial challenge, and eventually the state had to resort to taking legislative action to require payer participation. The commitment of the Governor, legislature, and a broad range of stakeholders was cited as key to the success of Vermont's program.

Chris Koller outlined the top three lessons learned thus far from Rhode Island's all-payer primary care and medical home initiative, *Rhode Island Chronic Care Sustainability Initiative*, and identified remaining challenges and opportunities for advancing multi-payer initiatives in the future. He emphasized that true delivery reform begins with payment reform and, since providers don't want to discriminate based on payment source, the money must work for the provider and the reform must engage all payers. Also, sometimes people don't want to change and, in such circumstances, the regulatory stick may be necessary. In Rhode Island, this was especially true in the effort to engage the national payers in the state. The final lesson was that gaining stakeholder trust is a process that is very local and also very essential.

The state also met a number of challenges in their reform efforts. Mr. Koller reminded the audience that part of making a collaboration work is being flexible about the end product and accepting that sometimes close enough is good enough. He also noted that local variation in delivery reforms is not only acceptable, it is absolutely necessary; we cannot have national uniformity and innovation in all aspects of health care reform. The Medicare medical home demonstration might prove to be a strong model for how the balance between federal leadership and state variation and innovation can be struck. Finally, providing too much choice both to consumers and to providers can be challenging. Unlimited choice of providers for consumers drives up costs and undermines efforts to establish financially accountable medical homes.

Finally, there is a broad need for greater leadership from Medicare and national payers in establishing clear standards for measurement and evaluation, and for greater participation by national self-insured payers. Mr. Koller suggested that Congress prioritize funding for primary care programs and program evaluations so that states can improve their accountability and refine their programs going forward.

NATIONAL PRIVATE PURCHASERS AND STATE REFORM EFFORTS

John Bertko opened the panel discussion by noting the number of opportunities that exist for making improvements in the health care delivery and payment systems and that, as was demonstrated with the first panel, there is also a great deal of energy for engaging in these reforms. Given that the private sector, represented by payers and large employers, comprises about 50 percent of the cost for providers (with Medicare and Medicaid making up most of the remainder) and that usually two or three insurance company payers are dominant in each market, there can and should be a concentration of efforts. Individual plans alone cannot address state and regional variation without the support of other plans and, in particular, Medicare. Working within a multiple payer system allows for greater influence on the delivery system, more effective engagement of providers who are more likely to pay attention to large patient populations as opposed to disparate payer efforts, and opportunities for data aggregation and economies of scale for providers.

Karen Ignagni echoed comments by Alan Weil and questioned whether individual states can be expected to act together without a national framework. She noted significant movement on the part of the National Association of Insurance Commissioners (NAIC) in responding to the issue of uniformity while allowing states the necessary flexibility to regulate and innovate. Ignagni also recognized the need to keep administrative costs down, agree on best practices, and implement

reforms in a way that makes the most sense for everyone. Given limited state resources, there is a need for a national response to these issues.

Other outstanding issues she detailed included a lack of agreed-upon state deliverables, funding for subsidies, uniform guidelines and measures for evaluation, and financial protection for providers engaged in these reforms. These challenges apply to efforts to improve quality, roll-out personal health records, and others. States need room to innovate. However, once we begin to reach agreement on what constitutes best practices, there also needs to be a discussion about how to implement them. This is where employers and professional societies can play a larger role.

Reed Tuckson began by reminding us that we all have similar goals. He noted that his comments are not intended to reinforce a false or unnecessary tension between what national health plans do and the extraordinary importance of local innovation, but are meant to highlight lessons learned from working with states on these initiatives. Using performance assessment as an example, Dr. Tuckson remarked on the multiplicity of well-meaning initiatives that all have resulted in the production or use of different measures. This has had the effect of overloading providers with competing measures without getting to better quality. Taking a more coordinated approach to reform efforts – such as performance measurement, and establishing a common and trusted methodology for how assessments are generated – will help to ease the administrative burdens, costs, and confusion we see as a result of the currently fragmented system and will help us get to better heath care faster and at a lower cost.

Dr. Tuckson also noted that these same issues apply to efforts to aggregate data and establish medical homes. Data aggregation becomes burdensome and administratively expensive for national payers and participating national laboratories and pharmacies when each state has their own system for extracting data, filling in data fields, and other processes. Likewise, providers struggle to provide best practice care without a clearly established and standardized medical home model. Across all these efforts, evaluation is a critical component to health care reform; however, UnitedHealth has struggled to address state-by-state program variation in its efforts to calculate national return on investments for these initiatives. He concluded by stating that while they are highly supportive of state efforts to drive reform, these efforts need to be more collaborative and coordinated.

Steve Wojcik noted that large employers, as the second-largest payer of health care after Medicare and the federal government, are an important source of innovation and have contributed to a number of efforts demonstrating promise for establishing better disease management, targeted financial incentives for wellness and healthy lifestyles, and evidence-based benefits. As large employers, they operate under ERISA and benefit from the administrative simplicity and reduced administrative cost that result from a national uniform standard. State efforts to transform the health care delivery system are laudable and employers who have a large presence in a state or region may see the value in and have participated in and supported these efforts. However, while state experiments to improve the delivery system are needed, there is a need for national uniform quality measurement standards that should be used to evaluate state delivery system reform initiatives. The large employer community would prefer one set of national standards and are encouraged to see that the physician community is coming to the table, as they were initially missing from broad-based conversations.

Mr. Wojcik also echoed earlier comments concerning the need for better evaluation of the return on investment in delivery system and quality improvement initiatives. He stressed that participation by large employers cannot be mandated; rather, there needs to be an attractive business case (which could be supported by better evaluations) that will drive employer involvement. Like earlier panelists, Mr. Wojcik also expressed some reservation over whether the medical home model

should be championed as the best model for primary care and cautioned that we should continue to explore other strategies for improving care and containing costs and evaluate these other models thoroughly.

Bob Margolis emphasized the importance of standardizing data reporting and transparency initiatives in establishing a rational health care system. While acknowledging the burden of administrative costs, he challenged Dr. Tuckson's assertion that administrative costs present a prohibitive barrier to national plan involvement. The majority of health care costs – 80 percent or more – can be attributed to how health care is delivered, which means that only a small percentage change in the way we deliver care can have a far greater effect on health care costs than efforts to save money through minimizing administrative efficiencies. That said, the focus of delivery reform efforts should not be on reducing costs but on improving quality, as quality improvement efforts will likely cost more in the short term.

Dr. Margolis also noted that he has been disappointed by the focus of the health care debate nationally. Although efforts to increase access is very important, missing in this debate are the quality and efficiency components that come from the better coordination of care across complex and multiple disease elements. The core of health care reform is management of populations and not the management of individual sick patients. Thus, the question must be, how do we get physicians and the whole health care system engaged in managing care for the population? Medical homes are clearly one important aspect of this movement, but we need to look for other strategies as well. In California, HealthCare Partners established a multi-stakeholder, pay-for-performance program that brought together major health plans to agree on a set of metrics. Future efforts to engage multiple stakeholders must include transparent measures that are both consumer relevant and scientifically valid. These efforts must also provide physicians with the necessary payment incentives to drive quality improvement, and must include steps to develop the necessary technological infrastructure to collect data in a ways that is useful across health care sectors and regions.

Conversation between National Private Purchasers and State Panelists

Following panel 1, **Mark McClellan** welcomed state panelists to comment on the challenges put forth by the national plans, large employers, and providers. State panelists agreed that there is a need for national standards, but argued that in the absence of national leadership from the federal government and from national payers, they had no choice but to implement their own initiatives and align them with nationally-accepted quality guidelines the best that they could.

Joan Henneberry noted that when 25 percent of the state's expenditure is going to health care, they have no choice by to act themselves. States will continue to work at the community and state level to address variation. However there needs to be room for a national conversation as well. Colorado has been carefully watching the reform efforts of other states and recognizes that it is very challenging to bring Medicare to the table. Consequently, the state has not yet moved in this direction.

Chris Koller echoed this point by noting that engaging Medicaid in Rhode Island was not a challenge due to the fact that the state built into their program much of the innovation pioneered by Medicaid in their primary care case management programs. He noted that the state has had success engaging their national payer, UnitedHealthCare in their efforts, but they have never tried to bring in Medicare. He also challenged **Karen Ignagni's** and **Reed Tuckson's** evaluation of the extent to which health care varies locally, stating that responsible local entities are pulling from the menu that's already being created.

The role of the national plans and the federal government is to create a limited menu of defined options and allow state and local leaders to pull from the ones that are most acceptable. **Craig Jones** agreed that a move to national standards is good and argued that it is misleading to characterize ongoing state efforts as so completely different that national plans and payers cannot handle the variability. He went on to note that states are looking for guidance through national standards and are adopting them when they're there but, in the absence of leadership from the national plans, states have no other option but to fill gaps. This has led to the development of a number of multi-payer databases around the country, which aim to examine common measures at a state level.

Finally, like the other state panelists, **Allen Dobson** also supported any effort to get to better standardization of measures and greater national involvement in reform efforts. North Carolina was the only state discussed at the forum that has pursued Medicare participation through a 646 demonstration. He also noted that there is a great deal of effort being put toward evaluating physicians on an individual level through tools such as physician report cards, despite a move toward more team-based approaches to care. To this point, it is not only important to develop standardized measures, but to reconsider what it is we want to measure and incentivize.

LUNCHEON KEYNOTE: CMS, State Reform, and Value-Based Purchasing

Herb Kuhn described some of the challenges facing the Medicaid program, specifically its long-term fiscal challenges, as well as some of its important accomplishments in the area of quality improvement. Since 2005, the number of states using national quality measures and publicly reporting those results has more than doubled, and significantly more states are engaging in efforts to pay for performance, address never events, and promote broad adoption of health information technology.

In that time, CMS has initiated its own six-step quality improvement strategy, which includes efforts to promote evidence-based clinical guidelines and performance metrics, promote value-based purchasing, address health disparities, utilize health information technology, engage with strategic partnerships, and disseminate innovative state practices. These strategies were designed to move the current health care system toward higher quality, more efficient care and to position CMS to be an active purchaser of health care. States, in particular, face unique challenges in their efforts to drive value-based purchasing – balancing their dual responsibility to both obtain the lowest price possible for high-quality, efficient care, while ensuring that rates are sufficient to maintain access. Mr. Kuhn also stressed that value-based purchasing encompasses not changes in payments, but also models for gain sharing, transparency, and consumer empowerment. He pointed to a recently announced Acute Care Episode demonstration as an example of how CMS is moving in this direction.

Finally, he stressed the importance of championing transparency and flexibility above all in efforts to align incentives across multi-stakeholders. Despite the many challenges for innovators, states, others engaged in reform, and CMS, the promising initiatives highlighted today are cause for optimism.

THE FEDERAL GOVERNMENT AS A PARTNER IN STATE-LEVEL REFORM EFFORTS

Dennis Smith acknowledged the great variation in efforts from state to state and noted several simple solutions that states can take advantage of, including better integration of Medicare Advantage Special Needs Plans to improve quality and contain costs that do not require federal waivers. Speaking to the waiver process, he noted that, though states often come into waiver discussions with ideas and concepts, CMS does a good deal of work to help states to frame their

waivers and vet the particular details of their programs. Federal guidance aside, states will always be the engines of innovation; the development of SCHIP is one example of how states are at the forefront of reform. For this reason, Mr. Smith is hesitant to over-regulate or prescribe reform efforts, specifically the medical home model. Given North Carolina's success in addressing the special characteristics of their community and driving health reform from the local level, we must be careful to not stifle innovation through inflexible nationalization.

Mr. Smith also discussed the notion of savings and its role in federal-matching and entitlement programs. With $2 trillion in health care spending, as purchasers we want to contain costs, but as recipients of those funds, we are not necessarily as interested in savings. Savings again become relevant when we talk about Medicaid as a matching program and the risk of a perverse incentive for states to not save because it would result in the loss of the federal dollar. He called for the need for a more candid conversation about what we really mean by savings and whether these savings would be for everybody, as he thinks they should be.

Tim Westmoreland remarked that Medicaid is a partnership between federal and state governments and, as such, should encompass four critical characteristics that define good partnerships: mutual respect, mutual communication, mutual assistance, and mutual responsibility. The first characteristic, mutual respect, calls for transparency and steadiness. States need to know what the rules are and live by them. Waivers should not be a substitute for rulemaking or a way to circumvent the law, and regulations ought not to be interim final unless there's a risk to life or health. In addition, regulations should be issued after discussion with the states and the beneficiaries and with notice that is sufficient to let states plan their budgets. The second characteristic, mutual assistance, calls for financial support when the states need it most. This assistance can come in the form of budget neutrality waivers for particular goals as well as the consideration of broad system-level investments in OMB calculations of budget neutrality.

With respect to mutual communication, data aggregation is key. The GAO has said for decades that Medicaid data are woefully inadequate and that at the federal level we can't even get Medicaid, Medicare, and Social Security information systems to talk to each other, much less to have federal systems talk to state systems. Without investments in data and systems, and better access to data for providers, advocates, and beneficiaries, these new programs will not work and they won't be replicable.

Finally, mutual responsibility at the state level calls for holding health plans accountable for the health care they are paid to provide. At the federal level, this means holding states accountable for meeting minimum statutory requirements of services. The same values apply to the relationship between plans and providers. Requiring plans and providers to participate in Medicaid as a condition of operating in the state, or perhaps as a condition of contracting with the state for its employees or retirees, would improve transitions and ongoing coverage immensely. Multi-stakeholder participation in these efforts is important, and should have at the table representatives of states and the federal government, for-profit and not-for-profit local and national health plans, health care providers, and beneficiaries and their advocates.

Conversation between the Federal Government and State Panelists

State panelists agreed in the need for greater accountability and more value-based purchasing, increased participation by national stakeholders in state-level reform efforts, and a more straightforward, flexible, and timely process for engaging Medicare through a template or other guided process. Participants acknowledged that the ideal is no doubt combining Medicaid and Medicare funds and participation in some sort of accountable way, but that reaching this point will require a great deal of leadership at both the state and national levels.

Mark McClellan noted that the main mechanism for getting reforms and payment that could align Medicaid and Medicare efforts and result in shared savings would be through a demonstration program. Securing one of these demonstrations, however, is not a straightforward process, and states could benefit from a more flexible waiver process to help nurture the development of local innovation through greater engagement of Medicare. Flexibility is particularly important, but such a template should not sacrifice innovation by forcing states to squeeze their program into a common mechanism or design.

Thus far, no such fast-track process or template exists on the side of Medicare. **Allen Dobson** suggested that perhaps a pilot approach, where the federal government has some authority to grant shared savings mechanisms to states based on some broad definition of innovation, could be one solution to this challenge. He also noted that Medicare ought to consider broad-based community support for a program as criteria for demonstration approval. In the case of North Carolina, there was an adequate demonstration of community support for the program, which is why the Medicare Section 646 demonstration in North Carolina would be such a good deal for Medicare. Another strategy would be to approach federal participation incrementally and bring Medicare to the table like any other payer.

Tim Westmoreland noted that engaging Medicare beneficiaries in state-level demonstrations, particularly demonstrations that include some form of mandatory managed care, may prove to be challenging. Transparency, accountability, and strong evidence will be key to moving these efforts forward.

Panelists also agreed that while Medicare is absolutely crucial to a multi-payer system or a multi-stakeholder delivery system, states also are addressing other issues in their partnership with the federal government. In particular, the issue of ERISA and how to engage self-insured companies is an important one that warrants a national discussion and leadership at the federal level. **Chris Koller** noted that the work of the NAIC around the national insurance compacts that **Karen Ignagni** cited in the morning session has been key to efforts toward standardization, making it easier for national employers and national companies to operate in these markets.

CONCLUDING REMARKS AND NEXT STEPS

Mark McClellan and **Alan Weil** concluded the forum with some summary remarks. Dr. McClellan noted the number of common goals for health care improvement efforts and health care reform efforts heard during the event – including getting to better care at lower costs for a whole population through better-integrated care, particularly for costly patients with multiple illnesses and issues, and working toward a greater focus on prevention and public health involving broader populations. States play a critical role in achieving these goals and are moving beyond efforts to squeeze down prices, cut benefits, or shift costs, and toward initiatives that actually contain costs by improving the way our health care system works. The recent economic downturn and the budget problems facing the federal government and the states underscore the need for health care reforms that focus on not just increasing coverage in the same old system, but also on improving quality and improving value.

Dr. McClellan reiterated the number of ways highlighted during the event to bring payers together to change incentives and also support providers and patients who participate in these efforts. The forum also brought to light the critical need for national leadership in developing standard, meaningful measures of quality and cost that are both clinically valid and relevant for patients, and that can be collected through electronic data exchanges. This is being advanced through the work of the National Quality Forum on priorities for endorsement of measures with the NCQA standards,

as well as the Quality Alliances and the Quality Alliance Steering Committee work that Brookings supports on moving towards patient-level and episodic measures of quality and cost and a national infrastructure for supporting it. While there are certainly challenges in getting to this point, opportunities exist to make a real difference as well. Brookings, through a partnership with Dartmouth Center for Health Care Policy Research, is working toward a better understanding of variation in Medicare costs which can support efforts to develop a potential template or a clearer path for Medicare to participate in some of these multi-payer quality improvement and reform programs. Other Brookings efforts include an emerging collaboration with the National Governors Association to develop some in-depth technical assistance for states that are leading or participating in multi-payer delivery reforms, as well as a collaboration with the Commonwealth Fund and NASHP over the past few months to establish a way for states to share information on their value-based purchasing strategies, common challenges, and lessons learned.

Alan Weil noted that states are dealing with a lot more than just Medicaid – although the Medicaid program is important, it is not the only role they play in the health care system and a multi-sector approach is needed. He commented that many of the innovations towards patient-centered care have their origins with complex populations and that these innovations emerged not only because of the great potential for savings, but because people's lives were at stake and because these systems were dominated by a single payer. As a result, the challenges of integration across payers were largely nonexistent and we didn't have the coordination issues that were addressed in this forum.

Weil noted that the forum included insurance plan executives who felt that that despite seeing tremendous variation in practice, they are unable to demand improvements because the market won't let them force that kind of change. The forum also addressed the need for leadership. However, less attention focused on accountability, which Weil argued is an area that we really need to pay more attention to. Finally, the forum included the perspectives of large employers, who defended their ability to be regulated under ERISA and the Department of Labor where there is essentially a complete absence of accountability.

Notwithstanding these challenges, and assuming that everyone is in agreement with where we want to go, Weil suggested that the question becomes, "How do we get there?" The most likely trigger point for national action is so much state action that the national players discover that it is more worth to them to make a tradeoff and cut a national deal then to live with the chaos and the challenges associated with state-by-state policies. If we believe that ultimately we should have national action in this area, we need to continue to push at the state level.

To this end, Weil suggested that we need to support states in continuing to develop these models and avoid federal action that blocks state action. Finally we need to return to this notion of the states as laboratories and the idea of a limited menu. Opinions on this varied greatly this morning between state panelists who felt that they were adhering quite closely to national practices and national representatives who felt that states were still all over the place. We need to acknowledge that we are narrowing, and that as we try out different things in different places, the menu will by definition become more narrow, a process that is not only good for states but for national payers as well. It is important for the national payers to let the states narrow this menu so that when we do finally act nationally we're doing it on the basis of some knowledge and experience as opposed to risking the possibility of adopting something at a national level that really doesn't work.