THE BROOKINGS INSTITUTION

ENGELBERG CENTER FOR HEALTH CARE REFORM

BENDING THE CURVE

PERSON-CENTERED HEALTH CARE REFORM: A FRAMEWORK FOR IMPROVING CARE AND SLOWING HEALTH CARE COST GROWTH

Washington, D.C.

Monday, April 29, 2013

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Overview of "Bending the Curve" Reforms:

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Media Question and Answer:

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Next Steps and Concluding Remarks:

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P R O C E E D I N G S

DR. McCLELLAN: All right, good afternoon, everyone. Thank you all for joining us today, despite the rain, for today's release of "Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth." I'm not sure that all of you here are counting, but this is actually the third report in a series that we've supported here at Brookings on "Bending the Curve" and effective ways to do that have involved a lot of expert collaboration from people around the country.

Now, our first report in 2009 brought together a group of distinguished health care experts and focused on some of the key elements for health care reform to bend the curve of rising health care costs. That report emphasized the transition to a health care system with more accountability for quality and costs based on four pillars. The first pillar was a foundation of improved information and

tools to support better care. The second pillar was provider payment reforms redirected towards supporting improvements and quality and reductions in cost growth. The third focused on health insurance markets and government subsidies to create more competition around quality and value and address risk selection. And finally our fourth pillar focused on better support for individual patients to improve their health and lower overall health care costs.

Our second report in late 2010 updated these recommendations in light of the Affordable Care Act. This report builds on that previous work in some ways, it's very consistent with those themes, but it's fundamentally different in some important ways, as well, and we're going to focus on those today.

For one thing, it's a good bit longer. We get into a lot more specifics here about how to get from here to there, but most important is the substance. This reflects a collaboration of a unique group of health care leaders who have worked together for over a year. I'm very pleased that two of those

leaders are with us here today, Senator Tom Daschle and Governor Mike Leavitt, to present this newest report. In addition, some of the new authors on our report include Dan Crippen of the National Governors' Association, Glenn Hubbard, a former CEA chair and dean of the Columbia School of Business, former CBO director and former OMB director Peter Orszag, former HHS secretary and University of Miami president Donna Shalala, as well as former OMB director and my colleague at Brookings Alice Rivilin, and Harvard professor and MEDPAC commissioner Kate Baicker.

As you'll hear, this group created a unique opportunity for dialogue not only about what Democrats and Republicans could agree on for needed health reforms, when they have to reach agreement, and that time is coming, but also how to make this work from a technical and practical standpoint. The result is not the usual list of cost-cutting measures; it is a framework that can be implemented starting now to put the focus in health care much more squarely on better higher value care for each person by supporting

innovative changes in Medicare, Medicaid, and private insurance. Our framework enables cost savings by moving our policies to support better quality care. That drives reform. It means more support for providers when they deliver better care at a lower cost, more accountability for doing so, and our framework also includes reform for beneficiaries that encourage better care at a lower cost, as well.

Senator Daschle and Leavitt are going to introduce the report and talk about how we got to where we are. Then I'm going to provide a little bit more of an overview about our proposed reforms. Then we'll have some time for questions.

Before we begin, I want to make sure that everyone's had a change to get copies of the executive summary that outlines all of our reforms. That's accompanied by a table summarizing the reforms and their cost impact. We estimate that those savings would be at least around $300 billion at the federal level over the next decade and much more after that, over $1 trillion in the second decade. More

importantly though, we will get to a better, more innovative system of care for patients much faster.

The full report and the supporting materials are going to be available on our Web site right after this event. It's at brookings.edu Bending the Curve Three with dashes in between, but I'm sure you can just use your search engine to find it, as well.

Now I would like to invite Senator Tom Daschle to start out with some opening comments. As many of you know, Senator Daschle is the former Majority Leader from South Dakota. He's also a senior policy advisor at DLA Piper, where he provides strategic advice on a wide range of public policy issues including health care.

In 2007, he joined with former Senate Majority Leaders George Mitchell, Bob Dole, and Howard Baker to form the Bipartisan Policy Center, an organization dedicated to finding common ground on some of the key pressing public policy issues of our time, and as many of you know, the BPC recently issued a report on health care reform that was coauthored by

Senator Daschle and one of our other coauthors here, Alice Rivilin. Senator Daschle's also the vice chair of the National Democratic Institute and a board member of the Center for American Progress.

Senator Daschle?

SENATOR DASCHLE: Let me begin by thanking Mark McClellan for the outstanding job that he has done in organizing this effort and producing this report. It has been a great pleasure for me personally to work with him over these many months. I also want to thank the Engelberg Center Project Team for their extraordinary work as well as the Robert Wood Johnson Foundation, the Irene Diamond Fund for their generous support.

I want to say as well how pleased I am to share the day with Secretary Leavitt. I've admired his work a great deal and appreciate his leadership in finding both solutions and common ground in health care policy.

And finally I want to acknowledge the important contributions of each of the members of the

Advisory Committee. We come from different backgrounds and philosophies, but in spite of our differences and personal approach and political disposition, each of them has worked and contributed significantly to the common set of proposals that we're releasing today.

I'm very gratified with our progress and the substantive results of our effort. Our country must address the critical issues of health quality and health costs now. It is essential for coverage expansion to succeed, for access to care, and for economic growth. This strongly-held view is clearly reflected in the broad range of groups and experts that have been working to develop this comprehensive set of reform proposals and despite the politics and deep philosophical differences around the issues related to health care reform, there is genuine potential for broad-based consensus about the key features of meaningful reform. We've attempted to demonstrate why that is true and what those consensus proposals for reform might actually encompass.

I'm very pleased that our new report shares many similarities with the recently-released health care reform proposals developed by the Bipartisan Policy Center that Mark just noted which Alice and I have been very privileged to develop, as well. In particular, I'm especially encouraged to see new ideas make the transition away from fee-for-service medicine towards a direct focus on supporting better care and lower costs at the person level.

For example, both the BPC proposal and this one describes ways for Medicare to become more person focused through Medicare networks in the BPC and through Medicare comprehensive care reform proposals in this one. Building on that focus of supporting better care leading to lower costs, our proposal today applies the principle to all major federal programs, including Medicare and Medicaid, as well as private insurance provided through employers and in the new insurance marketplaces.

As part of our Medicare proposal for Medicare Comprehensive Care or MCC as we call it, we

all propose updating Medicare benefits, including new opportunities for beneficiaries to save when they choose to get their care through MCC providers but deliver better coordinated care at a lower cost and we propose reforms in how Medicare Advantage Plans compete with a level playing field among all participants. This enables coordinated care better and makes other compelling improvements to get to a more sustainable and innovative Medicare program, one that achieves per beneficiary spending growth in line with growth in the economy's GDP.

We're not saying these changes will be easy and we describe how they can be phased in over 10 years with no short-term cuts in payment. Instead, our reforms use savings in Medicare in the first 10 years to make these reforms possible in the first place. We reform physician payment and help providers transition to the new system.

I would emphasize our proposals for slowing spending growth in tradition Medicare and Medicare Advantage are not another premium support approach,

our framework does not shift more costs to beneficiaries in traditional Medicare over time. Instead, by reforming Medicare, we slow down overall spending growth, and as a result Medicare Advantage subsidies will also grow at the same slower rate. By adopting our framework, we can avoid the blunt instrument short-term approaches that shift costs, disrupt care, and impede innovation in the health care sector.

I'm also gratified with the group's consensus approach to Medicaid. That is true primarily because we propose to enable states to get a larger share of the savings from implementing Medicaid reforms that lower per beneficiary costs and achieve substantial improvements in overall quality. We also offer ways for how the federal government can better support these state reforms through an infrastructure that better supports quality measurement, evaluation, and improvement.

We're building on some of the promising recent Medicaid waivers states like Rhode Island and

Oregon and California have adopted by making it a more systematic approach, but we would emphasize that this is too important to deal with in waivers alone. This is not a block grant proposal; it is simply the best way to build on current trends in Medicaid to support person-centered care. States that improve quality of care and reduce per capita beneficiary cost trends get to keep more of the savings. This means states get more resources to support the steps that they need to take in implementing Medicaid reforms to achieve better care.

Our report also describes a range of other reforms in such areas as private insurance and anti-trust regulation and provider licensing and in liability reform. All of these proposals fit in the same underlying goal of improved health and improved care at lower costs and we describe the legislative and administrative steps that can be taken starting now to get there.

In summary, this report is an important marker for some of the emerging consensus in what's

needed for health care reform to be truly successful. It also provides some clarity in how we can get from here to there starting now. It's time to start turning these proposals into action and from the standpoint of getting to sustainable health care cost growth but especially from the standpoint of more affordable care, we can't afford to wait.

DR. McCLELLAN: Thanks very much, Tom, and now I'm pleased to introduce Governor Mike Leavitt, who's currently the chairman and also the founder of Leavitt Partners. Previously, Governor Leavitt served as governor of Utah for three terms, also as administrator of the Environmental Protection Agency, where I first met him, and then as secretary of Health and Human Services when we started spending an awful lot of our days together and especially around the implementation of Part D, a lot of nights, as well.

Governor Leavitt?

GOVERNOR LEAVITT: Thank you and I join Senator Daschle in the well-deserved accolades to Mark and to Brookings and to those who have worked so hard

to make this happen. I would also like to acknowledge those who have sponsored this effort.

The report will stand basically on its own and you'll all have a chance to read that. And, so, I thought perhaps in a moment or two, but delegated to me, I would just comment on some of the purposes behind and maybe a bit of the dynamics and summarize as best I can how it came forward and what purposes we hope it will have.

I think if I were to summarize what the force behind it would be, this really began to get momentum with us about the time that the sequester began to take effect. This is the core group working on this. These are very experienced policy people with a broad amount of experience in the way policy is made and I think it's become evident to all of us that in the democracy there are inflection points, there are moments when the pressures just become big enough that something is compelled to happen and we all sense that the sequester was a step toward moving that direction, that something's going to happen here and

when it does, there needs to be a proposal that Republicans and Democrats can in fact agree upon. And, so, essentially what this group was was a group of thought leaders in both parties deeply experienced in how Washington works, the way the legislative process works, and the way the health care issues unfold that got together to essentially say when you get to the inflection point, what are the things that Republicans and Democrats could agree upon?

Now, I would say there are four things that we very clearly found we had common ground on. The first was that integrated care is better than uncoordinated care. The second was that this needed to move us toward away from the fee-for-service system and toward a risk-based payment system. The third is that we need to preserve the quality of choice because consumers have opinions here and interests and they need to be preserved. And, lastly, it needed to be scorable.

So, as you read through the report, you'll see those four core agreements reflected over and over

with respect, for example, to the integrated care. Obviously, it introduces the whole concept of Medicare Comprehensive Care. This clearly moves us toward a more coordinated care system as opposed to simply fee-for-service, which is less coordinated.

The second part is the risk-based payment. This clearly will begin to hasten the transition between fee-for-service and risk-based.

The third thing I mentioned was choice. This builds upon the lessons that we learned in Medicare Part D, that there are ways in which you can use plan-based competition to drive quality up and the cost down and builds on that six years of experience.

And, lastly, scorable. Let me just emphasize it does recognize that there could be up to $300 billion in savings over 10 years and roughly $1 trillion over 20 years.

Now, could I just say I'm speaking now on my account, not necessarily the entire panel, as we went through this process of estimating, all of us know that that process when you get out 10 and 20 years is

a fairly inexact science. And, so, we were using estimates based on very good actuarial advice.

I believe those estimates to be fairly conservative in the way we've estimated them, but given the fact that the report says what it does, time will tell whether or not they were low or high, but I think it's a very conservative estimate, but I'd like to suggest that the $300 billion number isn't the number to focus on in this report. The number to focus on here is GDP plus zero because that's the bending the cost curve, recognizing that Congress needs to have the ability to balance their budget and that they will have to have a scorable number. I believe that number is real, but the real focus here needs to be GDP plus zero.

I'd like to also point out that it was the considered opinion of this group that this needs to be real. We have all dealt over time with a series of scoring mechanisms that have yes, moved us toward a technically balanced budget like the SGR, but they never happen and that they aren't necessarily in the

long run real. You'll note we haven't used that. We've put in what we believe to be $220 billion of real Medicare savings over that time. We have also focused on mechanisms other than the SGR to get there.

So, in summary, we think an inflection point will come, whether it's next month or next year or some other point, there will need to be a point where Republicans and Democrats can agree. We identified those four things: integrated care is better than uncoordinated care, that choice is an important component, that this needs to move us away from fee-for-service and towards a risk-based payment and it needs to be scorable and this proposal I think does prepare a place where Republicans and Democrats can agree and it's doable. Thank you.

DR. McCLELLAN: Thanks very much, Mike.

So, you got an overview of how we got there from Mike Leavitt and you also got an overview of our recommendations from Senator Daschle. I'm not going to go back through all of those topics now, but I did want to give you a brief overview of our

recommendations, just some guideposts for what to look for in that summary and in the detailed report.

The recommendations are grouped into four major categories. There's a section on Medicare, a section on Medicaid, a section on private health insurance, spanning both employer coverage and the emerging individual insurance reforms, and finally a section of system-wide reforms that cover a number of key regulatory issues like transparency and antitrust enforcement as well as state-based initiatives that we want to support.

There are a lot of specific proposals in all of these sections. All of them share the same goal of creating better support for improvements in care to reduce per capita spending growth by changing care, by promoting care coordination and integration, by promoting innovations in how providers and product developers can better results for patients and do it more efficiently and by avoiding unnecessary costs.

This is probably the only report related to health care cost growth that starts out by describing

the opportunities for quality improvement quantitatively and how they can be achieved along with the opportunities for improvements in cost growth at the person level and how they can be achieved. That's the systematic focus here in shifting our financing and regulations to support better care and lower costs at the person level. Through these changes, as Mike said, our proposals aim for a target of gross domestic product plus zero per capita long-term spending growth not by shifting costs, but by driving towards more efficiencies and better quality in how care is delivered.

Now, I'm not going to go through the proposals in detail, but if there is one acronym to remember it's probably MCC, Medicare Comprehensive Care, in which providers can receive payment for the overall care for their patients, building on what many accountable care organizations and integrated systems and also new contractual arrangements among providers who are working separately but also who are organized separately but are paid increasingly together can

deliver better care.

Also, Medicare Comprehensive Care providers can receive payments on a bundle basis, building on the bundle payment reforms implemented now through case-based payments for primary care, through episode-based payments for surgical care and other types of special needs of patients.

Now, we also have proposals to reform Medicare benefits along with this to support the same goal of more comprehensive care at a lower cost. There are two parts to this; the changes in the Medicare benefit structure itself and in Medigap to make these programs more up-to-date, one deductible, more rational copayments, better protection against high out-of-pocket costs, steps to eliminate first dollar Medigap coverage, but coupled with that, the opportunity for beneficiaries to get lower savings not only because their average costs are going to come down from these Medicare benefit reforms, but also they can choose to get their care from MCC providers and share in those savings, as well.

We have reforms for the Medicare Advantage competition, as Mike already described, aiming for that same rate of GDP plus zero per capita cost growth through stronger competition and cost savings, but no shift in costs to beneficiaries who choose to stay in the government Medicare plan rather than switch to Medicare Advantage. We have altogether over $220 billion in savings from these Medicare reforms over the coming decades and we use those savings to stabilize Medicare and support providers in the transition to MCC in the years ahead.

For example, the physician payment system in Medicare will see SGR replaced by a stable approach in which physicians receive more of their payments on a case basis, as in medical home payments for primary care or case-based payments for surgical services for surgical episodes of care all supported by better data and more meaningful performance measures. Instead of reducing overall Medicare spending further in the next few years, we intend to make sure that Medicare can continue to achieve its recent low rates of spending

growth while providing more up-to-date and innovative care for beneficiaries.

Similarly in Medicaid, we have a framework for transitioning from the current waiver process to person-focused Medicaid. This would become the standard process for states to implement their Medicaid program. It would include consistent performance measures, better data, and a more complete evaluation structure for all states and everyone who's concerned about the Medicaid populations to use in evaluating and supporting the implementation of these reforms.

We have similar ideas for converting the CMS Capitated Financial Alignment Demonstration for Medicare and Medicaid enrollees, dual eligible enrollees with a much stronger and more systematic ongoing evaluation in implementation capacity a permanent one. Now, this doesn't mean rushing ahead with unproven reforms in Medicaid and limited ability to measure their impact; it means making a systematic commitment to the infrastructure and the program

support needed to focus more on better quality and lower costs at the person level in Medicaid and that also means giving states a significantly larger share of the savings when they achieve improvements in care along with the cost reductions.

For example, in our analyses, we examined models in which states would keep half the federal savings when they achieve lower costs with better performance on quality for their beneficiaries. This is a general approach that takes its foundation in some recent Medicaid waivers, but, again, we're describing much stronger and more systematic framework to move this forward throughout the program in a way that can have the most positive impact. Through the performance measures, through more person-level financing, it will also make it easier for states to integrate these Medicaid reforms with other initiatives and financial support that's badly needed for lower-income individuals to facilitate care continuity to improve efficiency.

For example, a lot of community health

centers and other local programs are focused on high-risk patients. This would make it easier for them to combine that support with efforts from the Medicaid program and this kind of person-based approach is working now around the country in places like Denver Health and in Camden, New Jersey, but it could be done much more widely and much more quickly.

I'm not going to go through the private health insurance reforms in detail. We do have a proposal for limiting the exclusion of the employer-provided health insurance tax benefits by imposing a cap that would also grow at the same per capita rate as federal subsidies in the Medicare Program and in the health insurance marketplaces, but that is in the proposal in more detail.

I do want to spend a minute on the importance of some of these system-wide reforms for supporting these overall goals. One of these involves a set of administrative simplification requirements and many of those requirements are around better reporting on quality and cost information, more

transparency on quality and costs, and also getting more consistent information more reliably to providers and patients so they can make more informed decisions in real time in delivering more coordinated and effective care.

I'd also like to highlight our proposals on antitrust enforcement. This is another good example of how we apply that general approach that I described to a very important area of public policy.

Today, antitrust review of the many kinds of mergers and consolidations and new coordination activities in health care involves an effort, a careful consideration of the benefits of this merger or coordination from health providers working more closely together on the one hand versus the potential adverse effects on prices that could come with greater market power on the other. Our proposal here describes how we can use much more specific and meaningful measures of person-level quality and cost of care in conjunction with merger and consolidation evaluations. We describe how this could give the

Federal Trade Commission and the Department of Justice more meaningful measures of the benefits as well as the risks of any proposed significant provider consolidation and by tracking these measures over time, it would be much easier to tell if the consolidation was having the intended effects on improving care without raising costs or if there were cost effects that would be a clear basis for further antitrust intervention.

We also have proposals related to licensing, as Senator Daschle mentioned, proposals related to help states developing more efficient medical liability systems, and implementing more systematic reform to the state level, as well.

So, there's a lot more detail on all of this in the report. What I'd like to do now though is give you all an opportunity to ask questions or provide some comments to us. We're going to have staff with microphones around the room. So, please raise your hand to ask the questions and I'd like to ask Tom and Mike to come on up to the stage and I think we're

going to try to take these questions from up here together.

So, thank you all again for joining us and please let us know if you've got any comments or questions. And if you could identify yourself when you get the microphone, that would be great, too.

MR. COOK: Sure. Michael Cook. I'm co-chair of the health care group at a law firm, Liles Parker.

Does the report do anything to address what drives most Medicaid directors to drink, namely how we finance long-term care and also does it do anything about the cost shift, for example, looking at trying to pay at same rates for the same care no matter who the insurer is?

SENATOR DASCHLE: Let me just start by saying that I think that while we don't specifically get into long-term care financing proposals, there is little doubt in my mind that the approaches that we've articulated and described here for changing the way we put the emphasis on a person-driven system will

certainly have long-term care implications. If I recall, about 62 percent of Medicaid goes to long-term care today. And, so, there is clearly a need for us to recognize the implications for long-term care.

As we go farther down the road, I think exploring ways of which to provide for better financing beyond Medicaid and of course post-acute Medicare as well as out-of-pocket expenses is something that we'll have to address.

GOVERNOR LEAVITT: And I would add that the basic concept of Medicare Comprehensive Care embraces this. I think if you look at the area that most Medicaid directors are most worried about right now, it would be the dually eligible population and that seems to be the place where everyone now who is focused on a coordinated care strategy is focused first because that's the area where there's the most capacity to increase quality and reduce costs.

So, if you go back to those four things that we believe that Republicans and Democrats can agree upon and you begin with the fact that integrated care

is better than uncoordinated care and that this has got to move away from a fee-for-service and more to a risk-based payment, you begin to see the solution I think that Medicaid directors are going to be welcoming and I think embracing in their search for a solution to that problem.

DR. McCLELLAN: Are there questions over here?

MR. BLOCK: Hi, Mark had mentioned exactly what --

DR. McCLELLAN: Just please if you don't mind identifying --

MR. BLOCK: I'm sorry, Jonathan Block with Modern Healthcare.

Secretary Leavitt had mentioned about dual eligibles and also Mark had mentioned to it. I'm wondering if you could talk a little bit about some of the proposal in this report that deals with that and also if you could talk a little bit about some of the capitated programs that are ongoing now. For example, California just got approved for the largest one so

far and whether you see that as a step forward for other states to follow.

DR. McCLELLAN: I think the kinds of examples like the California model provides are very consistent with the details in our proposal. So, what we would do is providing more systematic framework for states that want to develop reforms that can achieve better quality and lower costs to have a straightforward path for doing it. That means an infrastructure with a standard and consistent basic set of measures available, better evaluation capacity because it's all focused on these kinds of reforms, and a smoother process for these kinds of Medicaid reforms being implemented. Also more support for the states in implementing them.

And the California waiver is a good example of this. Senator Daschle may have some additional comments here. I know you've been following that closely, as well, but it was those kind of examples that were the impetus for us including the systematic approach in our framework.

SENATOR DASCHLE: It may or may not be true that dual eligible reform is the low-hanging fruit for longer-term health change, but I think that there is some real rich opportunity and I think it is fair to say that most states recognize the need to address it sooner rather than later. So, as Mark noted, what we provide is a framework within which this can be done, recognizing that there has to be flexibility from one state to another and I think our shared savings approach to bringing about these kinds of incentives to change will really add in a very catalytic way to the kind of momentum behind the need for reform and the recognition that we need to do it soon.

DR. McCLELLAN: David?

MR. NIXON: Hi, David Nixon with the Advanced Medical Technology Association.

Mark, you and David Cutler did an article several years ago about the value of medical innovation and technology and I remember for heart attack, I might not have these figures quite right, but if I remember correctly, the real cost of

treatment for heart attack tripled over the 30 years or so that you looked at, but the mortality rate was cut by 50 percent and the value of the innovation clearly exceeded the cost.

DR. McCLELLAN: Right.

MR. NIXON: When you have incentives all aligned as in the providers, health systems, hospitals, all have a very strong incentive to drive costs down.

Does the report deal with ways that you can prevent that incentive from preventing adoption of new technological innovation which may raise costs, but also deliver better clinical care?

DR. McCLELLAN: Absolutely. As the considerations around medical innovation were central to this proposal and David Cutler is actually one of the coauthors on it, as you know, so, let me say a few things about this and Tom and Mike may have something to add, as well.

First of all, one of the most important threats to innovative technology today is just the

overall rate of increased health care costs. If we're spending more overall, it makes it harder and harder to spend on truly innovative approaches to care and that's one reason that motivated our push towards more of a patient focus, a person focus in health care financing. Because a lot of the technologies are coming along and have contributed to improvements in things like cardiovascular disease outcomes are increasingly becoming individualized, it's getting harder and harder to fit them into a fee-for-service system where the prices just keep getting squeezed down, the thing to do is increase volume.

Well, the future shouldn't be about higher volume across the board, it should be about better combinations of treatments that are very well suited to individual patients. And, so, that's really the direct focus of our report is putting more of an emphasis on measuring those impacts and documenting when medical technologies are really having a positive impact both when they're first introduced and over time on patient care.

So, that's a very important step towards supporting where I think medical innovation is headed, which is getting to much better higher value treatments at the person level, but treatments that are increasingly customized at the same time that don't fit in well to a fee-for-service framework and while some kinds of medical technologies do get reimbursed well under fee-for-service, many that involve things like better care coordination through IT or diagnostic tests that help target technologies more effectively don't and also technologies that are used in a different setting and so forth often have a lot of barriers to adoption. So, we're really trying to overcome those kinds of barriers directly with this emphasis on person-level quality of care improvement.

The second thing I'd add is going back to Mike's emphasis on choice as part of this effort. We do envision much stronger competition among not just competing health plans, but among health care providers on delivering better results both short-term and long-term to patients and the only way that you're

really going to get there is by keeping up with and really being on the cutting edge of effective innovative technology adoption.

I'd add to that, as well, we have proposals for steps like risk adjustment, risk corridors, further incentives to support innovative technology and this is definitely something all of us who have been working on the report want to see remain front and center in these reform debates. Absolutely better medical technology is one of the driving forces for this report.

GOVERNOR LEAVITT: Could I comment on that? I believe the proposals in the report, particularly the idea of integrated care, is better than non-coordinated care and risk-based payment are very supportive of this.

In the past, innovation has been brought about by a formula that if you have a new device or a new chemical or a new protocol, FDA approval, and a CMS billing number, you're in the innovation business.

In the future, I think an entirely new

category of innovation is beginning to develop and it’s driven by proposals like this and it is the innovation of being able to identify which devices, chemicals, and protocols actually produce better quality at a lower cost.

We have talked a lot about that over the course of the last decade, but the truth is we haven't been very good at it and now we’re beginning to see because the incentives are aligning, we’re now beginning to see a new category and a new definition of what innovation is and I think we started with that fundamental. If we produce a proposal that will kill innovation, neither Republicans or Democrats are going to agree to it.

SENATOR DASCHLE: I think there's very little to add to the eloquent comments made by both of my colleagues, but I would just simply say that I think the essence of what it is we’re trying to do is to create an outcomes-driven environment that allows more innovation, but far better evaluation of that innovation not driven by fee-for-service models as

we've done for so many decades, but real outcomes evaluations that allow us a far better appreciation of the contribution of these innovative new approaches, and, therefore, a real opportunity to innovate for reasons other than simply adding to the bottom line in terms of the dollars and cents required.

DR. McCLELLAN: I saw some other questions. Maybe up here in the front.

MR. WILKERSON: John Wilkerson, Inside Health Policy.

Do the antitrust proposals make it easier for providers to consolidate initially? And, if so, how important are those measures to the MCC proposal?

DR. McCLELLAN: I think the proposals should make it easier for providers to consolidate if they have a really clear plan for getting better care at a lower cost as a result of consolidation. Essentially what the reforms call for is a much greater emphasis on actually getting measures, baseline measures included of the quality and cost of care. I'd say all consolidation efforts today have a good story behind

them of how better integration either through mergers or through some kind of contractual relationships is going to lead to better coordination of care and lower costs.

The problem as we've seen, as many of the experts on the panel have studied extensively, is that that's not always the way it works out. By having a clearer emphasis on better quality and cost measurement from the beginning at baseline and then over time, at least for these major mergers that have significant market shares involved, it will be more clear whether those coordination approaches really are going to lead to better results. After all, this is 2013, and especially in light of our reforms, we should be expecting providers that want to work together in new ways to be able to show how they're going to track quality of care, how they're going to improve outcomes, how they're going to reduce overall costs for their patients. So, this is just really setting antitrust evaluation expectations in line with the overall direction and theme of our report.

If any additional comments --

GOVERNOR LEAVITT: I agree.

DR. McCLELLAN: Great. Maybe to the back.

MR. McNEELY: Scrambling on the Android to take a look at the full report. I want to congratulate the authors of the report.

My name is Larry McNeely. I'm with the National Coalition on Health Care, and there's a lot in here that is certainly in line with what our organization has talked about.

I did want to ask in terms of the design of the shared savings approach with the states what kind of safeguards folks had talked about to make sure states were really getting together and grappling with the real drivers of cost as opposed to making their health spending numbers look better by sacrificing either quality or access or those kind of pieces.

DR. McCLELLAN: Thanks, Larry, and I think you all may have something to add to the answer on this, but I also wanted to use this opportunity to thank NCHC for its efforts around reform and I think

Tom mentioned earlier there really are a large number of these reports, ideas kind of coming together behind some of the same basic themes that we've described here.

And now as you've pointed out, we did try to go into a bit more detail about how exactly this would happen in Medicare, in Medicaid, and so forth, than a number of the other reports, and in this case in Medicaid in particular, we lay out a very clear framework for state requirements around not only reporting on cost per beneficiary, but also on having infrastructure for tracking and monitoring quality of care over time, as well. This is something that is a part of all of those innovative waivers that are being adopted now, but as much of the discussion around the California waiver showed and as much of the debate around the Financial Alignment Demonstration Program for the (inaudible) of duals is showing, we don't have as much of an infrastructure there as we would like and it's very hard to get one in there with just a one off approach to individual waivers or a temporary

demonstration program in the case of duals.

We need something that's permanent, we need something that's a long-term committed infrastructure with a very clear set of long-term goals and expectations in mind around better performance measurement, better data systems to support states in implementing these reforms, better data for evaluating the impact of the reforms and modifying them as they're going along.

So, we think this can substantially accelerate some trends that are existing now in terms of opportunities for states to deliver better care at a lower cost, but also give people a lot more confidence that the reforms that states are implementing are actually working.

SENATOR DASCHLE: I couldn't say it better than Mark just did, but I would just say I don't think we've ever really incented either savings or a real reform to Medicaid at the state level. That hasn't been what the federal government has done and they've done it now in a patchwork way with the waiver system

that we've increasingly relied upon, but as Mark said, the waiver system isn't the way to develop a national federal infrastructure and to create a better environment for a real partnership between the federal and the state Medicaid programs, it's really going to be critical to lay it out with greater certainty and with enough flexibility and incentives to save and reform that we just don't have today. That's what we attempt to lay out in a proposal in this report.

GOVERNOR LEAVITT: And I will just say that in my service as governor and in my service as secretary of Health, I observed what Tom just said. (Laughter)

And I would also just add one other punctuation point and that is I heard about quality problems a lot quicker as governor than I did as Secretary of Health. These were my neighbors, these were people who could grab me at the grocery store or on Main Street, and if you don't think I heard about them, you're wrong. I heard about them, I saw them, I lived with them, and, so, I think there's a great

sensitivity about this in states. What has been missing is a lack of incentive. In fact, what has often played out to be disincentives, and hopefully Congress can cure that.

DR. McCLELLAN: Way in the back there.

MR. SHANELL: Hi, Eugene Shanell from the American College of Physicians.

Thank you for putting out this policy paper, and the question I had was in terms of the MCC organizations and their approach towards promoting a collaborative physician network taking care of physicians while driving down costs, what are the mechanisms in place discussed in the full paper that you can go into briefly that account for potentially patients sort of bleeding out of the MCC organization to outside providers who are not involved, yet still accounting for that in terms of collecting the statistics for cost efficacy for efficacy of the benefits of delivering quality care. So, overall, how do you balance that in your report?

DR. McCLELLAN: I think maybe I can do a

little bit of a technical answer to that question and Mike or Tom might have some points to add, too. We start out in these reforms by building on the attribution systems that Medicare is using today. So, beneficiaries have a choice of any and all providers in traditional Medicare and that doesn't go away in this proposal and there are mechanisms in place today whether it's medical home models or accountable care organizations or bundle payment initiatives for attributing patients. Those are imperfect, but they are a starting point and we believe they can get better over time.

We think that those are going to be reinforced in a couple of ways. One is through changes in provider payments, even though we see the MCC Program as something that providers would opt into, we want to make it as easy as possible for them to do that. So, we would expect to continue and we lay out in the report how to do it, movements in all of Medicare's traditional fee-for-service payment systems towards more of an emphasis on case level or

beneficiary level of payment.

It doesn't have to happen overnight, it doesn't mean that every primary care physician is going to go right into a capitated system, but this movement towards having more of your payments at a case level related to the quality of care of your beneficiaries and their coordination of care and what they really need as opposed to just fee-for-service for each and every visit and then nonpayment for things like e-mails or phone calls or extra time that you take or that your nurse is taking or office to spend time with patients, that’s the direction things are going anyway and we are definitely reinforcing that. So, there are some steps for providers to move in this direction and we’d say that our reform of Medicare physician payment goes in exactly that same direction.

Second, there are some steps for beneficiaries, as well. We do think that Medicare benefits need to be updated. I think some people have regarded that as another third rail or something in

this process, but as we lay out in the report, we can do this in a way that both saves money overall and supports this transition to MCC, it gives beneficiaries better protection against high costs, it gives them lower cost on average, even if they don't do anything differently, but then if they do engage more with these providers that are taking steps like setting up programs to help them manage their chronic diseases or using allied health professionals to give them more convenient services closer to home, they can get some savings from that. They will have an opportunity to share in those savings, as well. It's not just shared savings for states for getting the better care, it's most importantly shared savings for the consumers in the health care system, starting with Medicare beneficiaries. So, that means additional savings for beneficiaries and additional push in the direction of implementing MCC.

SENATOR DASCHLE: I would just add one small thing that I'm very -- excited may not be the word, but certainly gratified to see and that is a

recognition in this report all the way through that we are going to embrace comprehensive reform on an incremental basis, that we're going to take this step by step to deal with the good question you raised, but to recognize that none of this, as we said, is going to be easy and if we're going to do this right, we really have to take it a step at a time and evolve over a period of a decade to get this right, but to do it in a comprehensive way, recognizing you can't just take small pieces and expect major change, you've got to look at it in a comprehensive way, but I think you implement it in an incremental way.

DR. McCLELLAN: Yes, I saw a question. Maybe go back up front here, Roger.

MR. CURRIE: Thank you, Roger Currie at West Health.

Congratulations on your accomplishment. You've got the most highly respected policy and political experts behind the report. So, I really look forward to reading it.

Another question about Medicaid. Since

you're looking at savings on a per capita basis if I understand how you presented it today, does that mean the report endorses Medicaid per capita caps or maybe more specifically the report contemplates moving to Medicaid per capita caps. I know President Clinton proposed them in his 1997 budget and I think there was some bipartisan interest during the Budget Control Act period a year or two ago, but I haven't heard as much lately.

DR. McCLELLAN: This is not a specific proposal on formal straight out caps in Medicaid. What I would like to emphasize is what both Tom and Mike emphasized about the proposal, it's about much stronger incentives for states to improve quality and reduce costs at the beneficiary level. That does mean that we would expect as a standard part of Medicaid to be tracking per capita costs per beneficiary along with measures of quality and performance are consistently while allowing for state flexibility on top of that and it does mean that if states get savings off of their per capita trends, they're going

to get a lot more of those savings than they do under current law and that's to provide that stronger incentive and that stronger financial support for states to take the steps they need to take to get to better quality. As Tom and Mike both emphasized, there's just not much opportunity for that now. So, we are putting a bigger emphasis on per capita Medicaid spending. We are giving states substantially larger share of the savings when they reduce per capita cost trends and improve quality, but it's not the same thing as just a straight per capita cap.

SENATOR DASCHLE: I would really draw the distinction between what we do the per capita. Basically I like this term, that I don't know if Mark was the originator of it initially, but I think most of us came to the conclusion that person-centered care really does have a great deal of meaning to me and that's what we're offering in Medicaid, person-centered care in much the way Mark has just described.

GOVERNOR LEAVITT: And I will just add that I think there is a difference in the impact that

states can have as an ecosystem and learning to measure what's happening by market as opposed to looking at a state cap as though the state was spending all the money. So, the idea, I think, is to begin to recognize that states have a lot of levers that they can turn that will have an impact on the overall spend and moving Medicaid in this direction is one of those.

DR. McCLELLAN: And we just highlight, too, that some of the other elements in the proposal describe how, as Mike said, to line up additional support for states when they take systematic steps to get better quality and lower costs in their health care systems.

Up here.

MR. COTTON: Hi, Paul Cotton with the National Committee for Quality Assurance.

Thank you for this report, especially all the stuff on quality measurement, which we obviously like. But you also called for greater transparency on costs, which has been a real challenge because so many

of the negotiated rates are considered proprietary. What the plan pays is not always what the consumer knows about.

How do you envision getting better transparency on costs to support all this?

DR. McCLELLAN: There are several ways and I'll let Mike and Tom add their perspectives on this, too, but there are several specific proposals in the report that relate to this. And first and foremost is the fact this is going to be the basis for our payment systems and Medicare and Medicaid and through many of the state-level initiatives, as well as national support, quality and cost reporting is the key way to go. With that leadership from the public programs, I think it's going to be easier for the private programs to get consistent measures and we have some proposals in the report for how to line up the public and private measurement of quality and how to get good total costs and out-of-pocket cost information to be more available.

Second, there's some specific proposals

related to the so-called gag clause, as it restricts the release of information on costs. Now, a lot of the details about cost transactions are not the real focus of our proposal; the real focus is on what beneficiaries, what individuals pay out of pocket and what total costs are that go back to determining in turn the premiums of the health plans. Those are the things where we focus on making sure that there aren't any restrictions on gag clauses and the like. So, the combination of the incentives and framework that we provide for quality and cost transparency plus the new reforms reflecting the relevant gag clauses for quality and especially out-of-pocket costs and total cost information we think will make a big difference there.

GOVERNOR LEAVITT: I just want to add when I was secretary of Health, I would receive from the CMS director each year a payment rule that had some 12,000 different procedures and it was always a head-shaker for me. I mean, I certainly didn't understand every one of those procedures and I wasn't sure anyone at

CMS did, but I was absolutely certain that consumers didn't and that there had to be a surrogate platform for competition where consumers could have a sense of transparency on what they were getting and that there could be a good platform and I think this plan-based environment when plans can compete for quality and costs has proven out to be a simple enough system that consumers can understand what they're getting and they can understand what it's costing them and there's a competitive nature or capacity to do that. So, I think that's an important element of this.

SENATOR DASCHLE: I think there are a few elements in reform that are more important than more transparency. I can really think of many and I would just simply say we haven't talked about health IT a lot this afternoon, but I think it's really going to be critical that we continue to see the evolution of good health IT in order to bring about transparency and as we say in the report in the executive summary, we recognize that in some cases, this may take some legislative action that will allow for greater

opportunities to deal with some of the restrictions on transparency that exist today, but clearly if you don't get started with proposals as we've made them here, that point and that result will never occur.

DR. McCLELLAN: So, as you can see, a lot of the proposals are related to meaningful cost transparency at the level of not the 12,000 specific price list, but the level of bundles of care, at the levels of care at the person level, at the levels of plan choices that we think are critical to supporting these reforms.

Jack?

DR. LEWIN: Thanks, Governor Leavitt, Senator Daschle, Mr. McClellan. Terrific contribution.

As the chairman of the National Coalition on Health Care and physician, we're struggling now with the partnership report that we came out with a couple of weeks ago with how we're going to implement this with a Congress that's struggling for a consensus and there's in the provider community a need for a

consensus.

So, what are your plans and your thoughts about how to go from here to be able to accelerate moving in this direction and actually even if it's incremental, Senator Daschle, how do we get on this path?

DR. McCLELLAN: I see that we're about out of time. This is actually a good last question. (Laughter) Please go ahead.

SENATOR DASCHLE: Well, maybe I'll start by saying that we've already begun the effort that we're sharing the report with key members of Congress, with members of the staff, and the important relevant committees. I certainly intend to speak to those with whom I've had the opportunity to work in the West Wing and the Department and I think that people are really yearning for ways of which to find common ground on health. I mean, I think the more this effort is exposed and the more we can share the ideas that I think are encompassed in this report, I think the more optimistic I become.

As I talk to Republicans and Democrats, I'm encouraged really by the degree to which there is this desire to get beyond the old battles and the old rhetoric and really see if we can't address this. I certainly know that the health sector especially wants that to happen, and, so, the only way we can do it is simply to make contact with members of Congress and others responsible in public policy and just see where it might lead.

GOVERNOR LEAVITT: Evidenced by the fact that you're here, there's a suspicion on my part that you've been around Washington a while and, therefore, you fully understand that these inflection points happen and there's some signs that begin to lead you to the conclusion it's going to happen. The intensity gets a little higher, the groups get smaller, and the timeframes get shorter and you begin to feel the pressure build.

Well, I think there's a sign that we're at least moving toward an inflection point and in those moments there has to be a place to start a

conversation. And, so, our whole effort here is to say in that moment when Republicans and Democrats in Congress have to find a solution, what could they agree upon? And we're hopeful that they will say some thoughtful people, a few months ago or a couple of years ago or whenever it turns out to be, spent a lot of time thinking about it. Maybe we ought to start with the four basic principles that they suggested we could agree upon because they will.

Now, we've done our part. Some of you are going to write about this. Now is your turn. We hope that you'll write about this in a way that will catch their attention and let them know that it's here because this is an important body of work and it's a very important problem that needs to be solved, and that moment will come, and when that moment comes they need to be able to take -- we hope they'll think of us as their staff, right? We have prepared a good place for them to start.

DR. McCLELLAN: I think that's a great point to end this event on, that our emphasis is it's good

that we had a press announcement and I really appreciate all of you who are writing about this today, but this is just a step in the process.

There is a lot more work to do going forward, the proposals in this report cover a lot of ground. We know it's going to take more than today's announcement to get action, but as Mike and Tom have said, the opportunity is there. We hope that by providing a clear vision for the future and a clear path for how to get there, we can make a lot more progress a lot faster in improving quality and lowering costs for the benefit of patients and for the sustainability of our health care system, our truly innovative health care system.

I would like to thank again Senator Daschle and Governor Leavitt for joining us here today. I'd like to acknowledge again the very important contribution of all of our coauthors that are talking beforehand about what was the hardest thing about this report, and it actually was scheduling. (Laughter) Once we were able to get everybody together, we were

able to really work on these very challenging issues and that gives us a lot of optimism for the future.

For making this possible, I also want to thank the Robert Wood Johnson Foundation and the generous support from the Irene Diamond Fund. I'd also like to highlight the support of the Merkin Foundation, which is funding our work here at Brookings on clinician leadership and the payment reforms that are going to be a critical part of this initiative. And finally and most importantly, the Engelberg Center staff here, Larry Kocot, Keith Fontenot, Beth Rafferty, Erica Socker, Sarah Bencic and Christine Dang-Vu, who is working with me all weekend, as well as a lot of other long days and nights ahead on this. I want to thank all of you for your support on this report and today's event and we encourage all of you to follow-up with us, all the coauthors, all those of us here on stage today as we continue to make progress on reforming our health care system. Thank you again for joining us today.

(Applause)

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