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Mark Masselli: This is Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, folks looking for Virginia to expand Medicaid or going have to wait two years. Democratic Governor Terry McAuliffe was fighting against the conservative tide hoping to expand Medicaid in the state but after much political wrangling during the budget process, Virginia legislature approved the budget that had a measure ineffectively blocking the governor from being able to do so.

Margaret Flinter: Well Mark, we have seen some five million Americans gained health coverage across the country and states that approved the Medicaid expansion. And this would have been a chance for hundreds of thousands of working poor Virginians to get health coverage, but conservative majority won out in this case.

Mark Masselli: The cost to that coverage is fully covered by the federal government for three years. There won't be another chance to expand Medicaid for another two years in Virginia.

Margaret Flinter: A number of conservative states that opposed the Affordable Care Act still opted to expand Medicaid in the states, it makes economic sense bringing billions of healthcare dollars into the state office and allowing millions of economically challenged Americans to gain coverage.

Mark Masselli: We only need to look at Massachusetts to see what that means, Margaret. In a few years since most of the states residents gained access to coverage, the death rates have gone down between 3% and 4%, that's due in large part to folks who have been uninsured before getting good preventative healthcare.

Margaret Flinter: And our guest today, he has been working in the trenches of improving healthcare for Americans for a long time. Alan Weil was the Head of the National Academy for State Health Policy. He is now the Editor-in-Chief of Health Affairs, the peer-reviewed publication for health policy in this country.

Mark Masselli: And we are looking forward to that conversation, Margaret, as well as hearing from Lori Robertson from FactCheck.org.

Margaret Flinter: And no matter what the topic, you can hear all of our shows by googling CHC Radio.

Mark Masselli: And as always, if you have comments, please e-mail us at www.chcradio.com or find us on Facebook or Twitter, we love hearing from you.

Margaret Flinter: We will get to our interview with Alan Weil in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. For the fifth year in a row, an independent survey done by the Commonwealth Fund has found U.S. ranks behind all other industrialized nations when it comes to value and outcomes in healthcare. The study conducted by the respected think-tank Commonwealth Fund compared healthcare cost and outcomes in the U.S. to nations like England, The Netherlands, France, Canada, and others. They found that for the fifth year in a row when it comes to cost, Americans fared the worst of all their counterparts in terms of out of pocket healthcare expense and that we ranked last in everything from infant mortality, maternal mortality, life expectancy, heart disease, diabetes and other life altering chronic illness. The study found 34% of those polled had waited or delayed seeing a doctor or failed to fill a prescription due simply to the cost. One of the key contributors to high cost and poor outcomes was the high rate of uninsured Americans. As millions of Americans gained access to coverage primary preventive care they will start do positively impact population health according to the study, but the report also elucidated systematic problems throughout the healthcare delivery system that need to be addressed before these rankings can meaningful improve. Meanwhile the other indicator of improved health outcomes is health literacy. The recent spate of newly insured Americans has revealed the chasm between those who gained coverage and those who actually understand how to use the healthcare system. This lack of health literacy has been addressed by the Centers for Medicare and Medicaid. They were offering outreach assistance to those having trouble navigating health insurance as well as the healthcare system. Bike sharing programs or sweeping the nation city good for the health of the riders, right? Well, the short answer is yes unless you forget to bring your helmet. The study looked bike related brain injuries in cities with bike sharing program versus controlled cities without those programs brain injury and the bike share cities was up on average 14%. I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Alan Weil, newly installed Editor-in-Chief of Health Affairs, a leading peer-review journal on health, healthcare and policy. Before that Mr. Weil was Executive Director of the National Academy for State Health Policy. Mr. Weil, an attorney was director of the new federalism project at the Urban Institute, a frequent speaker and author on Health Reform

Policy. Mr. Weil co-authored several books including Federalism and Health Policy and served on President Clinton's consumer commission on the quality in healthcare industry, co-authoring the patient bill of rights. He earned his masters in public policy and law degree from Harvard. Alan, welcome back to Conversations on Healthcare.

Alan Weil: It's nice to be back, thank you.

Mark Masselli: And it's been since 2011 when we discussed the Affordable Care Act and lots have happens since then, eight billion Americans enrolled on and received coverage on the exchange and five million access covers to Medicaid expansion. Now if you break it out by states it's been a patch work quilt, only about half of the states choosing to expand Medicaid and we are seeing many Americans still left out on the promise of health coverage. What would your assessment of the outcomes from state to state is that is you envision would happen?

Alan Weil: I don't think anyone had anticipated the country is splitting quite the way it has and two elements were certainly not foreseeable by me. The first I think I have a lot of company on which is the Supreme Court after all is responsible for having made the Medicaid expansion something that the states could choose to participate in or not as the law was written, all states were to expand to Medicaid and we are going to have a uniform national platform of coverage. Now with the court's rewriting of the statute they said the federal government cannot tell states that if they fail to expand Medicaid they will lose their base funding for the program and we have what you just described. I truly don't know a single person who thought that was where we are going to be at this point. We knew there was disagreement obviously over the Affordable Care Act when it was enacted. But what I didn't foresee was how much states would become a place where even after the law was enacted and signed that there would be such a division about whether or not implementing the law was something states we are willing to participate in it all. And so you have the significant element within the Republican Party that basically said anything you do that is involved in implementation of the law is asthma but actually you should not take any steps to implement. And that is a big factor I think in a division today and certainly not one that I expected.

Margaret Flinter: Well certainly, Alan, you obviously are a long time health policy advocate and expert, you have contributed frequently to Health Affairs and now you are the Editor-in-Chief of what we think of is the peer-review journal for health policy. Now the journal began back in 1981 and we understand (inaudible 7:22) over 120 million unique visits per year at the website. So for our listeners, may be tell us a little more about the journal's history, who the major participants and contributors are, and if there is any new directions that you are planning for the publication.

Alan Weil: So we started with the luminaries in the field and I would say we still have them. We call upon a broad cross section of health services researchers, physicians and economists, and sociologists and statisticians. We cover the range of issues in healthcare as they relate to the policy environment in which we operate and of course, it's a very busy exciting place to be right now. As for new directions, mostly, I will say I pick the helm of this terrific journal that is so strong, I don't need to layout a big plan of transformation. But I do think we are in an era of faster information where the traditional peer-review journal is coming under fire both from the time that it takes and the resources it takes as well as the many distribution channels that are available to those who don't want to subject their work to peer-review and want to get their message out much more quickly and I think navigating that changing environment really is my top priority.

Mark Masselli: Let me pull the thread a little on that is you take on the metal as Editor-in-Chief and so in this ever-changing world of how readers consume sort of where that audience is not so much on the content side but on the delivery side, thoughts about that even in the state position that Health Affairs as you have others who are quite anxious about the transformation and what it might necessitate for organizations like yourself?

Alan Weil: Well, we occupy a unique space and one thing I think we all have to remember is there is not one typical reader particularly for the policy work we do. We are reaching CEOs of organizations, we are reaching young staff members on Capitol Hill, we are reaching practicing clinicians around the country, and indeed, around the world who are trying to understand the changes that are occurring. And I think we all know with the pace of change in how information is distributed and disseminated. Those different audiences are looking to different sources. It's making sure that as we think about our audiences we have appropriate distribution channels for the range of mechanisms that they are accustomed. Our core asset is credibility and non-partisanship is a very important part of that. Our peer-review process and as long as we build from that core some people will be Googling at topic and they will find that some people will read a blog entry, some people will read a tweet, and as long as we retain the quality of our content, I think we can reach people the way they are used to gaining access information.

Margaret Flinter: Let me take a quick look back if I can, Alan, you were in the health policy trenches back in 1990 when the Clinton Administration took it shot at passing comprehensive health reform. And you have noted that the conventional thinking back then was that the three pillars of reform improving access, improving quality, **contenting** cost were actually competing interest and couldn't it be simultaneously achieved. But you have more recently said that the Affordable Care Act have shifted that landscape on these three goals and perhaps the ACA has made it possible to envision the three pillars of access, quality and cost shifting for competing forces to actually reinforcing one another. What do you mean by that? Expand on that thought for our listeners.

Alan Weil: I remember going to dozens of conferences a couple of decades ago where people said that you can't have high quality affordable system for everyone. I really believe it's the practice of medicine and the evidence-based behind that practice that's changed in these years along with some good thought leadership. We now understand that when people get access to appropriate care they actually stay healthier and it cost us less certainly in a long run and sometimes in the short run if people obtain care rather than if we denied them care. We have also learned a lot about quality that was in its infancy a couple of decades ago and understanding the problem of overuse. So there is now a framework in the Affordable Care Act obviously now everyone agrees with the approach it takes but most of the attention goes to the elements of the Affordable Care Act design to expand access care through more health insurance. But there are major elements having to do with cost particularly modifications to the Medicare program which is the biggest **level** the federal government has and major initiatives to improve quality. And the hope of course is that we can bring those together in a reinforcing way as opposed to a competitive way. I do think our thinking about those three elements has shifted fundamentally with a very positive sense of what's possible as opposed to what I remember which was sort of resignation that well this is the best we can do.

Mark Masselli: We are speaking today with the Editor-in-Chief of Health Affairs, a leading peer-review journal. Before that, Mr. Weil was Executive Director of the National Academy for State Health Policy, a non-partisan organization, helping states achieve excellence in health policy and practice. On he focused much of your efforts on improving population health on the state local levels, you work at NAHP and the Urban Institute centered on the importance of state policy directors being essential to improve population health, and what do you see in the states, what's exciting about population health?

Alan Weil: When I think about the Affordable Care Act it creates a number of tools that states can use, the coverage expansion creates a financing mechanism to give people access to care, the changes in Medicare payment are catalyst for thinking about accountability in healthcare system. So between state and local, there are opportunities to think more holistically about the health of the population and particularly to identify priorities for action. And so one of the most powerful efforts that I observe is when a community looks at its own population health statistics and they say we really need to focus here on children with asthma who are ending up in the hospital when with appropriate preventive services, they wouldn't have to do that. Then you cannot just generalize about population however you can harshness the resources of the community to actually do something concrete.

Margaret Flinter: I think it ties to something that you have talked about this federalism and healthcare. And there has been this fierce debate on states rights that the Affordable Care Act precipitated. So may be talk just a little bit

about this new federalism and also do you see the possibility of increased regionalism coming into play around healthcare in the future?

Alan Weil: Well, we are certainly seeing regional differences in the response to the Affordable Care Act. And many of our largest cities set on state borders and so certainly, the opportunity to work across state lines to try to solve problems is a practical necessity. And we do see right now I think it would be in naïve to deny that the Affordable Care Act embraces an activist role for government in a healthcare sector. It says we have a market failure. We have lot of people who can't afford coverage and we are going to solve that by resources to those who otherwise wouldn't be able to afford it. And that **raw [PH]** conception of the word that the state has a primary role in addressing their social problem that not everyone agrees upon and we have regional differences and the view of that. So some of this is state federal but actually much of the attention around the Affordable Care Act is just around public sector versus private sector and the role of government no matter what level. Now what I have not seen is a serious effort to define an alternative pathway to achieving the goals of the Affordable Care Act. On the one hand, the state roles and implementing the law are many and that's been my focus for some time. But a national division over the role of government is somewhat discussion than division over whether it should be federal or state and I actually think a lot of the opposition to the Affordable Care Act is much more about role of government than it is federal versus state.

Mark Masselli: We want to spend a little time talking about payment reform, Massachusetts started off, it's initial reform and they have some good outcomes in terms of their access issues. But talk a little bit about the landscape around payment reform.

Alan Weil: The Affordable Care Act was a catalyst. It's happening in the private sector as well as in the public sector. The term often used as Accountable Care Organizations and the idea is to pay for the care of a population and to reward those who deliver cared to that population. They can keep depending on the payment models on share of what they save by reallocating their resources so there is no question that this is a real phenomenon. Payment reform is a tool and the real question is what the goal and then you can ask given the goal what kind of payment will support the goal. And to then reimburse them, pay them for each thing that they do on the expectation and understanding that what they did was valuable. Well, we are now starting to understand and many physicians would agree that a lot of what they do is not valuable, interventions that help people live a healthier life tend not to be paid nearly as well as cutting someone open and fixing something their body or scanning them.

And so payment reform for what to enable those who delivered care to think differently about the choices that they make. But that then gets to our quality matrix, our quality matrix are still fairly primitive particularly when it comes to people with complex healthcare needs. Again returning to my federalism

routes/roots, I would say that the working out of the meaning of quality and the purpose of payment reform is something that is much better done locally or at the state level than nationally that our efforts to change payment at the national level tend to be pretty clunky. They are directionally appropriate but the details are complex and they need to be worked out by people who are sitting around the table with trust who can say this is how we are going to measure quality, yes this is how patients view quality, this is how clinicians view quality, this is a payment model that will support. That's – from my perspective, that is by necessity a local discussion and it's what ties all of these topics together.

Margaret Flinter: We have been speaking today with Alan Weil, Health Policy expert, and Editor-in-Chief of Health Affairs, the leading peer-review journal on health policy. You can learn more about his work by going to www.healthaffairs.org and you can follow him on Twitter by going to www.twitter.com/healthaffairs. Alan, thank you so much for joining us on Conversations on Healthcare today.

Alan Weil: It's been a pleasure.

(Music)

Mark Masselli: At Conversations on Healthcare, we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org, a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Well, in a new twist a democratic group is attacking a republican senate candidate for supporting "government-run healthcare." That phrase has been a mantra for republicans attacking the Affordable Care Act and those who support it, but neither this new democratic attack nor the old republican ones are true. The democratic group senate majority pack is (inaudible 20:25) attacking the Representative Bill Cassidy, Louisiana Senator Mary Landrieu, main GOP opponent. It says Cassidy wrote a plan that's been called Obamacare lite. True, it was called that by an opinion columnists but it's not an accurate description. In the 2007 Bill Cassidy wrote while Louisiana State Senator wouldn't have created "government-run healthcare," add claims with government bureaucrats making medical decisions. There is nothing like that in the bill which would have set up the state insurance exchange to serve as clearing house for individuals and businesses by insurance.

The proposal also was a far (inaudible 21:06) from the federal Affordable Care Act which didn't exist at the time. Cassidy built didn't include subsidies for low income people, a mandate to have insurance or pay fine or a set of essential health benefits that insurance had to cover like the ACA. The Louisiana Bill

called for state officials to come up with new health insurance proposal design to reach universal coverage in the state but that never happened. The bill died quietly in committee without even a public hearing. Cassidy meanwhile has (inaudible 21:36) attacking the ACA saying he voted against it because it would lead to cancel plans, expensive premiums, no guarantee that you could keep your doctor. But that was all true before the federal law was passed. And that's my fact check for this week. I am Lori Robertson, managing editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, e-mail us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. According to Michigan Organic Farmer, Michele (inaudible 22:31), healthcare spends too much time and money trying to fix the problems that are caused by a poor diet that the powers would be at the Henry Ford West Bloomfield Hospital, I agree with her. For years she had offered organic food growing and cooking demonstrations at the healthcare facility just outside of Detroit. But when officials drew up plans to renovate the hospital three years ago, they decided to take it to the next level. A million dollar certified organic hydroponics greenhouse and garden were built and less as hired away from her farm to run the operation.

Michele: We really wanted to change the way that food culture was done in a healthcare setting. When you have the opportunity to heal someone it is very important that what they are eating becomes part of that plan.

Margaret Flinter: The facility now provides most of the nutritional organic greens, vegetables, fruits and (inaudible 23:16) used in the food that is prepared there, not just for patients who come there to heal but for their families and hospital staff as well.

Michele: It's rather seasonal. In the winter time and in the fall, we changed to more "tolerant" crop and then in the summer time like this time we are now transitioning to the point where we were picking tree, tomatoes, and we had sweet peppers, and things like that that we will be supplying for the kitchen.

Margaret Flinter: (Inaudible 23:38) says there is an educational components for the program that's ongoing and multi-generational.

Michele: Right now, we are averaging 3,000 students per academic school year that go to Healthy Habit program. We have a demonstration kitchen inside of our hospital and then we have the greenhouse right behind the hospital. So we utilize those components to make sure that we have (inaudible 23:58) especially our use and our community what does it take to have the foundation of Healthy Habits.

Margaret Flinter: And hospitals chefs worked to incorporate more super greens and medicinal herbs into their recipes reducing the reliance on sugar and salt for flavors. The nation's first hospital based year around certified organic hydroponics greenhouse one that provides fresh fruits and vegetables to patients who are healing and the clinicians working to heal them, improving health and well-being for the assistant community wide and teaching the next generation about the benefits of organic produce for healthier diet.

Michele: The idea of being just the hospital doesn't work anymore. You have to be a community center for wellness.

Margaret Flinter: Now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.