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Female: Welcome to Conversations and Health Care with Mark Masselli and Margaret Flinter, a show where we speak to the top thought leaders in health policy, health innovation, and the great minds who are shaping the health care of the future. This week, Mark and Margaret speak with Adam Boehler, Senior Advisor to HHS Secretary Alex Azar, Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services. Director Boehler discusses their new initiative to transform primary care in this country, creating incentives that will pay clinicians for value and outcomes not volume of services delivered.

Lori Robertson also checks in Managing Editor of FactCheck.org, looks at misstatements spoken about health policy in the public domain, separating the fake from the facts. We end with a bright idea that's improving health and wellbeing in everyday lives. If you have comments, please email us at CHCradio@CHC1.com or find us on Facebook, Twitter, iTunes or wherever you listen to podcast. You can hear us by asking Alexa to play the program Conversations on Health Care. Now stay tuned for our interview with Adam Boehler, Director of the Center for Medicare and Medicaid Innovation on Conversations on Health Care.

Mark Masselli: We're speaking today with Adam Boehler, Senior Advisor to Health and Human Services Secretary Alex Azar and also Deputy Administrator and Director of the Center for Medicare and Medicaid Innovation, also known as CMS Innovation Center. Prior to joining the federal government, Mr. Boehler was Founder and CEO of Landmark Health, a company that provides at home health care for chronically ill and vulnerable populations. He also held several executive level positions at other health industry entities. He graduated from Wharton School at the University of Pennsylvania. Adam, welcome to Conversations on Health Care.

Adam Boehler: I'm happy to be here.

Mark Masselli: You know, we read in Forbes Magazine that you're being described -- HHS is running the most important agency that very few people have ever heard of, we heard of it, the Center for Medicare and Medicaid Innovation. It was created to test new ways to both improve quality and drive down cost at the country's major health insurance programs. When you add up all of the people who are in Medicare, Medicaid and the CHIP Program, the Children's Health Insurance Plan, it's roughly around 120 million Americans. There's been significant acceleration of new rules at HHS and CMS to advance those larger goals, getting better quality care and reducing cost. What's driving this acceleration activity?

Adam Boehler: I think we're at a crossroads in health care costs, the Medicare trustees report amount of money for Medicare, looks like it'll run out by 2026. We're now at a point where roughly one in every $5 spent is related to health care. It's funny I was looking at spend in different areas in government over the decades, and health care is one of the only spends that continually increases as a percentage, it's cut out from 10% to 20% over the last several decades. I think we need to accelerate our efforts to think about how we do things differently. The goal of CMMI is to change payment to lower cost and improve quality for patients. The most difficult things about our health care system today is that we pay for volume. When you pay for volume of services, our system called fee for service, then you get volume of services. A lot of what we're thinking about is how do you shift from a system that pays for volume to one that pays for outcomes.

Margaret Flinter: Well, Adam, let's zero in on the most recent initiative that was released aimed at transforming primary care. The Department of Health and Human Services has announced an ambitious strategy to shift primary care away from the historic fee for service payments to a system that pays for outcomes. You have long been a proponent of blowing up the fee for service system and the person who's really guided the development of this new CMS Primary Care Initiative. How does it work? What do you see the role of federally qualified health centers, community health centers in this innovation as well?

Adam Boehler: Sure, I have been quoted as saying blowing up fee for service, and it's an easy and kind of fun thing to say.

Margaret Flinter: Right, hard to do.

Adam Boehler: But a lot more difficult -- yeah. There's really two very important things. One is a very strong commitment to primary care, primary care is 2 to 3% of Medicare spent, but it's so much more important. The second thing is what does an outcomes or value based system really look like? What was important to us, if you wanted to design an outcome based system that works for every physician, not just large groups, but down to the individual doctor, and so there's really two tracks to our primary cares initiative. The first is, for smaller physician groups, the initiative is called primary care first, where instead of paying a fee for every service, we're going to pay a simple payment, half monthly, half simple visit. Then physicians will have a downside risk amount of about 10% and a symmetrically high upside amount of 50%.

If you're a primary care physician today, and let's say you make $150,000, you would have downside of $15,000 if your patients went to the hospital and didn't stay healthy. You would have an upside of 50%, so you would make significantly more from 150 to $225,000 if you are one of the leaders, and keeping your patients healthy, and at

home. Physicians didn't go to medical school to churn and burn through patients every five minutes, they want to spend time with their patients. Our goal has been, let's get time off of the computer and let's simplify so that we can spend time with patients and those patients that need it. The second track is called direct contracting, that is very sophisticated physician groups are going to say, you know what, if you have a whole bunch of patients and you would like, you can take full cost of care accountability for those patients.

It's very hard for the central government to manage every aspect of health care. If we can empower local physicians and local communities, that's going to be much more effective, they know their patients. That's not what our job is, our job is to empower and enable them. To your third question around federally qualified health centers, part of the things whether they're primary care physicians, they can partner up to form direct contracting entities. I would imagine given the role of F2HC the important role in serving communities that they would certainly be a part of this.

Mark Masselli: Adam, I think it's axiomatic that the folks who lead HHS, CMS think about data is a force multiplier, and obviously, that data needs to be good. But you're also thinking about data in another bold way, and you've announced a plan to make electronic health data available to all patients on their smart phone at no cost. I can't say enough about how exciting that is, at this year's health data Palooza [PH] you recently addressed that gathering to talk about another program and that's the AI data challenge. I'm wondering if you could talk about the drive to move data more freely into patients hands, getting developers to create a better artificial intelligence to take on this new challenge of moving from volume to value.

Adam Boehler: If I were to simplify our two jobs to lower cost and improve quality, I come to two things, release the data and change the incentives. We sort of spoke earlier about the change the incentive aspect and -- but on the release of data, you'll see a lot of CMS's interoperability efforts are focused on that area. This country spent billions and billions of dollars on electronic medical records. Really what we got are revenue cycle systems that don't speak to each other. The interoperability initiative is saying, hey this need to speak to each other, and we need to be able to freely exchange data. We need to empower patients and their physicians, that's patients information, if they want it they should be able to get their own data. We don't want to hear stories of I can't get my own data, that's yours, or here's a CD-ROM with your data. I'm not sure about you, but -- I mean, why don't they give me an eight track ---

Mark Masselli: My old Mustang might have them but outside of that ---

Adam Boehler: Exactly. You can go and listen to your patient's record maybe in your

Mustang. Then we just introduced an AI channel, the million dollar challenge. What we're saying is, as we're releasing this data what can we learn so that we can help physicians treat their patients and if you're a primary care physician, you're going to have 2500 patients. I want that one physician, Akron, Ohio, to have all the learnings of every physician in the United States, so that when something presents to him, that's unusual, somebody can update and say, hey look you may want to look for this.

One of the concerns that comes up around AI is, oh does it dehumanize health care? I would posit just the opposite. If you have a good technology that takes the technical time out, it actually humanizes medicine because it's going to enable the physician to spend more time with the patient, so that's the goal, the challenge. We're really saying, hey how can we reinvent metrics now that people are going to care about keeping people healthy at home, since we've created those incentives?

Margaret Flinter: I want to go back for a moment to the initiative to transform primary care. You've talked about payment reform as one way to facilitate transformation and allow physicians and nurse practitioners and the PAs in primary care to really focus on their patients and not on the volume of visits. But another approach you've talked about is the idea of collapsing the office visit. Certainly, telemedicine and telehealth have an important role to play here. But what other strategies are you recommending deploying in this pursuit of collapsing the office visit that might spur this kind of transformation that you're seeking?

Adam Boehler: What we need to do on all these is how do you modernize definitions of things? Does the hospital have to be in physical location, if it can provide the same services. 20 years ago, yes, because there is no other alternative. Now, that may not be the case, there may be hospital services that can provide it in a 24/7 cents at home, as an example at the very high queuing side. Then as you go on the telemedicine side, there may be plenty of opportunities for visits. I think at the end of the day, our job is to define services but then empower patient choice.

If somebody would like visits over video, then I think as long as the clinical value is there, our job is to kind of remove regulation and then empower things like that. We hear a lot from rural communities, and what models are appropriate for them, because we need to consider of those challenges as well. We're looking at ways and working with rural communities that we can help transform, maybe from more of a hospital based setting over time toward behavioral health more than the ambulatory setting. I think there in particular, we need to be flexible on what will work for patients there.

Mark Masselli: We're speaking today with Adam Boehler, Deputy Administrator and

Director of the Center for Medicare and Medicaid Innovation. Adam I was thinking about the number of folks that are heading towards having full onset of diabetes. I think it's one third of all Americans by 2050 and not only sort of the personal impact, but the associated health costs are just staggering. You all have been thinking about ways to start moving dialysis into the home, finding ways to prevent end stage renal disease. Talk about the work you're doing to dramatically increase home dialysis.

Adam Boehler: The current status quo cannot continue between the end stages of chronic kidney disease and then renal failure. We spend about as much as we spend on drugs in the United States. I mean, you're talking over $100 billion of spend a year. I think our system is set up to wait till somebody has end stage renal disease and then treat them in dialysis in a center. Not only does it cost a lot, but a patient that's in a center and spending hours and hours on a daily basis really loses their ability to live an independent life. The quality outcomes are not great, and so we've been saying how do we re-envision this sector. It hasn't been alone, I mean, we've been doing this with the dialysis centers, and other physicians, primary care.

In the United States today, about 11% of Medicare patients did dialysis in the home. In Hong Kong that’s 75%. Then when you get dialysis at home, not only is it lower cost but you’d have better quality outcomes. We want to change the system to one that says okay, as somebody is progressing, and they have chronic kidney disease and they're going up the levels, there's five levels of chronic kidney disease, let's slow that progression by focusing on different preventative services so that people don't ever get from CKD4 or 5 end stage renal disease. If they get the end stage renal disease, let's get a transplant as soon as we can, let's get them home for dialysis if it's appropriate as a last resort. It’s kind of reversing in that direction.

Margaret Flinter: Yeah. For a moment, let's go way upstream. You really are proposing some ideas that are gaining traction about using resources to pay for the upstream issues that can impact health and prevent the onset of disease. I don't think this is widely known that CMS has issued a rule allowing the Medicare advantage dollars to be utilized for such things as fresh produce, or even carpet cleaning for people with lung disease. We also saw that the innovation center announced updates to the model of value based insurance design which offers Medicare advantage plans flexibility to offer more tailored benefits that might be completely non medical interventions, but yet have a chance to make a big impact on overall health. This is a concept that's been around for a long time, but still not monetized. Tell us more about your vision for reducing medical cost through interventions like these upstream approaches.

Adam Boehler: Secretary Azar and I have four focused areas for transformation of health care. The first is patients as consumers, the second is providers as accountable guides, the third is paying for outcomes, and the fourth is prevention of disease before it occurs. Between Medicaid and Medicare today, we spend about 1.3 trillion a year. The only way that we're going to significantly change that is by prevention and preventing disease. I used to run a large physician group that took care of patients in their homes. We would have Medicaid patients that would not have homes that would be homeless, that would go to the hospital, significant amount of time in a given month, sometimes honestly just because they were lonely. I'm very interested in how can we invest to be proactive.

Other programs, I think there has -- a food program called Farmacy with an F, where they're giving healthy food to a diabetic patients. Not only are the patients doing a lot better, they've saved a lot of medical cost. If I'm saying to a large physician group or provider, you have accountability for your community, as long as they're doing it in appropriate way, why wouldn't they be able to invest with certain populations in these areas. They're going to have a better sense on the ground at what's going to work, our approach is to say, hey, let me create an accountable structure and let's empower local communities and providers to offer services like this.

Mark Masselli: One of the cost of health care people don't often think about is the cost of moving patients to where they can get care. We've been focused in on one particular area which has been e-consults which I know CMS has been supportive of. But sometimes you have to move the patients to where they can get care. Your department is exploring really new initiative, emergency triage, treat and transport which will incorporate multiple treatment options for EMTs in the field. Utilizing these EMTs not just to transport to the hospital, talk to us about this concept.

Adam Boehler: It was funny when I started at CMMI they said, hey I'd like to hear from the team. I say, what are your best ideas to lower cost and improve quality? Somebody came up and said, well I've been talking with the fire department in New York and when you call 911, he said I don't know if you know this, but they're only paid if they take people to the hospital, and that was surprising to me. I thought of the incentives. Obviously, that creates kind of a poor incentive. We met with the chief medical officer there, he said 30 to 50% of the people that we take to the hospital, we certainly don't need to. We could either treat them in place, or we could take them to an alternative destination, like an office location for physician or behavioral health center. We would just lose so much money if we did that, and that's what patients want.

We want to kind of create a neutral incentive. You're paid to do what's right for the patient, and not open it up, so they're paid for treating place. Also, for alternative destination, they can listen to what the patient and the situation demand and do what's right. My favorite thing about the initiative actually is he said, Adam if we're allowed to do this, we have a fixed amount of ambulances. The key if somebody really calls 911, because they need it, they're having a heart attack, they're having a stroke, response time, the most critical for every minute of response time, our survival rate is so much better if we get there quicker. What you're doing is you're focusing those trips at the hospital where people need them and so our response time is going to improved and we're going to save lives too. I think it was really kind of a win all around.

Margaret Flinter: We've been speaking today with Adam Boehler, Deputy Administrator and Director of the Centers for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services. You can learn more about their work by going to innovation.CMS.gov or you can follow Adam on twitter @AdamCMMi. Adam, we want thank you for your creativity, your commitment to innovation, and for joining us on Conversations on Health Care today.

Adam Boehler: Thank you, Margaret, thanks Mark.

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Mark Masselli: At Conversations on Health Care we want our audience to be truly in the know when it comes to the facts about health care reform and policy. Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org a nonpartisan, nonprofit consumer advocate for voters that aims to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Senator Bernie Sanders introduced the latest version of Medicare for all legislation on April 10th with 13 democratic co-sponsors, including four other presidential contenders. Senators Kirsten Gillibrand, Kamala Harris, Elizabeth Warren and Cory Booker, let's take a look at what Medicare for all would be. As the name indicates, Sanders's plan would expand Medicare, which now covers primarily those age 65 and older to everyone, creating a new universal single payer health care system in the United States. The Veterans Health Administration and Indian Health Service however would remain.

The new universal Medicare program would cover comprehensive health services, including dental hearing and vision coverage, which aren't included in Medicare benefits now. There would be no copays, deductibles or premiums with the exception of prescription drug co-pays capped at $200 per person a year indexed for inflation. The bill calls for everyone to get a Universal Medicare Card four years after

enactment of the legislation. As for private insurance, it could still be available but in a very limited role. It could only be sold to cover additional benefits that the new universal system didn't cover. There's also the potential for direct pay private contracts between health care providers and individuals for services for which the provider will not seek reimbursement from the government.

The Secretary of Health and Human Services would set a global budget each year, set fee schedules for providers and negotiate drug prices. As for what the plan would cost, there's no firm price tag. The Urban Institute estimated in 2016 that a similar plan put forth by Sanders would increase all national health spending by $6.6 trillion over 10 years. It would increase federal spending by 32 trillion over 10 years. Sanders has proposed various suggestions up for debate on how the plan could be financed, including through payroll and income taxes.

A house version of Medicare for All is co-sponsored by Representative Tulsi Gabbard, Tim Ryan and Eric Swalwell who are also running for president. Other congressional bills would make much less sweeping changes. They call for a public option based on Medicare or Medicaid in the Affordable Care Act exchanges and Medicare buy in programs at age 50. That's my fact check for this week. I'm Lori Robertson Managing Editor of FactCheck.org

Margaret Flinter: FactCheck.org is committed 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'd like checked, email us at CHCradio.com we'll have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

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Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. Baltimore, Maryland has one of the highest emergency medical call volumes in the country and it results in a significant number of patients being taken to the ER for conditions that could have been treated outside of the ER. The University of Maryland Medical Center and the Baltimore City Fire Department teamed up in the hopes of reducing unnecessary ambulance trips and hospitalizations. They created a new pilot program which pairs doctors and nurses at the hospital level with paramedics in the field, bringing medicine right into the patient's homes.

Male: We monitor the 911 system so that we co-dispatch a paramedic and either nurse practitioner or doctor to the scene of low acuity calls. Ask the patient what they would like to be treated as scene. We then treat them at scene, discharged them with prescriptions as needed.

Then we follow up with them within 24 hours to make sure they got what they need.

Margaret Flinter: Dr. David Marcozzi of the University of Maryland Medical Center says that this mobile Integrated Health Care Community Paramedicine Program has a two prong goal. One, reducing unnecessary trips to the ER, two, to keep vulnerable patients being released from the hospital healthier was paramedics doing frequent follow ups over a 30 day period.

Dr. David Marcozzi: For THS or the Transitional Health Support the 30 day follow up program, our data demonstrates that the patients who are followed in our program are admitted to the hospital significantly less and utilize their primary care services significantly more. That translate into lower cost to the system, from a physician billings construct, from the hospital construct, from an ER construct.

Margaret Flinter: Dr. Marcozzi estimates that the two year pilot will save the University of Maryland Medical Center at least $4 million and the fire department expects to save just under 2 million. The Mobile Integrated Health Care Community Paramedicine Program rethinking how paramedicine is deployed in the field, reducing unnecessary emergency room trips. Now that's a bright idea.

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Mark Masselli: You've been listening to Conversations on Health Care, I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Peace and health.

Female: Conversations on Health Care is recorded at WESU at Wesleyan University, streaming live at CHCradio.com, iTunes or wherever you listen to podcast. If you have comments, please email us at CHCradio@CHC1.com or find us on Facebook or Twitter, we love hearing from you. The show is brought to you by the Community Health Center.