(Music)

Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well Margaret, I just want to take a moment to remember a pioneer in our midst and a woman who stood at the very foundation of our health care journey here, one of our founding board members of the Community Health Center, Lillian Reba Moses, passed away on October 18th and I can't stress enough how inspirational, how vital, how important she was to our mission. She inspired us to do great work for people who have been forgotten and unseen.

Margaret Flinter: Well Reba was really the heart and the soul of our founding belief that health care is a right and not a privilege. And she showed that spirit in her words, in her deeds and her life, always inspiring us try to do better, do more in our health care quest.

Mark Masselli: She was so many things to so many people: a community activist, a pioneer, a mother of her own to six great children and to many more, a tireless advocate, a foot soldier in the war on civil rights and poverty in America and right here in Connecticut but most importantly, she was a caring, gracious, inspiring lady, a great friend and certainly somebody who we will miss.

Margaret Flinter: And she gave us this opportunity to continue to serve all of those who need quality health care. So I would say her legacy and her work goes on.

Mark Masselli: You are right. The Affordable Care Act will likely go down as the lasting legacy from President Obama. Here we are down to the final two weeks before the Presidential election and it's just simply too close to call.

Margaret Flinter: Too close to call and if ever was time for a good cliché I will use the one ‘every vote matters’; this no time for voter apathy.

Mark Masselli: And it would be a shame to see those efforts derailed after so much hard work and progress on health reform.

Margaret Flinter: Well Mark, I am sticking with the position that most of the reforms that are legislated under the Affordable Care Act are going to go forward no matter what happens.

Mark Masselli: And our guest today can shed some light on how near-universal coverage is working in the State of Massachusetts. Robert Mechanic is a lead

author on a report. And it's the first in-depth study looking at the impact that statewide health coverage has had on cost containment in health care.

Margaret Flinter: And he will share his insights on how measures passed in Massachusetts have set health care spending targets for the state that lead to real cost containment.

Mark Masselli: You know, and he will also look at the rapid growth of the public-private partnership to meet the (02:22 inaudible) in the health care law in Massachusetts that could provide an excellent example for other states to follow.

Margaret Flinter: And in our neighboring State of Massachusetts, Governor Deval Patrick announced last week that the expanded health law in that state was having a real impact on outcomes as well as an effort to contain cost. Screening for cancer up, smoking down as more people get regular preventive care and have access to primary care.

Mark Masselli: Well the governor was a great guest on our show and you can hear that interview and other shows just by Googling us at CHC Radio.

Margaret Flinter: And as always, if you have comments, please email us at www.chcradio.com, or find us on Facebook or Twitter because we love to hear from you.

Mark Masselli: We will also hear from our own FactCheck.org's Lori Robertson.

Margaret Flinter: We will get to our interview with Robert Mechanic in just a moment.

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

(Music)

Marianne O'Hare: I am Marianne O'Hare with this Headline News. It's the home stretch of the campaign and the political ads are amping up at least in the key battleground states like Florida and Ohio, and women and seniors are figuring prominently in both campaigns. In one ad, President Obama is shown in a café setting, surrounded by seniors, promising not to voucherize their Medicare. Romney's ad is showing a concerned woman sitting at a kitchen table worried about the growing national debt. The third and final debate between the two candidates focused on foreign policy, little mention of health care. Meanwhile the race is still a statistical dead heat.

One of the provisions of the Affordable Care Act is starting to have an effect. Insurers were ordered by the act not to deny coverage to any children up to age

19 with preexisting conditions. Initially some insurers stopped selling child-only policies. Now some 22 states across the nation have plans for children that insure their complete access to coverage.

Speaking of children, boys are hitting puberty at an earlier age than in recent generations. A study out shows African-American boys start the process the earliest at around 9 years of age, Hispanic boys on average are now launching into that process at 10 years of age, and Caucasian boys 10.1 years of age. Experts who conducted the study say they don't know what the cause is but they suspect it's something in the environment. I am Marianne O'Hare with this Headline News.

(Music)

Mark Masselli: We are speaking today to Robert Mechanic, Senior Fellow at the Heller School of Social Policy and Management at Brandeis University. Mr. Mechanic is Executive Director of the Health Industry Forum, a national program established to develop practical strategies for improving the quality and effectiveness of the US health care system. He is the lead author of the report out in health affairs this month which analyzes the recently passed laws governing health care cost containment in Massachusetts. Robert, welcome to Conversations on Health Care.

Robert Mechanic: Yeah. Well Mark, it's a pleasure to be here. Thank you.

Mark Masselli: You know ever since Massachusetts passed health reform for all six years ago it's really been a laboratory for researchers. And your team recently published an in-depth analysis of the progress being made in the State of Massachusetts on health cost containment and payment reform and we have had several great guests from Massachusetts on the show including Governor Patrick saying coverage was the first step but that cost containment was going to present a much bigger challenge. I wonder if you could describe how achieving near full coverage in Massachusetts has changed the health cost landscape in that state.

Robert Mechanic: Well, you know as you recall, Massachusetts expanded coverage in a way that's similar to the Affordable Care Act. First of all, there is now mandate that individuals have coverage. Secondly, we have significantly expanded the Medicaid program. And then the third is we have created a series of new subsidies for individuals to purchase private health insurance whose incomes are below a certain threshold. And the costs of these expansions are primarily going to be shared between the state government and the federal government. So when this bill was passed, there was a broad coalition of support in the state, which included the health care providers, insurance plans, employers, consumer groups, and of course, the policy community. But, as they were passing this they realized a couple of things; one is, you can't force

individuals to buy coverage if coverage isn't affordable and the second is, because the state is picking up new cost for this coverage, state spending has been very tight not just in Massachusetts but all over the nation. And I think people realized it would be very difficult to sustain these reforms over a long term if they did not at the same time address costs. In sort of traditional thinking of how to contain costs there are some simple ways you can do it. One is that you can limit coverage from programs; obviously the state was not going to do that. The second is reduced benefits. Third is to cut payments to providers and fourth is to try to improve the system. And once you have made the commitment to universal coverage, well coverage and reducing benefits are off the table so you are really left with provider payments improving the system. And I think as we look to this bill, the focus here is on improving the system going forward.

Margaret Flinter: Rob, Massachusetts, as you have said, had this challenge to get to this near full coverage in the state, and that generated a public policy culture that really seems to now support cost containment measures. And maybe other states have focused more their efforts just in the Medicaid arena but in Massachusetts the cost containment culture really focus both on public and private sector. So I would like to take a look at the first of the three cost containment measures in Massachusetts, the act to promote cost containment, transparency and efficiency that focused on cost transparency. But one of the things that they revealed in that transparency was these enormous differences in payments being paid to providers by insurance companies for the same procedures and services. Maybe you could share with us what did this revelation accomplish and has it affected the cost and payment models at all?

Robert Mechanic: Well I think there has been lot of focus particularly in the difference in rates and so there has been a lot of focus on the provider groups that have been on the high end of the rates. And I think a lot of public pressure, pressure on the newspapers and so forth because nobody likes to see themselves up there as being the most expensive. The other thing though that they looked at besides the specific rates was there are wide differences in the total cost of taking care of a population of patients. And so I think that's gotten people to focus on the second piece, price is important but also what's important is how effectively is care coordinated. Particularly as we think now about budgets or global payments, you want the health care system to really think about making sure that people get the right care at the right time, that they use appropriate settings of care and not use the emergency department when care is available in clinics or urgent care, and you want to avoid unnecessary care or duplicative care. So I think this report put some of the focus definitely on the overall cost of care and both the price issue but also the care coordination issue. And I think it's made the whole system really look inwardly and I think the people who are on the high end of the list have some motivation to move themselves down towards the middle if possible.

Mark Masselli: You know Rob, I want to pull on the thread of “As Goes Massachusetts, So Goes The Nation” and you guys are leading the bell curve on so many things. And there is a lot of scrutiny on health care payment reform in Massachusetts, and with that, new transparency has led to a push towards global payments to providers, again, a big shift in payment culture in Massachusetts. Describe the global payment model on how the state was able to enlist the supported health care and business community to make the transition to this model and what does this really mean for the various stakeholders as well.

Robert Mechanic: You know Mark, the first thing I would say is we are part of the way along the way with global payment but it's not all the way. It's not clear that it would really make sense to try and get the entire state under a global payment. In Massachusetts, we have a large number of integrated health care systems. They have hospitals and doctors that work together; they have shared electronic medical records and so forth. And these type of health care systems, they have the tools and the integration that would allow them to manage health care on a budget or a global payment. It's probably true that small physician offices or some of the independent community hospitals, if you try to put them on a budget, you are really putting them at risk for total health care spending. And so I think we moved quickly in part because of the structure of our system but I would also question how far down that continuum we should go.

One of the benefits of global payment is for an integrated system it allows them to say rather than to get paid we have to do more services. They say we are working on a budget now, what's the best way to provide that care; how can we provide it more efficiently? And so I think ultimately, these integrated systems combined with a budget that is perhaps growing more slowly than it has historically provides the best way to really reward these groups for improving the way they deliver care. But it's going to be slower I think in many parts of the rest of the country than it is here and the federal government is going in with a somewhat alternative model. So you have heard of the Medicare ACO program or Shared Savings Program, they are starting that I will call it sort of a foot in the water by putting people on a budget but saying you can keep the proceeds if you save money but if you spend more, well in the first several years, we are not going to make you pay the money back. But overtime I think the federal Medicare Program wants to move in the same direction with their ACO Program.

Margaret Flinter: Rob, the next set of cost containment measures, and these were passed in 2010, focused on the individual insured and the small business market, which is the same market that we think will see the biggest growth in coverage under the Affordable Care Act in the exchanges. And that measure gave the Insurance Commissioner of Massachusetts the power to decide whether changes to insurance rates for that group were excessive or unreasonable, and I understand it also required insurers to offer a discounted plan option and also maybe describe these discounted plans, how do they compare with the concept of the essential benefit plans as outlined under the

Affordable Care Act and what kind of impact has this had on both cost containment.

Robert Mechanic: Sure. Well let's start with the issue of setting a cap on the small group growth. And that was a little bit of a shock to the system. Now remember that insurance plans don't negotiate difference sets of rates for the small group market and for the large group market; they have one contract with each major provider. So with the state coming in and saying, wait a minute, you can't raise your rates more than a set level, they look at that and say, oh boy, well we have got all these contracts out there and we have to find a way now to get our contracts in line with where the state is holding us on a small group in individual market. So actually it affects the whole market not just the small group from the perspective of the insurers. That really I think has changed a little bit of the dynamic of negotiation. It's forced them to go back and be much tougher as they sit down with the groups looking at the rate increase because they have got the state axe over their head to keep the rates down. So it really changed expectations in the market. So providers are looking at it and saying, they are expecting the insurers to come in and negotiate harder and try to bid lower rates.

With respect to the discounted plan option, that's a so-called tiered benefit option or a narrow network option. So what the law required is it required insurers to offer at least one of these plans. They would pick a network of lower cost but good quality providers and say this is your provider network, you cannot go outside of this network, or at least not with paying more. And so by virtue of using these lower costs more efficient providers, it would bring the premium down 12% below a standard plan. Now you asked about the essential benefit plan. Massachusetts actually setup its own what they call the Minimum Creditable Coverage. So when they passed health reform in 2006, they gave our health insurance exchange which is called the Connector and they said, look, we have to make a decision about what is the base minimum coverage. So the state set its own minimum creditable coverage. This new law for these discounted plans doesn't change the benefit per se, what it is asking for is for the insurers to come out with a more limited network of providers that I will say it reduces access to the highest cost, most expensive hospitals and doctors out there.

Mark Masselli: We are speaking today with Robert Mechanic, Senior Fellow with the Heller School for Social Policy and Management at Brandeis University. Mr. Mechanic is Executive Director of the Health Industry Forum, a national program established to develop practical strategies for improving the quality and effectiveness of the U.S health care system. He is the lead author of a report out in this month's Health Affairs, which analyzes the recently passed laws governing health care cost containment in Massachusetts. Rob, the state most recently passed a cost containment measure this summer that had very stringent regulations to govern cost growth but you say it lacks enforcement measures. So tell us a little bit about the things that are lacking but also tell us about what it

does do and why this should accelerate the pace of cost containment efforts in Massachusetts.

Robert Mechanic: This is the first time that a state has ever set a health care spending target that covers the entire system. So it really encompasses spending for Medicare, for Medicaid and for private health insurance and for what consumers pay out of the pocket. And they have tied this spending target to the economy. So essentially what they would like to do is bring the long term growth in health spending down to a rate of the long term growth of the state's economy, which they peg in the first year had about 3½%. Now remember historically, heath care spending has consistently overtime grown at 2% to 3% points faster than the national economy. So by saying, we are setting this target at the rate of economic growth that is a very, very stringent change. Now the second thing beside the target they have done is they have set up a new quasi-public agency, it's called the Massachusetts Health Policy Commission. So I would say the next couple of years they will be setting up the infrastructure, really an ability to track the health system that has never before existed. And then we will see how it goes and then the legislature will have to make a decision if they feel that the system isn't performing whether they are going to give the commission more powers.

Margaret Flinter: So Rob, as we look at all of these cost containment measures and payment reforms, it's clear there is a lot of change, an increased emphasis on creating and leading the ACOs on patient-centered medical homes, on the global payment models. Where is the expertise to lead all of this enormous systems change coming from? And I guess the secondary question would be, what are these institutions and organizations doing to prepare a next generation of leadership to lead radically different health care systems than what we have seen in the past in Massachusetts or anyplace else?

Robert Mechanic: Yeah. Well this is a very challenging thing because you are taking on these big complicated organizations that span across multiple sites and multiple providers and you are asking them to do their work differently. But the truth is this is very hard, very challenging long term work. You know you have to change culture; you have to get physicians who have been trained to be super smart and resourceful to now to work in teams. I think that the combination of the global payment model along with now this threat of really keeping the cost trend down has energized systems to begin doing the work they need to do. You said, where is the leadership? I mean I think this law sort of sets the context and sets expectations. But the leadership comes from within these systems, individuals, individual doctors and nurses and administrators who recognize that they are going to have to do their work differently. And I think these groups are most effective if they also think about how do I put the patient in the middle of this, how do I look at how we deliver care and think about what is really value added for the patient and where can I take out waste. What (18:35 inaudible)

global payment are doing are creating a different set of incentives. But I think the leadership is going to come from the rank and file, the people doing this work.

Mark Masselli: Rob, we like to ask all of our guests this final question. When you look around the country and around the world, what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Robert Mechanic: I have had the ability to spend some time over the last couple of months with a group in Cambridge Massachusetts, Cambridge Health Alliance. They are a safety net delivery system. They are actually in -- the majority of their patients were previously uninsured or on Medicaid coverage so they treat a low income patient population. And they have been working very hard to develop a series of medical homes and into an accountable care type of model. So we were going in to talk with a gentleman who was the Chief of Emergency Medicine. So we got there. There was one person sort of standing behind a podium; she took our names, she said, well let's go back and find (1928 inaudible). She comes out and says, well come on in. So we walked in and we sat down with them and I said, well it must be a slow day today, there is nobody in the waiting room. And he looked at me and said, no, he says, there is never anybody in the waiting room. He says, we are at 130% of capacity today but we have made the decision that nobody waits. We see them within 5 minutes; we don't worry about paperwork or their insurance until after we have taken care of them. And basically, this gentleman and his team had said, we are going to take on a different philosophy of taking care of patients, and it blew me and my colleagues away because all of us had taken a kid or been in emergency rooms ourselves and waited for hours and here is a system that decided to change and they did it, and I went 'wow'. There is one organization to look at but there are hundreds of them out there and the question is not whether we can develop these new models, the question is can we spread them and can we spread them fast enough.

Margaret Flinter: We have been speaking today with Robert Mechanic, Senior Fellow at the Heller School for Social Policy and Management of Brandeis University. You can find the report at www.healthaffairs.org and find out more about the Health Industry Forum at healthforum.brandeis.edu. Rob, thank you so much for joining us on Conversations on Health Care today.

(Music)

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 aim to reduce the level of deception in US politics. Lori, what have you got for us this week?

Lori Robertson: Well, Mark and Margaret, at last week's debate, President Obama made a comment about Planned Parenthood and mammograms. He said millions of women rely on Planned Parenthood for more than just contraception; he said they rely on it for mammograms for cervical cancer screening. But actually mammograms aren't performed at Planned Parenthood clinics. Doctors and nurses at the clinics do conduct breast exams and they refer patients to other facilities for mammograms. Some clinics do occasionally arrange for mobile mammography vans and they help low income patients find grants to help pay for mammograms. Planned Parenthood of Western Pennsylvania for example has a Breast Health Care Fund, which helps patients obtain mammograms. The president is correct to say that Planned Parenthood does more than just provide contraception. The largest category of services in 2010 was testing and treatment of sexually transmitted diseases, which accounted for 38% of all medical services, cancer screening and prevention like the breast cancer screening made up 14.5%, abortion procedures made up 3%. 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, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Health Care.

(Music)

Margaret Flinter: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives. In the never ending quest to find ways to contain health care costs, researchers at Brigham and Women's Hospital in Boston have identified at least one possible contributor. It turns out maximizing the use of hospital observation units has the potential for generating significant savings in the hospital setting. Lead researcher Dr. Christopher Baugh, an ER physician at Brigham and Women's, says, hospital observation units function something like a wait station for patients visiting the emergency room. It's for those patients not quite ready for either immediate release or full admittance to the hospital.

Dr. Christopher Baugh: This is a dedicated area where there are staff that are trained and prepared to take care of patients who are undergoing observation. And we put patients there who need more time for evaluation, serial physical exams, other things that take time beyond their typical emergency department stay.

Margaret Flinter: These observations units allow for the patient to be moved from the acute section of the ER to an adjacent area where they can be closely observed and monitored for another 24 hour period.

Dr. Christopher Baugh: If you are able to get a patient home within 15 hours versus 30 hours, and the more time that patient spends in the hospital the more risks you have for those infections or falls or other complications with being hospital patients and it's a dangerous thing to be. And if you don't have to be hospitalized then you shouldn't be and the observation unit allows us to be very efficient in getting people home.

Margaret Flinter: The researchers at Brigham and Women's determined the cost savings could be significant, as much as $4 million per year per hospital. The study suggests that number translates into $3 billion a year throughout the U.S. health care system. Dr, Baugh says this is a great way to meet new demands for cost containment while ensuring that patients get the quality care they need. The hospital ER observation unit closely monitoring patients in the ER before determining if they need further in-patient care, now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

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

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