Transcription of Healthcare Executive Group Webinar on Thursday, January 25, 2018

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Kim	Thank you for joining us. We're going to get started thank you for being here on time I know others may be joining us but we want to get started. So welcome to the first Healthcare Executive Group webinar of 2018. Our topic today is the 2018 HCEG Top Ten Health Care Opportunities Challenges and Issues. I'm Kim Sinclair the chief information officer at Boston Medical Center health plan and the chair of the board of HCEG. I'm excited to be hosting this webinar as HCEG kicks off its 30th year. HCEG is a national network of health care executives and thought leaders with the vision to promote transformation and innovation in healthcare.
Kim	HCEG brings together thought leaders from across the healthcare industry; payers, providers and sponsors to discuss strategic issues facing healthcare organizations today. Our mission is thought leadership through the collective contributions of a select network of healthcare executives and industry experts; while building relationships that provide critical access to market knowledge, resources and strategies. Members of HCEG established lifelong relationships that assist with current and future career development and advancement. We provide strategic development and mentor opportunities for member executives and provide insight and knowledge to advance our member organizations. These are just a few examples of the value of HCEG.
Kim	We're fortunate to have the sponsors you see on this next slide. Our sponsors bring industry knowledge from many perspectives in their work with payers and providers across the industry and provide HCEG members access to a broad range of ideas, strategies and experience.
Kim	David Gallegos from Change Healthcare is one of our panelists today. And David is one of our longtime sponsors. We're also joined by Ferris Taylor who has participated with HCEG for many years in many ways. I'm going to ask each of them to introduce themselves. David let's start with you.

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David	Thank You Kim. Good afternoon. I'm David Gallegos, the senior vice president Of Change Healthcare Consulting and I have been in the industry for about thirty years - both on the payer and provider side. And of course, the vendor side of the business. I've been with Change Healthcare for about ten years and have been part of the Healthcare Executive Group for about fourteen years. First as a CIO and a health plan executive and then as a sponsor. I'm very happy to be with you here today and looking forward to the discussion.
Ferris	And welcome everyone. I too am pleased to be on the call today, the webinar. I also want to congratulate Kim Sinclair. She stepped up this year. January is her inaugural month as our HCEG Board Chair. I occupied that seat last year. Most recently was the Chief Operating Officer of Arches Health Plan one of the coops based here in Salt Lake City - based in Utah. Likewise, as David, I have about 30 years in health care going back to the Harvard community staff model HMO days working with partners. And I spent about six years driving payer market strategy for Optum. It's a pleasure to be panelists with Kim to discuss the HCEG Top Ten today.
Kim	Thank you. The 2018 HCEG Top Ten was compiled and ranked at our annual forum in Nashville this past September. We started with a list of about 30 critical issues to be considered. And 115 health care leaders attending the forum voted on this list. We then took the HCEG Top Ten items and asked the same participants to rank the issues. What you see here is that final HCEG Top Ten for 2018. This is the 13th year of the HCEG Top 10, identifying the most current pressing priorities facing our industry. The HCEG Top Ten serves as a framework for future discussions, monthly webinars, blog posts and provides input into the agenda for our HCEG annual forum.
Kim	Throughout the presentation we'll be taking questions from participants through the chat box, which we will respond to later in the hour. So please feel free to submit your questions.
Kim	David, as you look at the HCEG Top Ten list for 2018 which three areas most interest to you?
David	Of course, they're all very interesting to me. It's been a very much a part of my life for the past few years being involved in Healthcare Executive Group and obviously being part of the industry. But really, I think the top three on the list are the top three for a reason. I look at these as the three pillars of value-based care.
David	And as everyone in this webinar probably knows, the industry really needs to shift to value-based care. But the reimbursements aspect of it and number three is really just a part of it. Any value-based program needs to ensure that it's that it's a win-win-win for the payer, for the provider and for the member, in order for it to be sustainable.

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David	So, in order for it to be a win-win-win, you really need these three pillars. You need alignment and financial incentives. You need to have strong payer-provider integration and cooperation to really create a true partnership between the caregiver and the payer. But you also need to have the provider and the payer partner fundamentally change the way care is delivered. Look at integrated care teams. Look at a whole person care because what we're talking about here is really, in many cases, getting ahead of disease before it happens. Ideally at least and when I look at healthcare, I look at it being more than just the absence of the disease. It's about preventing sickness. It's about overall well-being.
David	And so really rethinking care so that you're engaging the member. Engaging the physicians throughout the entire process of a person's life is really a fundamental shift on how health care is delivered. This means addressing the social, behavioral, and financial issues that go on in one's life and in their family. And ultimately improving one's quality of life. Analytics, of course, is also on the top three. We need analytics to better understand what it is we're doing and learn from our interventions. So again, these three are critical to evaluate healthcare and I think are appropriately at the top of the list.
Ferris	And David I have to say every time you and I talked about the critical issues in healthcare it's really hard. Kim, to answer your question as to what three are the most interesting items on the HCEG Top Ten list, I think David you've you hit on the top of the list. And those have been in the Top Ten at various times - especially last year. Value-based payments were number one and clinical data was number three on the Top Ten list as our members selected them. I don't think we should minimize the topic of costs in healthcare and that probably shows up in the Top Ten most significantly around cost transparency. A lot of that discussion in the recent months has been around pharmacy cost but it's not exclusive to that.
Ferris	There's a lot of dimensions of the cost equation, of the price equations that our health care consumers, our members, and our patients just don't understand. It isn't consistent with what they experience in the other aspects of their life and I think that takes me to the consumer discussion. And that's clearly one of my top three.

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Ferris	But here in the HCEG Top Ten is also cyber security and it's interesting to me that it - like the data and analytics you mentioned David - cuts across almost all of the issues. Right after being published, I had a reporter interview me and she seemed quite upset with me in the interview that cybersecurity wasn't at number one. And of course, I don't personally create the HCEG Top ten. It's our membership. But in fact, I had to agree with the reporter: that if we can't assure the consumer of some sort of privacy around their data and some security, then we have an issue. Cybersecurity was not on the HCEG Top Ten list for many years going back. Three or four years ago it came up to the top of the list. And we may talk about that later but I love these (Top Ten items that David listed) and my top three would also have to include that bigger bucket of consumerism. It's on the list as Total Consumer Health. It's on the list as Harnessing Mobile Health Technologies. It shows up in the list again in terms of The Engaged Digital Health Consumer. We can talk about each of them. But we are in a major transformation of healthcare from the consumer to the buyer being the employer to the consumer. So, I would add those three Kim to the list that David has pointed out.
Kim	Thank You Ferris. David, as Ferris talked about consumerism it struck me that this has been a very major topic in healthcare over the last few years. It's been on our HCEG Top Ten now for several years but the topic means many different things to many people.
Kim	Could you give us your perspective on consumerism and what you're seeing in the industry absolutely?
David	So fundamentally, I think consumerism is about giving people what they want. So, at a high level that means affordable, accessible high-quality care that improves their overall quality of life. That's simplistic in some ways but I think everyone could agree that that's what people want of health care. You must look at a more granular level as to what consumers want and need as they can vary significantly. And then, so from that perspective, consumerism really needs to be about customization.
David	If you look at Amazon, the experience that I might experience, it's different than what you may experience at Amazon because they've done such a good job of customizing our individual, personal experiences on their site. As example, so looking at consumer as customization really changes the perspective of how healthcare should be delivered.

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David	This means it needs to be delivered, the right service and/or right content at the right time and at the right place and by the right caregiver. 1. It's about 24-hour access to care. 2. It's about multi-channel access to information and services. 3. It's about providing relevant content to current or predicted life events. 4. It's about customized care plans to take individual patient specific conditions, genomic, social determinants all into consideration. 5. It's about empowering and enabling the consumers so they have the right amount of information to make the right decisions for their health, cost, and quality etc.
David	This information needs to be delivered to them so they can make decisions about: 1. What to buy at the grocery store 2. What doctor to see at the clinic 3. What exercises they should be performing at the gym. 4. What are the best hospitals to have a baby
David	It's about helping people along their journey from cradle to grave. It's about really partnering with your consumers throughout that unique and individualized journey. So that's what I think consumerism is about in healthcare.
Kim	Thank you, David. That's very helpful.
Ferris	And David and Kim, that's hard to add to what you've described without going into a lot of the other details around healthcare consumerism. AHIP (American Health Insurance Plans) in December had their entire three-day conference on consumer and digital health last December. In a nutshell, and I heard this a few months ago, it really stuck in my mind that as health plans, providers and technology vendors in health care we really need to stop thinking like health plans and providers and technology vendors; and start thinking like consumers.
Ferris	People don't look at healthcare as the only thing in their lives. It's our responsibility as healthcare stakeholders to find a way that our healthcare messages and our healthcare initiatives can fit into the life flow of our members and our patients; and that of their families, their work, their community and what we need to weave into our initiatives the day to day things that we know, if consumers did them.

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Ferris	And David, you mentioned wellness activities. But we need to weave those wellness activities into the things that people just naturally do. It isn't hard because we're all consumers of healthcare. So, we have a good perspective. As I said earlier, I think the world is changing; from the buyer of health care being the employers to the buyers of health care being consumers.
Ferris	Possibly because of the ever increasing cost and that consumers are finding they can't deal with our industry the way they do in other aspects of their lives. So, the challenge is for us, I note and David you track this as well, that consumerism was pretty much missing on our HCEG Top Ten list ten, twelve years ago. But it steadily rose to the Top Ten over the last few years. And so, Kim, I would say more than anything that consumerism is here to stay. And I would also say that I think we as an industry are still behind the consumer TBD a slow to really a at 2:00 this transition in healthcare and this will surely be a topic Kim for other webinars where will bill just specifically with that topic.
Kim	Great thank you. I think it definitely warrants its own webinar. First you mentioned cybersecurity. Earlier, as a CIO, cybersecurity is very near and dear to my heart. In recent years, this has become a topic for the boardroom not just CIOs and IT departments. It seems each week there's a new threat with the latest being the spectrum and meltdown vulnerabilities that everyone's seen in the news.
Kim	How are you seeing cyber security and cyber threats impact healthcare organizations beyond the tactical day-to-day front prevention activities?
Ferris	It’s a critical question Kim. And I wish I could in a nutshell give some silver bullets around cybersecurity and how I see it and how I see us dealing with it. But again, as I said, I think it's fundamental to our healthcare future. It definitely is something that's on the minds of our consumers, our members. We've had initiatives over the last five years for more electronic medical records. We have regulatory things that are developing where the lab companies now are required to give the patient access, electronic access to their medical data. So, it's fundamental that we need to innovate and improve cybersecurity in all of our healthcare processes to consider cybersecurity. That really means giving people a confidence that their personal information won't be used in ways that that person doesn't want it to be used.

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Ferris	So, it ties back to consumerism. In some ways, historically (Consumerism,) ranked low in the HCEG Top 10. I can drive this home with a personal example: Here in Utah, about three years ago, there was a baby that was born in the hospital that was heroin addicted. And of course, the Department of Social Services immediately went to the home and removed the three children from that home. The fundamental problem was that the mother of that heroin baby was not the mother in that home. And it took her three months to get her children back. It was a case of medical identity theft where the baby was born. The mother checked out and in we can relate to the personal impact that that lack of security around medical information caused for that family. So, there will be more discussions.
Ferris	A couple years ago we had an NTT Data HCEG webinar on cybersecurity. We will have more on Cybersecurity this year but this is an issue that is that is getting worse day by day. I don't know David, what you would add to that? This is a critical issue.
David	Well I definitely feel for Kim because the world has definitely changed since I was CIO ten years ago. So, Kim hats off to you. I can't imagine how you can sleep at night anymore. The world has gotten a lot smaller and technology a lot more complex over the past decade. And clearly cyber terrorism is a big part and a growing concern that every organization needs to take seriously. But you need to keep in mind that the safest computer is one that's turned off and unplugged. And clearly that's not very useful.
David	So, we need to balance both security and usability. The sharing of clinical information is going to be critical to our care model redesigns and our clinical collaboration. This data is also going to be important for us to leverage artificial intelligence and to help us determine optimal courses of treatment. In some cases, this information is even going to be needed to help really define how whole populations are treated. So, we really need clinical information to fully transform the way care is delivered and to transform our industry. Given this, cyber security obviously needs to get all the attention it deserves. We need to ensure that our important work is done securely and protects the privacy of consumers.
David	I would note, and again Kim, you can probably attest to this that we can have the most secure networks and the most secure buildings in the world, but security is only as secure as its weakest link. And I think the statistic is something in the 80-percentile range where a lot of their intrusions that occur are really done through phishing and email scams.

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David	So, a lot of security has to do with training our own people. We need to make sure our folks are aware that the prince from a country in Africa that's sending you an email about the millions of dollars you can gain by clicking this email is unlikely true.
David	And they should not click on that attachment. there's a lot of complexity to this. It's something we have to fight but we have to do it knowing that without addressing this issue our arc or healthcare transformation will be stymied.
Kim	Thank you, David. I definitely agree about the importance of awareness and training for our own staff. That's definitely a critical measure in securing our environments.
Kim	Ferris earlier you mentioned costs including pharmacy costs which continue to rise and are a significant driver of healthcare costs. It's a topic that's constantly in the news. Many have probably seen the articles in the last week about nonprofits joining together to form their own pharmacy companies.
Kim	What are your thoughts about what we can do as healthcare leaders about these pharmacy costs?
Ferris	And I will, for everyone's benefit, reference just last month a webinar we had on pharmacy costs. People can go to the HCEG website to get that.
Ferris	One of our sponsors Cumberland Consulting Group had some experts on the call to talk about specific actions.
Ferris	Yesterday I saw some statistics on pharmacy costs that struck me to the heart. It was from the Health Care Cost Institute over the last four years. It was actually 2012 to 2016 and the cost of prescriptions in the marketplace had gone up by 25%. But the utilization of prescriptions had only gone up by 1.8%. Ad it wasn't just pharmacy costs. ER prices have gone up by 30% and visits went up by 2%.
Ferris	There is no silver bullet or single solution.
Ferris	We hear the discussions about CMS or Medicare Medicaid doing global negotiations on pharmacy costs. We hear the discussion that consumers ought to be able to go to Mexico or Canada to get the prescriptions. But I think without a doubt the topic needs detailed deep discussion to be understood and explained and addressed. part of the issue is the way our system grew up around rebates. Rebates were a very key issue when the employer was the purchaser - to lower the overall cost of premiums.
Ferris	But today the consumer or the employee selects their health plan. They basically make the decision on the premium. But when they go to get their prescriptions, they don't get a benefit from the rebate or the actual purchase process.
Ferris	So, I think, once again, we haven't transitioned from the buyer being the employer to the consumer becoming more and more important in that purchasing decision. As we discuss pharmacy costs, the other thing that I think we need to recognize is that we have a free-market economy. But industries have responsibilities to govern themselves. And I know some of the bad players in the pharmacy industry are outside of the Pharmacy Association. So, it's hard to regulate them. But I use those key issues as the things to help us start to address the pharmacy costs.
Ferris	David, I don't know about you but let's just start in the discussion

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David	yeah, Health care is such a unique industry. I don't think there's anything like it. And again, everyone on the phone probably knows that. When I go into a grocery store with $10, dollars and I look at Product A and it cost $8. And I look at Product B and it cost $8 - but I only have $10 dollars - I have to make a choice. Do I buy Product A, or do I buy Product B? But in health care, we can say we'll buy both. And I only have $10, I don't have $16. But somehow, miraculously, often it's because somebody else's money. I buy $16 worth of goods for $10. That doesn't work at a market economy when there really is no balance between the consumers ability to pay and what the supplier wants to charge. We have a problem.
David	What I look at the state we're in with pharmacy costs. To me it's entirely self-made. We've created these regulations that allow schemes like pay to delay, or evergreening – that's really pushed generics out further in terms of their development. We create, in a sense, quasi monopolies. We criminalize the ability to negotiate for larger population blocks. I mean it seems ridiculous to me, actually, that drugs that were invented and manufactured here in the United States can often be purchased cheaper outside of our country. And I do understand it's a complex issue. I understand the FDA process is too long and development costs too high. And I do understand that some of the profits for the blockbuster drugs go to fund things like vaccines and other less profitable medicines. Clearly drugs are very important. They reduce admissions that would use other high cost care. And some of them are miracles. They can literally cure diseases - cure the incurable. So, I understand this is not a simple problem. But if a drug cost a million dollars and the person can't afford it, is it really a miracle? And in any other market, if there was a product that nobody could afford, the supplier would price it differently. And that's what we have in our market.
David	We have a problem where there's not that balance. So, we really need to figure this out as a country. And I think the pharmaceutical industry really needs to be a major part of the solution because the game they're playing is really a short term. Because if they don't change, then it will be changed for them.
David	So, it'll be interesting to see but I do think that there's a wakeup call coming. And there'll be a time where the pharmaceuticals problem will be solved. Whether it's with them or to them, sometime here soon.

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Ferris	David, I want to add just another challenge to all of us on the phone today. With respect to not just pharmacy costs but the technology and the innovation in healthcare. And I will do that by going back to my undergraduate work as a nuclear engineer physicist and being very adept with a slide rule. It was the first year that my MBA program required a hand calculator; and this was an archaic calculator. Nothing like the HP calculators we have today. It was an inch and a half thick and about four inches tall and it had four functions. No memory. It was called a summit calculator and it costs $400, which in the early 70s was a lot of money. There were healthcare technologies at the same time and I'll use the pacemaker. I don't know the exact price of a pacemaker in the early 70s but over time the quality and the functionality of hand calculators has expanded dramatically. And at the same time the price has come down. Ad I don't really understand why the functionality of that $400 summit calculator today is a giveaway on an exhibit hall floor - the size of a business card with a solar panel in it that recharges it. And it probably costs 13 cents but a pacemaker now is $10, 15 $20,000.
Ferris	And it goes back to your value proposition David, where quality and functionality improves dramatically without the cost going up exponentially. I agree a calculator will not kill somebody and a faulty pacemaker may. So, there's a little different paradigm there but we need to think differently about the value proposition in not just pharmacy cost but everything else.
Kim	Kim: Absolutely. That's great. Thank you for rounding out our discussion with broader costs.
Kim	Kim: David it wouldn't be a conversation about healthcare these days without mentioning health care reform and the uncertainty we experienced in 2017 with multiple attempts to repeal and replace the ACA.
Kim	What do you think is going to happen in 2018?
David	I have to admit, I'm an eternal optimist. I really think 2018 is going to be a watershed moment. I believe we're going to make a lot of headway in a number of areas. For one, I believe that Congress is going to enact a stabilized the individual market so that we have a viable individual market in 2019 and beyond. I know, given the status of Washington recently in the shutdown last week, that seems hard to believe, but I doubt any politician wants to see people losing health insurance come October/November of this year. So, I do think that's one of the major things that will happen and will benefit everybody: health plans, providers, hospitals, community hospitals especially, and of course, the citizens of our country.
David	I believe that Medicare Advantage plans will continue to demonstrate value and more beneficiaries will adopt those types of programs for their care instead of Medicare fee-for-service.
David	I believe Medicaid expansion will continue, maybe taking a different approach including having people of lower incomes buy-in to Medicaid.
David	I believe the push for value-based care particularly through the use of bundled episode-based payments will accelerate.
David	I believe technology and care model redesign will enable more frictionless coordination making our fragmented system really feel a little more unified. It won't be perfect, but a little more unified.
David	I believe analytics and genomics will enable more personalized holistic care.

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David	I believe that diet and exercise and even meditation may be prescribed as frequently as pharmaceuticals.
David	As people are beginning to talk about and realize the importance of really looking at the whole person. As Ferris talked about earlier, health care is a small part of our life. We go visit our doctor once or twice a year, in some cases. And then the rest of the time that we're not with the doctor we're doing other stuff. We're eating. We're drinking. We're exercising or sitting on the couch. And so, the majority of our health it really is impacted during the time we're not with our doctor; and that's becoming more acknowledged.
David	And I think there'll be more of a push to try to nudge people along toward the right behaviors. And then, lastly, I really do believe the power of the consumer will be strengthened by new disruptive entrants. And we're already seeing this with the CVS acquisition of Aetna. But I think, obviously, Amazon is hinting that they're going to get into this. And I think that's really going to change the dynamics. I think that's just the beginning. So, to summarize: I'm super excited about the new year and all that we can make it. I do think that 2018 will be the year that we change healthcare.
Kim	Great thank you. I love your optimism and I'm hopeful we'll see some of those changes in 2018.
Kim	Ferris, do you have anything you'd like to share on your thoughts for 2018?
Ferris	Well, you notice I didn't jump right in right after David. I've known David for a long time. And David you continue to push the needle and move the industry forward. But I'm struggling with the reform question. It's interesting that, of course, when the Affordable Care Act was passed in 2010 and all the preparations leading up to 2014 in our top ten, this regulatory environment in the healthcare reform was up at the top of the HCEG Top Ten list. It moved down and an off the list actually. And has come back on this year in the seventh place.
Ferris	And I'm not trying to give a lot of priority to where this (healthcare reform) ranks in the list but I do I do think we are struggling. And I'll go back to my consumer concept that I introduced; and that is that the consumers, as David is, that are also voters, and yet, from a health plan and a provider organization and even the technology companies – our sponsors and others - need to plan out in the future. And the political posturing is making it very difficult to do that. Issues being pushed out two or three weeks or one year or two years. And the only caution I put David, around your optimism, is that a radical change in the public political leadership in DC could whipsaw back in the other direction. And that's going to make it less stable.

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Ferris	I could quote Ian Morrison at an AHIP meeting when he shared his future view of 2018 and 2019. It was that we may be in for a lot more strategic chaos. As I look at the Top ten, let me also look more broadly and say 'yeah, health care reform is here on the Top Ten list,' but the majority of these issues that our HCEG membership have identified are things that we as payers, providers and technology developers can come together and solve outside of the Beltway around the District of Columbia. These are things that are fundamental no matter what happens with health care reform. We need to address the opportunity with clinical and data analytics. We need to get upstream from the chronic illnesses with population health and our initiatives there. Without a doubt, we need to move from the volume-based fee-for-service payment system to a more value-based set of relationships. And so, the fundamentals I think are in the Top 10. I was hoping we would duck the health care reform issue Kim. It's a challenging one but it's there in the HCEG Top Ten and I'm glad you brought it up. I don't know you may have different perspectives on reform as well Kim.
Kim	Kim: I think it's challenging and I think we're all anxious for things to settle down. The repeal and replace that's been on the table; there's been a lot of change in the ACA over the last year. And as a health plan, we're just looking for some stability. So, I'm looking forward to hoping that will really be the case this year. So, thank you both for your thoughts.
Kim	I'd like to open it up to questions from the audience and I believe Ferris you may have been receiving some of those.
Ferris	Yes. I think Juliana has been tracking the chat and there are several here. One is fairly long but let me take the first one that came in because I think it's a good question.
Question	How do we get the provider community providers and their staff to embrace their role in consumerism including transparency? There is such a pushback from the provider community to engage patients in any sort of financial consideration.
Ferris	And I know David, we didn't hear a lot from your perspective on that question. But Kim and David, the questions there: How do we apply a nice to embrace

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David	well I think consumers need to demand it. I'll give you a personal example. When I first moved to Florida about 14 years ago I went through my provider directory, like everybody else did, and I kind of randomly picked a PCP and over a few years of interacting with that physician I received what I would normally would receive, which was I would make an appointment a year or every 18 months because sometimes I would forget. The doctor would walk in after the nurse and see me for 15 minutes and that was it. Never did I get the follow-up call that I needed to show up, never would they ask me about my eating habits or my drinking habits or anything that was going on in my life. They didn't have an electronic medical record, and so as I was thinking about this I'm thinking "I'm a consumer. Is this the type of care I want to purchase?" So, I made a decision that I was going to go out and interview PCP's. And I called a variety of PCPs, and I actually called one and said I want to consult with you. I don't want a checkup. I actually want to come in and talk with you about you being my PCP, and I interviewed them. I went in and amazingly they actually sat down with me for about 45 minutes talking with me about the way they do business and at the end of it they said, "you want me to look you over now that you're here?" and I said sure. I didn't even leave the office without them signing me up for the electronic on portal system. So, they had me just sit down in the office because I was sold at that point. That PCP is my PCP for the past eight years. I get all my lab results online. I get alerts if anything comes up. They tell me where my screenings are available. I get content pushed out to me that's relevant to my age and my family.
David	I think at the end of the day consumers need to take charge and when consumers do the medical community will respond interesting
Ferris	David maybe I'll move to Florida that isn't the experience I'm that I've had in health care here. Although I think Utah has a high-quality health care system. I would add to what you said and I think there is an answer to the person that asks the question. I think there we are approaching a tipping point that you alluded to and that is that we have to make that transition. Our traditional discounted fee for service contracting system has clauses in it that doctors can't disclose their reimbursement rates. There are discussions that I'm hearing at the state and at the federal level that challenged that. But more fundamentally, if we don't make that transition to a new form of health care I think we'll be in trouble.
Ferris	I'm reminded of Michael Crichton's quote on I think page three or four of Lost World where he said extinction is the inevitable result of one of two things: Too much change or not enough change. And I think we're in that balancing act right now of whether we, providers, payers and technology vendors make that transition to the consumer driven and consumer engaged world. Or whether we become a government-run system like many of the other parts of the world. Kim, I know you may have some thoughts on the negotiate with them. So please weigh in
Kim	Yeah well BMC HP serves a low-income population. So, I think one area that you can focus on is the benefit that really involving the member in the consumerism functions. And the different capabilities and discussions for a provider really needs to come back to the benefit to a member's health. And with a low-income population social determinant of health have an even bigger impact.

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Kim	So, making sure somebody is signed up for their medical record and they're aware of when their next appointments are or they know who to contact to get their transportation or automatic notifications about refills that are ready or whatever. It is understanding what their choices are even with a Medicaid plan. Whether choices are to go to different hospitals and different doctors. And I think if you can tie some of that back to the benefit to a patient's health it might be a better starting point.
Ferris	Terrific. There are several more questions. Kim when time requires you can cut off the questions. There's a series of questions from one of our listeners here that III will break into. A couple of three questions and read it as best I can: Isn't the current trial-and-error regulatory model of care and reimbursement the government applies getting in the way of true health care reform progress? Instead of the driver shouldn't government be an active listener for the long-term policy need policies that are needed. Now how would you respond to that?
David	The only thing I would say is that the government is probably the largest purchaser of health care services in our country - both at the state and federal level. I don't think they can be passive. And I think there's lots of vested interest as we talked about earlier with pharmacy. But there are a lot of other very powerful lobbies with this $3.5-$4 trillion-dollar business were in. So, I think the government has an active role to play but it needs to be a responsible role, it needs to be a balanced role. And markets do have a role to play with this also. So obviously, if it was easy we would have figured it out already. But that's what I think there Ferris.
Ferris	And I see in in the question here something that has troubled me for the last four or five years. All of my previous years in health care there was a process. Legislators were elected, the legislation was passed, it was passed to regulators who drafted regulation, it went out for comments – a 60-day comment period. It came back. All comments were responded to and regulations were established. I don't know where that fell off the wagon but as this listener has stated it really has. The model has changed and hopefully at some point with a bit more stability we'll get back to that more long-term perspective. As the listener asked here a follow-on question.
Ferris	David this will be a good one for especially you Kim wearing that right now I see if cost becomes the major driver, then quality of care will undoubtedly suffer much like it did with HMOs and fee-for-service. As opposites, how does quality come into that cost equation? Kim and David,

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Kim	I'd say that you can't have one without the other. So, the definite focus I think especially we're seeing that in Massachusetts with health care reform and moving to a cos from Medicaid that there is a balance of total cost of care as a significant driver. But quality is equally important and when you look at accountability scores for these a COS there's a percentage driven by total cost of care. But there's an even larger percentage driven by quality. So, I think the drive needs to be overall, how do we reduce costs but without making that that mistake of letting go of quality? I think you really do need to balance the two for this to be successful.
David	One of my favorite books of all time is from a guy named Phil Crosby. I think it was written in 1978 or something crazy like that. And the book is called Quality Is Free. And the general premise is that any effort driven toward improving the process and improving the outcome, in his case he was talking about manufacturing, but any quality-oriented endeavor ultimately is going to do is going to be value-added. And ultimately is going to be less cost than the investment made.
David	So, I actually look at this a little bit differently. I think it has to be driven toward quality first and then the cost will fall accordingly. And I think the incentives have been totally misaligned. I think when care givers are responsible for the ultimate outcome first and then they get paid for that outcome, by very nature of their business they're going to have to focus on quality.
David	And so, it'll be less likely because they're financially responsible for it, they're letting someone get discharged before they're ready. They will make sure there's appropriate supports outside of the hospital, for example. They'll make sure that there's appropriate follow-up visits and screenings done. Because at the end of the day that quality care is going to drive their ability to make money.
David	So, I think they're tied together, but I think quality has to be first.
Ferris	I already talked about my hand calculator issue and it does the traditional processes quality improves and costs go down and that's the definition of that value proposition. I think you get to the heart of it both you Kim and David that the transition from a fee-for-service to value-based care will naturally carry with it that quality component. I don't know Kim if we have time for one more question. It’s a short one. The answer may not be short but the question is. Isn't fraud, waste and abuse still an issue in health care? What are you seeing?
David	yes, I think the biggest piece of that is probably the waste and abuse and then fraud. I mean they're still fraud, but there's the waste and abuse think that’s the larger piece of it simply because people are still providing defensive medicine. They're still providing medicine maybe to meet those financial targets they have. But again, I think value-based healthcare helps drive that out. You might still have fraud, but the more and more you get away from fee-for-service care reimbursements, the incentives for the types of abuses that have been taking place just go away. Maybe I'm just too idealistic, and I've been called worse, but I think value-based care really is the holy grail of health care

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Ferris	I mean this is not a minor transformation that we're talking about from fee-for-service to value-based reimbursement. And healthcare is the first industry that had to do had to go through humongous transformations.
Ferris	I've used the analogy of the transportation industry a hundred years ago moving from horse and buggy to automobiles. And in that process, in that transformation process there wasn't a role for the buggy whip manufacturer. I think we're in the middle of this - what you call David a Ten or more-year 15-year 20-year transformation of healthcare. But we're still driving around with our automobiles with buggy whips attached to them. And in health care, those buggy whips are somebody's revenue. But that waste and that duplication will come out.
Ferris	I think the technology and the consumerism are going to be drivers that will help us do that.
Ferris and Kim	I know we're running out of time Kim. So, I'll shut up at this point. Thank You Ferris. To wrap up the meeting, payers and providers on the phone, if you aren't already a member organization of HCEG, please consider joining us. Your registration would include two paid registrations to our annual forum, which will be in September, unlimited access to HCEG content and regional events. And I'd also stress it's a great way to connect to other industry thought leaders in a really meaningful way. Please save the date for our 2018 HCEG annual forum which will be held September 12th to 14th in Minneapolis. You can reach out to Juliana Ruiz if you're interested in HCEG and the forum. And lastly please follow us. And I want to thank David and Ferris for participating in the panel today and sharing their insights. And thank you to all of our participants. And I wish everyone agree with all of you and Kim. We did have questions that came in that we didn't get to. We will step back and farm those out for the three of us and get some responses back. We appreciate everybody participating. Have a great day! Thank you!