Viewpoint

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David Blumenthal, MD, MPP, is president of The Commonwealth Fund, a private foundation that aims to promote a high-performing healthcare system. Dr. Blumenthal is formerly the Samuel O. Thier Professor of Medicine at Harvard Medical School and Chief Health Information and Innovation Officer at Partners Healthcare System in Boston. From 2009 to 2011, he served as the National Coordinator for Health Information Technology, with the charge to build an interoperable, private, and secure nationwide health information system and to support the widespread, meaningful use of health IT. He succeeded in putting in place one of the largest publicly funded infrastructure investments the nation has ever made in such a short time period, in healthcare or any other field.

Previously, Dr. Blumenthal was a practicing primary care physician, director of the Institute for Health Policy, and professor of medicine and health policy at Massachusetts General Hospital/Partners Healthcare System and Harvard Medical School. He is the author of more than 250 books and scholarly publications, is a member of the Institute of Medicine and serves on the editorial board of the *New England Journal of Medicine*. Dr. Blumenthal received his undergraduate, medical, and public policy degrees from Harvard University and completed his residency in internal medicine at Massachusetts General Hospital.

What are the major areas of focus of the Commonwealth Fund right now?

Our long-standing mission, to promote a high-performing U.S. health system, is currently centered on four key strategies: One, expand coverage and access to services; two, pursue healthcare delivery system reform; three, identify international innovations and areas for collaboration and learning; and four—novel for us—seek breakthrough opportunities that fundamentally transform healthcare.

DAVID BLUMENTHAL, MD, MPP, PRESIDENT, THE COMMONWEALTH FUND

We also pursue initiatives that touch on all of these strategies, such as controlling healthcare costs and developing analytics to track health system performance.

In the delivery system area, what problems are you concentrating on?

In the area of delivery system reform we're primarily focused on two groups. The first we call "high-need, high-cost patients"—people who often have complex, multiple morbidities and accrue the lion's share of healthcare costs. The second group we refer to as "vulnerable populations," people who, because of economic or social disadvantages, are at risk for poor healthcare quality and outcomes.

To give an example of how we operationalize these strategies, one area we're exploring right now is how to optimize an accountable care organization for the sickest and frailest. That involves stratifying the population to identify these patients, and then channeling them to the most appropriate and efficient care. A key question is: "How do we measure coordinated care for these populations?" It's one thing to have a patient-centered medical home; it's another thing to design one for multiple-morbidity patients.

You recently issued a report card on the Affordable Care Act (ACA). What did you conclude?

The report card originated in a blog post (Commonwealth Fund VP for Coverage and Access) Sara Collins and I wrote in the middle of the disastrous launch of healthcare.gov. We said, "Let's keep our eye on the ball. What is success?" We identified benchmarks: Do more people get insured and does the uninsured rate fall? Is the quality of insurance adequate? Also, what's happening to the quality of care? The cost of care?

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So we revisited the subject this year and asked, "What do we know so far?" What proportion of Americans is still uninsured? Our work, that of the Urban Institute, and RAND have all recorded a decline in the number of uninsured adults of between 8 million and 10 million. That translates into a drop in the uninsured rate from 20 percent to 15 percent. In this area, the law is doing a good job and the market is working.

A second standard is the quality of insurance, which we've been measuring over the past 10 years. We've recently found that one-in-five insured, working-age adults spend more than 5 percent of their income on out-of-pocket medical bills—including two-in-five low-income adults. In the coming months, new data will allow us to examine trends in the "underinsured" rate, giving us a better picture of whether the protection offered by insurance is changing in the post-ACA world.

Another benchmark is quality of care. It's too soon to reach a definitive judgment, but there are some promising signs that care is improving. For example, there has been a 10 percent decline in the rate of Medicare hospital readmissions since 2012—a drop that coincided with the ACA's Hospital Readmissions Reduction Program.

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In terms of cost, there has been a historic moderation in the growth of healthcare spending. I don't exclude the economy as a possible factor, but Medicare spending—which historically has not been tied to the economy—has actually fallen on a per-beneficiary basis in recent years.

In terms of the functioning of the marketplaces, the ACA got an F for the first few months. They were much improved by the end of the first enrollment period, but the new enrollment period will bring new challenges. There's certainly room for improving the user experience.

The ACA is playing out very differently in different states. What are some of the implications of that, and what, if any, challenges does it create for the law and for the U.S. healthcare system?

While the ACA is a national law, it is really 56 programs in the states and territories, each of which implements it in their own way. The biggest questions are whether the states run their own marketplaces and whether they opt to roll out the Medicaid expansion.

There is a geographic pattern. The Fund features a "Scorecard on State Health System Performance" on our website (http://www.commonwealthfund.org/), which rates the states on 42 measures of healthcare access, quality, costs and outcomes. What we've found persistently over time are that the Northeast, North Central, Northwest and parts of the Midwest perform well; the South, Southeast, and Southwest perform poorly.

It happens that the low-scoring states tend to be those that have not expanded Medicaid and have not been supportive of the ACA. If you believe health insurance promotes health—and the evidence is incontrovertible—you wonder if over time this division will grow even more dramatically. What does this mean for the future of the country?

The Fund is noted for its international work. Do you believe that studying other countries can be useful to U.S. healthcare delivery systems?

The U.S. generally has not been very receptive to high-level policy ideas internationally, such as how the U.K., Switzerland or France organize their health systems. We've shown ourselves to be insular in that way. We believe at The Commonwealth Fund, however, that there is a lot to be learned from other countries' experience.

My personal conclusion as a clinician is we're all treating the same illnesses, the same chronic conditions, cancers and infectious diseases. We have the same fund of knowledge, read the same journals and belong to the same societies. I'm on the board of the New England Journal of Medicine, which is international. This is one world in terms of scientific knowledge and we're all trained in the same skill sets. There's got to be something we can learn from each other. If there's a way to manage people with chronic diseases to achieve better outcomes, we need to share that knowledge. For example, hospice started in the U.K., and has improved care for countless terminally ill Americans.

We believe when CEOs, COOs, CFOs and department heads are truly accountable for costs and outcomes, their need for solutions will make them more open to international experience. Being practical will be a lot more desirable than being isolationist. Ascension Health is setting up a facility in the Cayman Islands to import innovations from India to deliver cardiovascular surgery at one-tenth to one-twentieth the price of U.S. procedures. We think that may be the beginning of a wave.

Your website discusses a breakthrough opportunity program. What does that include?

This is an area of experimentation for us. We define a breakthrough as any innovation or bundle of innovations with the potential to reduce the cost and improve the quality of

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healthcare by at least 20 percent over the next 5 to 15 years. So, it's not marginal. This is an attempt to push ourselves to think about disruptive change.

We're developing surveillance systems to learn about potential breakthroughs, and have a couple of stalking horses. "Provider Incentives 2.0" is a new look at incentives, of which the healthcare industry has very little understanding. Sometimes *how* you pay providers can matter as much as *how much* you pay them, but these methods are largely untested. We're using the principles of behavioral economics as well as non-economic tools to study the effects of both financial and non-financial incentives, and are getting a lot of interest from health-system leaders and academia.

> *"For the Commonwealth Fund and the Scottsdale Institute, the question is: what would happen if consumers really did become careful consumers of healthcare? Can it happen now?"*

Great progress has been seen in ACO-like and other value based reimbursement models. How can or should the U.S. achieve real transformation and reform short of—or while waiting for—larger scale payment reform?

Although there's a great deal of progress being made, waiting for a large-scale, "silver bullet" payment reform is probably not a great strategy. Fortunately, even in the absence of comprehensive reform, we think that healthcare markets have the potential to improve in the coming years. One potential pathway is what we're calling "IT-enabled consumer engagement." For years, healthcare policy makers and pundits have wondered at the lack of authority that consumers have in the healthcare system. We've never been able to motivate consumers except in marginal ways. High-deductible plans have attempted to change this, but enrollees have mostly lacked the information on cost and quality that they need to make informed choices. For the Commonwealth Fund and the Scottsdale Institute, the question is: what would happen if consumers really did become careful consumers of healthcare? Can it happen now?

Fortunately, with the information and communication revolutions that are upon us, we now have the capabilities, which are expanding at light speed. If we could deliver accurate and relevant information at the point of action in healthcare, we could change the way people use healthcare. That's happening to some degree already. Silicon Valley, Silicon Alley and Boston Route 128 are all aflutter with health apps, and billions are being poured into healthcare startups.

However, my impression is the apps being created are not well informed by clinical insights from caring for high-morbidity patients. Most of the apps are developed by 20- or 30-year-old male engineers for their male-engineer colleagues.

In contrast, we are most interested in developing information ventures that are designed for the 5 percent of Americans that account for 50 percent of healthcare costs. They tend to be patients with multiple morbidities, behavioral health issues, who are on multiple medications and may have cognitive impairment. We think that's where the impact will be and where the market incentives are currently not working.

The Fund's data demonstrates that MN, MA, NH, VT, and HI have consistently out-performed other states in overall measures of health performance. What are the attributes of these states that could be takeaways for others?

The short answer is we just don't know. I tend to think areas like New England, the Upper Midwest and Northwest that perform well have relatively low rates of uninsurance. That's a factor I'm confident will be a predictor. Other than that we don't have a good answer. The Commonwealth Fund also publishes a health system scorecard at the local level, and we've found high-performing cities—such as Miami and Austin, Texas—within low-performing states. We need to study it more.

~ *Chuck Appleby*
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