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- Thank you.

- Everyone here is aware of the contentious tone in Washington nowadays – conversations are polarized – conflict seems the norm. But on one matter, almost everyone does agree: cost is center-stage now. The Federal debt and deficit are unsupportable. And that puts health care center-stage, too, because health care costs are linked tightly to the economic vitality of our country. And that is not just true for the Federal government; it is true for States and for the private sector, as well.

- I know that each of you in your State is feeling this pressure directly and severely. Your executives and legislatures are looking for solutions to a health care

cost burden that feels – at the moment – unsupportable. You need answers, and you need them now.

- This is a very tough passage we are going through. It has short-term needs – emergencies, effectively: "What can we do now – right now?" And it also has longer-term implications: "Where are we headed, after all?"

- Now, I don't have any easy answers. But I do have one strong, general, overarching view of where we should head.

- That view is that these cost pressures bring to us a choice – a choice that is, I think, very often less clearly recognized – less clearly understood – than I think it should be.

- Here is the choice: “cut or improve.” There are basically two ways to reduce our health care costs in the long-term, not just for Medicare and Medicaid, but for the private sector, as well. In fact, these are two ways to reduce costs anywhere – in any sector.

- The first way is easier – it is seductively easier. That is to cut care … to reduce the level of care that Americans can get… to become less ambitious. Cuts have their advantages: they are relatively quick; their cost savings are relatively certain (at least in the short run); and they generally lie in the control of the payer, no matter what those who deliver care choose to do.

- But, I do not think that is right; I think that cutting care is the wrong way… wrong at least as long as we have the other alternative. The better way.

- The second way – the better way – is to improve care. It is harder, less certain, more indirect than merely cutting back the budget, but I want to make the case that improvement isn't only the better option – but also that it is within our grasp.

- Improving health care has been my hope and my driving goal for over two decades, and that has also been true since the day I first arrived at CMS – over a year ago. I believe that CMS can and ought to see itself as, not just a payer, but as part of the solution…. a part of the improvement solution.

- I have urged my colleagues in CMS to consider our own vision of who we are… "We will be a major force and a trustworthy partner for the continual improvement of health and health care for all Americans." Indeed, I would propose that that vision is not a bad one to share among all health care

payers in the nation including you who help lead Medicaid.

- That statement implies a need for change – change to a better system of delivery, more capable – much more capable – than the one we now have to deliver on what we in CMS call the “Three Part Aim” – better care, better health and lower cost through improvement.

AREAS FOR IMPROVEMENT

- Now, if costs are the main problem, how can we use improvement as the solution? And how can we make sure that patients and families and communities aren’t harmed as we do so.

- Here is how: focus on waste – focus on reducing waste in our health care system. Reducing non-value-added activity – things that don’t help people –

is a modern approach to improvement. You'll find it in every mature company in any competitive market. I'd even venture to say that, in many industries, it is the primary form of improvement. That can be so in health care, too.

- What's more, the Affordable Care Act arrived at just the right time; it gives us tools to fight waste

- Some of the tools in the Affordable Care Act aim to reduce costs in rather blunt ways. They can reduce costs without aiming at waste, and they can work even if there are no changes in provider or patient behavior. For example, direct changes in the levels of payment to providers fall in that bucket. They also include the productivity adjustments and other payment adjustments required in statute. Direct savings are easy to quantify, and easy to attribute to a specific program or policy.

- Direct savings are important, especially in the short run, and, especially in these tough economic times. But, for a number of reasons, “direct” savings programs and policies are also less than ideal as foundations for a better future, and they are most certainly not the best route to the better health care we all seek. They invite conflict, of course, as we debate proper payment levels, and they can also be harder to sustain over time. And, they don’t aim squarely at waste.

- But, the Medicaid program already gives us tools—and the Affordable Care Act also gives us important additional tools – call them “indirect” tools – to work with stakeholders across the board that do help reduce waste in the health care system. Indirect programs and policies have as their intent and effect to help to change and improve the care, itself, and to encourage and support providers and other stakeholders to reduce waste in care – waste we can

ill afford; things that help no patient.

- Waste in health care takes many forms and no one policy or program can possibly address any of them – let alone all of them – fully. But, together, across the policy landscape, and in full partnership with others, we can do a great deal to recover wasted resources and reinvest them where help is truly needed.

- Here are some examples of major types of waste in care – non-value-added activities that we, together, can be smart enough to tackle while advancing the interests and outcomes of patients, families, and communities. The savings can be immense:

    - Failures to Coordinate Care – When we drop the ball as patients – especially the chronically ill – transit through the complexity of modern care – leading to avoidable complications, readmissions, duplication of effort, and confusion for the people

we are trying to help. Our new tools – ACO's, bundled payment, community-based care transition programs, and more – are policies with promise of reducing this waste.

- Failures in Care Delivery Processes – When we fail to offer patients reliably the benefit of the best-known processes, leading to injuries in care, delays, complications. Our new tools, like the Partnership for Patients from our Innovation Center, and better metrics of process and outcome quality, can tackle this waste.

- Overtreatment – When we subject patients, for whatever reason, to care that cannot help them and, often, that can harm them. Shared savings programs, paired with solid and trustworthy quality assessment and patient feedback, can

increase interest in reducing care that doesn't help.

- Excess Administrative Costs – from redundancy, from legacy rules that no longer have purpose, and from irrational variation in procedures for certification, accreditation, conditions of participation, measurement, and more. Under a President directive, CMS just two weeks ago issued a proposed rule on Conditions of Participation that will eliminate almost one billion dollars of needless bureaucratic hurdles for caregivers that don't help patients at all.

- Excessive Health Care Prices – when market forces are not allowed to exert their influence on proper relationships between supply and demand. Our recent, extraordinarily successful pilot effort in Medicare on competitive bidding for

durable medical equipment shows how powerful those forces can be on behalf of patients. Competitive bidding for nine supplies in nine market areas reduced prices by 32% on average, and dissatisfaction was nearly nil. We can help States take similar steps in Medicaid.

- Fraud and Abuse – which cannot be tolerated, and which, at last, will start to yield to the several important mechanisms the Affordable Care Act brings to us.

- The potential gains for our health care system – patients, families, communities, employers, payers – all of us, that can come from a successful assault on waste in all of its forms can potentially dwarf the relief we get from shorter-term, less stable, and far blunter manipulation of the direct levers that we also have access to. Reducing waste is the best way to assure

sustainability of the high-quality care we want and need.

- That is true for Medicaid, as well as Medicare. An agenda aimed at stopping non-value-added costs will help you, the States, the beneficiaries, and their families.

- I know that this is more difficult. This is harder to achieve than just cutting payment or budgets. Reducing this kind of waste may be harder to obtain, but the potential savings may be larger, will be more sustainable, and will mean better care for the patient over the long term.

- But, I know we can do it. Every day in hundreds of places throughout the country, innovative entrepreneurs and dedicated people like yourselves

are breaking down barriers and redesigning care to better help their patients and communities.

- Let me get a little more specific.

    - Around Acute Care Improvement

    - Six months ago, we launched the Partnership for Patients, a major national initiative to improve patient safety.

        - Our goal is to reduce preventable hospital-acquired conditions by 40% and improve care transitions so that readmissions fall by 20% over the next 3 years.

- Thousands of hospitals have already pledged to help us meet our goal through redesigned care and better transitions from hospital to home.

- Lean production – removing waste in all its forms from care

    - Denver Health
    - Virginia Mason
    - Theda Care
    - All are reeducating their entire workforce to identify waste and systematically redesign to remove it
    - A new wedding of systems thinking, modern engineering sciences, and health care delivery

- Modernizing information systems – RECs, ONC, Beacon Communities

- Telehealth and Telemedicine

    - ECHO Project in New Mexico – projecting top-notch specialty expertise far-flung primary care settings – began with Hepatitis C, now expanding

    - The Alaska Native Medical Center in Anchorage – using remote imaging in Alaskan villages to get instant consultation and follow-

up. Reducing the need to travel and eliminating delays in referral. AFHCAN equipment – US Department of Commerce grant. 31% drop in waiting times for ENT consultation. Travel prevented for 85% of encounters in ENT. 60-70% reduction in travel for specialty care. 30,000 telehealth consultations in 2011. ROI 10.54:1. 80% managed in 24 hours.

- In addition, the CMS Innovation Center has a new Innovation Advisors program that will serve as a network of experts in improving the delivery system. Advisors will test new models of care delivery in their own organizations and create partnerships to find new ideas that work and share them regionally and across the United States.

- Applications for the program are due November 15th. Please visit the Innovation Center website at www.innovations.cms.gov for more information.

- Seamless Care

  - Strong focus on community based care transitions

  - Aster at Baylor Heart Hospital

    - Lowest readmission rate for CHF in the nation

- Call within 24 hours – instant problem-solving

- Juanita Crafts Diabetes Health and Wellness Center – 50% decline in ED use.
  Community colleges training community-based outreach and education workers. Essentially *promotores*.

- Nuka System of Care – integrated teams

  - 50% drop in urgent care and ED use
  - 40% drop in hospital admissions
  - 60% drop in specialty utilization
  - 1/5th the previous staff turnover
  - 75th-90th %ile on HEDIS quality indicators.

- Imagine starting an ACO today…. Who would you need to assure the most seamless and effective care and transitions for the patients in your charge?

- Prevention – taken seriously

  - Southcentral Foundation – Family Wellness Warriors - over 3000 people trained.

    - 1500 Southcentral Foundation employees in 3-day core concepts training.

    - 66% of criminal offenders in Alaska return to prison. For the Family Wellness Warrior inmate participants at 3-year follow-up, only 16% had committed new crimes.

        - 75^{th}-90^{th} %ile on HEDIS quality indicators.
    - Advanced dental technicians in Alaskan villages
    - Drain, Oregon – retired dentists

- Bringing the best of our system to every community in the country is the health care challenge of our time. The good news is that we are making progress, as it needs to be made, in partnership between the public and the private sectors.

- We are all agents of change and it's going to take determination on everyone's part to achieve this transformation.

- This is an answer – the best possible answer – for the years ahead. If we had started on improvement as a

strategy five years ago, many of you would be in far less pain today.

- But, will it help in this crisis? Is it a satisfactory response to emergency? The fact is, I don't know. Direct savings and budget cuts may be the best you and your governors and legislators can do for the present.

- But, I say, bet on improvement. Get started now. Even while you tighten your belts, start changing care. The *status quo* is not a formula for the future; it dooms the future. We in CMS want to be partners with you in the States to cause health care delivery to change for the better.

- Thank you.