[00:00:01.290] Announcer: Welcome to APG on American Healthcare, the official podcast of America's Physician Groups, where we discuss current issues in the healthcare value movement, APG members are at the forefront of national healthcare reform, practicing in risk based prospective payment and other population based payment models, the very models described by federal legislation for the entire nation. And now for an inspiring and educational look at the transformation of America's healthcare delivery system. Here's your host, APG President and CEO Don Crane.

[00:00:36.540] Don Crane: I sat down with Andy Slavitt the other day to talk about the COVID pandemic, the value movement and related matters. Andy, as you may know, is a former administrator of CMS and just generally a tour de force who has devoted himself to communicate, discuss and analyze the pandemic. His current work almost feels like an act of patriotism. He may be a little bit biased, but his COVID coverage is almost always timely, insightful and accurate, I think you're going to like this session.

[00:01:08.130] My guest today is Andy Slavitt. It's our good fortune to have had Andy during the period of 2015 and 2017, served as the Acting Administrator for the Centers for Medicare and Medicaid Services under President Obama. He was, prior to that time, an Executive Vice President of Optum. Optum, of course, owns some seven or eight or nine of our current members and a number of other physician groups. So you can see a connection and overlap there.

[00:01:38.880] He's currently the Board Chair of the United States of Care, a new nonprofit think tank and advocacy organization. And I'm going to ask you about it later, because I find it very interesting. He is also perhaps known well, to those of you listening today, as the Host of a new podcast called In the Bubble. In fact, today his guest was Michael Osterholm, the University of Minnesota Professor and Epidemiologist that is playing such a large part in this sort of American discussion of the pandemic.

[00:02:11.280] He's got a gazillion, I think that's a number, of followers on Twitter and elsewhere. And all in all, it's been this most amazing thing to watch is, Andy, we always admired you for all of your skills and so forth. But you have now really become, I think, in my opinion, perhaps the most respected and certainly most recognized voice in America on the COVID

pandemic. And so my first question for you Andy is, how did that happen? What is this mission? Did you anoint yourself or did someone else? Talk to us.

[00:02:45.660] Andy Slavitt: Yeah, the Kanye of COVID.

[00:02:48.600] Don Crane: Perfect.

[00:02:49.550] Andy Slavitt: I like that. Yeah. No, that guy is not my model. I'd say the truth is, I don't really know. I would say that part of it may be that I had, you know, coming out of Washington and wherever I was and everything I did. I was sort of what people would consider to be an insider. Right?

[00:03:15.590] Relationships with the same people that you do, Governors, Senators, the White House and CEOs, etc. But I think I made a decision that I really would rather be a helper than an insider or maybe an outsider's insider. Its not that I don't value my relationships with people I do, but I realized I value helping people even more. And that means, you know, I have the privilege of being able to speak out clearly in all directions.

[00:03:55.470] And sometimes that pisses people off. Maybe sometimes they respect it. Some days they like it. Some days they don't like it. But you know, you realize that there are, as you know, hundreds of millions of people who are just worried every day about healthcare even before the pandemic. And they're so worried that a bunch of people they don't know in places like Washington are making decisions that are going to impact their lives and they have no say in it.

[00:04:24.750] They have no visibility to it and it just sort of happens. And so you know, I think I've tapped a little bit into that ability to help people sort of see and feel what's going on a little bit.

[00:04:35.600] Don Crane: Oh, Andy, this will sound like blowing smoke, but I think you're being a little bit too humble. I mean, you're absolutely right, in my view, that we are in this amazing environment of really poor information. I mean, can we trust the CDC?

[00:04:51.390] I mean, you hear what's going on what's said down at the water cooler. It's novel, no pun intended in terms of the nature of the virus. So there isn't good information not even in the science where we're learning as we go. And so as I listen to you and I watch this environment, I watch it closely because it's really a part of my job description. I think you're making a big difference. And I need to salute your sort of tone of voice bias, though you are.

[00:05:19.830] Clearly, we can see that there is a sort of an objective tone, very data driven and so forth, that I think is really welcome and worthwhile. So if you're not getting good feedback from your dog and your kids and your wife and others, you can take that to the bank from me anyway.

[00:05:39.990] Andy Slavitt: Thanks. I'll call you when I'm feeling low and need a virtual hug.

[00:05:44.130] Don Crane: When you're feeling low and you need a virtual hug.

[00:05:46.170] Well, I will deliver it. So anyway, thank you very much. So let me ask about U.S. of Care. So this popped up. You're the Founder, I think. Who is it? What is it? How does it figure into your sort of mission with respect to I'll say all things communications, but mostly pandemic?

[00:06:07.010] Andy Slavitt: You know, when I left the Obama administration the next year was really, quite honestly, taken up with this big fight over whether the ACA was going to be repealed or not.

[00:06:19.190] And, you know, I got drafted into that or I drafted myself into that. Whichever way history, whichever it lands on history you take, and we ultimately won in a matter of speaking and the ACA didn't get repealed, but boy, along the way it felt like this is not a good, sustainable way for things to be where whichever party wins election gets to make the rules and gets to decide on their system behind closed doors. And we never have a consensus again.

[00:06:57.310] And therefore, when if the Republicans passed something, the Democrats spend all their time trying to shoot it down. If the Republicans, Democrats pass something,

Republicans spend eight years trying to shoot it down. And that I saw I started to think about, OK, every decade or so we go at this again. Right? you go back to the 60s, all the way to the 70s through the 90s, CHIP and Clintoncare and Obamacare and all.

[00:07:25.990] So there's no question in 2020s we're going to try it again. And so what I decided to do was to say, rather than just fighting this fight constantly, what if we started planting the seeds today? Let's say that for something that's going to happen sometime in the mid 2020's how do we plant the seed today so that we don't end up with a situation like that and we get the best possible outcome? And the first thing I did was I called a lot of very, very smart people who I respected in healthcare from across the aisle and basically asked the question, what does a good outcome look like?

[00:08:02.560] And that was everybody from Republicans and Democrats like Tom Daschle and Bill Frist and CP SCHEAR [?] and Mark McClellan and others to regular ordinary people, healthcare people, advocates, clinicians, business leaders, everybody. And those people form what we call the Founders Council. And it's a great group of people with everybody from Mark Cuban to, you know, hospital CEO's and everybody else. And no insurance companies, nobody who is sort of part of the coverage process.

[00:08:38.500] And what we decided was there were three outcomes we wanted that we could all agree on and one was that everybody in the country should have access to a regular source of care. That in itself, if done over time, will make people healthier and there's nothing to do with insurance. It could happen a lot of different ways. But that bond between a care provider and a consumer needed to be an individual, needed to be at the top.

[00:09:11.050] Secondly, that nobody should ever have to choose between a medical expense and some other expense in their life, that there is a measure of protection. People should be able to take care of their family if someone gets sick, they don't want necessarily a handout from the government, but they want to be able to afford the care they get. And then third, this is the sort of the wrench in it was that we support policies that we can get 60 to 70 percent support for, not 51 percent.

[00:09:44.380] And that we are overtly against things like breaking up the filibuster because we think that if we'd rather have something that's 90 percent as good a product and completely

durable than something that is 100 percent of what one party wants, but it's going to be changed every few years.

[00:10:06.230] And so the organization I committed to raise one hundred million dollars for that cause over the next decade. And that organization is working with states and working on passing policies and models and owning public opinion that really solve problems for people, because by the time policies get done, they often lose their purpose. They started out with a great title that everybody loved, but the details underneath them got negotiated away. Now, for the last six months, the organization's been entirely focused on the pandemic and providing support to states policy support to states, to Congress, to clinicians, to the community on a whole matter of speaking.

[00:10:50.660] But that's because we're just in one of those moments where everybody throws in.

[00:10:55.720] Don Crane: So when you're speaking on the pandemic today, are you representing just yourself or is this also a representation of US of Care?

[00:11:04.900] Andy Slavitt: Yeah, I wouldn't force my opinions on anybody. So I have and I founded an investment fund called Town Hall Ventures, which we invest in underserved communities, healthcare innovation in underserved communities. I'm associated with Bipartisan Policy Center or Chair there at United States of Care. I probably have several other affiliations and I invite all of them to disown anything I say that they don't like, or they don't agree with.

[00:11:37.570] And of course, that's the reason why United States of Care has a completely bipartisan board. Everyone doesn't agree on everything. That's not the problem. The problem is the way we disagree with one another and the ability to work on issues together. There are perfectly legitimate multiple solutions to every problem. That's OK. But you may surprise people to know that I talked to the White House two or three times a week. I can get in the room with and I will get in the room with anybody who's working on a solution that is focused on making people healthier, saving lives, but doing it the right way.

[00:12:17.650] And we all ought to have that attitude or we're not going to get better.

[00:12:23.530] Don Crane: So we've watched your support of the resiliency or the support of the United States of Care of the resiliency proposal. I think it's being kind of commonly called that the Duke Margolis Foundation, Families USA and the United States of Care. So got it on that work. I want to put that to the side for a minute and spend a while talking about the pandemic. You and I can flex our considerable muscles in terms of our vast knowledge of epidemiology and virology.

[00:12:56.140] Then we'll talk about the value movement, because I do want to circle back on it. I don't want to leave that point.

[00:13:03.160] I think that you hear in the press, even this very day, a certain amount and maybe last night. Maybe a certain amount of kind of congratulations among some in some quarters that we're doing well with the pandemic in the United States, that we have a certain modicum of control over it. But I note looking at the CDC website a little earlier day today that we're at, I think, 36,000 and change new cases every day. So that rate is down from the 60 70 where it got but strikes me as a high plateau.

[00:13:38.140] So in light of that statistic, I think I'll start by asking you, so how do you think we're doing now seven months in, if that's where we are Andy?

[00:13:48.290) Andy Slavitt: I think we're doing poorly. I think we're doing poorly because I think at this point in time we should have things well under control, given where we were even with a bad start, even with not coming to grips with this thing in February and March like we should have. And I think our sin, the second thing was taking May off and disbanding the task force, leaving testing up to kind of a sort of free market approach, attempting to say that we can open the economy and have the economy work without addressing the public health crisis.

[00:14:27.830] States who had not seen the pandemic spread to them, patting themselves on the back for what a wonderful job they were doing, as compared to New York. Governors peacocking around strutting with holding their suit lapels at how wonderful job they did, not realizing that there are certain immutable properties to a pandemic, which is that a virus is going to go where it hasn't been before. And it's going to go and it's going to take refuge in places that

are indoors that are where it's easier to spread, where there's larger events and much to people's surprise, turned out to be the South because largely, I think because people needed to be indoors in larger settings. There were governors that were not willing to accept the lessons of what they saw in the Northeast.

[00:15:20.300] But even if they had been, I think there would have been trouble because it was difficult. So I think some of this is just what happens in a pandemic. And we have a lot of people who sort of thought, hey, if we wish it away and you point to things like you're pointing to a case going, hey, things are better, cases are dropping. With all due respect to that statistic, it's nonsense. We're testing about 10 percent of the cases that exist. We are discovering about three percent of the spread through our testing. The CDC today has made a baffling recommendation that testing be halted or that people not be required to test if they're asymptomatic and were exposed to the virus. In other words, if I found out that you and I spent half an hour together, I found out later that you had COVID-19.

[00:16:20.720] CDC is now saying, I don't need to test. Things like that are going to be used by counties across the country and people across the country to bring down the case numbers. Unfortunately, they will not bring down the hospitalizations and the death tolls. They'll bring them up because this is a boomerang. And then the final thing I'd say, the place that I'd say I'm fairly disappointed is our society is we prize certain values and we prize individual liberty, freedom, entrepreneurship, rugged individualism, things that are sort of part of our mythology.

[00:17:05.150] And indeed, they are what a lot of us value in our country. But we haven't ever really done a good job of having that conversation about where do my own personal liberties stop and where do other people's rights and their health begin? What are our responsibilities. What amount of sacrifice we're willing to undergo to prevent death toll? Can we, in fact, be a society that gets everything that we want when we want it? And then, by the way, when we find out that the death toll is happening to other people and by other people, I mean black people.

[00:17:42.290] I mean brown people. I mean people in the Rio Grande Valley in Texas. I mean people in the Central Valley, California, I mean people in San Quentin Prison or the Chicago Cook County Jail or Mel's nursing home in New Jersey. Do we say, oh, that's not me. That's other people, and therefore, maybe I'm not so concerned with the spread and I am concerned with going to the bars and restaurants that I've been going to my life and I don't know why I'm not able to go to them.

[00:18:10.620] And so we have this sort of discordant response that is beyond the politics, beyond economics. It has to do a lot with the sort of the culture of our country.

[00:18:25.600] Don Crane: So maybe that's the reason why I think I observed what I do now, which is a sense that maybe there's a stasis going on between measures to suppress and basically new cases and overwhelming hospitals. So here in California, I think the governor is going to announce some new relaxation on certain counties and so on at a time when other counties are having trouble.

[00:18:55.120] So I'm wondering if

[00:18:56.290] Andy Slavitt: He's going to announce more testing today

[00:18:59.590] Don Crane: Well even so, my question remains, we've got a certain level of suppression going on right now, so you can't go to a bar, but you can go to an outdoor restaurant. And it does seem to yield a given number of new cases, hospitalizations and deaths. And I think my sense is perhaps this is tragic to even have to ask it this way. But are we in a certain sort of tacit fashion getting to an agreement very tacit that this level of death and hospitalization is somehow tolerable and kind of fits with the level of restriction we've got going on?

[00:19:37.210] Or are we going to see the piston oscillating quite a bit more volatilely, big shut downs followed by big openings? Or are we getting to a kind of a new status quo stasis, what do you think?

[00:19:51.190] Andy Slavitt: Yeah, Don. I mean, it's because this is more like the crack epidemic at the moment than the opioid epidemic. You know, the crack epidemic was happening to other people and we treated it very much at a distance. We criminalized the behavior of taking drugs and we really looked down upon and kept our society. Our goal was keep our society safe from not solving the problem. With the opioid epidemic we felt that everywhere. We felt that happening to us.

[00:20:19.450] And our policy response, well, I wouldn't argue was very good, was at least more understanding. And right now, I think, you know, as long as people can say that, you know, I mean, I have people tell me all the time and I'm sure you I don't know anybody who's died COVID-19 in my responses. That's because you don't know the people who grow your food. That's because you don't know the people who bring the food to the distribution center.

[00:20:45.070] That's because you don't know the people in the distribution center and you don't know the people in the grocery store and you don't know the people delivering it to your door. Those are the people dying. And they're not your friends anymore because our society is cleaved that way. And so, yes, those numbers become more acceptable to people at least that's one of my perspectives. I also think it's aided by the fact that we have not had by and large. This has not been a visual event.

[00:21:18.970] We've not had cameras for some obvious reasons and some other not so understandable reasons inside hospitals and nursing homes. So the first time we hear of 30 deaths is at the end of a nursing home. And of course, finally there's the fatigue that people get. But if you do this thought experiment, Don. If I had said if we were not in August of 2020 but we were in August of 2019 and I said to you and I were talking on the phone and I said, Hey, 35,000

[00:21:50.890] people are scheduled to die in the next two months and we can do something about it. You would say, Andy, holy crap. 35,000 people out of nowhere. That's ten times 9/11. That's a huge number. That's a tragedy. We've got to do something and I think most people would. But now we get news that we are going to have tens of thousands more deaths if things don't change in the next few months.

[00:22:23.340] And they really and it's amazing there is no longer much of a response.

[00:22:29.410] Don Crane: So it's a sad dynamic, to be sure. You've now projected a little bit into the future. So let me ask you some more questions about the future.

[00:22:38.030] I mean, given this kind of current posture of suppression and such how much longer are we going to be living with all the social distancing and so forth? Do you have any kind of prediction on that?

[00:22:53.380] Andy Slavitt: Well, I think it's up, it's unknown, but there's a couple of variables. One is, are we willing to bite the bullet and take some short-term pain in order to crush the curve? Because we know that from what other countries have done and what New York has done and what the NBA has done, that if you give the virus six weeks of nowhere to travel, the virus dies.

[00:23:19.240] And we have not done that. People think that's what we did. But by declaring over 50 percent of the people in the country essential workers, we kept the virus circulating even in moments when we thought we were staying indoors. If we wanted to be serious about it, we absolutely know what to do. We absolutely could. It would require six weeks of significant sacrifice. Now, if I told my grandmother, who is no longer living but who came here, landed at Ellis Island, lost seven of her brothers and sisters, and lived through a 10 year depression and a six year world war, that we were having a difficult time figuring out whether or not we could muster six weeks of sacrifice.

[00:24:05.600] She would have smacked me around. So I think you've got to get the country in a posture where it's willing to make those decisions. And then, of course we're waiting for science. We're waiting for vaccines.

[00:24:20.500] Don Crane: So do you think that the vaccine we're waiting for will be some kind of a knockout punch or is it going to be a disappointment or somewhere in between?

[00:24:27.040] Andy Slavitt: Yeah, look, I think a vaccine is more likely to be a tool that converts some immunity for some period of time or more like an influenza vaccine than like what people think about as an MMR kind of vaccine for life. So its job is to give us some level of herd immunity that we can do without people dying, which is the way we earn herd immunity now. There's a lot to be learned about immunity, how long it lasts.

[00:25:02.420] We know it doesn't last forever. We know that there are other strains. I don't think there is a silver bullet. What I think there is instead is a gradual improvement. Things gradually get better. And as things gradually get better, that will be from a number of sources, almost like a cocktail, which includes better therapies, better treatment protocols, some sort of monoclonal antibodies, vaccines plural, and probably some continued non pharmaceutical interventions.

[00:25:37.840] I suspect there will still be times on occasions and seasons and people that will still need to wear masks. Maybe we will. Maybe we won't go back to the ritual of handshaking again. You know, there will be some adjustments and I think it will be gradual with hopefully some step function progress soon along the way, very likely in 2021.

[00:26:01.630] Don Crane: So let me play a little bit contrarian here, and I actually hope that this view does not materialize, but I think it might. So, you know, three hundred and thirty million Americans supposedly we get to herd immunity when half of them have been either infected or received the vaccine. Factor in I won't do the math here, Andy. I'll let you. But factor in the anti-vaxers; those people are otherwise skeptical about taking the vaccine. So maybe 50 percent of the population willingly takes the vaccine in the early stages.

[00:26:39.070] Factor in the level of efficacy, which could be 70 percent, could be 50 percent. You start to do the arithmetic and you recognize that we have only, I think, had something on the order of six million cases thus far. It feels like we're going to need we've got forty or fifty million cases out in front of us, which at a case rate of thirty six hundred a day or whatever it is, this looks like something that may last years, plural. What do you think?

[00:27:10.630] Andy Slavitt: So I think there's a couple of variables there. So first of all, we haven't had six million cases, we've had probably ten times that. But it shouldn't make us sleep well at night because we don't know for sure how long immunity lasts. We don't know about t-cell immunity. There's a bunch of unknowns. But there is some level of immunity. It's not, you know, in places like Phoenix and in New York, it's twenty five percent.

[00:27:40.270] But we don't know if in a year from now, whether that twenty five percent will still be there or whether that will go away. But there's some level of natural immunity. And then I think a vaccine if it works on 50 percent of people and half the people take it, you know, that's another quarter. If you do that math in your target now it will get a little wonky on you. If your target is to get to an R-naught of say, point seven five or below, because and I'm sure all of your listeners know what that means.

[00:28:17.400] Don Crane: Everybody's saying it has an R-naught of three, Andy.

[00:28:19.450] Andy Slavitt: There's no such thing as an R-naught as you know. I mean, there are individuals that have spread this to literally thousands of people on their own. And there are individuals that aren't very contagious at all. It's both very likely human based and situation based. But so the averages can be deceiving. But if you just work with the averages and you had, as your scenario points out, a 50 percent effective vaccine and 50 percent of people took it, you would have to have just over a 1.0 natural R-naught to get down to a point seven five and deliver it to live at a 1.0 is living with quite a few restrictions. It looks a lot like the world does today. But over time, you know, that would drive the numbers down if in fact, either you could get to efficacy of it. And by the way. Right, you point out something very astute. Efficacy and trust are equally as important. So you can have a vaccine with 100 percent efficacy. If it has five percent trust, it's five percent effective. You could have one with 75 percent effectiveness but it has, 95 percent trust. It's very effective. And so I think, again, all these things gain on it. And if in the meantime the case fatality rate continues to drop because monoclonal antibodies, better testing and so forth comes along, you can picture a situation under which we may not be able to do everything again. We may not be filling in the near term a hundred-thousand-person football stadium, but we're able to give students entry level strip tests to go to class and people are just not as worried about dying. There's some variables even in that, because there's one more variable of who does it work on. And if it doesn't work, say, on older people, which is as you know is sometimes a problem with the influenza vaccine, you end up having to put in place different types of strategies like cocooning strategies and others that are adjustments. I don't think this goes away, but I think this gets materially better over time. This is not this is not the zombie apocalypse virus. This is a very manageable virus, but you have to manage it, and so far, we just have not been willing to do the work.

[00:31:01.450] Don Crane: So let's talk about another variable that we've not yet mentioned. A little more difficult, perhaps, to talk about. But that is there's this little thing called an election playing out on November three. I think we've been sort of talking as though, you know, there's sort of no change in the administration. Let's assume for the sake of discussion that we have a Biden administration based on the election. How do you see that affecting the course of the disease and our management of it?

[00:31:30.730] What do you see that the Biden administration doing differently on day one? What do you see them doing differently over time? How much difference will that make?

[00:31:40.690] Andy Slavitt: Well, I think the good news is they've already started in preparation in case they do win. I think the only responsible thing is for them to be ready if, in fact, they need to take this over. In many respects and I've talked about this with them. Do you remember in 2008 when the transition at the US Treasury, when Tim Geithner took over and the economy was tanking. The transition at HHS and then the White House and over the task force and pandemic response is equivalent to that. So the good news is that gives the team a lot of time to think about it. The better news is, depending on how you approach it, the talent level of scientists and those who want to be part of the solution is quite high. And those have felt, relatively speaking, shut out by the Trump administration. I mean, I assume you've got supporters of President Trump that listen to this and supporters of Biden, and that's fine. The truth is that what the appeal of Trump is that he can override the pointy headed bureaucratic scientists to keep the country moving and not bow down to them. And that's been true with the EPA and that's true with the CDC and it's true of the FDA. So, you know, he is much more comfortable running a government that looks like the Trump organization. And his interest so far has not been to run on how many lives he saved, but how much he can keep the stock market up and keep our, quote, unquote, way of life happening and some people like and respect that. But there's not much evidence and I'm not even talking about observationally. I'm talking about firsthand. There's not much evidence that I see that he's much interested in saving lives. And I would not have predicted that. I did not predict that Don. I mean, it gives me no joy to say that. At the beginning. I said very publicly that he is interested in saving lives and doesn't want people to die. And I actually don't think he wants people to die. I'm just not sure he cares very much relative to other priorities of his. I think Biden is an interesting person for this moment because he sees himself as a unifier, somewhat of a transitional figure, someone who will be president of the whole country, as he says. And he is a great believer in respect of science. But he's also not apt to be pushed around by the scientists either because he knows his way through that. He's got some great people on his team and great staff and experts. I suspect he'll be inclined to take the recommendation to try to crush the virus as quickly as possible so that it doesn't get in the way of everything else. And he can move on.

[00:34:53.950] Don Crane: Might he go so far as to adopt your suggestion authored by you, I think, and others for a real crush, a six-week complete shutdown. Might Biden go that far or is that just too politically impossible?

[00:35:08.680] Andy Slavitt: Well, I'll tell you what, what I put on the table, which people call the kitchen sink approach, which is six weeks of crushing the virus. I put on the table to say this ought to be part of the dialogue. It ought to be an option that is considered. It's been effective all

over the world and it was not even presented to President Trump by his staff as an option. So obviously, in the course of picking options, you don't select an entire option.

[00:35:38.380] You select the best elements of the options you like and try to create a cohesive plan. I think he will absolutely consider the pros and cons of that. I think we are a lot smarter today than we used to be. So when people hear shut down, oh, my God, not again, but the truth is like I could I don't care about a small shop or a small store, retail, any place where there can be one to one transmission doesn't really concern me. What concerns me is not cases but what concerns me are outbreaks. So there are a lot of things that we closed down before because we just didn't know we precluded outdoor activities entirely. We now know we don't have to do that. We were hyper vigilant about surfaces, which made a lot of things very difficult to do. We now know we don't need to do that. So there are some things that we need to do. We need to prevent people from coming from high, intense prevalent cities to lower ones without some level of quarantine measures. We need to prevent people from being indoor bars and unfortunately, college campuses, church choirs, indoor arenas, big family gatherings. We know those are sources. And then we really need some more complex solutions in places like farm labor camps and in jails and other places where people are in congregate settings.

[00:37:07.420] Don Crane: So Andy, time is flying by and I've got to move into my favorite subject, of course, so near and dear to APG's heart. And that is the value movement. We, like you and everyone else, have watched with utter amazement as the fee for service payment model has failed the country and left a whole lot of physicians insolvent and revealed itself really to be insufficient for public health crises and probably really chronic disease management. And at the same time, also, no secret, we've seen that prospectively paid groups like APG members have continued to provide care to both COVID and non-COVID patients and do all the kind of outreach and things they do pretty much without missing a beat. And that's been pretty darn dramatic and has spawned a conversation we've relished being a part of across the country about the need to really accelerate the value movement. So the question I would put to you now is what do you think the pandemic has done to the value movement? Has it made it more risky to go into risk-based arrangements? Is it less risky for that reason? Will it accelerate it? What sort of impact is it going to have on the value movement?

[00:38:21.370] Andy Slavitt: My first piece of advice is to take the opportunity to cast what you call the value movement in terms that real Americans can understand, because if there's a teachable moment here, you know, it's not about teaching the wonks and CMS and the insurance companies and those of us who pay attention and influencers like yourself. It's really can this become one of several takeaways that people take away from this crisis? So a simple one. People understand telemedicine, right? They understand why that is important and positive. But you know, so instead of saying prospective payments and value movement and value-based care and all of that, I wrote a paper that was in JAMA. And what I said was, we have an opportunity to allow one thing that the virus is really brought to light is that we really need individuals to build their relationship and pay directly to their care provider. The care team that's going to take care of them, and that ought to be the permanent portable part of their life and that insurance companies in that function, while not unimportant, doesn't belong in the middle of that. It belongs behind that carrying out various functions, like making sure people get paid and the care is coordinated and that a whole series of other things that they do that are important continue to happen if they're important. But they not be the place where a consumer has a relationship. And people go, aha, you know what? I don't want my primary relationship if I had a choice to be with the insurance company, I would much rather have it be with my care team, my doctor. However, it's defined in my local community and maybe that's virtual, maybe that's personal, whatever that is. That's what's important to me. And making that sale and making that case and planting that seed, even if it doesn't create immediate benefit, there's an opportunity to change the culture and change the dialogue so that over the longer term there is the energy and momentum behind broader change. So I absolutely agree and it's apparent on its face what happened and why fee for service medicine is bad, but the healthcare industry has got to stop talking to itself and each other about these things and if we have any hope that patients will feel, hey, this is good for me and this is what I want and then that will bleed into the way people make policy.

[00:41:09.610] Don Crane: So I love that as a theoretical construct, Andy. If what you're saying is Americans everywhere prepare themselves to self-pay some amount of the total cost directly to their physician in order to establish that relationship, I mean, they're already struggling with co-pays and coinsurance and deductibles. So what am I missing?

[00:41:33.030] Andy Slavitt: What I just described to you was capitation. But it was in terms of consumers and it was actually who and how you might select where you get care instead of an insurance company that may or may not have all the doctors and networks that you want in them. So it's a bit like a funded direct primary care model, a bit like a capitation model. But my point is whether you agree that that's the right exact model or not, Don, the point is we have to

do is put this in terms that people say, yes, that's what I want. And if you can't do that, then I don't I think the chances of really substantially structurally changing this are low.

(00:42:24.830) Don Crane: So that's sort of segues into the resiliency proposal, which and you can correct my misstatements here, among other things, allocates, I think thirty-five billion to physicians and physician groups to assist them into moving into value. And then, period there isn't talk about involving consumers. There's not talk about incentivizing plans to develop the readiness and infrastructure to do these things. There is not talk within that proposal and maybe there shouldn't be. This is a better proposal, nor is there any specifics as to conditioning the receipt of money on an agreement or a commitment to move into value. There isn't any kind of criteria, processes, attributes. It's just a hunk of money. So I worry that a hunk of money isn't sufficient. I hear you talk about interesting elements of detail, Andy. Somehow reconcile this. You guys have supported this proposal. We have likewise supported it. Makes a lot of sense, but it feels like it needs more detail.

[00:43:33.330] Andy Slavitt: Oh, I agree. It's, look, it is an interesting time and a very tough time to start a dialogue about this with Congress. But right now, I mean, educating Congress about these things in ways that they understand and that their constituents can understand. And that's kind of way I was using that language is the most important thing because the time will come and you know that will happen where there will be some must pass legislation. It probably won't be on this side of the election. And having to socialize is really important. But I think we in healthcare fail to keep in mind is that your typical congressperson or senator is expected to keep up with national security, healthcare, immigration, transportation, infrastructure, the economy, jobs. And so we are continually I think when you bring people into Washington and they walk away saying, well, those people don't understand healthcare. Yeah, they're not. They were selling cars four years ago and now they're trying to understand the entirety of the US government system. So educating them, using really sophisticated terminology and this is not to insult them. This is to say we have a citizen legislature history in this country, get away from it a little bit. But educating them in terms that real people understand why is good for my constituents. Why will I get people happy that I did this instead of crafting something where a bunch of industry people get around the table and basically cut up the math, which is how every bit of legislation in healthcare gets done. And so I'm a little bit more becoming more of a believer in setting the table, building the energy and the momentum and then it's amazing how things happen. And I can give you examples. They're not examples in healthcare, but they're examples that are really vivid and really fresh of how people have done it right and it made substantial change and change people's minds because they've gotten a combination of grassroots commitment and very simple, clear messaging around why a change is good. We don't

approach it that way. We have people have too much money at stake and they shut the consumers out.

[00:45:59.180] Don Crane: Well, no question we've got an employer sponsored model where the employer takes care of the healthcare coverage, pays money to a health plan and then makes the payments. So indeed, I think our patients and consumers are divorced from what's really going on. But I also wonder, Andy, if some of these issues, with all due respect to the elected, who should be following, you know, the NBA and the bubble? I think that these issues are pretty esoteric. And I then ask, is it sufficient then for their proxies, the Families USA, for example, and other consumer groups who are right now calling for a movement to value an accelerated movement. Is that enough? Can it be done via proxy and representation? I'm having a hard time thinking the three hundred thirty million people are going to start raising their hands and cheering for capitation.

[00:46:51.740] Andy Slavitt: Well, you're right, I think you have to ask yourself, what is it that people care about? And you have to do that by listening to what they actually care about

[00:47:00.090] Don Crane: Well, their doctor's office is closed right now. Thank you to the fee for service payment model. So they come to the door and their primary care doctors closed or moved away, maybe got hired by a hospital or something like that, and they go, what the heck happened? And then somebody explains to them, well, it's because the fee for service and the COVID and so on. It's a bad system. I don't know.

[00:47:23.230] Andy Slavitt: Yeah, I don't think that's the take away people get. But I will tell you that you and I are the last two people that will know the answer because we're too close to it. And the truth is that you have to listen to the words people say and what they value. What matters to them. The reason that people are enamored with single payer and why there's a movement there and why it's more than just people who don't know what they're talking about is because the system doesn't work for people and people want to just know that it's there. They just want to know the healthcare system is there. That's really what people are saying. That I want to know that I have a healthcare system there for me and that there aren't people reaching into my pocket making it more expensive and doing things that make it not work. And there are increasing number of people and I think the younger generation in large numbers who want a more dramatic do over system, but a very simple, you know, I think with a very simple message caught fire and it didn't just catch fire on the left. The truth is, polling shows that's quite a bit of support on the right as well. And I'm not saying that that's going to happen because our political

system doesn't work that way. But that's just an example of connecting in that way. And if you say to people, that's why I use the word, you know, have the relationship with your care provider and make that the center of your relationship instead of the insurance company, how does that test? And in what is the right language? What is the language that people use? And think about it. In the meantime, you know, yes, we're going to keep proposing bills, but we'll be a hell of a lot smarter to propose bills, resiliency plans and so forth if we can use language that includes people instead of excludes them. If we can even run listening sessions with folks. I started to make by the time I was in CMS when they were making models is a requirement that people have met with a kind of 360 degrees of people because some people have great access to CMS. And so it's like, sure, all the other pharma companies and insurance companies and hospitals are there all the time. But they present something to me and I'd say, who have you reviewed this with? And I'd say, OK, well, have you reviewed this yet with any patients, people? Well, then I'm not ready for a presentation. Go do a 360 degree. Go sit down. And you know what's interesting is that some people come back with is not stuff we would have always predicted, but inevitably things would change. And there were some really low hanging fruit that people think is important that made them like, for example, the ecology model and program better. People like certain primary care elements better. And I just was uncomfortable with having me sitting in a room deciding being the last word or have someone in the White House being the last word on how a model should work with absolutely zero input from patients. That would never happen in the commercial world.

[00:50:39.030] Don Crane: Right, right.

[00:50:40.170] Andy Slavitt: I mean, I don't mean commercial healthcare, I mean like I you'd never build a technology product or a service without some amount of consumer testing input.

[00:50:51.240] Don Crane: So I think we got some work to do. It's very interesting as you watch the Medicare for All sort of movement and so forth, and it does, I think, depend on a lot of education and a lot of listening. And I think we'll do that. I detect a note of optimism in your voice, Andy. Any concluding thoughts? Is that a fair estimate on my part?

[00:51:14.990] Andy Slavitt: Yeah, I mean, look, we have no choice to be optimistic for the following reason. Take the pandemic of 176,000 people have died. Yeah. What about the 176,000 in first? Right? So the number keeps crawling because if we despair or if we look backward, but there's an opportunity to keep doing it better and just not accept the fact that there are I will not accept the fact that thirty thousand people are due to die before Election Day.

I just can't accept that. And by not accepting it, it makes me optimistic. It makes me think about all of the things that can be done. And people in my position, you know, I'm not like people listening to this podcast. You take care of people every day on the firing line. You have my undying respect. I don't do that. I don't contribute that way. So I better fricking get off the sidelines and do something or I'm not earning my peace. I'm just a piece of the problem.

[00:52:25.940] Don Crane: I got a better idea. Let's work together. We'll harness your smarts and skills with those of APG and we'll see if we can't make the world a better place quickly. So I think that's our mandate Andy, sound good?

[00:52:39.650] Andy Slavitt: That sounds good.

[00:52:41.230] **Don Crane:** OK, well, I think that's a wrap. We're at our end, and unless you got any final words, I'll just thank you very much. Look forward to working with you. We look forward to enjoying your podcast. And with that, I just said thank you. Want to thank you very much, Andy.

[00:52:55.700] Andy Slavitt: It was fun to do this Don. I really enjoyed it.

[00:52:58.100] Don Crane: OK**,** and you stay well.

[00:53:01.340] Announcer: Be sure to register now for the APG virtual Colloquium, November 17th through 19th. Save $125 per person if you register before October 1st. Register now at APG.org. If you enjoyed this podcast, please leave us a five-star review wherever you tune in. Thank you for listening to APG on American Healthcare with your host APG President and CEO Don Crane. For more information about APG and transcripts of this show, visit the APG web site at APG.org.