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Making Medicare Sustainable: Transforming Our Health Program for America's Seniors
Luncheon Keynotes
New America Foundation
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ROBERT BERENSON, M.D.: —1996, the district is comprised of 19 counties along the Mississippi, and western Wisconsin, includes Eau Claire and La Crosse; after earning an undergraduate degree with honors from Harvard, Mr. Kind went on to receive a Master's from the London School of Economics, a Law degree at the University of Minnesota. Earlier, I had a pejorative thing to say about economists, so you are at least not just an economist.

He practiced law for two years in Milwaukee and served as a special prosecutor in numerous counties throughout western Wisconsin. In particular, for our group, he is currently a member of the House Ways and Means Committee and the Natural Resources Committee. In addition, to his committee responsibilities, he is deputy whip and co-chair of the new Democratic coalition. We are very pleased to introduce Congressman Ron Kind. [Applause]

REP. RON KIND (D-WIS.): Thank you very much, Rob. Thank you for that kind introduction. Good afternoon, everyone. We just got literally called for votes. So, I am going to have to try to abbreviate my remarks and run back up to Capitol Hill but first of all, I wanted to comment, and hopefully give you a little bit of perspective of some of the discussions that are taking place in Congress and I am serving

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on the Ways and Means Committee the health– Hi, Nancy.

CONGRESSWOMAN NANCY JOHNSON: Hi.

REP. RON KIND (D-WIS.): I did not know you were going to be here. Just to give you a little insight about what kind of discussions are taking place. But I did want to also thank New American Foundation for organizing this and bringing everyone together in the work that you are all doing to help us down the path for much needed, long overdue healthcare reform in this country. It is, literally, and I think Nancy will have a chance to talk about this herself, given her involvement and so many years on this, the 800 pound gorilla, that is facing our nation today and the federal budget and everything that we are doing and it is an exciting time but also a challenging time.

It is exciting, in the fact, that you have a presidential campaign, and hopefully, in the course of the coming months, as people start to focus, we are going to be hearing more of the details on a broader nationwide discussion of where we want to go with healthcare and those discussions, quite frankly, are already taking place. In fact, just before coming over here, we were meeting with many of my colleagues in the Ways and Means Committee about what the healthcare agenda will look like next year, the first year of a new administration and what are some of the issues that we want to

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address.

But, first of all, it is kind of self-evident and you probably all know the statistics, it is easy to identify what the problem is. We are spending 16 to 17-percent of GDP healthcare funding every year, 48 million uninsured, we ranked 26th on healthcare indices around the world. There is a sense that we can get a better bang for the buck and that is the overall challenge that we are facing. We are going to be looking upon many of you to start coming up with some solutions that does not necessarily expand the GDP allowance for healthcare, but figures out a way to get the universal coverage and also improves the quality of care, the outcome of care and the investment being made in healthcare in this country.

It is a daunting challenge but it is one that is so complicated, so emotional, yet so important that I come from this from the perspective that one party acting alone cannot do it. We have to work in a bipartisan fashion to find that sensible center on policy in order to move this forward. And you can imagine what the various proposals that is out there, one from single-payer system, to one strictly market-based, and all the hybrids in between, how difficult it is to develop that consensus in a bipartisan fashion.

But, hope springs eternal, every four years in this country, when you have Presidential elections and a new

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Congress coming in and that is really what the discussions are about right now. Whoever, the next administration is that first year is really the window, as far as domestic agenda, and trying to advance things and getting things accomplished. And healthcare will be one of the top priority items, barring any emergency or catastrophe overseas that might divert an administration's attention to all foreign policy or all national security and God forbid that we face that next year.

But, I see that later this afternoon, you are going to have a panel discussion too about whether or not Medicare, whether you can become a value-based purchaser. I think the question is, it is not can it becomes but how do we get there? I do believe that we have to revamp the reimbursement system in this country both through Medicare the public health funding and the Net will have a tremendous influence in private healthcare reimbursement and I think we are long overdue to move into a system that rewards value and outcomes and performance, rather than just utilization and the cost of healthcare.

You look at the regional geographic disparities when it comes to Medicare reimbursement, I hale from a part of the country that ranks very high in quality of care, yet it is one of the lowest reimbursed areas in the entire nation. And you take a look at Dr. Wenberg and others, the Dartmouth Atlas is

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producing every year with regional variation and the various cost savings, that they identify in and it makes sense and it is also one that is easier to argue to.

How do you argue against a system that is going to be reimbursed on performance and the outcome of care, rather than just on the length of stays, number of tests ordered, and the various geographic disparities in the approach of healthcare? But, in order, to get to that value based Medicare system, you have to be able to collect the data and it all has to be interoperable and you have to build out the IT infrastructure system and that too is a very important discussion that is taking place in Congress.

What incentives do we need to help create in order to get this IT buildup accomplished universally throughout the country? Some of the providers are way out in front of others. Obviously, if you are bigger and have more resources and making this investment and you typically want to protect that investment but we also want to end up with a system. We have a creation of a bunch of silos where it is not interoperable at the end of day. We have to be able to figure that out and then how are we going to create incentives or additional resources to those who are not doing it for a variety of reasons to get them to do it.

Will it be based on penalties and reimbursements? Will

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it be based on incentive payments thorough the reimbursement system? Will it be based on outright federal grants or low-interest loans to help you get there, or maybe using the tax code through 179 expensing or accelerated appreciation, or a hybrid of all these various proposals. And, that is something that we have to come to grips with quickly while also dealing with a very dicey, privacy and security issues of electronic medical records and that too has been kind of a weight in the progress of HIT legislation and where we are going to go.

But, it is crucial and we have got to figure out a way to get there and with your help and with a lot of the great thinkers that are devoting a lot of time to this, hopefully, we will be able to come up with some real practical workable solutions for us then to be able to move on, as soon as possible.

We can do better but we also need to incorporate more preventive healthcare measures in our system today. We also have to come to grips with end of life healthcare decisions and the impact that, that has. Now, the last time I talked about this on a campaign, and I do not know if Nancy ever experienced this but my opponent immediately seized on those remarks and started accusing Ron Kind as Dr. Kevorkian or someone going into ICU wards and pulling the plug on seniors and it is easy to scare people when you start talking about end of life care.

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But, it is also a large part of healthcare reform that we have to come to come to grips with, whether it is the conversation across the kitchen table about medical directives or power of attorney, advanced directives, or whether looking at the various geographic disparities when it comes to end of life healthcare decisions because it is stark, it is real, and there is a lot of money involved.

And, I personally believe that if those of us in the healthcare profession, the provider business, were to listen to the consumers of healthcare closer, patients, especially, when it comes to end of care decisions, I think are inherently more conservative than we give them credit for.

Typically, what we are looking for is the ability to stay in the home, deal with pain management, and have a chance to spend time with their family and if we listen to the consumers of healthcare, especially the older generation of those facing chronic fatal illnesses, I think that would be a more typical reaction that you would get from them. Rather than prolonged hospital stays and multiple tests and the latest technology to try to extend life a little bit further but at what expense and at what quality? And, that too needs to be a part of it.

So, we face challenges and the solutions are not easy but I think if we can develop within this group and with the

policymakers here in Washington, overriding principles of guidance of where we need to go, as a nation that would help set the table then for, hopefully, some quick and deliberative action next year, after the elections. So, that is a quick menu in a snapshot of what is being discussed on the hill and some of the items we are still considering this year.

We might have another debate about children' healthcare, expansion of children's healthcare, comes September after the August recess. That final decision has not been made but certainly whether it is an Obama or McCain administration, I am fairly confident in standing here before you today, that this will be a high priority area. It has to be, or it is going to gobble up and consume everything else that we want to do for the sake of our nation.

Finally, I just want to put a quick plug in because Richard Simmons comes in tomorrow to testify with me and Zach Wamp but we have been promoting a more comprehensive children's healthcare platform as well and we have this legislation called Fit Kids. Unfortunately, one of the unintended consequences in, No Child Left Behind, school district's dropping physical education in the schools and we know that it is impossible to develop a healthy mind without a healthy body and we see the statistics with childhood obesity and Type II juvenile diabetes. This is an attempt to try to have reemphasis on

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physical activity in our children's health.

Richard has been great, what you see on TV belies his true character and dedication to the issue. But we have to figure out a way to make sure that there are positive reinforcements with the youth of our country wherever they find themselves, whether it is in the home setting, the neighborhood community setting, in the school. So, that every time they turn around, they are getting hit with a reinforcing positive message of good lifestyle choices that they have to be making, being physically active, eating properly, staying away from the drugs and the smoking and that is something that is going to require a comprehensive approach.

So, Fit Kids is just a small sub stat, as far as physical education in the schools to that comprehensive approach that we need to take or we are going to be playing catch-up and healthcare is going to become even more expensive. And we could be talking about the great old days when it was only 16-percent GDP and now we are looking at 25 or 30-percent without any real enhancement of the quality of care that we should demand in this country.

Sorry, I have to cut the remarks a little bit brief, Bob, but I appreciated the chance to come by and give you a little snapshot and what is going on. Thank you very much. I am going to have to run.

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ROBERT BERENSON, M.D.: Okay. [Applause] So, we are going to have Congresswoman Johnson answer the questions that you wanted to ask Congressman Kind. I am sure for this audience, Nancy Johnson, does not need an introduction but I am going to do it anyway and then make just one or two personal remarks.

Former Congresswoman, Nancy Johnson, is currently in the federal public policy group at Baker. Donaldson, you all know her as a former head of the Ways and Means health subcommittee, she was first elected to Congress in 1982, was the first Republican woman to be appointed to the House Ways and Means Committee where she enjoyed a long career as a highly regarded thought leader particularly in health and tax policy.

As House Ways and Means Health subcommittee chair for six years, Mrs. Johnson co-authored, The Laws that Modernize Aspects of the Medicare Program, expanded it to cover prescription drugs. She was heavily involved in the Medicare Modernization Act of 2003, chronic care and management increased preventive health benefits, care offered by nurse specialists, physician assistants, nutritionists, essentially anything that was happening in Medicare during that period of time and has also introduced legislation related to HIT that led to the establishment of the office of the National Coordinator for health information technology at HHS.

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On a personal note, I remember when I was at CMS, being invited and spending a very enjoyable day with Nancy Johnson, visiting nursing homes in Connecticut where I got a lot of education about what those issues were all about. We developed a friendship then and I would say if we actually are serious about bipartisanship and trying to find some solution to cross these ideological and political spectrum, that Nancy Johnson should be part of the group that works through that because she really wants to improve the health system and works in a bipartisan way.

And, I would also point out that she has been here for most of today and I give her great credit. I think she sort of knows what we are talking about and one of the issues which I briefly asked her to address, I do not know how much time she will, is, and can CMS get some immunity from Congress's meddling I guess is the way, particularly, in the cost containment area.

She has been there, she knows the dynamics and is it, we have already been told, and Glen and I have been told that our proposal was unconstitutional but are there more practical problems related to, what are you guys kidding? How is Congress sort of not going to have its hand in all of this stuff? We very much look forward to hearing your remarks, and thank you for being here. [Applause]

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CONGRESSWOMAN NANCY JOHNSON: Thanks very much, Bob, nice introduction and for your many years of contributing to the development and a thought universe around the public health programs in America, Medicare being amongst those and one of the most important but certainly not the only one. It is really a pleasure to be with you, and it was a pleasure to be with you much of the morning because the thought that is occurring now the nature of the research in our academic institutions, the nature of the projects that are being done by professionals, are really important to us and they are more on point in my estimation than in some eras of our journey together. It used to strike me when I was, years before I was chairmen, how kind of irrelevant much of the academic involvement in health research was, to what I felt were the problems before me that I had to be responsible for dealing with.

Let me just make a brief introduction, some introductory comments and then some thoughts about where we are and what the solutions might be.

First of all, I have been out of Congress almost two years now. And I do not exactly remember when GAO gave his testimony but it was not very many years before I left Congress.

In 2020, and I tell teenagers, think about 2020, or to

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give yourself a little more leeway, think where you will be in 20 years. Think how old you will be, think about the wife you might want to have, the cars you might want to have, the house you might be buying in 20 years because that testimony was very powerful and it is probably still as true today as it was then. At that time, they said in 20 years, and that meant about 2022. But in 20 years, every single dollar of tax revenue would go to fund entitlements, Medicare, Social Security and Medicaid. 20 years is not very long to find an answer to a problem of those dimensions. So, here we are a number of years later, the growth trend in all those programs is pretty much exactly what it was when that testimony was given.

But Medicare, in my personal estimation, is as fragile a public program as I have ever seen and I say that with as much seriousness as I can possibly bring to those words. And I have seen a lot of public programs been very deeply involved in a lot of programs for people of all ages, urban support programs that are how I got into politics, being very active in the human service network of my city. I chaired the Human Resources subcommittee, the Ways and Means Committee that does foster care and all that, and I was very involved in welfare reform. I have never seen a system that is on the brink as Medicare is.

Look at this last extension of the physician payment

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system. They did it by agreeing to a 20-percent cut down the road. I must say we started that precedent by agreeing to a 10-percent cut. So, this is not a solution and docs get it. This whole law, by which we pay doctors, is not working, and we have known that for 10 years. When I introduced the first pay for performance bill, I was begged by the committee members not to and told by the chairman not to, because he said we cannot pass it. If we do not start talking about it, if we do not start looking at what kind of quality measurement, how do you do this, what is going to be the physician's role?

So, we needed to start the thinking. So, it is not that we did not know the problems. We knew the problems, we did not believe they were as serious as they were and they are. So whether you extend physician payment or not, physician attitude about serving Medicare patients is still the same and for five or six years, we have given them one- percent or 5-percent or something.

Malpractice is going up, energy is going up, and the cost of nurses is going up. Oh, well. So, is it surprising that the kinds of doctors that have aged with their patient base and have primarily Medicare are looking forward to retiring, if not retiring early? And, the younger guys are getting it, especially, when they have seen this with Medicaid. They have learned not to take more that a certain percentage of

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their practice as Medicaid and they will learn not to take more than a certain percentage of the practice as Medicare.

This is not rocket science, if you worked for an employer who said that they were going to cut your salary five-percent a year for six years, you would think about another job. Would not you, or another employer? Well, we told them that a number of years ago and we are doing it. I mean, almost. So, the reasons I dwell on that because I know that you know that but you see we are not outraged. We are not telling the real story. Nobody wants to criticize Medicare. The minute the physician payment system under Medicare is unfixable the law has to be repealed, the law has to be changed.

In 2003, we slapped in, I never quite knew how it got there, and the criteria for how to spend it, and it was very Lucy goosey, $900 million, because we had so many problems in the hospital payment system. I had two hospitals 20 minutes apart, that is 6 million dollars difference in reimbursement for the same book of business on Medicare. This is hard, if you are the hospital that gets the six million or less and you are competing for the same nurses and so on and so forth, this is very hard. So, to kind of fix those kinds of problems, Medicare was given $900 million and now we have this new group of hospitals called the 508 hospitals and their reimbursements

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are due to expire in the first few months, I believe, of the next administration, I think it was put off until then, I am not quite sure.

But, in addition, we have rule floors, we beef those payments up because Medicare did not work in the rural area. We have a new set of floors that we put in 2003 because Medicare was not working in areas like mine, old, and high-cost, small, urban. There were special provisions for dense, urban and so on and so forth. What I am trying to say is that we have patched the system. The old wage adjustment system and then you adjust it for inflation over 20 years, failed us.

That law has failed us and we are getting to where, I do not know how they will extend the 508, and take care of the next group around the cliff of the 508 areas.

So, when you are not paying your hospitals right, and you are very interested what someone said today about how the hospitals were doing well. Some certainly are doing well. But, for years, I tried to get MedPak to help me look at who are the negative margin hospitals? And, why are they negative margin? Who are the ones that have been negative margin for one year, for two years, for three years? We apparently do not look at that. So we do not know if it is a management problem. We do not know if it is a Medicaid under-reimbursement problem and so on.

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Medicare right now is characterized by payment systems that are literally failing and a knowledge base that is inadequate. Now, we have been working on the knowledge base, and I agree, absolutely, that the MedPak has done some wonderful work in the last few years and that the administration, in fact, is trying a lot of new things and working hard to stimulate criteria for quality and so on and so forth. But, it is a time in which we do not have a lot of time to respond. But, of course, we are a free society and we are terrifically good, and so we will just do this and it is beginning to happen.

The pace of change is now, and part of the problem is that these are old systems, bureaucratic systems that are not built to respond to change rapidly and we are living in an era, in which the pace of change and the scope of change are more rapid than at any time in our history and I just want to comment a minute on scope because the real issue here and others have said, can Medicare Act alone or does not Medicare need to act for the rest of the medical community? We are at a different point and we need to understand just how big a different point that is.

We are no longer a country that can afford an illness treatment system; an illness treatment system will bankrupt Medicare but it will not serve the people so the reason this is

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so hard and the reason the old laws do not serve and we have to really create anew, is because we have to create a health system. A health system that can develop preventive care, a wellness incentives, as well as peer management and treatment for illness, that is a different system then an illness treatment system.

So, the scope of change is tremendous, the pace of change is more rapid than we have ever known it, both in the science of medicine and in the ingenuity of those who deliver care but then, in addition, we are a really remarkable country, we are just beginning to apply health information technology to the challenges of not just managing care but judging the quality of care.

Talking with care deliverers about quality, talking with patients about self-management and these things are happening quite rapidly and I firmly believe and I think the evidence is out there already, that innovators out there and HIT and the new knowledge that it gives us about health and the outcomes of health actions are going to change the system very rapidly and we need to be part of that so that the public policy dimensions of this move smoothly and the public programs benefit from the changes that, frankly, innovators are developing. And, that we develop a uniform integrated healthcare system that can serve not only all people of all

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ages but all of the uninsured as well, because we can no longer possibly, we just cannot continue to have the kind of in-system, out-of-system problems that we have had in the past. It is not fair and it is not healthy.

So, when we look at the future, when we look at what is coming down the track and we look at, I mean one of the most exciting aspects, is the personalized medicine. Not that I am in favor of that, of a personal medical record, I think that will have its place but the personalization of medicine. It is very important to understand because medical knowledge is going to be so individualized as genetic information comes into play. And it is going to affect diagnosis and treatment. It is going to affect the relationship between the doctor and the patient. It is going to affect those teams that we know are so important to care management. And, that personalization has a very important implication for what we look to do now.

I think it means that Medicare is going to have to learn not only how to provide healthcare but to do it in a way, that it can very personally, tremendously, and yet be acceptable. In other words, care, quality, appropriateness of care, is not going to be just a system issue. But, it is going to be also an individual issue.

Let me just tell one story in closing. I was there when we did welfare reform and welfare reform evolved over time

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and became in the end a quite radical bill. It became a radical bill because it repealed the requirement that states provide for people who have no means and it stopped telling states how to do it. On the other hand, if you wanted to do it, you got this block grant and with the block grant came standards and what you were accountable for.

So, in the first welfare reform, you were accountable for getting people into jobs and you could do it more or less any way you wanted. In the second round, we talked more about career ladders. You need to do better than getting people into dead-end jobs, you need to help people get into jobs where they understood what the future was and could prepare themselves and have the support and so on and so forth but I will not go into the details.

The point is, welfare, is now an outcomes based law and it is not the kind of prescriptive program it used to be. I do, personally, believe that we have to move healthcare to that point. We have to look at, what are the outcomes, instead of telling everybody exactly how to do it.

Now, you can look at outcomes, you can measure quality, population based, and therefore, then you do not have the problem of the noncompliant patient because there is always going to be some of those in a population based system. You can set your standards appropriately but there are lots of ways

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in which we are going to have to change if we are going to be able to have the level of individualization that a real healthcare system that is health and wellness as well as illness treatment should enable us to have. And, we are going to have to have much better tools, when you look at the tools issue, CBO, budget neutrality.

CBO cannot estimate the kind of system change we are talking about because, frankly, it is unprecedented. We do not know a lot about it. But RAND is developing a new model so at least we will have two models out there to look at long-term system change. Why do we always have to have budget neutrality? When CMS makes a change on their own it does not get paid for. So, we have to look at how we do this and at least look at budget neutrality and long-term then savings without having to make it dollar for dollar, this here. Quality measurements certainly have to develop much further. Insurance designs have to develop much further. Medicare Advantage is a tremendous tool, a tremendous opportunity that Medicare does not know how to use.

The private sector knows how to use those plans but Medicare really does not have anyone that understands how the private sector insurance world and consequently, Medicare Advantage, has not been held accountable for the mandate that goes with it which is to provide chronic disease management.

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So, we do not have nearly the information that we intended that we would get from that plan, about coordinated care, and what it could do to save money and what else it could do. So, when you look at the possibilities to learn from Medicare Advantage to move it out into fee-for-service Medicare, I think we have tremendous opportunities before us. We do not have a lot of time to do it. We put a lot of seeds out there for change. I think the model of a law based on outcomes is one we need to keep in mind, and figure out, how do we get there in healthcare?

I do not think you can go from DRGs to APRDRGs to ever more detailed categories and expect the system to do well. So a lot of the models that we have inherent in the system are models that cannot serve us over the long run but other things that we are learning about integrated care, and system care, are models we can allow to grow in the system. But, whatever we do, it has to be absolutely something that has done well by the fee-for-service system, as well. And, I think perhaps is amongst the challenges that is the biggest, is to see, how can we provide integrated care in a fee-for-service setting?

Let me just conclude before the questions, about this issue of the gain sharing. Gain sharing, medical homes, bundling all of those are ways of looking at integrated care in a fee for service structure. But, if you look at the

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regulations for gain sharing, I do not see how they work. We are trying to write regulations for a different world, on the basis of what we know from the old world and that is really, really hard. So, if you tried a gain sharing group of regulations that shows you can never do anything differently than you were doing except integrate. Part of what gain sharing does, part of what that collaboration does, is to get rid of some things that were not very productive and focus on the things that are very productive. So, this view of you cannot "cut anything" and yet it is true. We do not want them to cut anything that matters to quality. So, it is truly a dilemma. It is like paying for physicians for performances. You can get into cookbook medicine, if you are not careful.

So, it is a difficult time but it is an important time and I think the big message is the system is far more fragile than I think we are acknowledging. I think one of the things we all need to do is begin to talk to members and to talk publicly about how fragile Medicare is, because I do not know how many years you can keep booting this down the line both for hospitals and doctors and still have the level of participation. I was stunned myself to find out that the Critical Access Hospitals now get paid below cost. And so, if they do not have some private pays involved, they cannot survive.

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So, the worries are many, it is not clear how we do it. We cannot wait until it is clear how we do it. We really have to start pushing on kinds of things that we know will help us with that 8020 number that Bob pointed to before. So, it is a pleasure to be with you, thank you for the good work you are doing. And, I think we have to speak up and be a little more rabble rousing to get the Congress's attention in setting the agenda for the next administration because no matter who is president, it will be a different start. There will be new people and we need have to have a more focused agenda for them to work on. Thanks. [Applause]

ROBERT BERENSON, M.D.: So you are able to stay for some questions right? That is great. I am going to encourage people to take this opportunity. I will start by perusing what I was saying before. You pretty clearly laid out what the challenge for the new Congress would be but is there any sympathy in the Congress about getting, sort of, decreasing the Congress's role in the day to day operational decisions. Is that something us academics are talking about? Is there any prospect for any kind of change in that area would you say?

LYNN ETHEREDGE: I think that it would be such a hard battle. I think Congress knows that they are too involved and they do not like it but to actually change their role would become so controversial that I think we do not have the luxury

of that kind of time. You look at the long struggle we had about just allowing technology to spread and in some communities, the hospital is the obvious best and most knowledgeable has the support system and that technology and letting the whole community get together and make a deal and get a low cost on technology and it has actually resulted in a lot of technology being given to small offices so they can communicate. Anyway, I will not go into the details but all of those kinds of things about what Medicare are going to do and allow have so many laws around them that it is very complicated for Congress to get the relief that we need.

So, under pilots and demos they can do that. There was one other model that I should have mentioned besides the Welfare form but the Medicare health support allowed the secretary on his own authority to move pieces of it forward and I know some are looking at how far does that authority go and should that be an authority that is normally connected with demo. So, if you learn something positive you can relay it out over the whole countries program rather than coming back to Congress which is a two to three year delay. So, I think what kind of authority we give the Medicare program to manage itself is very important and we now know that we need that authority to be much greater because we need flexibility and the ability to respond to all kinds of new things and if Medical Home works

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very well in one area but it is variant, we may want to spread it out over the part and let a different form.

We are not going to be able, anymore, under Medical Home to do what we have done in the Siload [misspelled?] system. The same form of Medical Home is not going to work in all parts. I have seen a home health group that does fantastic following on the basis of the trusts and the relationships to build during the episode but they have come to watching him because they are afraid that they are going to come to grief under another part of the law that if they serve the person too well after the episode that they will then be accused of, I forgot what it is called but courting them should they need you again.

So, we have to allow relationships that are built to continue to serve. We need to over see them but a medical home could be a home health provider in a rural area and just coordinate with a doctor when it was necessary or whatever combination of doctors. We did not allow home health organizations to be medical homes in the medical home build but we did allow specialists and that was a subject of a lot of discussion between myself and the administration because originally it was a family practice kind of thing but you see now two years later, we are learning that there are actually other sites that could be medical home.

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So, we do not want to limit the coordination concept and the care management concept by what we though of five years ago although that is certainly one place we can see that we should have an additional payment for that office having the capability to support and manage care. I would also say that technology is charging ahead and there are not some small companies who can actually follow the medical charges associated with coordination and so on in compliance with care routines. And so, then the role of the staff and management would be very different but also could be worked into a program where there was some accountability.

There is a problem with a medical home issue. If you pay people to have the capability whether they have the patients to use it or not, you may not be accomplishing very much. In other words, you pay someone to have a capability to manage care and they only have five patients that fit in that category, is this right? On the other hand, if a doctor has a lot of patients that fit in that category and he does a lot more work. So, the reimbursement issues are not easy and I am not so sure we can continue down this line of defining exactly what we are going to pay you for and paying you for it.

We have to find a way to look at outcomes and pay for the outcomes and say these are the kinds of things you could be doing and you should be doing. So, that is going to be hard.

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ROBERT BERENSON, M.D.: Okay. We have some people in the audience who want to ask questions.

JIM HUNG: Jim Hung [misspelled?] with the Congressional Service; I know most of the discussion today has been on the expenditure side but I wonder if you could share with us some of your thoughts about whether it makes sense to continue to have: A) finance primarily by payroll taxes, B) will a combination of general revenues and premiums and cost sharing or whether as we go and think forward about Medicare reform, what would be a more appropriate way to try and finance Medicare?

LYNN ETHEREDGE: Well, first of all we do subsidize the premiums of low-income seniors and just as we have, we eventually will do that for working people who cannot afford health insurance premiums whether we do it directly through premiums or through direct care, whatever the system is, we will pay for those who are above the really low income level for them to get into the care system. And, in Medicare, we may need to provide greater help to lower income seniors but I think fundamentally having everybody contribute is healthy and I think the battle to change how we fund Medicare would be so consuming that we would not really get to the real issue in my estimation which is what care is it we are going to provide and how do we get it to the person in a timely fashion.

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With the Medicare health support demo that was written off as a failure, it was written off after a report that had six months data. We are not going to see much in terms of care management outcome after six months data. And, one of the really big problems is this is why I do not think a guardian board really can do a lot better than where we are now.

What happened fundamentally with that was that the administration identified the participants a year and a half before the program was able to start. Now, these are very sick people. So, what percentage was already dead? They found a big problem with the people that they had been given. Then, the system itself was incapable of the kind of timely feedback that you need if you are going to manage care. So, the fundamental dynamic that is really essential to work with patients about their care in order to keep them healthier or out of the emergency rooms or out of the hospitals was really impossible to create. And, nobody thought it was impossible. That is why the thing went forward. Neither the companies involved nor the administration but it turned out to be impossible.

There was a lot of agreement about how it would work but it turned out to be impossible. The computer systems and this is that; are you going to give reconciled bills or are you not? The payment system in Medicare was just too complicated

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to get back to the pilots the information they needed in the kind of timely fashion that is possible in the private sector.

We do need to really understand more of how we do some of the STAT communications that you need in care management under a system where payment flow to a central bureaucracy and they get this and that and the other process and then they come back and so on and so forth. So, we could be using Medicare Advantage much more aggressively than we are now to pilot these things, to evaluate them and to hold them to standards. And, I think maybe in the next administration that is one thing they could do.

I would have to say, someone said earlier that Medicare has a sufficient demo authority. That has not been my experience especially since I have gotten out and am working with more complicated larger demo possibilities that would really show you what you need to know. Their demo authority is quite limited and their funding for demos, now someone just told me this so it could be untrue and certainly you would know better, but they said they do not have any where near the kind of money for demos that they had before they did DRG's.

ROBERT BERENSON, M.D.: There is no question that almost all of the demo money is going for congressionally mandated demos and that leaves almost nothing for self-generated. That is my understanding. Anybody who really knows

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that world want to talk about that? Okay. But, I think you are absolutely right on that.

LYNN ETHEREDGE: I think to your question is right on point and it goes to some extent to the guardian issue. I do not think that this is the time when we can fight wars that create big controversies about public/private national healthcare. Not national healthcare. I think we just need to focus really hard on how we fix the system before it collapses because I do not think— I mean, in five years, this system will be travesty of itself. It will be just terrible. I personally believe and I think five years is probably a generous estimate.

ROBERT BERENSON, M.D.: No. I think that is right. Tim?

TIMOTHY JOST: If I could ask a cynical version of Bob's earlier question. [Laughing] If it rebuilds the task with veto overrides in the recent past have been the farm bill and the water projects bill and the Medicare bill and it seems to me what they all three have in common is very strong, very focus constituent interests and broad and not very well represented public interest and I guess as I look through the latest Medicare legislation and I will take that as an example because you were not responsible for that directly but there is just an awful lot in there that seems to me very focused on

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particular providers and their interest and really not in the interest of the country.

LYNN ETHEREDGE: But, see, that is a symptom. The first 10 years I served on the Ways and Means Health Subcommittee and Pete Stark we would have long discussions and talk and everything and we were not involved in the detail that they are involved I now. It is because the system is in collapse that there is this— And, we are trying new things. The competition for DME is a perfect example but on the other hand, the administration, no administration has ever tried to compete nation-wide.

Now, first of all, we are a nation of small businesses. What is going to happen if we start providing healthcare through national competed contracts with just a relative hand full of winners? It is particularly important from the point of view of women because actually women start a lot of the small little health agencies and small business that deliver oxygen and so on and so forth.

So, we are trying to solve the problem of Medicare from the old mind set. It is spending too much money so how do we cut costs? Well, competition will help to cut costs or cutting reimbursements will help to cut costs. So, we have frozen some peoples reimbursements for eight or 10 years. I mean, we just

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do big arbitrary things because we do not really know how to do this.

Now, one thing we do know is that if you deliver more care to 20-percent earlier in their illness cycle, you will save yourself money. So, we need to really focus hard on how to do that and give ourselves the time. The idea that Medicare health support has been declared a failure after review of six months without— Actually, if you read the report, you could see the problems in the setup. Now, the tragedy is that we are not stopping long enough to look at the problems. What did we learn?

We learned some negative lessons of some important significance. Where we learned some positive lessons— What is that group that could be managed that way? You look at the end-of-life people. They want a different kind of medical support and those that are slow aging community is helping us to see that. A lot of these different areas whether it is end-of-life care, whether it is care management, whether it is genetic counseling, whether it is diabetes; there is an educational component now to both illness treatment and health that we have never had before and we do not know how to talk to ourselves and we are putting very little money into how we talk to ourselves.

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But, you talk to the various physician group practice demos that were very effective and they will tell you one of the hardest things was to learn how to bury their conversation with their patients so that the patients understood how to comply and kept complying and how do you keep in. If you do not like telephone calls, what are the mechanisms? So, if we could just kind of strip away and focus on some of the systems changes that have to be made because we are going to have to change those payment systems anyway; our hospitals are not going to survive in the rural areas. They are not going to survive. The doctors are not going to survive. So, if we can begin even letting groups shape their own allocations.

We have to think much bigger than we are thinking now. We do not have time to do small systems. I have been talking to the people who are the CFOs of the big institutions; the health finance management people who keep the books. I said, what you think should be bundled together because you are the ones that are going to have to figure out how to account for it. So, when you look at your books and how this all works and it relates, get the physicians in your community to sit down and think how to do that.

See, the game sharing regulations are a perfect example. They are watching them thinking about how we are going to let you talk to each other. Why not ask them? How do

you do this? Now, in New Jersey where it started from the bottom up and spent three years in developing and all the issues anyone would be concerned about were talked about extensively. There was a whole different foundation laid because all these new systems are going to require a level of trust. I mean, when doctors work together— My husband was in a group practice. They worked together. They would call on the people they trust and that they think are good doctors to get an opinion on their patients and patients build networks of trust.

So, I mean, the idea of fee-for-service Medicare Advantage which I never was a fan of was to at least get a network out there and then see if it can translate itself. If it can invent the way then it could translate itself into a Medicare Advantage plan under which that it would have the requirement to provide coordinated care. And, so, we have to find a way to stimulate group so providers, particularly in— Telemedicine is going to be a wonderful agent for this. Talk about the law that will have to be changed for child medicine and across state lines certification and all kinds of things but they are not fit to change.

Now, that kind of challenge Congress could work on you with. What is telemedicine in a more holistic approach? What is a coordinate care system that can provide health and

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wellness and what are the exceptions? We have done this better in Medicaid by giving them waivers and long-term care issues than we have in some other areas. But, I think if we are not ready when the next president comes in, we will get a response to the old system and the old system does not provide the care that a population that is living 20 and 30 years after retirement needs. So, that is not the system that we want.

We want a system in which the government has the power to assure that seniors have access to the care they need at the time they need it and that it is high quality but we have to release our minds from the current way that concept is achieved because it is not working and it is going to work worse and worse and worse with every year that we fail to fix the laws. So, instead of fixing these laws one by one, is there some way to look at a hospital in a serving area and the seniors in it? We have to be able to do better than we are doing.

So, you have raised a lot of good questions here this morning and the presentations were very thoughtful but do not think that the government can— CMS does not know how to do it and this Congress certainly does not know how to do it and do not blame the Congress for being driven by their providers at home who are literally— I mean, I had an oxygen provider go through with me, line and verse, all of Connecticut's very heavy requirements for them. In our reimbursement system we do

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not take that into account that they have to be dual certified, that they have to meet all these state requirements too.

So, our reimbursement system is now so removed from any honest analysis of cost that it is hard to— That is one of my concerns about average and reimbursing on average and then what about the high cost areas. You reimburse on average, you will put New England under.

ROBERT BERENSON, M.D.: So, if in fact it is a diversion to waste the political effort to talk about governance and removing Congress which I am sympathetic to that point of view but at the same time we need to really be having a new blue print for how healthcare should be. What do you suggest and is it a blue ribbon commission that can come to Congress and say this is it or what do you think? How do we get there?

LYNN ETHEREDGE: No. I think talking about governance is very important. I do not think putting in place a new board but I think the technical paper on the barriers, I think some of the things that you know about how to get care systems in place. We have to be just more focused on— For instance, what part of the whole start concept? And, I know he is rethinking this too is valid and what is not. I mean, to what degree inurnment is really a motivation for physicians and to what degree in a market economy is that bad. So, instead of being

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on that territory, let us be on the territory of quality and appropriateness.

How do we use our technology to judge appropriateness of care and quality of care? So, this is one company that has shown me software that can put if you are a diabetic and so and so. Whatever you are, it has the protocol that comes up when you go to see the doctor. He knows what to check but he does not have to try to remember who is your provider and what does that particular provider require and then yes, by the way you have diabetes so let us see where you are in that.

All of that comes to him and with evidence based protocols whether he did it or not is absolutely checkable. This is one of the physician group practice demos that was small offices, all three and under. Some with paper only and it was phenomenal the accountability that you could get through over sight of record. Is the government better of looking at that accountability than doing a lot of things that we are doing in the system. But, you have to ask the providers how do we get you the money and then let you share it. But, one of the doctors said to me, this guy never does his check. Blue Cross Blue Shield actually funded this by giving people 2-percent, 4-percent or 6-percent more depending on if you did everything right, you got 2-percent more or maybe 4-percent

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more but only if the whole team did everything right did you get the whole 6-percent more.

So, it is out there and it is being done and as one of the guys who was involved in the technical parts of this, his wife is a doctor and she said, I kept seeing that he did not do what he was supposed to do so I told him, I am not sending you another patient because I want somebody who will work with me. I do not want somebody who will just go their own way. So, there are ways to do this to implant coordination of care in the fee-for-service system and that is what we should be looking at and that is what we should be telling doctors. Well, you get a 1-percent this year but if a group of you of at least 50 unrelated get together and adopt the kind of technology that allows you to do this, then you will get more.

So, I like the fact that this last bill at least said you are going to have to do it e-prescribing. I mean, are we nuts? This is a fairly affluent sector of the professional community and we have got to require that. I think in the end we have to require electronic records and the private sector has to be— The different kinds of technologies now that are coming up in the private sector are really exciting and some of them are very cheap.

ROBERT BERENSON, M.D.: We have time for one final question. Well, actually I see two hands and then we will

stop. Over there. You have got one here. Alright. So, one in the back and one over here; in the back first.

IRIS PORTNEY: Great. Thank you very much. I am Iris Portney [misspelled?] and I am a healthcare and technology writer and my question is— And, also a patient advocate for cancer patients in terms of access to care. So, my question which I would love to hear your thoughts on is about the potential for increasing the role played by nurses in terms of creating both a more affective, more accessible healthcare system for patients as well as expanding a results based system at chronic care management across the board and I am sure that you have thought about this and are interested in it but to the extent that nurses can make this system a team medical system more effective, how do we address the nursing shortage?

It is wonderful for people to talk about incentives for health IT and that is key but nurses are an important component of qualified people to use that health IT via email follow up, phone follow up, the records, et cetera, terms and maintenance. I would love your thoughts on that.

LYNN ETHEREDGE: Well, I absolutely agree with you and I have one community health center system that has developed a one year residency for nurses and they are trying to get the government to notice. This might be a good thing because they say the difference between what you are in nursing school and

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the complexity of working with the doctor, with the family, with that community to coordinate compliance and care and other family issues. You cannot teach that in medical school and it takes time to teach that. So, again, I think that if we set criteria and allow groups to do this that is a higher level of— Then they will pay their nurses.

They have no flexibility. The money does not allow them to be flexible about who does what. And so, we are under utilizing nurses scandalously and not paying them what we should in the office setting if they are part of that team. And then, the doctor can actually see more patients if we use his knowledge. So, it is complicated because I do not want to imply that the doctor's relationship with the patient is of no merit or importance. It certainly is but there are times in that patient's relationships to the office where the patient needs to spend more time with the doctor and less with others and there are times when frankly they need to spend more time with others and less with the doctor. And, the Medical Home, hopefully, will be able to get at that but the Medical Home is going to need to have to have criteria that, I think, with experience are going to find are going to be a little different than those that we have got out there. And, then money has to be significant and that is not too hard.

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When you look at what the private sector systems are now beginning to do in terms of paying doctors more for providing the kind of care we all know we need to be providing, then it tells you they are saving money. The could not be doing this if they were not keeping people out of the emergency room or keeping people out of more expensive care. So, there are a lot of field to be plowed out there but more and better use of nurses, of advance practice nurses, physician assistants, of lower levels of training. Even the nurse has a lot of education that could go on. There are a lot of personnel we have that do breathing and things like that that can be cross-trained to do a lot of different things.

I think we are going to have to get into a lot of cross-training so you do not have one person coming in about nutrition, one coming in about this, one coming in about that but that will evolve but we can push it more rapidly if we set criteria and easier upgrade them. Look what is happening in the hospitals in quality. The first year there were what, three and then eight and now they expect it and as one of the hospital administrators said to me, he said, I had to hire two new people to handle the paperwork that came out of this particular hospital quality requirement but he said we cut our blue codes. Is it blue codes or red codes?

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ROBERT BERENSON, M.D.: Red. [Interposing] The code is called a lot of different things for different hospitals. [Interposing]

LYNN ETHEREDGE: The STAT code in the hospital. [Interposing]

ROBERT BERENSON, M.D.: The cardiac arrests. [Interposing]

LYNN ETHEREDGE: That is right. They cut the incidence of that in half. So, he was thrilled. So, there is a lot. We can be more powerful in setting criteria, focusing on knowledge, developing better knowledge. You need health information technology to do that. You are going to need evidence based practice. We are going to have to move ourselves to that whole next level of knowledge about what we are doing. I mean, FDA is under a lot of fire. I mean, well, of course they are under a lot of fire because they have now the old idea does not work. You should not be approving a drug. You should be moving a drug from its trial stage to a national sales stage but you will never know from a trial what you know from national sales.

If you are part of national sales, period, then you have an obligation to get back to your doctor about side effects. So, that is part of it. Otherwise, you cannot renew your prescription. So, after three months, you look at the

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national side effect experience and then— So, the old structures do not suit us anymore and we have to change them to get a better systemic process that moves our knowledge level so that we understand the pluses and minuses more rapidly. So, bottom line, I think we need to be much more aggressive about how fragile the system is, how many problems it has. I think we need to be much harder driving about how we overcome these silos and the authority that CMS needs for flexibility and then we may want to— I will have to think more about how we keep Congress from meddling so much because notice they did not meddle in some of these regulations until closer to election time. [Laughing]

ROBERT BERENSON, M.D.: That is right.

LYNN ETHEREDGE: So, it has gotten to be a real problem and we do need to think of a solution to that and I will also— [Interposing]

ROBERT BERENSON, M.D.: We have time for one quick question and one quick response.

TIM COOS: Tim Coos from UNLV [misspelled?]. I want to certainly thank you for your leadership on the health information technology and my question is large physician practices and hospitals have sort of moved a long the continuum in terms of investment and the relaxation and loss has certainly helped but in order to put in a large EMR system, it

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is a significant capital investment and the time horizon for that investment is several years. And so, if you could comment on that the current reimbursement system and specifically for Medicare does not necessarily allow you to make those kinds of long-term investments especially for physician practices that are 50 or more.

LYNN ETHEREDGE: Well, first of all, I think have the expensing provisions helped you as a large practice? That has helped. In this new bill that they have got, I think the best way to do this but that is there job and they can do that however they want but we do have to put money out there and I think if every state had a revolving loan fund and they had the right to say whether it was a grant or whether it was a no interest loan or whether it was an interest baring loan because credit is a big problem right now in the system in health. And so, even for a hospital that is plowing along pretty well, they are not necessarily loanable in the bank size.

So, having access to that capital will really help. There are plenty of people who cannot bare the interest costs and there is plenty more who cannot front the whole costs. But, those kinds of sliding scale issues is another thing that has to be done, really, at the state level because they know the circumstances but if we do not basically just give that hardware to the real practices out there and the smaller

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hospitals, they will not be able to get and in many ways those are the areas that will benefit the most because if every critical access hospital also had a telemedicine capability that every physician around had the right to use, then we will get a lot of preventive care moving and care management moving that will improve the lives of our seniors in rural areas tremendously and prevent emergency trips and so on.

That, of course, we pay tremendously for because now we not only pay a higher that goes through but we pay by the mile and that is far. So, there is a lot of win wins out there and the experts need to get together more and look at what systems work. I think that the work that has been done in that regard could be a starting point for immediate changes in reimbursements but the main thing is and what is really hard is, and this did not happen in the welfare reform debate until about the last month or two because nobody was actually looking at repealing that but when they really thought about work, they really thought the state should have the right to do that.

And, it has worked. It is the difference between the 88 reform and the later reform. So, I think for instance, value based insurance design. Why are we allowing the supplements to do first dollar coverage or at least why are we not learning something about no co-payments for preventive care, no whatever, free drugs, for chronic disease. I mean,

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there are lots of things we could think about that in the private sector there is reason to believe improve compliance and personal discipline but people are going to have to pay higher premiums like they do in the private sector when they smoke.

And if they are Medicare and they smoke, they are going to have to pay higher premiums. So, we have to get real about this and one of the votes that was most used against me was the vote to allow Medicaid to have the special programs for the disabled because the old law was everybody has to have the same and so I was saying it is destroying Medicaid for the poor. Now, that is life and that is politics right now but there was no one there to say— No one was there to say, no, we really need this and now every Medicare system is better off because they have the special needs program capability.

And, we are going to have to do those things but the professional community is going to have to— Why are the members so vulnerable? Because no one speaks up but certain groups that always speak up and even AARP sometimes does not speak up. Everybody has complex issues, interests, conflicting issues but I think the professionals need to help the public see how urgent this is and how much they have to participate. They do not have to pay more but they have to participate. We have to find a way to keep you out of the hospital.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ROBERT BERENSON, M.D.: With that we want to thank you very much for spending an hour with us. Thank you. [Applause] We are going to reconvene in 10 minutes. The purpose of this—

[END RECORDING]

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