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Making Medicare Sustainable: Transforming Our Health Programs for America's Seniors Session 2 New America Foundation July 23, 2008

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ROBERT BERENSON, M.D.: For at least the last 5 to 10 years, there has been increasing focus on a certain population of Medicare beneficiaries who it would seem offer a great potential for increase quality and, for budget people, cost savings. A number of people have estimated— Jerry Anderson, Ken Thorpe and others— the share of Medicare spending associated with beneficiaries with chronic conditions, and it seems to be— well, partly we are defining chronic conditions more generously, but under anybody's definition, a very small percentage of Medicare beneficiaries with multiple chronic conditions are responsible for a highly disproportionate amount of spending. It is pretty much the 20/80 rule. About 20-percent of beneficiaries are responsible for about 80-percent of the spending. And so, it is appealing and logical to develop interventions specifically targeted to that population, given the belief and some evidence that there is a lot of wasted spending associated with care provided to that particular population.

Recently, I have had the opportunity of reviewing the literature on Medicare programs, mostly demonstrations under the Offices of the AARP's Public Policy Institute, and one of these days that paper will be out and published. And lo and behold, Medicare has been focused on this population for over

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30 years, demos have come and gone, and it is apparently not easy to generate cost savings associated with programs targeted to that population. There have been programs for dual eligibles, programs for patients with chronic conditions, programs for patients who were in nursing homes, all of which were trying to improve care, with the hopes of decreased spending.

We have commissioned Chad Boult to take a fresh look at this issue, and he will describe what he did. Chad is as knowledgeable about care for this segment of Medicare beneficiaries as anybody. He is Professor of Public Health with joint appointments in medicine and nursing at Johns Hopkins. He is Director of the Roger C. Lipitz Center for Integrated Healthcare. He is the Department of Health Policy and Management at the Bloomberg Public Health at Hopkins. He is a practitioner. He is involved now with developing programs targeting this population to improve care coordination and management. He has also critically looked at the literature.

For commenter [misspelled?] we have asked Randy Brown, who has probably evaluated most of those programs and demonstrations that I have referred to. He is as seasoned a veteran as exists on what Medicare has tried to do in this area of chronic care management, he will be our commenter. I should say that Randy is at Mathematica. He is a Vice President at

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Mathematica and is often a senior member of the team for many of the CMS evaluations of these demonstrations.

With that, let me turn it over to Chad.

CHARLES BOULT, M.D.: Thanks, Bob, and hello everybody. It is good to be here finally. I just drove down from Baltimore. I was delighted when Bob called me, about a year ago now, to do this paper. I direct the center at Hopkins called the Lipitz Center for Integrated Healthcare, and its whole mission is to try, through research and education, to improve the healthcare for older people with chronic conditions, so this is right up our alley.

What I am going to do is very briefly provide a summary of the paper that I wrote over the past year. You have a full copy of that in your packet, as well as all of the slides. Because it is so voluminous and there is so much information in the paper, I hope I will not be too tedious as I describe at very high level— kind of a 30,000-foot view— what we found.

The whole idea here, as Bob said, was to try to identify types of healthcare that have been tested and rigorously evaluated in solid scientific studies and found to actually produce the better outcomes that they were predicted to produce. In other words, you hear a lot about things that should improve healthcare outcomes, but I focused entirely on

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those for which I could find solid scientific evidence that they have improved health outcomes.

And then, as a second criterion, we wanted to focus on those types of interventions that actually worked, because sometimes they work in places where I come from, highly controlled scientific environments, but they do not work when you put them on the street. So, we applied a second criterion, which was that the models had to be what we called diffusible. They had to have characteristics that made them potentially adoptable across America in all kinds of settings.

And so what I am going to present to you today is the synthesis of all of that and how we got down to a handful of models that met both of those criteria, they work— they have been shown by scientific studies to work— and they are diffusible. And then I will finish with a couple of comments about potential policy options that would help in diffusing these particular models.

To define some of the terms, vulnerability in old age takes a number of forms. There is poverty that makes people vulnerable. There are various forms of abuse that can render people vulnerable. And then there are chronic health conditions. I laid this out to emphasize that we are focused on interventions that reduce medical vulnerability— that is, vulnerability that is brought on by chronic health conditions

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such as the D's of geriatrics, the discomfort, disability, dependency, depression, dementia, and ultimately death. These are the things that render people vulnerable with increasing age.

So, how does one go about reducing that kind of vulnerability? Well, there are two basic approaches. One is that you prevent them from getting vulnerable in the first place by giving good healthcare and good lifestyle modification and so on early, some say— and it is probably true— from childhood or at least from middle age on so we do not have so many sick old people. The other approach is to provide good, high-quality, cost-efficient healthcare for people who have gotten chronic disease. That kind of care— there is pretty much consensus now— should be patient-centered, evidence-based, comprehensive, coordinated, and ultimately affordable for society.

Unfortunately, chronic care in America is none of those things. It is provider-centric, not patient-centric. It is idiosyncratic, rather than evidence based. It is very fragmented, uncoordinated, and, as we all know, very expensive. If you define value as quality in the numerator and cost in the denominator, in American chronic care the quality is low— in international studies it ranks sixth among six in developed nations— the cost is high at two to three times greater than

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any of the other individual developed nations. This is Karen Davis' commonwealth report from last year.

So, that is the bad news. The good news is that a lot of people have been working on this to try to improve chronic care in America by developing alternative models for providing chronic care. These models are designed to reduce the quality chasm between what is possible and what we have, ultimately with the goal of protecting these medically vulnerable people, and, of course, to improve the efficiency of resource use because we cannot just go on spending without limits.

So, the goals of our project for this paper were to describe the recent innovations that have shown promising results, to discuss those models' diffusibility and then suggest policy options, as I mentioned, that could support the diffusion of the most promising sound models.

We conducted a literature search of over the past 20 years looking for models that met these criteria. We then created many tables, which you will find in the paper that you have in your paper, summarizing the evidence in a much distilled way. It is just very brief, but it gives you a sense of which models have improved which outcomes.

We then classified each of the models that seemed to be successful according to the strength of the evidence. So, one study does not prove it. We required there either be a

metaanalysis of multiple studies or at least three controlled trials of any individual model in order to say, okay, we believe that the evidence is strong enough that this really does improve outcomes. We then convened an expert panel which rated each of the successful models on six diffusibility criteria. Finally, once we had identified those that were both successful and diffusible, we then discussed these policy options.

So, here are the results of this endeavor. We initially identified 15 successful models, which I will show you in a minute. They are roughly categorized according to where people receive care. There is the community— in other words, people who are living at home and they are active in the community. And then there are people who receive care as they make transitions between their home and the hospital and back home or hospital to rehab— people that are moving between healthcare settings. The third category is the inpatient setting— inpatient meaning hospital, nursing home, rehabilitation center and that sort of thing. The table shows for each of these models the effect in the studies on the health of the beneficiary, on the quality of care they receive, on its effects on the efficiency or use and cost of their care. And then the final rating is according to their diffusibility

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potential. As I said earlier, many details of this are in your packet in the paper.

This is the grand summary slide that really shows what we found. These are the models that turned out to be both successful according to our criteria and diffusible. I am going to say a few words about each one, just to allow you to know what some of these code names mean. Advanced practice nurse-physician team for dementia patients— so, that is pretty much what it says, usually a nurse practitioner and a physician teaming up to take care of the people in the primary care practice who have dementia and who have special needs because of that. This column shows the quality of the evidence. So, here there was one randomized clinical trial supporting that outcome and a diffusibility score of 19. The range of diffusibility, according to this scale— and we can talk about how we did this later, if you would like— the top score, if it was extremely diffusible, would be 30 and the lowest possible score is 6. What we did is define diffusibility as a model that was in the top half. These are the half most diffusible models. In other words, they were the ones with scores of 18 to 30.

Interdisciplinary team care of congestive heart failure patients— these usually result from a doctor and a nurse, usually an RN, working together in the care of people with that

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specific condition. So, these two are very condition-specific. You can see the evidence and the very high diffusibility rating here. That is borne out by the fact that this model is actually in use at a fairly wide spread in the U.S.

Then there is guided care. This is a model of care that we have developed at Hopkins that is interdisciplinary care for multi-morbid older patients. In other words, people who have multiple chronic problems, rather than just a particular problem. This uses many of the same principles. We are in the process of doing a multi-site, randomized trial now. The results continue to come out every few months, but it is looking pretty good. We designed it to be diffusible, so it is fairly diffusible. Now, these are all in the group of what we call enhancements to primary care. This is interdisciplinary primary care. It is building up the primary care practice, sort of like the medical home model does.

The next group, which is in yellow, is all models that are supplements to primary care, but they are not really fully integrated into it. Usually it is delivered some other place by some other organization and with varying degrees of communication between the model and the person's primary care.

So, we have care management for congestive failure, much like this, only it is done separately. It is highly diffusible and is being diffused. Pharmaceutical care usually

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refers to pharmacist involvement as a supplement, somebody who can help patients to understand their medicines, take them properly, know what to look for and make sure they are not running out and that sort of thing. These models have been quite successful and diffusible.

Self-management training is something that is not really done in a medical setting, but usually in a community setting. This is the Stanford Kate Lorig model of training people who have chronic conditions to be good managers of their own health. This model is being widely diffused now across the U.S. and the world, for that matter.

Proactive rehabilitation is pretty much what it says. It is finding people who are somewhat disabled, but still living in their homes and trying to rehabilitate them before they get to the point of requiring nursing home residence.

Finally, caregiver support and education— this is dealing with the family members or other caregivers of people with multiple conditions to train them to be good caregivers and support them in this very important role. Often, if they get sick or burn out, that is when the older person ends up in the nursing home.

So, these are the strategies that have been tested. They have been shown to work and that they are relatively

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diffusible. Oh, here are a couple more of them. These are really the ones in the inpatient settings.

The first is transitional care, which is usually going into and out of an institution. There is pretty good evidence there. Basically, the way this works in most settings is a nurse or advanced practice nurse sort of holds the hand of the patient and prepares them for the transition, then often visits them. Let us say a transition from hospital to home, the nurse would have seen the person in the hospital, helped plan the discharge, prepared the patient and the family for what is going to happen on the day of discharge and immediately thereafter, and then they go home with the person or visit them the next day. They may sure the patient knows what medicines to take and how to use their equipment, especially the new stuff, and what to look for and who to call if they have a problem. This is point of great confusion and often results in what is called bounce-back admissions where they are in the hospital, then two weeks later they are back in the hospital. This is an attempt, which has been fairly successful, to reduce those readmissions. It is being tested fairly widely now.

Finally, there is the advanced practice nurse/physician diet. Some people know this as the Evercare model because they popularized it, but it is being picked up by other

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organizations as well. There is fairly good evidence for this and it is fairly diffusible.

That is just a really brief overview of what we found. The policy options that I just want to put on the table for you to think about relate to each of these. You will see that in each case what I am basically saying here is that Medicare or other parts of the federal government are in the policy to support these models. Many of these are potentially diffusible, but only if there is a payment source.

And so, for instance, regarding fee-for-service Medicare, what could be done? Well, CMS could be authorized, as it has been recently in the Medical Home Demonstration of laws, to make supplemental or care management payments to primary care practices that are willing to provide all these other services besides just office visits. In other words, somebody to educate and coordinate, empower and connect with community resources. If a practice is willing to add those services and CMS could pay for that, it would work; otherwise, it is not going to happen.

You probably are familiar with the Medicare Medical Home Demonstration. The law was passed in 2006 and then just last week, part of a Medicare bill that passed injected an extra $100 million into this demo and allowed CMS to expand and

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extend it if they see fit. So, that is one option that seems to be in a fairly promising position to be followed.

Second are payments to some of these supplemental care providers that supplement the care of primary care, so payments to pharmacists that help the vulnerable elderly people, to nurses that help them through transitions or rehab therapists. All of these are what I call supplements, yet for these supplemental services the payment is really not authorized right. So, a policy option would be to consider authorizing and paying for those services in the hopes that it would not only improve outcomes of care, but that it would ultimately reduce some inpatient utilization and therefore save money for Medicare.

Moving on now to private plans, special needs plans, some of them— like the snips that focuses on the nursing home population— could be extended. These contracts, as far as I know, are still due to expire in 2008, but the snips that are using that particular model, the diad nurse/doctor, the diad in caring for nursing home patients are the ones for which there is evidence that they probably are going to be cost effective.

To the Medicare Advantage plans— there is lots of controversy there, but what I would like to put out is the possibility of adjusting the payments to them, not only on the beneficiary's risk, but also on the quality of care that they

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receive as measured not only in the traditional HEDUS-measured [misspelled?] way, but also by surveying members, by surveying the patients and asking them, according to defined quality indicators, about the quality of the care that they receive. I think that this might drive even greater quality than measuring hemoglobin A1c.

And finally, the Administration on Aging, through the AAA Network across the country, could consider funding self-management courses, caregiver education and support, such as classes and/or support groups, and then counseling in helping people to select— older people have a hard time selecting among all the options that they have today, so they could use some help in selecting their health plans and their options for end-of-life care.

All right, that is it. I just want to acknowledge the foundation, Institute of Medicine, and the expert panel that helped us to do this work. Thank you. [Applause]

RANDALL BROWN: Thank you, Chad. Despite Bob's comment that he has heard quite enough from economists, I do not think he means it because he is the one who invited me here today. What I would like to do in my 12 minutes is to first take a quick look at a couple of [inaudible] major past efforts to control cost and why they have not work, and then discuss some thoughts I have about Chad's paper and some concerns I have

about what is not given enough attention in it maybe, based on my experience doing evaluations of disease management and care coordination interventions for the last 15 years. I will conclude with a description of some ongoing work that is taking place and what we hope to learn from that.

Before bemoaning too much the lack of effort to make Medicare sustainable, we should note that over the past 25 years CMS has, to its credit, made repeated efforts to find lessons from the private sector that would make Medicare a more cost-effector purchaser of healthcare, and it is still continuing that effort. The lack of progress in controlling Medicare cost growth is not necessarily due to lack of effort of attention to the problem, but to two other factors, I think.

First, the federal government has relied too much of the hype of those who stand to gain from large-scale Medicare enactment of a change and relied too little on the evidence generated by their own demonstrations and evaluation and to experts like other panels today. The second problem has been poor, or at least uneven, implementation of the concepts being tested. CMS' first major foray into controlling costs was HMOs, which began in the 1980s.

Now, it actually costs more than fee-for-service. It was enacted into law before the demonstration findings from the early '80s were available. HMOs got CMS to delay for many

years the needed adjustments to the payment methodology to account for the net increases in cost due to favorable selection. Medicare Advantage continues to be overpaid and expended without any evidence at all that it saves money for Medicare or improves the quality of care.

More recent efforts have focused on care coordination and disease management, but Congress mandated the large-scale Medicare Health Support pilot while evidence was emerging that even smaller-scale programs run by clinics and academic medical centers were having difficulty generating any savings or improving quality. They at least have the potential to work closely with the primary care provider.

So, both of these situations appear to be driven largely by big business and lobbyists pushing the administration and Congress for these changes, not by legitimate evidence that it would work and sometimes in spite of evidence that it would not or does not.

So, let me turn to Chad's paper. It is a tremendous paper. There is a lot of work that went into this, and it is a great summary of the evidence out there. He has identified four interventions with the best potential for dissemination, and it is encouraging that there is some favorable evidence in support of each one. The evidence of transitional care I think is particularly strong, and the need to co-located nurse

coordinators and physicians is very consistent with findings that we are getting from the Coordinated Care Demonstrations. The focus on diffusion potential as well as effectiveness is a wise and major step forward, I think, but the findings raise a few concerns.

First, despite the extensive review, the evidence for effectiveness is still pretty weak, so it is hard to assess what should be disseminated. Many of the studies have pretty small sample sizes and many are metaanalyses that are not necessarily based on rigorous studies themselves. More importantly, though, there is too little recognition that for every favorable study finding, there are other very similar interventions that do not show favorable results. The studies cited show that interventions can be successful, but what we do not know is how likely that is or what factors determine whether a particular intervention will be successful and cost-effective or not. The details of how well a clinical practice implements an intervention are often more than which intervention it chooses. The most effective programs have highly specific protocols that need to be followed.

The second concern is that there is no discussion of whether the benefits of the intervention are worth the cost to implement it. The didactic care of nursing home residents sounds like a great idea for improving quality, but does it

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cost more than it saves? If it does, it is not going to help with the problem of sustainability.

The third concern is the lack of discretion about targeting. The interventions recommended were found to work for certain target populations, but will they have similarly favorable results when applied to beneficiaries with different chronic illness, different levels of severity of the same illnesses, combinations of illnesses, or in a different setting?

So, let us talk about the recommendations for a second. The first recommendation was more payment to various types of entities that the study finds to have the most potential for diffusion and some effects on effectiveness. The problem is having to define precisely what interventions you are paying for and monitor the fidelity to it to be sure you are getting what you pay for. It is not easy or cheap to do this. The difficulty with this is what led CMS, in part, to approach this like managed care and Medicare support. You give program operators the money and the risk to generate savings, but that has not produced savings in these two incidences.

Second, the recipients of the funds need to be accountable. Is the recommendation to just give them money for services without requiring any sharing of the risk if expected savings do not materialize to cover these enhanced payments?

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And third, there needs to be adequate and realistic time frames. There are many examples of follow-up periods being too short to realistically expect there to be savings in cost. It takes time and the amount of times varies with the conditions. With CHF the conventional wisdom it takes at least a year. For diabetes it is often at least three years.

There are also problems with the seconds suggested reform, which was paying more for capitated programs with higher beneficiary ratings of their quality. I think that may not be the only criteria to use. I think, as Chad said, it needs to be linked with clinical indicators on things like preventable hospitalizations and things where it could actually generate some savings. Everybody often rates their primary care provider as excellent, so you do not get much discrimination there sometimes. More importantly, the efficacy has to be considered, too. It is easy to make patients happy if you do not have to generate savings.

The third suggest about paying AOA to provide self-management courses seems like a pretty reasonable suggestions, but the Coordinated Care Demonstration experience was that it is often difficult to get much uptake by the patients in these programs.

So, we need to continue testing new ideas because we have not figured it out yet. So, we need to build on what we

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have learned, for example, in designing a medical homes intervention and what is going to be paid for. We need to take into account the lessons learn from the Coordinated Care Demonstration and other research and demonstration where some programs were effective and others were not. I also think we need to continue the CMS approach of rigorous tests of interventions to avoid confusion and mistrusted claims of effectiveness, which could result in increases, rather than decreases, in cost. Once we do find an approach that works in one or two or three instances, like those identified in Chad's paper, we need to test the replicability of these findings in other settings and perhaps with other types of patients.

Let me tell you about a few efforts to build on recent experience that I am most familiar with. Two of them are follow-ons to the Coordinated Care Study, which was a 15-site randomized trial of care coordination where each site chose its own target population of fee-for-service beneficiaries with chronic illness, and they chose their own intervention. The goal of these follow-up studies is to develop comprehensive descriptions of the most successful care coordination programs so they can be replicated faithfully or built into medical homes or ACSs, and to see whether the programs were consistently more effective for some severity of illness levels than others or their subgroups. One of these studies, the

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Medicare Coordinated Care Practice Research Network, was developed by eight of the programs from the Coordinated Care Demonstration that have banded together to develop a detailed set of best practices to be tested. They hope to be funded as a learning laboratory that could be used for a rapid and ongoing testing of innovations in care coordination, patient outcomes, and cost savings.

In addition, CMS is extending the Coordinated Care Demonstration for the 3 programs out of the 15 with the strongest evidence of effectiveness over the first four years of operation. They are doing the same kind of extension for a large-scale, population-based disease management program for duel eligibles in Florida that showed savings for the subset of participants that had CHF and lived in a high-cost area around Miami. The goal of the extensions is to see if the favorable effects of these programs are sustainable and replicable with a new set of patients.

CMS is also testing some new idea. You know about the Medical Homes Demonstration. There is an Electronic Health Records Demonstration. There are also broader-based resource use reporting and pay-for-performance demonstrations. As you have already heard, the idea behind pay-for-performance demonstrations is to pay more to fee-for-service providers that deliver the highest quality and less to those who deliver sub-

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standard care, but CMS also wants to reduce the tremendous disparities and resources used, so it is going to provide feedback to individual physicians on how they compare to other physicians locally on their patients' cost per episode of care of specific types, then test whether that information alone will reduce the disparities. That is the Resource Use Reporting Demonstration.

Ultimately, it would seem that to make Medicare sustainable CMS is going to need to reward not only physicians who deliver the best quality of care without any regard to cost, but rather physicians who deliver good patient outcomes the most cost effectively and penalize those whose patients overuse services. To slow the growth of Medicare expenditures overall, any extra payments to efficient providers has to be offset by reduced payments to inefficient providers and/or getting more physicians to improve their efficiency.

So, CMS will ultimately want to link these measures of efficacy and quality to come up with a comprehensive system for incentivizing change. If you think incentives do not matter, just look at what happened on hospital length of stay when the DRG System of Prospective Payment for Admissions was introduced. It is important to keep in mind that opposition from these changes from various types of [inaudible] is likely to be pretty fierce. As Larry said, some providers may go out

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of business, as many some physicians who cannot get their utilization profiles in line with the average. That is not necessarily a bad thing for the country.

There are a lot of problems with these approaches for measuring quality and efficiency, but as the saying goes, I do not think we want to let the perfect be the enemy of the good. Both physician-level and practice-level interventions need to be implemented, monitored, and evaluated over a long enough period that it is reasonable to expect savings and expenditures. The systems need to be continually refined with ineffective components eliminated or revamped, and providers with poor performance need to be educated and incentivized to more closely emulate the successful ones.

So, I think these are positive and potentially promising concepts to test, but I do not think we have the answers yet. Unless we head the lessons already learned about the details of what works, I am afraid some of the new attempts, like medical homes or ACS may be doomed to failure just like most of the earlier ones. Thank you.

ROBERT BERENSON, M.D.: Thank you very much. We have a few minutes for comments and questions. Larry, just one second— I want to give Chad a moment if we wants to make any sort of comments on Randy's comments.

CHARLES BOULT, M.D.: Well, as usual, I agree with Randy, including all of his criticisms of our paper. I have just a couple of things, particularly the issue about the early nature of this evidence. It is the best that we have, so that is what we focused on, but, in reality, all of these are preliminary work. The translation of these models into practice is a major obstacle to them working. Randy appropriately pointed out the need to make sure that the model that was tested and found to work is the same model that is taken up in the community, in terms of targeting the same patients and having fidelity to the clinical models, so you have the same kinds of practitioners doing the same kinds of activities. There need to be incentives to drive that system to keep doing what it did in the research setting.

I will point out that some of these actually have a net cost savings associated with them. Actually, even the example you gave of the didactic care in nursing homes. Bob Kane's [misspelled?] showed I think a savings of around $100,000 a year per nurse practitioner after accounting for the cost of the nurse practitioner, so that is compelling evidence of an economic future for a model like that.

And the only other thing I wanted to comment on is the notion of adjusting payments to health plans not entirely on the basis of patient's ratings of their healthcare, but

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incorporating that along with the other adjusters that we already have, particularly you are right that if you ask most people to rate their doctor of their healthcare provider they rate them very highly. The instrument that we have had some experience with is called the Patient Assessment of Chronic Illness Care, developed by Ed Wagner's group. It is not asking them, do you like your doctor or are you happy with your healthcare. It says specifically, how often does your healthcare team do this— for instance, talk to you in a way that you understand what they are saying? How often do you think they understand your problems? How often does your primary doctor coordinator with your specialists? They will rate it on a scale of 1 to 5. Admittedly, there is a halo effect of if you are happy in general, it will move your scores up, but we think this is a better indicator of quality than just simply asking about satisfaction. I will stop there.

ROBERT BERENSON, M.D.: Let us go to the audience. Larry, you had a quick question?

LAWRENCE CASALINO, M.D.: Yeah, I just want to highlight something because I think it could get lost in the detail, a very fundamental policy choice for the Congress and for Medicare, if Medicare is going to do anything along these lines. So, if you do have interventions or processes— whatever you want to call them— that are shown to be effective, the

kinds of things Chad was talking about, the basic policy choice is whether Medicare should then start to pay for these things individually, or should Medicare be paying large organizations, such as ACS or whatever, and let those organizations decide internally what processes to use and what not to use? Myself, I have a position on this. I think that Randy mentioned some reasons, such as that it would administratively difficult and expensive, for example, to pay for each of these things individually. I think the other two arguments against doing that are, one, that it can keep the delivery system very, very fragmented and make it even more Rube Goldbergian than it is. The other, again, is who is in the best position to decide which processes are likely to be effective in their environment, the organization on the group, if there is one, or Medicare on a national basis?

So, Chad and Randy, I would just be interested in your comments on that— paying for each individually or letting the larger organizations, if we had any, decide what to do with the money that you are giving them.

RANDALL BROWN: It may not be an either/or thing, since not everybody is going to be in the ACSs, like you were saying. But for the ACSs, I think that makes sense, as long as there is accountability. You have to generate the savings. I think that is fine to let them figure out whichever makes the most

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sense. That is the best way to do it because, like you said, for every organization, what works in that organization has to be tailored.

CHARLES BOULT, M.D.: And the concern about basically just giving the money to large organizations and letting them tailor how they use it— we have experience with that in the Medicare Advantage plans and the earlier Medicare Plus Choice plans where, basically, they returned the money to their shareholder and care really did not improve. There is that concern that that would happen again.

ROBERT BERENSON, M.D.: Other questions? I will get to Tim and we have one over there.

SARAH THOMAS: Am I next? Okay. I am Sarah Thomas with AARP's Public Policy Institute. I have a narrow question and a broader, more philosophical question. The narrow question is this. On your chart, where you looked at the improved healthcare efficiency, what was the nature of the measures that would indicate something was more or less efficient. That is the narrow question. The more philosophical question is whether we are holding improvements in care delivery to too high a test to actually ask that they save money when so many other treatment therapies, in fact, do not save money at all, they just fuel healthcare spending? Yet we adopt them because we think that they will lead to better

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outcomes. So, should that not be the same test for new ways of delivering care that improve outcomes?

CHARLES BOULT, M.D.: I am just looking at the paper on page 19. That is table eight which summarizes the evidence on the chronic disease self-management programs. That is the one you were asking about? So, you see, if you read across the column headings to the right, you see the domains that have been measured, largely in the area of quality of life and functional autonomy. If you just look down there, you can see that there have been a number of different instruments used to measure those concepts. I do not think you really want me to go over all of them right now, but they are listed there, and I would be glad to go over them individually later if you would like.

And the other thing about the standard— I think we may all want to comment on that. Again, it is a great question and people always ask, who holds cardiothoracic surgeons to a standard of reducing healthcare costs? They are not. Large, expensive procedures are authorized for payment if they improve the welfare of the beneficiary, period. Yet most of these models are being held to a much higher standard that they have to do that, plus be cost-neutral.

RANDALL BROWN: Yeah, if you want to get a handle on sustainability, somewhere or another you have to worry about

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what it costs to do it. And so the trick is to find good outcomes. You can find good outcomes produced in the hospital or in outpatient surgery for some things. There is a wide variation in the resources used across the country, as everybody knows, without this wide variation in outcomes. In fact, the outcomes are often worse in the places that use the most resources, so that is the kind of change that needs to be made. So, I think that if you are worried about sustainability, it has to be tied to your efficiency.

ROBERT BERENSON, M.D.: Could I add to that before I take one more question? Theoretically with chronic care, going through self-management skills and having teams and doing that will presumably produce savings, but maybe not immediately, maybe over the long term. Are we constraining these demonstrations by looking at budget neutrality in a fairly short time period, and do you have any suggestions for a manageable way of budget neutrality over an extended period of time?

RANDALL BROWN: I think that is a great question. I think it is absolutely true that we often do jump the gun there. They are looking at results a lot of times only one year after somebody has been in the program. That is almost impossible to do, I think, in many cases. The claim is that you can do it with CHF, but it depends. Maybe if you get them

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right out of the hospital, it works, but it depends on when the year starts, too. So, I think at the very beginning there needs to be this logic model thought out that says, okay, this is the length of time before we expect to find effects. If you do not expect to see effects over the first year, than do not look at the first year. Look at the second year if that is when you are expecting effects. If you look over the whole period, you are averaging zero for the first year with some impact in the second year. Make realistic expectations about what it is and then measure that.

CHARLES BOULT, M.D.: Implicit in what Randy is saying is the time that it takes to roll out one of these interventions, to set up a new system of care. You have to hire people and train them. You have to enroll the patients. You have to develop your measures. There are all kinds of things that are going on in the first 12 months that really have very little opportunity to affect the outcomes that you are looking at, so I wholeheartedly agree. I think in many of these cases we should not even measure what happens in the first year with regard to the primary outcomes, but only start measuring after we think that that whole thing we are measuring is up and running smoothly. Why measure it while you are building it?

ROBERT BERENSON, M.D.: Last question, Tim?

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TIMOTHY JOST: You have several years experience now with special needs plans which are supposed to be focused on medically vulnerable adults. I am wondering to what extent those have been evaluated and what we have learned from that experience.

CHARLES BOULT, M.D.: Well, I will say a little bit and then Randy can take it from there. I tried to find out in preparation for this paper, and all I could learn at the time was that Mathematica had done an early evaluation and submitted it to CMS, but it was not public yet. I still have not seen it.

RANDALL BROWN: Neither has anybody else. Reports to Congress that we write often sit for a while at various levels. Part of the problem with evaluation of the special needs plans is that because they are managed care there is not data on utilization of services. It was not set up in a way that could be very well evaluated, so I am afraid that when people do see it they are not going to be wowed by the ability of what you are able to say, what the effects are. It also is probably too early to really expect anything anyway, in terms of effects. So, who says two wrong do not make a right, huh?

ROBERT BERENSON, M.D.: With that, I think we have to end this session. Let us thank the speakers. [Applause]

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TOM EMSWILER: Hello, my name is Tom Emswiler. I work for Len Nichols at the New America Foundation. Len and Bob hired me two years ago to work on this Medicare project, and they have generously included me as a co-author. I thank them for that. I do not know if you go to rock concerts, but sometimes at a rock concert the lead singer introduces the rest of the band. Well, I kind of feel like a roadie introducing the two lead singers. I do not know which one of you wants to be Art Garfunkel, but you can raise your hand.

Bob Berenson is a Senior Fellow at the Urban Institute. He has been a practicing internist. He served on the Domestic Policy staff in the Carter White House and was a former CMS official in the Clinton Administration.

Len Nichols is the Director of the Health Policy Program at the New America Foundation. He is a health economist by trade. He chaired the Economics Department at the Wellesley College for a number of years before coming to Washington, where he worked in the Office of Management and Budget during the reform efforts of 1993 and 1994.

Joe Antos is my favorite health economist at the American Enterprise Institute.

JOSESPH ANTOS: Very nice, thank you.

TOM EMSWILER: Joe Antos is the Wilson H. Taylor in Healthcare and Retirement Policy at the American Enterprise

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Institute. There he studies the economics of health and medical reform, health insurance regulation and the uninsured.

Without further ado, I will introduce Len Nichols.

LEN NICHOLS: Well, thanks Tom. I am going to be very brief and get out of the way for Bob, then come back and talk a little bit more about governance, and then Joe will tell us why we are crazy. This is our sort of summary paper. I will very briefly review the problem, just outline the nature of the solution, then Bob is going to take some time to walk you through his expansive vision of value-based purchasing and then also some useful interim steps that Medicare could do, even if we do not get national health reform by February of 2009. And then I will come back and talk about governance, which will hopefully be provocative and get us going.

We know that healthcare costs too much. We know the Cassandra cries [misspelled?], in our view at least, sort of exaggerate the short-run problem. The rhetoric that we cannot afford Medicare tomorrow is wrong. The rhetoric that we cannot afford Medicare in 30 years is correct. We want to think, I think, personally about. The defenses against Cassandra, however, do, in our opinion, somewhat optimistically ignore congressional history. That is to say that they have not done the kind of en masse passing of things that we know they show.

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That is why we feel compelled to try to do something about the governance.

Some of you know I have kind of drifted off and moved from analysis into sales in some ways and I have picked up a little religion along the way, so I have been thinking about the imagery here. Fundamentally, it is about helping Congress to protect itself from temptation. You see, the problem is that Congress cannot avoid the temptation to intervene, and so what we want to do is create a creature. We are going to call them guardians. I actually looked at Plato and I thought Joe would like that, you see, because Plato is a favorite of conservatives. They like the authoritarian nature and the daddy figure there. The guardians represent sort of a multipurpose metaphor because they both guard Congress from overzealous and inefficient providers, but they also guard the program from overzealous and inefficient bureaucrats. So, it is quite a new thing. We think of it like a board of directors for the Medicare program. The fundamental point is this, to hold the guardians responsible for the performance of Medicare and to turn Congress from a focus on how to a focus on what and a focus on whether we have accomplished it, then leave it in a sense to the guardians and the professionals to make it happen. Okay, Bob?

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ROBERT BERENSON, M.D.: So, you have heard a couple of versions of value-based purchasing today. Larry has a very nice paper and MedPAC, I have to give them credit— Mark has left, but basically over the past few years they have introduced a number of value-based purchasing ideas. They may not have called them all value-based purchasing, but they have been doing it, so I am reminded of that phrase that everything has been said, but not everybody has said it. I am going to, in my 10 minutes, sort of give you perhaps a little difference in emphasis or opportunities around value-based purchasing and then very specifically about cost savings, which I think then leads into why we need to seriously consider an altered-governance model for how decisions are getting made relating to Medicare.

The first point I want to make here is that even though CMS and to some extent Congress, particularly the Senate Finance Committee, has adopted the term value-based purchasing to replace pay-for-performance— I guess there was a decision that pay-for-performance was upsetting to physicians, so they are calling pay-for-performance value-based purchasing. It is much broader than pay-for-performance. In fact, in the next slide I am going to identify it as one of many complementary interventions or tools that a purchaser would have to try to improve care for the beneficiary population.

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Pay-for-performance really looks at particular services and asks whether we get better quality for that service at a reasonable cost, but it does not ask a lot of questions about whether the service was appropriate. Ultimately, it does not ask whether the mix of services we are providing the right mix of services for the population of people we are responsible for caring for. So, in the Medicare population, some of us have been writing about how we still have an acute care orientation to the Medicare program, even though increasingly the beneficiaries in the Medicare program have chronic conditions that need chronic care management. If you just look at rewarding individual hospitals or physicians based on a service-by-service basis, you might improve how that particular service is provided, but you really have not changed the mix of services for the population. This is no time to go through each of these items. I have written about this in the past and this is my model, but it could be somebody else's. Again, some of this is just terminology. I like to think about all of these things as part of value-based purchasing, but it is to sort of make the point that if you are just focusing on pay-for-performance you might be missing out on other opportunities.

So, for example, if we are looking now at how to improve the performance of physicians in Medicare, yes, we

might be coming up with 134 PQRI measures and asking each of the physicians to report, we might— I am a little skeptical about the advisability of doing that— but we would also surely be looking at issues around conflict of interest that physicians have related to self-referral and related to relationships with pharmaceutical companies. Senator Grassley is looking at that issue. MedPAC has now identified that issue deserving that they are recommending that there be disclosure about relationships. A value-based purchaser would be looking at that and coming to some judgment about balancing the various initiatives and not putting all the eggs into the pay-for-performance basket.

Now, one of the issues that is raised— it came up in the commentary that one group of economists, the Aaron et al group, had about the first group of economists who were recommending triggers on Medicare— is the view that we need to reform the whole healthcare system and really Medicare does not have much opportunity to act on its own or really should not take that opportunity to act on its own. You heard in my introduction that I was part of the Carter Administration and, indeed, we recommended hospital cost containment in those days. All-payer cost containment because we were worried that if it was Medicare only there would be cost shifting onto private payers and maybe Medicare beneficiaries would become viewed as

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second class, so it has to be all payer. That did not pass the Congress and within a couple of years the Reagan Administration and Senator Dole and Congressman Rostenkowski got together and did hospital prospective payment for Medicare. It was a successful innovation. I argue in a book with Rick Mayes that, in fact, Medicare acting on its own stimulated the private sector to do a number of things, for better or for worse, including much more active contracting with managed care to try to deal with the cost shifting the might occur.

I think Medicare can act on its own, at least in a number of areas. There are concerns not only about cost shifting, but about Medicare overusing its market power and if Medicare really was concerned about cost, it could drive prices down to really take advantage of its market power, reducing quality and producing what economists call inefficient prices.

But value-based purchasing inherently involves balancing access, costs and quality. There are built-in restraints to what Medicare could do acting by itself. That is manifest in the whole thing around the SGR. Medicare could drive prices down to physicians and have a 10-percent cut this year, but that is compelling information that that would drive docs out of Medicare. I believe that. There is beginning to be evidence that that is happening now. And so Congress wisely— they are not doing it very well, but at the end they do

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not go through with the SGR-imposed cuts because they are balancing cost, quality and access. So, I think a value-based purchasing concept is not incompatible with Medicare acting alone and balancing.

Why can Medicare act alone? It is because there are Medicare-specific actions that can actually move the system and be emulated by others. It happens that for hospital DRGs most private payers did not adopt DRGs. They did some other things in response to the potential and the reality of cost shifting. When Medicare moved to an RBRVS-based payment system for physicians, over a period of number of years, private payers actually emulated the RBRVS system. Indeed, as you heard Mark Miller talk about earlier, private payers are asking Medicare in some cases to take the lead so they have a basis for essentially following Medicare.

I have argued and will say here that I think there are opportunities for private payers to influence Medicare policy making that has not been taking into account. In this area—again, I know the physician fee schedule issues very well—RBRVS, for better or for worse, the AMA and the committee set up under their office, has too much power in setting the relative values in Medicare. As Len emphasized, it was the notice and comment rule-making requirements in Medicare—private payers could be sitting at those tables. Private

payers could be providing much more input in the public rule-making process, if they are going to use the results of that public rule-making process.

So, in fact, private parties can have more influence on Medicare policy, but they tend to be a little distant right now. Clearly, there needs to be a lot more collaborative purchasing. This whole area of chronic care management and medical home will only work if, in fact, private payers and Medicare do these demos together. Now, it is logical that Medicare would lead because they have the largest share of patients that Chad described as vulnerable, those with chronic conditions. Private payers have the same cost maldistribution, small numbers of patients with chronic conditions generating costs. There should be multi-payer demos. There should be collaboration, but, in the absence of that, if Medicare actually went forward with good demos, they would be a market-maker in this area and people would emulate what they are doing.

With Medicare, we are talking about a potential crisis 30 years from now, but, in fact, the challenge is to flatten the growth curve by about 1- to 2-percent. This is not necessarily something that today is easy to do, given what we are going to argue— what are arguing are political constraints— if, in fact, Medicare spending went down to GDP rather than

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1.5- to 2.0-percent above GPD, all of the dire predictions of 3-percent of Medicare representing 3-percent of GDP going to 9-percent of GDP would not happen. That is what we are talking about. Indeed, Chapen White [misspelled?] has written and documented that in more recent times Medicare has actually been more successful through its payment policies involving reduced updates to providers, as well as putting in prospective payment systems in most of the areas, at actually doing a better job of constraining costs. So, I do not think this is unachievable.

The Dartmouth group emphasizes unneeded service volume at as much as 30-percent excess growth. There is some disagreement over whether or not that is a high estimate. We cannot get 1-percent reduction, so I do not think we need to sort of resolve whether it is 30-percent or 20-percent or 5-percent. We need to change the growth curve by 1- to 2-percent. I do not think it is appreciated enough that the prices paid in a program like Medicare can directly influence the volume of services. When the Dartmouth people talk about supply-sensitive services and trying to then come up with approaches to affect supply and the practice patterns of physician, I would suggest that one of the ways that you do that is by changing the relative profitability based on the prices that you pay to providers. The marketplace signals where there are distorted prices affecting volume.

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So, in fact, we found out— only because the specialty hospital issue arose— that in fact the DRGs that had been used for years, the weights of the DRGs in Medicare had really not been re-calibrated and that hospital administrators knew that there were winners, mostly in cardiac surgery and certain other surgical services, and losers, which were the medical DRGs for chronic conditions. That should have been self-correcting. It should not have required sort of this separate issue of specialty issue of hospitals to come along.

If you go out and talk to docs now, you can identify which are the winners in the RBRVS system and which are the losers. There are some that are remarkably profitable and one should be able to change those. It is paying too much, number one. You could reduce the prices and those services would still be provided, but perhaps not quite as many of them. And you would change the sort of entrepreneurial behavior, such that physicians might not be purchasing PET scans, which is what they are doing or what they have been doing.

So, Medicare should have— and this now is really getting into the nitty-gritty of value-based purchasing— broadened inherent reasonableness authority. There is something in the statute that actually permits Medicare, CMS, to reduce the prices of DME supplies based on surveys of market-based prices. In fact, this was reaffirmed in 1997, but

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because of Congress essentially intervening on behalf of the DME industry, Medicare, CMS, has not been able to implement inherent reasonableness. It has adopted this other approach, which is competitive bidding, which also is not being allowed to actually go into effect.

So, why not let CMS use its discretion to make limited price changes when it gets marketplace signals that prices are distorted and then enter into the more systematic approach to changing those prices based on the required— what has been promulgated in legislation and regulations? Give CMS some authority to correct way out-of-line prices. Improve the estimates of average costs. I am sorry Mark is not here, but my understanding is pretty much that for most payment systems Medicare tries to pay average costs. That is a reasonable thing under the current model. It should not pay marginal costs. Medicare is a huge payer. It should pay the average cost. But what med does not do very well is change the definition or change the calculation of the average cost when volume growth is exploding. So, for example, imaging services in the Physician Fee Schedule doubled between 2002 and 2006, but the prices did not change, even though the fixed expenses of the equipment which makes up most of the component of those prices are now being spread over twice as many services, Medicare has not done a good job of keeping up. It could, I

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would argue. I think there are other opportunities to use marketplace prices where feasible, not just based on sort of administered pricing calculations.

And then finally, I want to talk about this. This is implicit in some of what Mark said and some of what Larry said. Typically, Medicare tries to get the average and pays average prices. I have suggested up until now that it could do a better job of making those estimates. But you also want to alter prices to accomplish specific policy objectives, so you move off of cost reimbursement when there is a compelling case made to reward different behavior. It is not really the same as pay-for-performance. You are not creating a new measurement system. You are not rewarding with marginal payments. You are embedding in the basic payment system new incentives.

So, there are some opportunities. Re-hospitalizations right now— MedPAC has made some recommendation that go along these same lines, but essentially, if, in fact, almost 20-percetn of Medicare beneficiaries experience a re-hospitalization within 30 days— and researchers tell us that the majority of these are avoidable, not in each individual case, but they are in categories of conditions where good care might reduce the rates of re-hospitalizations— just do not pay as much for a re-hospitalization. Pay less and if the hospitals got significantly less for that re-hospitalization,

the hospitals would then get into the business of supporting the kinds of programs that Chad and Randy talked about, the hospitals in all those communities.

It is similar with medical home payments. It may be that we cannot justify raising payments to primary care because the cost of their practice is at a certain level, but we want to support those activities. Well, let us pay for that as a specific opportunity.

Let me finish and then turn it back to Len. I know I am going too long. I think there are other opportunities for substantial cost savings in this program, but Congress has not supported CMS authority to do it. Why I think value-based purchasing is a broader concept than just thinking about how specific services are provided by specific providers is the benefit package. Karen Davis and Marilyn Moon and others wrote a piece a few years ago basically picking up on the reality that because Medicare does not provide a good catastrophic coverage— no out-of-pocket limit for a year— that is a primary stimulus for why beneficiaries want supplemental coverage. So that essentially provides catastrophic coverage. In the process, they are buying first-dollar supplemental coverage and it has been well documented now that that first-dollar supplemental coverage drives increased Medicare spending. We could pay for an expanded catastrophic benefit and probably

save money if we were allowed to change the benefit package in Medicare.

And then the final one would be there is obviously a lot of talk now about comparative effectiveness. In fact, the original statute gives CMS the authority to do comparative effectiveness and cost effectiveness analyses two times, one in a Republic administration and one in a Democratic administration. When I was around, we tried to promulgate rules that would explain how the agency would do comparative effectiveness and cost effectiveness, and twice the industry beat down those rules so that they were withdrawn or they did not go forward. CMS actually does comparative effectiveness and then the Congress overrules it. The most recent example was a front-page story two weeks ago in the *New York Times* about CT angiography. There is no good evidence of it improving patient care. CMS wanted to study it with Mark McClellen's idea that we will put it in certain places, collect evidence and decide whether it works or not. But the Congress essentially got 180 or so sponsors of a resolution to override that decision and in the end CMS threw in the towel.

So, in talking about comparative effectiveness institutes or centers, the issue is really a political governance issue. CMS does the work. They just are not empowered to go ahead with it.

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With that, I will turn it back to Len.

LEN NICHOLS: I think we missed a slide there, yeah. Why MA plans cannot be the cavalry. We all know it is because Congress will not let them. And then it turns out that it is not in their interest because you can make way more money selecting risk and getting overpaid if you can get lobbied to do that.

The key to Medicare reform is to enable Congress to delegate appropriately. It seems to me that when you look at what I would call the trajectories of spending, the fundamental case for doing something like this, to the member of Congress who obviously is going to be conflicted, is if we do not do this we are going to have to make some really ugly choices, I mean really ugly choices down the road. Joe's paper, Aaron's paper, everybody's papers show it is clear that there are ugly choices coming down the road if we do not do something. That is why we are trying to suggest this trick, which is to delegate with appropriate accountability.

So, what we would call for then is enabling legislation of our guardians, which would be empowered and they would be like a board of directors, but they would have a general council— his name would be Tim Jost. We would commandeer him for at least two years to write the specific law. The first element of the law is the performance criteria by which the

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guardians would be evaluated or their performance would be evaluated. That would be things like the health of the population and the resources used to achieve that. I do recommend you go through Tim's paper, though maybe in small doses, but if you take a deep breath you can actually get through quite a bit. It is well written. It would also, as Tim's paper teaches you quite well, specify the due process rules of information. As you have heard throughout the day, due process is an absolute requirement of making this eventually tolerable by the population.

Here is the metaphor for where I think we are and then I will do some pictures and then I will quite. Basically, you have stakeholders in the lower right-hand corner of this triangle, Congress at the top, CMS through HHS through the White House at the bottom left. Stakeholders fight with CMS. If they lose, they go to Congress and get it fixed. This is not all that complicated. It is the way the world works. What we are suggesting is basically the following: Insert the guardians and put them as a way as a buffer. The guardians would then be this sort of dual-reporting thing. They would report to Congress. Obviously, the guardians, through due process, would entertain lots of information processes. CMS and HHS would still be doing their jobs. The White House would still get to appoint and control and fire them and tell them

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what they think they should do, but this little funny-looking thing, which I pulled out of some PowerPoint clip deal, is meant to say that CMS kind of has to do a detour through the guardians. By the way, the Congress does, too, because you want to focus the discussion at the guardian level over whether you have achieved the criteria we told you to achieve in the legislation and now whether you paid this provider $14 and this one $12. That is not where Congress should be, and it is where most members of Congress know they should not be.

This is another diagram, a lot more complicated in some ways, but it is the same concept. The concept is the White House still controls what it controls. The difference is that the guardians are really the filter through which the evaluation of the Medicare program occurs in the public space at a sort of high level. We want the guardians to be appointed by the comptroller, like MedPAC is now. We think, in fact, the MedPAC appointment process works pretty well. The difference is that we want to elevate the stature. It is not that the people are not excellent, but that want to elevate their stature by having them confirmed by the Senate. Let the guardians elect their own chair, their own vice-chair, and they both have to be confirmed. To simplify and streamline and speed up, we will have joint confirmation hearings, finance help, aging and budget. We will send the right signals in all

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dimensions. CMS would still report to the guardians and to HHS, the guardians would report to Congress and so forth, but the point here is that the guardians would be making the decisions about how— coverage, pricing, administrative— along with the due process rules defined and identified by the Congress in the enabling legislation. If compliance with performance fails, as per chance it might once or twice, guardians would be compelled to come and explain why and work with CMS to fix it, and maybe to advise Congress, as MedPAC does now, about how maybe they want to change the targets— go back and listen to Randy Brown. You have to be realistic here. The point here is to insert a set of adults who are empowered to speak the way they should.

If disagreements arise of a very serious nature— that is to say if a majority of Congress really thinks the guardians are overstepping in the how business— okay, fine, we will allow the system to breathe, a 60-percent vote could override a specific guardian decision. Note we are empowering Congress over White House— if the White House is pissed off, they have to get a two-thirds vote because we think, in fact, what we want is to simultaneously strength Congress' hand, but strengthen the accountability to the Congress because we think, in fact, the likelihood overall of the guardians being overruled obviously is sort of more dangerous with the White

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House being that only one person has to be persuaded. For continuous non-compliance, we could impeach the secretary, but I think that probably will not be a problem.

Basic conclusions— something like the guardians needs to be created in order to enable value-based purchasing, which a lot of folks agree should be done, to happen. In our view, the guardians would strengthen the hand of Congress in setting the goals and sort of what we are shooting for and whether we achieve them. There are lots of alternatives available. There are lots of different models— Lynn Etheredge has suggested at least three of them in his career that I can remember. A lot of people are now talking about the Federal Reserve kind of model. I saw Senator Bachus, at his summit on June 16, talk to Ben Bernanki about, gee, why do we not have a health fed because I do not think I should be decided what one kind of doc makes versus another? That kind of thinking is what led us to believe this was indeed a conversation worth engendering. I would just say that our version of the guardians, in our view, is preferable to the Federal Reserve model because that is pure delegation and then you are completely outside the prevue. This is much more interactive, much more, in my view, accountable and therefore much more likely to survive in a real democracy. And if it survives Joe Antos' comments, we will actually get to lunch. Thank you.

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JOSESPH ANTOS: Well, we will see about that. [Laughter] Everybody had to walk through an enormous crowd of people this morning who were, I guess, getting advice on how to get out of their mortgages, so that is really quite and appropriate backdrop for this [laughter] for mortgaging the future.

I just want to say a few words about Cassandra, one of my favorite relatives. The demographics are nearly certain, so there is hardly any question— short of some horrible epidemic that kills off a bunch of us— that over the next 20 years or so we are going to have a huge increase in the Medicare population and they are going to live— well, if you look at the projections, it looks like they are going to live forever. I intend to be one of those.

It is a little harder to say about excess cost growth, but when you look at those projects, what is excess cost growth, anyway? Well, it is really a way of characterizing, of monotizing [misspelled?], of quantifying what could happen. It reduces down to dollars the real things that could and would and probably will happen, which means not only will we have more spending and therefore more taxes, but we will also get worse access, reduced innovation, lower quality— in other words, a crappier health system in Medicare and in general.

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So, the emphasis in this paper and I suspect in the other paper as well, though I have not seen all the other papers, the emphasis on improving the performance of the health system is a good one, but we have to remember that unlimited cost— which is something that at least this paper does not really address at all and which politicians never want to talk about— remains a big issue and probably the issue that we will eventually have to deal with holding our nose and probably having circumstances stick our head in the water.

Okay, so the paper— which I recommend many sections of [laughter]— points out these particular things, which I want to mention, sources of the problem. I thought the paper was a little clearer. They identified four sources of Medicare's problems. One is over-reliance on fee-for-service payment mechanisms, emphasis on mechanisms. Second is that it is without much accountability from providers. Third is Congress' micromanagement. Forth is conflicting policy and constituent interest that makes it very difficult to manage the program. Congress, of course, thinks it is managing the program and so does CMS. Who is? Well, that is a good question. I think that is a good way to look at it, and I think the major new suggestion in this paper is an attempt to mainly get at the last two political points.

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So, what it says is really that that hypocriful [misspelled?] Medicare beneficiary, that hypocriful senior who, when asked by the polltaker what should be done about Medicare, responds that whatever we do, let us not let the government interfere with Medicare. That is right. That is what these guys are saying. I could not agree more. Okay, I did not get a laugh, but that means you agree with me.

Can or should Medicare act on its own? Well, it does not matter what the answer is to that question. It is going to anyway. So, the question is what it will do. To maybe slightly paraphrase something Randy Brown said, but that I will update for Medicare, let us not let the inadequate be the enemy of the dysfunctional. I think that is really what Bob and Len are really talking about here. Let us do some things, but let us not pretend they will be perfect. Let us build in some flexibility in what we do so that when we inevitably— I am going to say make a mistake, but actually find out that something was not going to work perfectly, we can make some adjustments. That is a really good principle which we do not have in the Medicare program so far. But is has only been 40 years, so who knows?

The fact is that through this long Medicare history of policy activities, changes, demonstrations, legislation and regulation some things worked and some things did not work, but

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they all had an impact on Medicare and they all had an impact on the broader health section, sometimes favorably, sometimes not favorably. So, there is a blessing and a curse here in Medicare's activities. Medicare could promote what some people call creative destruction, which is the hallmark of the competitive market ideal. Bob mentioned the DRG system as being an example of that. Another example is sort of the mother-may-I Medicare analysis. They will not pay for never events, then two weeks later all the major insurers say, we will not do that either. Somebody has to move first. That may not be a great example, but it is a current example. However, it is much more likely, because of its history, to be a force for creating and maintaining rigidity in the market, rather than solving problems. Again, I think that is why Len and Bob were talking about this other governance structure.

So, what is the proposal? I really liked Bob's slide which gave about a dozen different aspects of value-based purchasing. If you look at those and you think about it, what is it? Well, it is what we think health insurers are supposed to do. So, in fact, what is this proposal? They do not quite get there, but what they are edging up to is that Medicare should act like a responsible insurer rather than merely acting as a spigot on a reservoir of taxpayer dollars. It will be

hard to do. We have 40 years of history not being very good at that. But again, it is a good goal.

Okay, I think a reasonable question is where we think we are going to get all of this good policy to happen. A lot of the paper talks about setting the right price. Well, what does that mean anyway? How do we know that? How are we going to find out? The useful suggestion, I think, on that is to do what some people call satisfizing rather than optimizing behavior. In other words, edge the prices up or down, hoping that you can detect a signal from the market. If you are going to be a rate regulator, than you had better hope you can detect what is going on out there. That is an argument against being a regulator, but you have to be able to detect reaction and you have to be able to anticipate before you do anything what direction that reaction will be because if you think it is something else, you will not look for it, and therefore you will not find it. There is a real risk there.

I am also a fan of what we used to call overpriced procedures. There are some things that you really do know what the direction is and you do not want to get all the way there, because you do not know where there is, but you want to move in that direction.

Let us see— I will skip a couple of things here. So, setting the right price— even if you set the right prices,

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remember that it is not a price or not a few prices and not 7,000 prices in physician payment. It is relative prices, so it is not just a few prices. You are really setting all the prices. If you are going to be a rate regulator, you have to set all the prices. You are implicitly setting all of the prices by changing one because you are changing the relationships to that one. So, as hard as it is, it is not as easy as you may think. So, anyway, I think that is a major, major challenge.

Now, let me hit the governance issue. Guardians— well, I do like the concept of guardians, but that is because it reminds me of science fiction, though not the classics, although there are classics in science fiction. These are the robots who are going to protect us. Isaac Asimov had this idea. I remember in one of his books the robots got loose.

So, what is the idea behind the guardians? This is an attempt to pry Congress' hands off Medicare's throat. In fact, even though in the paper they dump all over certain other distinguished authors who all they were trying to say was, let us try to change something about decision-making processes and hope that decent decisions come out of it. That is what this paper is all about. They want to change the decision-making process in some way to get us off of right where we are and right where we have been for the last 40 years.

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And so, however we do that, if it is possible, good. However, it is science fiction and as they correctly criticize everybody— and they ought to correctly criticize themselves— it does ignore the long congressional history that will not let it happen. I was really a thrill to hear Len say that he wanted to have the confirmation gridlock of all times by having every committee weigh in on who would be confirmed for the guardian positions. God help us. We cannot even get public trustees in the Medicare program. If we are really going to have guardians, we have to somehow get Congress and the executive branch to agree to this. That is the hard part. Ultimately, that is the problem. It is the political problem first.

Now, let us not dismiss the technical problem. I want to end on that note. I am skeptical even of the proposal that I am associate with that process changes will really work, although I think we ought to try it because we have been doing the same old things for 40 years. However, the real problem is that once we get the process changed, we still have to do something. We have to actually change something in the program and we have to hope that we can edge our way into better, rather than worse, ways of managing the program. If you emphasize government control, you will get that solution. If you emphasize sort of fake competition, which we essentially

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have the way the Medicare Advantage program is set up, you will get that result.

So, what do we really need here? For my taste, it is getting Congress to lay off quite a bit. It is giving the fee-for-service Medicare program an opportunity to act like a sensible and responsible insurer and meet consumer demand in a responsible way. But it is not to drive out the possibility that other kinds of health plans could spring up that could, in fact, help us lead the way. Thank you.

MALE SPEAKER: Very good, Joe. I really appreciate that. I think you and I probably know that we agree on a lot. I think that was very nicely done. I think in the interest of lunch and everything else, we are not going to take questions at this moment because, in a fundamental sense, the afternoon panels are all about discussing all of these ideas. I do not want to slow down the access to the member of Congress and former member of Congress who are going to address you while you dine.

But before you break, let me just suggest something. I need to do one bit of housekeeping that is extremely important. That is to thank the people who actually made this meeting possible. You have already met Tom Emswiler. What I want people to do is just stand up, and then we will have applause in one round. Tom was the guiding light of this project and

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made everything possible, so, Tom, please stand up. You have notice Sarah Axine [misspelled?], who is probably now going to get my car because I have to go catch a plane— and Hannah Graff [misspelled?] running around with microphones. We really appreciate their enthusiasm and endeavors. Let me also call to mind that Guy Pifton [misspelled?] asked a question in the back. He is my resident neurosurgeon who keeps me from doing really stupid things about the delivery system on a daily basis. Joanne Keenan [misspelled?] in front of him is our writer and blogger and editor and requisite former member of the fourth estate who advised us about that. Elizabeth Carpenter, who has floated the room I think in a number of different settings, is sort of our main congressional liaison and message queen. And then finally, let me call attention to Julie Barnes, who is the Deputy Director, alter ego, and true master of my schedule and life in making all of these things possible. So, join me in thanking them for making this and everything else possible. [Applause]

[END RECORDING]

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