Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, it's a season to be merry jolly and I think reflective of some of the gains we have made to ensure access to quality health care this past year. We have seen some notable improvements in statistics and much of it due to the Affordable Care Act.

Margaret Flinter: And I think our listeners know, Mark, that we are die hard optimists, but we do believe in reporting good news when we see it. And we are cheered by the recent report that senior citizens have saved $1.5 billion on prescriptions in the past year, using the 50% drug discount through Medicare Part D that the Affordable Care Act put in place. And that was great news.

Mark Masselli: That's right. Those folks in the so-called "donut hole" of Medicare were able to realize some significant savings. We are not seeing their premiums rise roughly about $550 per senior on average and that's a tardy sum of money.

Margaret Flinter: And also on the good news front – and Mark, I think I might have said this last week because I found such good news – the number of young adults who are uninsured is falling as they are able to retain or continue coverage under the Affordable Care Act, thanks to that provision that allows young adults to stay on their parents' plan until age 26 up until now. And nothing else has worked, but this seems to be working.

Mark Masselli: There were a lot of naysayers who said there weren't enough young people to take advantage of it but the data is in, 2.5 million young adults, many with preexisting conditions or those having a tough time finding a job in this economy. We are able to keep their health care coverage and consequently stay healthier. That's pretty significant step forward both for our seniors and our young adults.

Margaret Flinter: So Mark, lots to be grateful for this holiday season I think, and we wish all of you listening to us continued good health during the holidays and in the coming year.

Mark Masselli: Thinking of things to be grateful, it was just two years ago on Christmas Eve, we had the unbelievable experience of watching the senate pass its version of what would become the Affordable Care Act, a real moment. Well, there has been a lot of water under the bridge since then but since plenty of forward motion. We will see how the Supreme Court handles the Affordable Care Act. Hearings are set for late March.

Margaret Flinter: Well, Mark, I do go back to that Christmas Eve experience of watching the senate pass their first version of Healthcare Reform, and I

remember how exciting it was. I remember calling you up, and we are back watching our lawmakers in Washington, again this time not so exciting matters being dragged out right to the end on the issue of funding the government, including Medicare Medicaid past 2011, and still as we have seen this last year, so much **parts into senate** on just how that funding will be mapped out.

Mark Masselli: Absolutely, and we are going to keep an eye on that. Medicare reimbursement formulas are still in need of serious revamping. And today, our guest, health economist and Senior Fellow at Project HOPE Dr. Gail Wilensky, is the former head of Medicare and Medicaid. She doesn't believe the system can be fixed until reimbursement formulas are overhauled.

Margaret Flinter: We will get to Dr. Wilensky in just a moment. But no matter what the story, find all of our shows and hear more about us by Googling CHC Radio.

Mark Masselli: And as always, if you have feedback, email us at Chcradio.com, we would love to hear from you. Coming up, our conversation with Dr. Gail Wilensky. But first, here is our producer Marianne O'Hare with this week's Headline News.

Marianne O'Hare: I am Marianne O'Hare with this today's Headline News. The Supreme Court has set the date for arguments to be heard on the legality of the Affordable Care Act. Oral arguments begin on March 26th. At issue, the provision in the bill that requires most Americans to carry at least a minimum amount of health insurance or pay a penalty. Challengers which include 26 republican-controlled states say, "Congress lacks the power to enact such laws."

The Obama Administration asserts the Affordable Care Act falls within its constitutional authority. Considering the long-term impact this case could have on interpretation of federal powers, the Supreme Court has allotted five and a half hours for arguments to be heard. The typical case only gets an hour before the high court. Still undecided whether cameras will be allowed in the courtroom for those proceedings.

One provision of the Affordable Care Act calls for the creation of accountable care organizations. So-called ACOs our networks formed between certain physicians at hospital groups to provide streamlined care for the chronically ill, to reduce the need for hospitalization. Health and Human Services Director Kathleen Sebelius announced that 38 pioneer ACOs would launch January 1st. The formation of the ACOs is expected to save a billion dollars in health care cause.

A small glimmer of good news on the childhood obesity front. There has been a 5% drop in childhood obesity rates in the New York City School District in grades K through 8. Researchers believe it's due in part to better nutrition programs in

preschool and a general policy change to get kids moving more during the day. Minority students, however, showed the smallest improvement.

And what's the most trusted profession out there? Well, according to a recent Gallup poll, nurses top the list again with 84% **fold** rating them very high. Conversely, 64% ranked Congress and lobbyists very low. That's the Headline News. Now back to Mark and Margaret.

Mark Masselli: Today, Margaret and I are speaking with Dr. Gail Wilensky, economist and Senior Fellow at Project HOPE. She was the administrator of the Health Care Finance Administration, now the Center for Medicare and Medicaid Services from 1990 to 1992 and chairwoman of the Medicare Payment Advisory Commission from 1997 to 2001. Dr. Wilensky, thank you for joining us on the show once again.

Gail Wilensky: My pleasure to be with you.

Mark Masselli: Dr. Wilensky, we have the pleasure of speaking with you back in February of 2010, just about a month before the passage of the Patient Protection and Affordable Care Act. Health care has continued to be a front and center issue in the national debate. In the past few days, we have seen the departure of Dr. Don Berwick, CMS administrator. Perhaps you, more than anyone, having held the position of leadership yourself, know the challenges of leading America's largest health care programs. And stepping down Dr. Berwick noted that the challenges of trying to move a complex set of changes forward. How would you measure his progress in improving care under CMS and what do you think we can expect from the new administrator Marilyn Tavenner?

Dr. Gail Wilensky: He is personally well liked, was very popular as an administrator, has a passion for patient safety and improving the processes of health care and transmitted that passion to the senior leadership and the rest of the agency. And that was really appreciated. He was charged with getting the beginning parts of the Affordable Care Act going on time in a proper way, and I think he did a reasonable job in getting that done. A few missteps, preliminary rule that came out on the Affordable Care Act was widely penned and I think put a damper on what had been regarded as a very highly advertised part of trying to transform the delivery system with accountable care organizations, but recently released the final rule which has been much better received.

So we are now going to be in that new phase of having a new person come on board, although not really new. Marilyn Tavenner has been there even longer than Dr. Berwick. She was the principal deputy, someone who is actually very well suited.

Margaret Flinter: What are the changes that you would want to see? Can we cut our way out of cost escalation by reducing payments and changing fee

schedules? Or is it possible to cut our way out through reducing waste and improvement quality, investing more in prevention and primary care?

Dr. Gail Wilensky: Well, the answer to the first part is easier which is no, it is not possible to get our way out of this problem by just reducing payments under the existing delivery system. The existing delivery system does not reward the kind of behavior we would like to see, which is that clinicians and institutions who provide good quality care, produced in a low cost and efficient way are rewarded, and those that don't are not rewarded.

Mark Masselli: Well, one of the major pieces of the Affordable Care Act was the shared savings through the Accountable Care Organizations, and you noted that they had a little snafu in the draft and obviously got thousands of people commenting on and hopefully got the final rules right and it's moving forward. What's your assessment of the potential impact of ACOs? And maybe you could explain them to our listeners. And do you think this offers a transformation or is it a tweak of the current approaches of improving care and reducing cost?

Dr. Gail Wilensky: I don't know that is either of those. I don't know that is exactly a tweak. It might be a transition to something better. That would be the most positive statement I could make. It is definitely not transformative in and of itself. It allows physicians and hospitals, who work together but are not formally part of a single system, to come together. And if they can demonstrate that they are providing care to a group of patients at a lower rate of spending growth than would otherwise have been expected to occur, they can share on the savings, I will be pleasantly surprised if they have much effect.

Margaret Flinter: Dr. Wilensky, Medicaid, of course, is also being scrutinized along with Medicare, and you have written about states' efforts not just to slow Medicaid spending but also efforts to improve on the value it delivers, really to their most vulnerable citizens and of course major changes to a state Medicaid program require the approval of CMS. I would be interested in hearing, what changes do you see in state Medicaid programs around the country that offer real promise of innovation and transformation? And maybe you would also like to look back to the early '90s and your tenure and innovations that were made then that have born through 20 years later as a best practice.

Dr. Gail Wilensky: What we need to focus on now are the areas that have been more or less ignored in terms of changing how we deliver care and that's to a group that are called Dual Eligibles. That just means that you are on both Medicare and Medicaid. That's an old sick frail population, low income as well by definition and also the disabled population, some of whom are part of this Medicare-Medicaid Dual Eligible group. But about two-thirds of them are not. And so those are the very high spending people in Medicaid. They are only about a third of the Medicaid population, but they account for at least two-thirds

of the money that is spent, and their care has not been very well coordinated and organized.

The question is how can we help states faster and quicker. The Innovation Center is just beginning – that was set up as part of the Affordable Care Act – is just beginning to get going. We will see whether there can be approvals that are quickly made. That's really going to be the test for the agency. They have talked a lot about the facilitating innovation. Talk is easy; delivery is not so easy. It's been pretty slow getting out of the box. We will see what happens.

Mark Masselli: This is Conversations on Health Care. Today, we are speaking with Dr. Gail Wilensky, a health care economist and Senior Fellow at Project HOPE. Dr. Wilensky, last time you were on the show, you talked about the importance of gathering information about what works best for which patient under what circumstances. This administration is invested in comparative effectiveness research in the 2009, Federal Stimulus Bill and in the Federal Healthcare Reform. Yet, we still often hear the **cry** hands off of my Medicare. It would seem that the art of communication between CMS in the public has to be top priority in order to engage people in understanding why such research makes care better and safer. How do you think we are doing in the country with that communication and what more could we be doing?

Dr. Gail Wilensky: We are not doing very much as best I can tell. There is a recognition that we need to get information out; we need to have better communication. I don't see it happening yet. This is going to be a test, all of this, how fast we can we learn information, can we learn from these studies and how quickly can we try to get it out to the people who need to understand what the findings are. Our history is not great in this area. We will see whether or not we can get a little bit better going forward.

Margaret Flinter: Dr. Wilensky, I am going to move a little bit our focus just on the United States now to think about the work that you are doing as a commissioner on the World Health Organization Social Determinants of Health group. And as a member of that group, you are making that statement of recognizing the profound impact of poverty and low educational achievement, women's issues, the effect that these have on health. What are some of the public policy initiatives that you would like to see implemented in the U.S. that address improving health by addressing the social, not clinical, determinants of health, particularly for young people? And is this a conversation that is happening at the policy level in health care in Washington?

Dr. Gail Wilensky: Our current awareness that we have in obesity epidemic in the United States is just reminder that if we don't do something to try to reduce the obesity problem, it will make all of our other efforts to try to improve access to health that much more difficult because we will have a very large increase in diabetes, heart disease, hypertension, many of the other ailments associated

with obesity. And it means trying to stress the importance of good nutrition, physical exercise, personal responsibility in terms of how we lead our lives. That's not been a real popular theme in the United States that there are areas that we as individuals need to take personal responsibility for in terms of how we conduct our lives. We know we shouldn't smoke, and there are taxes on tobacco products, some very high.

But we need to push this issue that, in fact, it is possible very chiefly for people to eat well and to engage in physical exercise, it means getting involved with your children and what they are doing and not letting them spend endless hours playing video games and watching television, and that we all need to get involved in doing it. I don't know how we resurrect the sense that we need to be more actively engaged in our local groups and communities than we seem to be now. It's going to be hard to fix these problems from Washington if possible actually, to fix these problems from Washington.

Mark Masselli: Speaking of fixing problems in Washington, you mentioned at the top of the interview about the impending cut that's coming in Medicare, and it seems like deja vu all over again. I think we have this ritual. Shed some light for our listeners on what this stance in ritual is all about and how do we get here and how do we get past it.

Dr. Gail Wilensky: There are two pieces in history to understand. One is that unlike the other pieces of Medicare reimbursement. Physicians' reimbursement has gone on a different path. The rest of Medicare pays for bundles of services. It used to be that hospitals were paid on a basis of every day you were in the hospital and the services that were provided. Now there is a single payment based on the diagnosis you had when you were discharged. If you are very, very ill with that diagnosis, there might be a special add-on payment. But otherwise, it's an average payment.

For home care, the home care agency receives a payment for every 60-day episode of care that you have based on the diagnosis you have. Physicians bill on the basis of 7,000 or 8,000 different codes. It means every little item of care that they provide. The reason I mentioned this is we observed back in the 1980s that this kind of billing system results in high spending. And so when they made a change in how they pay physicians, but they didn't change the 7,000 or 8,000 coding that the physicians used, they started using a spending limit. They made some changes to that spending limit in 1997, and part of what they did is say physician spending for Medicare in the aggregate, that's all told, should grow only as fast as the economy.

Some people like myself said to Congress, "Don't do that. That might be something you would like to think about." But we have no historical experience of physician spending growing at the rate of the economy. Although in the 1990s when the economy was growing very rapidly, it actually wasn't so hard to do. Of

course, it was clear at some point, the economy would slow down. That happened in 2001 and 2002. And ever since that time, the expected change in physician fees has been negative because the total spending has grown faster than the very slow growth in the economy.

And that's the problem we face is that Congress comes in; they make a patch for one year. But the law has it as though the reduction actually occurred going forward. And so we have this accumulated change that we have to fix. That's why it's so big, 27%. And either we will make another small patch, which is what I assume we will make, we will let fees drop precipitously, which I hope doesn't happen, or we will just add to the deficit, which is also possible.

But fundamentally, we need to change how we pay physicians. You can't have them billing 7,000 or 8,000 different codes and ever think that you are going to be able to have any sense of accountability and responsibility so that the physicians that take good care with the patient's assistance, of course, of the patient, have good clinical outcomes. Don't spend more than is necessary in terms of treating their patients. Get rewarded. And those that don't have that kind of outcome don't get as well rewarded. You can't have that system with our current billing system. You have got to fix it. And if you just push away the problem, pretend the problem isn't there but don't change how physicians bill, you won't fundamentally make anything better.

Margaret Flinter: Dr. Wilensky, we like to ask all of our guests this final question. When you look around the country and the world, what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. Gail Wilensky: I have recently joined the board of Geisinger's Health System Foundation in rural Pennsylvania. They and other groups like them seem to be able to do a good job taking care of the patient and producing good health outcomes. But I am impressed that in our private sector, we are seeing a lot of innovation in terms of how care is organized and delivered. And we need to encourage that and reward it recognizing that how we deliver care across this country is not going to be a single or a uniform way of delivering care.

Circumstances are just too different; people are different; the geography is different; the physicians are different in terms of their training or their orientation. And that we can't expect to have everything done in the same way, but we do need to encourage more in the way of evidence-based medicine. Now we know we could do much better.

Mark Masselli: This is Conversations of Health Care. Today, we have been speaking with Dr. Gail Wilensky, a health care economist and Senior Fellow at Project HOPE. Dr. Wilensky, thank you for joining us today.

Gail Wilensky: My pleasure.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities in everyday lives. This week's bright idea looks to better health on our nation's highways. Obesity is a problem for many of America's truck drivers for many exercises consist of pressing the gas pedal, and meals are limited to greasy fatty foods at truck stops and fast food chains. According to the Journal of America Dietetic Association, 86% of the estimated three million truck drivers in the United States are overweight or obese. However, the problem affects everyone who shares the road with them. In 2010, truck drivers accounted for 13% of all fatal occupational injuries according to the preliminary data from the Bureau of Labor statistics. Many crashes where the truck driver was at fault were due to falling asleep at the wheel, heart attack or diabetic shock.

But trucking companies, industry organizations and even truck stops are working to reveres this. Many have begun rolling out nutrition and exercise program for truckers, **nap** walking trails, healthier foods and fitness facilities at truck stops. Employers are also offering financial incentives to employees who stop smoking or lose weight. Some drivers have taken their own initiative and begun cooking in their rigs and walking and biking around stops. Tackling health issues in the transportation industry and spreading better health and safety onto our nation's roadways, now that's a bright idea.

Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

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