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CHRONIC CARE: GETTING ITS COMPLEXITY AND COST UNDER CONTROL

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Keynote Address:

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P R O C E E D I N G S

MR. GAYER: Good morning everybody. My name is Ted Gayer. I'm the vice president of Economic Studies here at Brookings. I want to thank you all for joining us today for what will be the first of many events hosted by the Leonard D. Schaeffer Initiative for Innovation and Health Policy which is a new partnership we started between Brookings and the University of Southern California.

Joining us today is Leonard Schaeffer himself, who is both a trustee at Brookings and at USC, and without whom today's event and our work in health care would not be possible. Leonard has been a Brookings trustee for 16 years and endowed a chair in health policy at Brookings now held by Paul Ginsberg, who is both a professor at USC and a senior fellow here at Brookings.

Leonard also recently made a generous contribution to the two institutions establishing the Schaeffer Initiative, the host of today's events which combines the strengths of both the Schaeffer Center at USC and the Center for Health Policy at Brookings.

Leonard was the founding chairman and CEO of WellPoint (now Anthem) one of the nation's largest health insurance companies. He is currently the Judge Robert McClay Whitney chair and a professor at USC. He's on the Board of Fellows at Harvard Medical School and is a member of the National Academy of Medicine.

He previously served as Administrator of the Healthcare Financing Administration and was Assistant Secretary for Management and Budget at the U.S. Department of Health and Human Services. In addition to that biography and all that Leonard has done for Brookings, he's also been an advisor and a friend to me personally—for which I am extremely grateful. So please join me to welcoming Leonard, who will introduce our keynote speaker Senator Ron Wyden. After his remarks, the Senator will stay for a moderated discussion about chronic care with the panel of experts. So, thank you again for being here this morning.

MR. SCHAEFFER: Well thank you, Ted, and let me join in welcoming all of you for today's presentation on chronic care, getting its complexity and cost under control. I don't know if it says Schaeffer enough times up there, but we can work on that.

So the Initiative for Innovation and Health Policy is, as Ted mentioned, a new collaborative effort between the Schaeffer Center at USC and Brookings. Today's events are the first of

what we think will be many that address the nation's most critical healthcare problems. Chronic disease is among those most critical problems. As the leading cause of death and disability, chronic disease has a profound impact on our nation. Over half of all Americans suffer from a chronic disease and the number is growing very rapidly. Eighty-six percent of all healthcare spending goes to treat chronic conditions.

We're honored today, and I'm particularly honored, to introduce our keynote speaker Senator Ron Wyden. He's the ranking member on the Senate Finance Committee where he's been helping to lead bipartisan working groups for many years on developing legislative solutions to improve chronic care in America. We were recalling—we met many, many years ago—and to see someone in Congress maintain that focus and the contributions he made, we should all be very grateful. He has long been interested in finding ways to better manage chronic care, including co-sponsoring the bipartisan Better Care Lower Cost Act with Senator Isakson of Georgia. Today the senator will share his thoughts on how Medicare can more effectively address the challenges of chronic disease including new delivery models to improve and coordinate care. Please join me in welcoming Senator Wyden.

MR. WYDEN: Leonard, thanks very much. When you're with Leonard Schaeffer you're running with the right crowd. What a wonderful panel Brookings has assembled. It is sort of the NBA All Stars of health policy and I thank you for that inflationary introduction. I think this morning we ought to make this a filibuster-free zone and I'm going to contribute my part on that by making some remarks, relatively short remarks, and then I think we'll have plenty of time for questions.

What drove me to want to speak today with all of you here at Brookings is I think the debate about American healthcare is way, way, way out of whack. And it is out of whack for a variety of reasons and we'll talk about those. But one that I find particularly bizarre is the striking lack of attention to what now dominates American healthcare, and that is chronic illness. For the last few years, and certainly throughout the election season, the debate has basically been stuck in one gear. Are you for or are you against the Affordable Care Act? My view is there are obviously ways if Democrats and Republicans could make a judgement about working together you could strengthen the law. What I will tell you is what is not on offer is going back to the days when American healthcare was for the healthy and the wealthy, and that's what you had for example when you allowed discrimination against people

with preexisting conditions.

So after trading the same blows over the Affordable Care Act for now six years it seems to me it is time for the healthcare debate to sort of grow up and turn to an issue of enormous consequence for older people across the country. And to me, the next major undertaking in American healthcare is updating the guarantee of Medicare for an era when chronic illness, heart disease, cancer, diabetes, and stroke are now what dominates the program and dominates American healthcare. Older people afflicted by these persistent illnesses now account for an astounding ninety-three percent of all Medicare spending. The days when broken ankles and a nasty bouts of the flu accounted for a significant share of Medicare costs are now really a memory of yesteryear.

Ever since 1965, Medicare has been grounded in a guarantee of defined, secure and high quality health benefits for America's older people. In 2016 10,000 people are going to become eligible for Medicare every single day. This is going to go on for years and years to come and many have at least one chronic illness.

Now it is my judgement for this new era of Medicare beneficiaries the guarantee is coming up short. So it is my view, and it's why this Brookings program is so timely, that Americans—not just seniors, but all Americans— have a right to know what the Presidential nominees and all candidates for the Congress are going to do to update Medicare in light of the facts that are now being ignored, and if that continues America is going to pay a real price for it. Americans have a right to know that the Medicare guarantee is going to mean as much in the year and decades ahead as it did a half century ago when Lyndon Johnson put pen to paper and signed Medicare into law. It is putting head in the sand politics into practice to pretend that chronic illness is something that political candidates can simply ignore.

I have no doubt that each and every person in this room has at least one family member or a friend who suffers from a chronic illness. I'd be willing to wager that some of you have seen firsthand, as I did with my parents, a few of the ways Medicare's shortcomings leave some of the most vulnerable, older people struggle to manage their conditions. Leaving seniors on their own when it comes to coordinating care after preventative visits and uprooting the elderly as a rule by sending them to hospitals when getting treatment at home can be as effective, more comfortable and less expensive, just defies common sense.

Charging inexplicable copay for coordination—same thing. A menu of plans in Medicare Advantage that can be insufficient for a person with complicated needs has to be addressed. Policies that keep doctors from helping stroke patients at the very moment help is needed most ought to be obvious; it ought to be obvious but it is not what we see in much of Medicare today.

These are just some of the most glaring ways in which Medicare now fails older people who have these chronic illnesses. So what I'd like to do is take stock of how Medicare fails to coordinate care, to bring together an army of doctors and specialists and pharmacies that a lot of seniors visit on a regular basis. I was just in Lakeview, Oregon and I was struck by a small pharmacy in town, those are the people who see the seniors and yet we just don't have that kind of connection and that kind of contact with them. So let's take John who is 65 years old and a new enrollee in Medicare B. Thanks to the Affordable Care Act he gets a free wellness visit as a welcome to Medicare. Maybe a symptom raises flags during his appointment or an odd result of a test program prompts a referral to an oncologist. John is better off as a result of having had that free visit. But after it wraps, seniors like him are largely on their own when it comes to managing their care. Seniors are told, 'here's what is wrong with your health now go figure out what to do.' If that's the standard in America we got a lot of heavy lifting to do. The burden of managing your care and keeping all your information straight is a lot to ask of somebody who's in ideal health. For the millions of seniors with multiple chronic illnesses, two-thirds of Medicare beneficiaries, it is pretty much a full time job. Cross town appointments to make in various offices. A battery of pills to take on exactly the right schedule, stacks of bills to pay. There are far too many chances for folks to make dangerous errors and missteps in American healthcare.

So now let's look at the coordination copay which to me is just a true health policy head scratcher. Phillip is a 77-year-old grandfather who is of pretty modest means. He's diabetic and he's a cancer survivor. He's on a fixed income. Social Security and a small pension from a career on the factory line, that's really pretty much all Phillip has to get by. So he spends a lot of time in the offices of healthcare providers, GP, an oncologist, a renal specialist, a physical therapist so as to help maintain mobility. Those offices need to talk to each other. They have to share information to make sure that Phillip's treatment is in order. Now in the long run, coordination is supposed to bring cost down. But Medicare says coordination is pretty much like anything else and the services come with copays. Some

doctors say it's not worth adding a new item to a patient's tab and so coordination kind of goes by the way side. Pretty much like what's happened to chronic illness in the debate about American healthcare in this election season. But Phillip, who is already walking an economic tightrope, has to pay for a coordination service that I believe ought to be free of charge and ought to begin right after the new wellness visit. Right after the new wellness visit is when all of this ought to start.

I mean, picture what happens today when you get your free wellness visit. If there is any real conversation, you think things are going well, and you get a good report, you go have three hot fudge sundaes at Dairy Queen. Things are great. If things aren't going so well according to the report, you go to the tavern and maybe you drink something else. But the point is care coordination ought to begin right after that free physical.

So now let's look at how little sense it makes to pull older people out of their homes by rule when they need treatment. Sharon is a 72-year-old woman suffering from arthritis and showing early signs of Alzheimer's disease. Sharon's physician ought to be allowed to provide her care where she is most comfortable, at home. There is a pilot project now that we were able to get into the Affordable Care Act, a group of us, including Senator Isakson, who's been such a good partner in these efforts. We were able to get this program into the Affordable Care Act, Independence at Home. Senator Markey was in the House when he started and has also done terrific work on this and the early results on this pilot project, treating people at home, are just extraordinary. The early results from this pilot show that it is bringing costs down by $3000 per older person. So think about that one for a second. Political system: nobody is talking about things like that. It is giving people better care where they want to be most, at home, for less money, the trifecta of sound health policy just being ignored.

Now for a minute let me just mention Medicare Advantage—because for seniors who need some of the most specialized care, it too is falling short. Our hypothetical senior here is Janet, 66, recently forced to retire because of a minor heart attack. She's been dealing with COPD for years, Type II Diabetes is common in her family, she's a long time resident of Florida; soaked up a lot of sun, so she's also kind of worried about skin cancer. The health insurance coverage Janet needs is not your run of the mill plan. She needs insurance that is tailored to her, but the rules on the books today don't encourage Medicare Advantage plans to offer that level of personalized care. So when Janet looks at the options

available to her, she's pretty much underwhelmed.

In my view, much more needs to be done to give Medicare Advantage plans the flexibility to design an innovative coverage arrangement for someone with a unique set of needs.

The last example is going to be how the Medicare rules slow down treatment for some who really require care and care quickly. I'm going to use the example of those who have had a stroke. Harvey in our case is 70. He's a lifelong athlete in seemingly good health. He starts every day with a three mile run. But one morning a blood clot travels upward to his brain and Harvey has a stroke. In that moment every single second is going to help. Getting to a neurologist as quickly as possible can save Harvey's ability to communicate, his mobility, even basic cognitive functions like reading, recognizing friends and really being able to enjoy family. Some hospitals in America don't have immediate access to a neurologist and, against all logic, Medicare rules today sometimes block the use of telemedicine when it could be lifesaving. So I'm not going to be subtle about this. It is time to throw those kinds of rules in the trashcan. They ought to be just thrown out and an outdated Medicare policy cannot be the reason that a stroke victim is left unable to speak with loved ones or live a productive life.

So obviously these are four kinds of cases and chronic illnesses are now so frequent in America, they are almost a fact of life for those entering old age. To me, policy makers just being lulled into ignoring the challenge they represent is unacceptable. Healthcare patients in America should not have to go it alone navigating an overwhelming healthcare system, fighting against outdated rules and being forced to receive treatment away from home when it's not necessary. That in my view is not the real promise of the Medicare guarantee.

Now the good news is that there has been growing bipartisan interest in the Congress in tackling chronic illness, and particularly chronic illness as part of Medicare. In the Senate Finance Committee, Chairman Orrin Hatch and I, along with Senators Mark Warner and Jonny Isakson, have been working on bipartisan chronic care reform. It has been a long process, now almost thirteen months, even longer if you look back to the hearing that I held as chairman of the committee in 2014. Mention was made by Mr. Schaeffer; we have a bipartisan bill in both the House and the Senate now, at a time when so much of Congress can't agree to order a Coca Cola. We've got bipartisan bills on what is the future of Medicare. So we've got to get moving and get to the point where the Committees in both the House and Senate can

act.

It is important to recognize, and I'll wrap up with this, that updating the Medicare guarantee as it relates to chronic illness is just one reason that I think the debate about American healthcare is just way out of whack. The Medicare guarantee is also a promise that older Americans will have access to the lifesaving drugs of the future. If the trend of high drug prices continues without a more thoughtful approach, too many seniors are going to be left holding the bag and Medicare can see a financial crunch that threatens access to medicines that amount to miracle cures in some instances. So here's what this means: the science has taken off, yielding breathtaking opportunities for real cures. And the question is going to be: can the American people afford them?

Senator Grassley and I again led a bipartisan effort, spent eighteen months looking at these blockbuster Hepatitis C drugs. And what we were stunned about is there is a cure here. You see it in their commercials. Harvoni, they're very comfortable talking about how there is a real cure. The question is: can Americans afford them? You know, we found in our investigation on the early Hepatitis C drugs that Medicaid was able to pay for like three or four percent of the Hepatitis C drugs that low income people paid. So you have cures here and you have the ability to pay for them here and that's why I'm telling you something is out of whack.

A second area that I think requires attention and has been missed by the political debate is that the Medicare guarantee is a promise of sensible pain management but that doesn't consist just of prescribing hundreds of powerful opioid pills with minimal planning and guidance or warnings. The opioid epidemic which has already torn apart thousands of American families has made it tragically clear in recent years that this country needs a top-to-bottom update when we think about managing pain. And the guaranteed promise is that Medicare's benefits are going to be comprehensive and accessible for all, and here I'm talking about especially low income seniors. That's why I put forward a proposal recently to cap out of pocket costs for seniors in Medicare Part D and there is a lot more that ought to be done to bring down out of pocket costs throughout the program.

So I hope that this gives you a sense that it is time to get this debate beyond just rehashing again and again and again the same old ACA fight. What I've tried to do this morning is lay out how Democrats and Republicans can move forward in a bipartisan way, not something where they just

spend their time pointing fingers at each other and throwing rotten fruit at each other and calling each other names, but in each of these areas, starting with chronic illness, there is an opportunity for Democrats and Republicans in effect to work together. And in my view it ought to start with updating the Medicare guarantee at a time when it is now dominated by chronic illness, dominated by a set of healthcare challenges that weren't there when Medicare began in 1965. I was co-director of the Oregon Grey Panthers in the 1970's, had a full head of hair and rugged good looks. I was not what Medicare was about. You did not see Medicare dominated by people who had two, three or four healthcare conditions. So it is time to set aside the politics. That's what we're trying to do in the Senate and get serious about dealing with what now really Medicare is all about. I'm looking forward to our panel discussion. I guess we're going to have some softball questions for me and again thank you, Brookings, for having me today.

MS. RIVLIN: Thank you Senator Wyden. Now you see why Senator Wyden is a true hero of the American healthcare system. He doesn't pontificate, he doesn't take partisan potshots. He gets in there and does the hard work of figuring out what is wrong with this system and what we can actually do about it, knowing fully that it is not going to be easy. It's a complicated system and fixing it is going to be complicated. But he has hung in there and worked on these problems to my knowledge for decades. I'm just very glad that he is here and ready to mobilize a bipartisan group to try again. He's focused attention on the biggest spending item in American healthcare: how to manage chronic care of seniors. I'm one of them, so I'm for that. I'm 85, I have several chronic conditions, I'm very healthy, but I'm my own care manager and that is not an easy thing even for somebody with a Ph.D. in economics. Somebody else ought to be doing this and helping me out.

So we have a panel of, as the senator said, all stars. We have Robert Moffit who is a senior fellow at the Heritage Foundation. He has had a long career in various aspects of healthcare policy and several administrations and helping on the Hill. Bob is another serious hero of the healthcare policy community. We have Keith Fontenot. Of course I think his greatest distinction is he worked for me at the Office of Management and Budget, but he has served in many capacities, including here at the Brookings Institution where he is a visiting scholar in our health policy. And Kavita Patel, who has also had a career in health policy in a couple of administrations and here at the Brookings Institution. I think the most important thing about Kavita is she's a real doctor. If you get sick, Kavita can help you. So she knows

both sides of the street. We'll have brief comments from each of them and then we will have a discussion and opportunity for audience questions. All that and wrapping up by 11 o'clock. Bob, let's start with you.

MR. MOFFIT: Okay thank you very much. First of all, Senator, congratulations. I think this is a wonderful effort on your part. The fact that it's bipartisan is going to give a lot of people in America confidence. We can actually accomplish something that is actually going to benefit millions of Americans.

Chronic care, this issue that the senator has addressed is kind of the busiest intersection where there is a massive collision of major healthcare financing and substandard healthcare delivery. Most healthcare policy analysts regardless of their point of view do basically understand this fundamental difficulty. The thing that I also particularly like about the senator's approach is his emphasis on flexibility. In his speech, and also in his article for Fox, he points out what do seniors really need? They need to be enrolled in a health insurance plan that specifically meets their specific needs. What we're talking about here is a grand effort at personalized healthcare which will include health insurance options as well. I couldn't applaud that more.

Why don't I just talk about some of things where I feel the senator is absolutely correct and then I'm going to exercise my judgement on reservations. I must say that we're not talking about red lights here on reservations, we're talking about yellow lights, which is be careful, be cautious. I love the financing approach here. A per capita approach in terms of financing, basically a variation of defined contribution, that's exactly where we ought to go on this area. I like the fact that he includes a sophisticated risk adjustment program based on two years of diagnosis. Dr. Rivlin has always talked about the fact that we know a lot about risk adjustment; it is kind of the holy grail of healthcare policy. We're never quite right but as Dr. Rivlin points out we're improving, and that is in fact the truth. We are improving in this area. I like the fact that there's an income basis here too. That is to say we're recognizing the fact that we have to adjust the contributions to people based on their income. We should be doing that throughout Medicare, I agree with that entirely.

I like the cost sharing restriction with regard to the better care plans and supplemental coverage. For years, health policy analysts have recognized that the existing relationship between traditional Medicare and supplemental plans has actually driven costs up not only for the taxpayer but

also for seniors, I think that is a step in the right direction. The most important contribution that this legislation is making, in my opinion, is that it is focused primarily on dealing with individuals. Obviously, in setting up the better care programs, basically either health plans or programs around the country, the secretary is going to have authority to make determinations on where that need is. I think the senator has set up a pretty good standard. That is to say where chronically ill patients basically are in geographic areas where there is 125 percent over the norm and that's terrific. That's a geographic focus. But the beautiful thing about this is what the senator is saying is (it is the first time I've seen this phrase used in legislation, either the House or the Senate) that the criteria of a plan has to be that it is person-centered. I think that is exactly where we ought to go.

I want to mention however, I must mention some reservations and let me just say that with these reservations again this is not a red light, this is a yellow light. I have some concerns about whether in fact existing risk sharing models are actually going to be able to save money. We are going through a lot of work right now with the Medicare payment system for doctors and as you know there is a lot of uncertainty in the medical profession. A lot of doctors are very concerned about this. CMS recently came out with a report that said under the existing value payment system something like eighty-seven percent of physicians in small practices are actually going to get penalties. I think when physicians wake up to this they get nervous. So here's the point: I think we have to be careful in this area. We have to be careful with regard to the definition and measurement of quality. That is what we all want but we have to recognize that the government has not really been really that good in establishing the measures. And that's still a work in progress. I'm not saying it cannot be done but the fact of the matter is that this is a work in progress.

One more thing and then I'll shut up. One more thing: there are reporting requirements here, and the senator and his colleagues have recognized that there has to be reporting requirements, people obviously on the receiving end of federal tax dollars. That is to say to the plans and the providers how they're doing in delivering quality and performance and outcomes. All of that is terrific. However, I just want to again raise an obvious point. And that is members of the medical profession today are becoming increasingly demoralized by the degree to which they must handle a lot of reporting requirements. There was a recent article in Health Affairs written by a group of researchers who looked

at the impact of current reporting requirements in Medicare, Medicaid and private health insurance. It was a third party payment issue. And they indicated that basically over 700 hours per physician is being spent in dealing with sort of thing. Now to the senator's credit he said there should be reporting requirements, but they should not be overly burdensome. Exactly. That is really critical. Because obviously the greatest ideas in the world, the greatest health policy proposals that you can imagine can be undone by bad implementation or inflexibility on the part of public officials managing government programs. So I'm very, very much in favor of where the senator is going. I think a bipartisan focus on this is long overdue. This is in fact the number one problem in America.

I'll just shut up with one more point: we got chronic illness and that is happening at the time when we're focused on it now because the costs are enormous in Medicare. But we've got to figure out a way to start to address the prevention of chronic illness before they get to Medicare. As one friend of mine who is a medical professional said to me, 'Moffit, the biggest problem in America is Americans are digging their graves with their knives and forks.' We have to wake up to the fact. Senator, congratulations it is a wonderful effort.

MS. RIVLIN: Thank you Bob very much for very constructive yellow lights. We'll give the senator a chance to respond in a minute, but let's hear from Keith.

MR. FONTENOT: Sure. So I think this is first off one of the finest examples I've seen of traditional Senate Finance Committee operation. It is a bipartisan process that goes on over a period of months and months and months. The senator has excellent staff who I know well. They've done good work here for him and so we have a product that I think is poised potentially to move in the lame duck session or further along. But this is just a classic example of what Congress does well, ought to be doing more of and I think it will go far.

On the topic of chronic care, remember chronic care is one example of multiple diseases. It is really a disease that a person has that persists for a long period of time and entails a lot of contact with the healthcare system. So you can look at it in sort of three dimensions. One is the treatment dimension which the Senator mentioned and that has policy implications on particularly costs sides, drug costs and so forth. But it can also be a huge improvement in human welfare. The second is prevention, which Bob just mentioned, which is a very long term, long orientation towards the issue. You think about

smoking prevention and things like that. The surgeon general's report first came out in 1964 about smoking and we've reduced it a lot, but we haven't gotten rid of it. So that's another important dimension.

What we're focused on here today is the care side. I like to think of this is kind of the mortar with the bricks. So if you have the various treatments and the various institutions that can care for people you have to tie those together and you have to make them work effectively. That's the mortar. It may not be as glamorous or have the appearance of this big bang for the buck as the rest does, but it is critical to making things function effectively.

Two-thirds of Medicare beneficiaries have chronic conditions and CMS did some great little chart packs on this you can find. But about fourteen percent have six or more. So when you drill into this and you look at it and if you read the Senate Products, the Working Papers and so forth, they're looking very carefully at trying to figure out how you target effectively to these very, very difficult cases, very hard to reach and make sure they stay connected. He mentioned the issue of stroke. There is something in Medicare known as the 'originating site rule' I believe it is called, and that can be an impediment to getting people connected with a neurologist or someone that can diagnose a stroke in the early stages.

Those fourteen percent who have six or more chronic conditions account for a huge share of hospital and post-acute care spending. They account for a lot of readmissions, very many things. And that's where the mortar getting people connected with what are very often not healthcare related services. It may be a transportation service, it may be a housing issue, it may be a nutrition issue. Kavita can speak to these; we were talking this morning on some issues she faces. A lot of these are not healthcare issues, but what this bill I think begins to do is recognize that in a lot of ways, for example supplemental benefits in Medicare Advantage and greater flexibility there.

So if you look at the major conditions you have things like stroke, chronic kidney disease, asthma and various sorts of combinations. So stroke, CKD, asthma, stroke, and chronic obstructive pulmonary disease, all of these things combined with depression and you can find triads or dyads of groupings of chronic conditions that are very, very high cost and very hard for the patients and the individuals that can benefit from better connection to care. And potentially, as Bob mentioned, how you can delay the onset or the worsening of some of these conditions could save money over the long term.

As Alice mentioned I worked for her at OMB and I'm a long time budget person. At various times I felt like I worked for the Senator when I was at CBO and other things because he is very persistent on these issues.

MS. RIVLIN: He is that.

MR. FONTENOT: I will tell you and it is a good thing. It is exactly what it takes to get stuff done. But I would caution here that we not look for big savings. The point here is to improve the care delivery for millions of people and improve their lives. Hopefully, we will save some money over time, yes and some things such as the independence at home demonstration has shown some promise. But we need more time to figure this out. And a lot of this does require some upfront investment and cost. To manage care better it takes time, effort, people, and resources. But I'm optimistic that we'll get something done and congratulations Senator, I think it is a great product.

MS. RIVLIN: Thank you Keith. And now let's hear from the analyst/clinician Dr. Kavita Patel.

DR. PATEL: Thank you for inviting me and thank you for all the work you've done, Senator. When I worked in the Senate it was always a pleasure because I think you have made a tradition of working in a bipartisan fashion and also trying to really do something that is moving healthcare in a very positive direction. As someone who trained in Oregon I can commiserate --

MR. WYDEN: Oregon roots.

DR. PATEL: Exactly. So the NBA all-stars we didn't have Portland in the series this year but maybe we can work that out.

MR. WYDEN: Damion Lower will be an all-star for years to come.

DR. PATEL: I was just going to say we can work on that. So three things—everything kind of boils down to three things. The first is this is incredibly important. While some of the aspects might seem like, well we're just doing tweaks here and there: the removal of copays, inclusion of hospice benefits in Medicare Advantage. In the supplemental benefits, these are incredibly important changes that will make a dramatic difference in seniors lives and I would say that we probably still have more to do beyond even what's in your chronic care working group documents as well as what's been introduced to date. A good example, just clinically, we still have vaccines that seniors need like the Shingles vaccine

and the Tetanus/Diphtheria/Pertussis vaccine. Because they are Part D vaccines I can't give them in the office when I'm giving my flu shot and pneumonia vaccine, and I have to tell seniors if we give them to you in the office you'll get a nasty bill from Johns Hopkins so please go try to get them from CVS or Rite Aid. Which as we all know is just a really bad way to coordinate care. So we have more to do and I applaud you for starting that and hopefully continuing to drum this through.

But the second piece is probably how can we think about the integration with key policy changes that have gone on that you have worked on since this working group has started such as MACRA (the Medicare and Chip Reauthorization Act) is exactly what physicians like myself are completely both focused on but also completely perplexed and bewildered by. So having some sense of how those important pieces of MACRA, which you and your colleagues help to push through, can actually facilitate what you're describing for better coordination of care is incredibly important. There are these very kind of generic words like "resource use" and "professionalism" and the devil is in the details. And right now those details are all kind of under a little bit of opacity at CMS. So when I worked in the Senate, one of our roles and responsibilities for our members was to try to understand how to encourage the administration to keep the site in line of how do we protect our beneficiaries? How do we not break our promise to the American people? And I hope that you can continue to do that with the work that has already been passed.

And the third piece is more of a call beyond even what you have worked on to date which is we also have to think bigger. I think that there's so much with accountable care organizations, patient centered medical homes, MACRA, there are so many things pulling at people and yet we're not doing enough to get to where patients and their families really need to be. We're still enrolling people way too late in hospice. We still have physicians and I'll stop talking about doctors because I don't think doctors are the solution to this, I think it is going to have to be a team-based approach because I don't have time as a doctor. As long as I'm still paid in a fee for service fashion, which is what ACO's, patient centered medical homes, all of those models that we talk about as policy makers are still based in fee for service. The truth is I am really only rewarded for the more patients I see, which takes away time for taking care of your parents, my parents, and people who need that time. So it has to be support staff, it has to be lay workers, community navigators. We don't even have RN's in primary care because we can't afford them.

So it has to be people who are trained to just focus on the needs of patients outside of my seven minutes of clinical visits.

So how can we think bigger about taking these constraints that were so important in the Affordable Care Act, and I echo your call that we can't go backwards, but how do we take it really boldly forward? How do we get doctors and their teams to think about total cost of care while also paying attention to what really helps patients?

I'll kind of end with two stories, which are failures. I have a patient who is 67 years old. I did everything everyone is supposed to do, wellness visits, I even gave her my -- I give all of my patients my cell phone because if they actually need something they'll call and that's when I know something bad is happening. She would call at the end of the month and tell me that she felt lightheaded and dizzy. She's a diabetic and so we always thought that her insulin needed to be adjusted and then I would always bring her in and adjust her insulin. It took me about five months of her going to the emergency room at the end of every month to realize my medical assistant, who has basically a high school education, said "Dr. Patel, she always comes in at the end of the month and I thought there is something weird about that." Her nutrition benefits ran out. She ran out of food but because I was such a crazy doctor she would keep her insulin regimented and she was just hungry and her sugars would drop. So we needed to figure out a way to extend her food benefits, but that's not what I went to medical school or OHSU to learn, and I had to then figure out how to get this woman food at the end of the month or figure out how to teach her to scale back her insulin. So there is no chronic management program and some of the things that we have like an ACO model can help with that, but instead what I see staff doing is clicking boxes in electronic records and trying to fulfill their reporting requirements, and that's not where we want Medicare to go.

And then the second story is someone who, one of my patients died yesterday. 72 years old had serious recurrent strokes. Would drive to my office which is in northwest D.C. from Anacostia because her church has told her if you want really good care you come to the wealthier part of D.C. and you can get better care. She would take four buses to try to get there. Every time she would come we would be monitoring all her conditions so that she wouldn't have a recurrent stroke. I would order CT scans every six months but you know as doctors we order these things and we don't know when patients

get them done. And she was not able to get the CT scan done and then had basically a ruptured aneurysm which we could have avoided if I had actually been able to make sure she got her imaging the way she was supposed to monitor her aneurysm. And it struck me when her son called me and said she died on her way like to the hospital in the ambulance and I knew why she had died. It struck me that that's a failure and despite all our best intentions within a very high technology medical system it was probably the most basic element which was, I ordered a test but I needed to make sure that someone with low resource utilization capacity and probably low understanding of her medical conditions needed a little bit of help. As a doctor I don't have a prescription for that.

So I think the final message is really how can we think as policy makers, patients, providers. And you're like the ultimate provider. You're trying to keep the stewardship of what the benefit that started in 1965 stands for in 2016. How can we honor that and go beyond kind of what we've put into place with all these regulations and rules. So how can we create and chart that vision? What does care need to look like where I really think about not just the population, but what impacts care beyond just the constraints of a kind of traditional medical system, as wonderful as it is. So thank you again for your work and keep the bigger picture in mind please because we need it.

MS. RIVLIN: Thank you very much Kavita. Senator, you have a lot to respond to and I hope you will respond to several of these comments.

MR. WYDEN: I'll be very brief. First when there is a Patel/Moffit coalition on goofy reporting requirements, everybody in government, Democrats and Republicans, ought to wake up. That's number one because it is clear both of them are saying some of these ideas of just having people check boxes at three or four o'clock in the morning is absurd. So that's number one.

Number two a little bit of good news. Mention was made about the fact that the hospice benefit too often is secured too late. We've had a very good development here recently and it really came about the end of the Affordable Care Act. We heard all about these death panels which didn't exist and I used to just grind my teeth for hours listening to silliness. And were able to get a very important pilot project into the ACA that for the first time, an individual would be eligible for curative care as well as the hospice benefit. Now what this does is address Kavita's point about being able to time the benefit better and the reality is also that American's are a hopeful people. We're always hoping that there may be a

breakthrough recognizing the realities of what hospice so often is about. But it has now begun. It is called Medicare Care Choices. Liz Jurinka the head of the finance Dem team on health has been working with CMS. I think we've ironed the kinks out now and I think that is really a bit of good news.

Last point and these are kind of issues that go to the debate. The Medicare guarantee is not a defined contribution health approach. It is a guarantee, a guarantee that American's are going to have secure, defined health benefits. So the challenge here is to say can we find ways to make these good quality health services available in an affordable fashion? So there is some semantics here but I really want to come back to the notion that what I'm trying to do, and you've got a Democrat and a Republican in the House of Representatives where people think they're very polarized. Peter Welsh and Eric Paulson. They have introduced a bill to update the Medicare guarantee, and that's going to have to be the key part of the debate.

MS. RIVLIN: On that note, Senator, could you say a word about legislative prospects and what might happen if all goes well either in the lame duck or in the next session?

MR. WYDEN: It is hard to see a major transformational Medicare reform between now and the end of the year. I mean I'm the original glass half full character. But I know people are talking about the lame duck session and based on everything that I'm told about the lame duck, it is now got so much potentially on it that we could be well into 2017 or 2018, and the ducks would be quacking and the like but there'd be no way to do it. So I think realistically enactment of a transformational Medicare update; updating the Medicare guarantee is a 2017 issue. Chairman Hatch has been reaching out to me and to Democrats. We want to get it as far along as we can in the Finance Committee but I think realistically it's a 2017 issue.

MS. RIVLIN: We have come to the end of our time. Would you have time for a couple of audience questions?

MR. WYDEN: Sure.

MS. RIVLIN: I believe we have microphones, yes we have microphones. So the lady on the aisle.

DR. POMPLIN: I'm Dr. Caroline Pomplin. I'm a primary care physician and I'm also a Medicare beneficiary. My question is about Medicare Advantage. You said they needed more flexibility,

those plans. My understanding is they already get more money for complex patients and there's no restriction on additional benefits that they can provide. There is only a floor that says you have to provide all the guaranteed Medicare benefits. If you make Medicare Advantage more flexible won't they use the flexibility to reduce benefits to favor healthier, less costly, more profitable patients.

MR. WYDEN: You're being logical and heaven forbid that logic should break out over all of this. First of all, the question of risk adjustment, this is an extraordinarily important area and getting it right is what this is all about. So from the seat of my pants and couple of minutes before running up to the Hill I'm not going to try to tackle risk adjustment science. But getting it right is hugely important. Matt Caison and some of our finance democratic staff here know more about risk adjustment then I possibly know having tried to get on top of this since my days as a Grey Panther, so that's number one.

Number two the point is to give the patient the choice of having a plan that is more tailored to them. I think your last point was rolling back the benefits. I'm not going to support anything, anything that rolls back defined benefits. The question is can the patient have the choice of coming up with something that is more tailored to their needs and that's what -- you know probably other than Minnesota, Oregon has the second highest level of MA in the country, Medicare Advantage. And the reality is, and you talked about the payments, we've come a long way in this. You can see it in the Finance Committee. So many senators who had questions about MA in the past now have been very supportive. And the reality is when we began, not all MA was created equal. I remember a hearing chaired by Max Bocus and they were talking about some of the problems and people were getting dressed up and pretending to by physicians selling MA and the like, and we had one of these serious discussions. I was a junior, young senator and we had a discussion about MA and everybody was talking all this finance-ese and about how we should consider appropriate disciplinary actions and the like. And I said disciplinary actions; I'm going to talk like a Grey Panther here. Those people ought to be thrown in jail. That's what we ought to do to people who rip off seniors in those early days of MA. So we've come a long way, and I think getting risk adjustment right and ensuring that this is about flexibility that gives the patient and the families the choice to get something that works better for them rather than rolling back benefits is what it's about.

MS. RIVLIN: We can take one more question back here and then we will let the Senator

get back to work.

MR. DONAHUE: Thank you. It's Sean Donahue with Eli Lilly & Company. Congratulations senator. It's a great bill and we're looking forward to it moving forward. Hopefully it will move forward. So often these types of bills that can be transformational are blocked because of the score that accompanies that bill. And CBO's position over the years to not do dynamic scoring and the conversation about the need for prevention benefits, the need for treatment of chronic care, and that the savings that may occur over time are not realized within that budget window. And so I'm wondering how that might play out and I'd be interested in your remarks or comments of your colleagues.

MR. WYDEN: I am somebody who has actually lived it. The Independence at Home program was something that we spent a lot of time on. It has been useful in other parts of American health care. As you know a lot of states have been interested in approaches with Medicaid that involve a bigger role for homecare. So I can only tell you that we said this would be a pilot program, it is a large pilot program and the results are better than we had anticipated, and those of us who are big believers thought it was going to be good. But I think we are also dealing with, and I think mention was made by my seat mate here that you may not make enormous savings overall in every single part of this. And Kavita made mention of the fact there is some investments you have to make. But, you know, my hope is that the bipartisan lineage here is going to allow us to say Democrats and Republicans can come together. We just had big breakthrough on Thursday last on child welfare. Marian Wright Edelman's very conservative think tanks are saying that the bipartisan Child Welfare bill, the Families First proposal is a breakthrough. So your point is a fair one and there have been evenings during my service in public life where I would just go home and be sort of beyond depressed because I would say to myself, "we're never going to be able to thread the needle in terms of the score keepers." But since we have now a special council on how to do it, we're a little bit ahead.

More than anything I want to note, one we so appreciate Brookings giving us a chance to get these ideas out and Mr. Schaeffer's wonderful assistance there, and this is in a very much to-be-continued department. And my one request as you leave, do not let anybody who is running for Congress or running for president off the hook on this chronic illness issue.

Bob made mention in the last line of the Vox story, when you see people asking for your vote

in the fall of 2016, whether they're Democrats or Republicans, I hope you will ask what will you do if we send you to the Congress to work to update the Medicare guarantee. So that was the special reason why I wanted to come and I so admire the, I look around the audience, I recognize a number of people, your commitment to this field.

Liz Jurinka, Taylor Matt, feel free to call them nights and weekends and take all their free time and we'll put this in the to-be-continued department. Thanks everybody.

MS. RIVLIN: Thank you, Senator, and thank you, Leonard, and thank you to all the panelists. This has been a very good moment.

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