

**Physicians' Call with Don Berwick –
The Future of Medicare and Medicaid
October 29, 2010 at 2:30pm EST**

Note: This call was off the record. The notes below are for informational purposes only.

Welcome from Vivek Murthy, President of Doctors for America

Good afternoon, and welcome to our conference call with Dr. Don Berwick, head of the Center for Medicare and Medicaid Services. My name is Vivek Murthy, and I am the President and Co-founder of Doctors for America. I am also an internal medicine hospitalist at Brigham and Women's Hospital in Boston. I would like to thank the organizations that have joined Doctors for America to co-sponsor this call:

- American College of Physicians,
- American Medical Women's Association
- American College of Cardiology
- Society for General Internal Medicine
- Committee of Interns and Residents

I would especially like to thank all of you for taking time away from your clinics and hospitals to be here. Your joining the call today is particularly timely given that this is a unique moment in history for our profession. For decades, everyday physicians have felt disconnected from major health care decision and decision makers. It was in direct response to this that we created Doctors for America - with the simple belief that the experience of practicing doctors can and should shape our efforts to rebuild our health care system.

In the last 2 years in particular, the organizations sponsoring this call joined together to give physician and medical students an unprecedented voice in the health reform debate. Our hope is that you will continue to be a part of this physician movement to create a better health care system for the country by participating in calls like this and by joining our future advocacy campaigns.

As we look forward to the monumental task of implementation, we are very fortunate to have Dr. Berwick with us who, along with Health and Human Services Secretary Kathleen Sebelius, will be overseeing much of the implementation effort.

Donald M. Berwick, M.D., M.P.P., is the Administrator for the Centers for Medicare and Medicaid Services (CMS). As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Together, these programs provide care to nearly one in three Americans.

Before assuming leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He also is a pediatrician, adjunct staff in the Department of Medicine at Boston's Children's Hospital and a consultant in pediatrics at Massachusetts General Hospital.

Dr. Berwick has served as Chair of the National Advisory Council of the Agency for Healthcare Research and Quality, and as an elected member of the Institute of Medicine (IOM). He also served on the IOM's

governing Council from 2002 to 2007. In 1997 and 1998, he was appointed by President Clinton to serve on the Advisory Commission on Consumer Protection and Quality in the Healthcare Industry.

Also joining the call today is Mr. Jon Blum, Deputy Administrator and Director of the Center for Medicare. We will have remarks from Dr. Berwick and Mr. Blum for about 15 minutes and then will open up the call to questions.

INTRODUCTORY REMARKS

Don Berwick

It's my pleasure, thank you so much. I apologize for the late start. We had a fire alarm in the building. John Blum is with me and will help with commentary and questions.

We have a tremendous opportunity to help health care improve in all the dimensions that doctors and nurses care about. That won't happen without the leadership of people on this call. Those on this call who want to move forward on cost control, quality improvement, etc are absolutely essential.

I'm excited to be here in CMS [Centers for Medicare and Medicaid Services]. I've learned a lot from people like John Blum who have been here for a while. Great place to work, great opportunity with the new ACA [Affordable Care Act] and new resources it brings to us. Important for newly covered Americans (32 million), people with preexisting conditions, people who need the subsidies. Lots of tools and levers to help physicians and families work on chronic illness. Works with prior legislation like IT legislation in the stimulus bill. This is historic.

In CMS, reform is helping CMS do what it always wanted to do – be a partner in improving health for all Americans. Help the whole system change in full partnership with clinicians. Within CMS, I've been insistent (and have met with little resistance) that the nature of success is the triple aim:

- 1) Better care (IHI's report – “Cross the Quality Chasm” – safe, effective, patient-centered, equitable, timely care),
- 2) Better health (CMS as a better partner/support to mitigate conditions that lead people to get ill – behavioral risk factors, nutrition, exercise, hazards, violence, disparities, things we can mitigate)
- 3) Social necessity to do that while lowering cost without harming a single hair on a patient's head
We can do it if we do it together, particularly physicians involved in and leading that. CMS needs to be authentic in that pursuit.

Within CMS, hold ourselves to account for whether we are providing timely, efficient, etc care. We're working with other federal agencies on specific causes (peri-natal, cardiovascular). Help the system focus on value and results for patients – all investments put into improving health, not wasting time and energy (including that of doctors).

ACA is a trampoline for doing that. I'm interested in forging partnerships with other elements in the health care system, especially physicians and nurses.

John Blum

We settle the payment rules and payment plans for Medicare fee for service and private part D as well. ACA directs CMS to think differently about quality and value. This work is largely new to CMS. We will need help, advice, comments, and considerations. We urge and encourage comments, suggestions. Your help is vital.

QUESTIONS

Jack Lewin (Washington, DC): The good news in US health care is that improving quality is the best way to lower cost. Over the next 1-2 years, how can physicians best work with CMS beginning even in 2011 even before the new payment models are in place?

Don Berwick: So many ways for physicians to be helpful. My confidence in our ability to improve quality depends on physicians. To work on that without physicians is to have unforeseen side effects. American College of Cardiology's focus project is imaging. When the cardiology world has opinions, I feel much more comfortable using that guidance. There are intentions in the ACA around integration of care esp. with people with chronic illness – even now, physicians can look at the ways we work together across specialties, with hospitals – incentives not yet aligned, but you can start working that way now. ACA and private sector innovations.

The best ideas for improvement will come from the physician community. Lots of creativity possible.

John Blum: Lots of different routes for CMS to improve quality. Fee for service is only one mechanism. Lots of freedom with private plans within Medicare and Medicaid. There are 8 clinical models. People here are good at promoting that.

John Haresh (Kitty Hawk, NC): “Small practices are vital to primary care in many areas. Small Ideal Medical Practices have been shown to outperform usual primary in quality and cost. Yet, most quality initiative pilots and recognitions require the resources of very large organizations. How will CMS support these critical, flexible, high-quality small practices?”

John Blum: We're working hard to help organizations enter ACO's [accountable care organizations] to achieve quality measures and achieve shared savings. We are going into the rule with the mindset that the ACO program needs to encourage hospitals, group practices, and small practices working together. Flexible models to accommodate different kinds of organizations – different models, different sizes. Recognize that there are different models of different places.

Don Berwick: Variety, coordinated care, ACO, bundled payments, patient centered medical home. There are opportunities for physicians and organizations to help patients through time and space. We are constantly thinking about how we can help rural physicians/hospitals participate, too. Large group/hospital is different from small. Want to make space for as many as we can. We are in partnership with the ARRA and HIT and ONC [Office of the National Coordinator for Health Information] and helping.

The new innovation center is in the final stages of design. Within the next 1-2 months, we will have a federal registry notice. I'm guiding leadership there to make sure innovation is available even to smallest practices.

Leonie Hayworth (Boston, Massachusetts): "We have been hearing a lot about primary care reform, and as a primary care physician, this is exciting. However, less hopeful are the numbers of medical school graduates choosing to pursue primary care over other higher paid specialties. How will fewer and fewer PCPs cover a growing body of insured people? I am curious to hear your thoughts on what incentives you think are important to attract graduates into primary care, and to keep PCPs happy in their field."

Don Berwick: need to invest in a more robust reservoir of PCP's and other practitioners. ACA has expanded support to primary care. HRSA working to make primary care more attractive. Payment plays a role. My daughter is training in primary care in Boston –a firsthand view of what kind of environment she needs to thrive.

John Blum: We'll issue final payment rules soon to implement ACA provisions. Bonus payments for 5 yrs for primary care with certain rules. Reform payment for graduate medical education to shift more slots into primary care, geriatric care training.

David Kibbe: My question has to do with what Paul Ellwood called "a patient-understood language of outcomes." Most of our quality reporting is about doctor and health provider organization performance in terms that only they understand. How can we more directly measure the experiences of our patients, and incorporate that knowledge into Medicare?

Don Berwick: Good news is that we've had 2 decades of better and better measurements. Can incorporate into hospital systems and payment. NQF (National Quality Forum) is a very important asset in vetting measurements.

Patient-understood measures is the next wave. Providers understand rationalizing payment. One of the most important is that the measures come from the patient. Want to encourage best practices from physician offices to ACO's to hospitals – listen carefully to patients, their families, and communities as we write new rules on PCMH, etc. Experience, functional status, satisfaction. Patient-centered health care system is the way to go. Need the meaningful measures.

Followup Q: How does CMS plan to include everyday practicing physicians in developing meaningful measures?

Don Berwick: We don't work alone here. Organizations around the country have depth and skill in measurement. We have that in CMS internally. NQF, JCO, specialty societies themselves: the measurement development process is very sensitive to the physician community. I myself before taking this position was involved with the NQF.

Mark Wallingford (Maysville, KY): "Why are physicians facing potential cuts in Medicare reimbursement when hospitals do not face these same cuts? Reimbursement for diagnostic Doctors' Call with Dr. Don Berwick: The Future of Medicare and Medicaid (10/29/10). Page 4 of 5

procedures in hospital facilities are not scrutinized yet physician owned diagnostic centers which typically are cheaper, more efficient, and geared toward outpatient practice to facilitate physician practices are scrutinized heavily. Emergency rooms are not held accountable for cost effective care, yet physician practices are held accountable?"

John Blum: Significant changes for certain physician services. We are changing payments as required by ACA. Physicians, hospitals, everyone. All parts of the system are being changed. At the same time, we are also putting in place reimbursement for care coordination for ACO's that will help balance it out. Goal is to use the most current and accurate data to pay as accurately as possible. I know the changes to physician payments last year, there was a concern of shifting payment to higher cost settings. Always open to looking at the data.

Dave Gilmour (Central Point, OR): Thanks to Senator Wyden, states can still apply for a federal waiver for public option. Do you support that?

Don Berwick: Support states being allowed to do what is best designed by each state.

Kevin Egly (Sandwich, IL): I have been practicing in a small town in Illinois along with my wife, both internists. We have used an EHR eMDs since 2004 to provide comprehensive services from scheduling, patient visits, health reminders, and electronic billing. We have kept our overhead low to provide more time with each patient and help them achieve better health.

Please help me identify ways that I may continue to improve this experience for my patients. Introduce me to the concepts of how I might reduce hospital and pharmaceutical costs further for my patients through meaningful use and ACO's.

My concern is that these entities already control so much of the healthcare dollar that I will have no influence and be but a pawn in the future of healthcare.

Don Berwick: I commend you on being so progressive going through the modernization. That kind of innovation at the local level will lead us to the health care system we need. Technology (ONC) with improvement of care, electronic health records – adolescent stage, will continue to find better ways to use tech to best advantage.

In this period of change, it's awkward. Anxieties everywhere. I've heard a lot from physicians about concerns over the power that hospitals or pharma have in the world. Large entities in the face of a small physician groups. We're going to have to find our way to the answer.

Important that we are interested in variety. ACO's could even be physician led. We hope every stakeholder that is interested in the triple aim can participate. I feel confident we can create that space.

Closing

Thank you on behalf of everyone. We are looking forward to working with both of you and the other leaders in CMS.